

# Chapter 1

## Introduction to CAPCE

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### Square of Care: Process of Providing Care

Common Issues ↓	Assessment	Information – Sharing	Decision- Making	Care Planning	Care Delivery	Confirmation
Disease Management						
Physical						
Psychological						
Social						
Spiritual						
Practical						
End-of-life/ Death Management						
Loss, Grief						

The CAPCE program is based on foundational concepts from *A Model to Guide Hospice Palliative Care; Based on National Principles and Norms of Practice*. (Ferris et al., 2002).

## Introduction

The Comprehensive Advanced Palliative Care Education (CAPCE) initiative is designed to align with the Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice (CHPCA 2002) and supports the outcomes of the Palliative Care stakeholder planning day November 27, 2002. CAPCE is sponsored by the Ministry of Health and Long-Term Care through the Palliative Care Initiatives of Ontario.

## Framework for Development of Hospice Palliative Care Expertise

The chart in Appendix A describes the settings, qualifications and role expectations of health care providers practising as:

- Primary Formal Caregivers
- Resource Professionals
- Secondary Consultants / Educators
- Tertiary Consultants / Educators.

The framework also identifies the education opportunities available to care providers involved in the delivery of hospice palliative care. This framework has been adapted from the Canadian Hospice Palliative Care Association “A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice”. The March 2002 document outlines the roles of providers involved in delivery of hospice palliative care and was produced after 10 years of collaboration and consensus building. (Please visit website: [www.chpca.net/home.htm](http://www.chpca.net/home.htm))

The current initiative provides for hospice palliative care education programs in every county and supports the development of education opportunities aimed at the Primary Formal Caregiver level of expertise. As in all healthcare situations, when these primary providers encounter care issues and situations beyond their level of confidence and expertise, they must be able to seek help and support from practitioners with greater knowledge and expertise.

## The CAPCE Program

To enhance expertise in the southwest, the Comprehensive Advanced Palliative Care Education (CAPCE) program for nurses was developed and launched in 2003. This CAPCE Program focuses on the development of Hospice Palliative Care Resource Professionals in facilities, agencies and communities throughout the Southwest.

## Local Expertise

Local professionals with expertise in Hospice Palliative Care assist with the facilitation of the local components of the CAPCE Program. Delivery of the majority of the components of this program at the local level will meet the needs identified by our stakeholders for education close to home. Incorporating a mentorship role into the program will promote transfer of knowledge and skill to practice at the bedside and assist individuals and organizations in their aspirations to deliver exemplary Hospice Palliative Care.

## Funding

The Ministry of Health and Long-Term Care Palliative Care Education Initiative funding in the Southwest is directed at the Primary Formal Caregiver and Resource Professional Levels of Expertise with the expectation that new knowledge and skill will be transferred to practice and applied at the bedside.

## The Hospice Palliative Care Resource Professional

The Hospice Palliative Care Resource Professional is any professional health care provider:

- With advanced level hospice palliative care education and skill
- Who is a member of an agency/long term care home/acute care hospital palliative care team or has been designated as a hospice palliative care resource professional within the agency/long term care home/acute care organization

Expectations of the Hospice Palliative Care Resource Professional include:

- Demonstrate proficiency in core concepts
- Promote and champion hospice palliative care within the role and work setting
- Assist in identifying local hospice palliative care issues
- Contribute to local problem solving
- Advocate for best possible care for the person and his/her family

Education opportunities available for a Hospice Palliative Care Resource Professional:

- Comprehensive Advanced Palliative Care Education (CAPCE) for nurses acting as hospice palliative care resource professionals in an agency/LTC Home/acute care.
- Canadian Association of Pastoral Practice and Education for individuals acting as hospice palliative care resource persons in pastoral care.
- Ian Anderson Continuing Education Program in End-of-Life Care for physicians acting as hospice palliative care resource physicians within the community/LTC Home.

### **The CAPCE Textbook – 4th Edition**

Winter 2006 saw a thorough revision of the 2005 CAPCE Resource Guide in order to further align with the Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice (CHPCA 2002). The revised textbook is designed as follows:

#### Section 1: Introduction to Comprehensive Advanced Palliative Care Education

- This section provides an overview of the CAPCE program, introduces the concept of the person and family as the centre of care, and describes the three foundational concepts of hospice palliative care.

#### Section 2: The Core Essentials

- Section 2 provides an introduction to the “core essentials” or foundation on which the domains of care and therapeutic encounter will build. These core essentials include: Communication, Culture, Conflict Resolution, and Ethics and Law.

#### Section 3: Domains of Care in the Context of the Therapeutic Encounter

- Section 3 provides a comprehensive look at each domain of care (see the square of care on the first page of this chapter) examined in the context of the therapeutic encounter which includes assessment, information sharing, decision-making, care planning, care delivery, and care confirmation.

## CAPCE Performance Objectives

Following active participation in all modules, completion of on-the-job assignments, mentoring, and seven months experience, the learner will serve in the capacity as a Resource Professional (see page 4) practising as a competent hospice palliative care clinician and supporting the development of skills among his or her peers. She or he will demonstrate an understanding of the essential and basic steps of a therapeutic encounter and be able to:

1. Utilize **screening questions and tools** to identify active (unresolved or new) and potential issues in the domains associated with illness and bereavement including; disease management, physical, psychological, social, spiritual, practical, end-of-life care /death management, loss and grief.
2. Complete an **assessment** to the extent she/he:
  - a) Gathers detailed information about each identified issue including the status, potential cause, associated expectations, needs, hopes and fears
  - b) Utilizes appropriate assessment tools and scales in data collection related to the issues identified
  - c) Includes information gleaned from physical examination and results of laboratory and radiology procedures being aware that only techniques with the potential to provide beneficial information without undue risk or burden are appropriate
  - d) Determines the perceived benefits and burdens of any previous therapeutic interventions
  - e) Notes any adverse reactions and allergies
  - f) Determines difficulties adhering to therapeutic regimens
3. **Share information** to the extent she/he:
  - a) Determines, documents and respects confidentiality limits defined by the person\*
  - b) Determines what the person and the informal caregivers already know
  - c) Assesses and documents the desire and readiness for information
  - d) Develops a process and documents a plan for sharing information in a timely manner, in a setting where privacy can be ensured and in a language and manner understandable and acceptable to the person and his or her family
  - e) Determines and documents the need for translation
  - f) Observes and documents the physical and emotional reaction to information provided
  - g) Assesses understanding of information shared and its implications by requesting feedback
  - h) Determines and documents the desire for additional information

\* the use of "person" refers to patient, resident or client

4. Assists in the **decision-making** process to the extent she/he:
- a) Demonstrates through documentation that the components of consent, disclosure, capacity, and voluntariness have been met whenever consent to a treatment or a plan of care is sought.
  - b) Assesses and documents decision-making capacity regularly and in particular when cognitive ability is questionable.
  - c) Determines and documents the legal substitute decision-maker and demonstrates knowledge of surrogate decision-making legislation and regulations.
  - d) Determines who the person wants to include in the information sharing and decision making process
  - e) Determines and documents the existence of previously expressed wishes (written or verbal) and encourages discussion related to advance care planning between the person, his or her substitute decision maker, family and other members of the health care team
  - f) Discusses current wishes and clarifies the person's and/or family's goals for care on a regular basis
  - g) Collaborates with the person and/or family to prioritize the importance of each of the identified issues
  - h) Offers and explains therapeutic options to modify the disease, relieve suffering and improve quality of life outlining risks as well as benefits and burdens
  - i) Assists the person and/or family to select treatment priorities from the options offered and obtains consent to treatment / plan of care
  - j) Discusses and documents requests for:
    - withholding, withdrawing therapy
    - therapy with no potential for benefit
    - hastened death, euthanasia or assisted suicide
  - g) Develops a plan for conflict resolution when indicated
5. Engages in **care planning** to the extent that she/he:
- a) Determines and documents wishes related to preferred setting of care
  - b) Develops a process to negotiate and determine a plan of care that:
    - Addresses issues and opportunities and delivers chosen therapies
    - Includes a plan for:
      1. Care of dependents
      2. Backup coverage
      3. Respite care
      4. Emergencies
      5. Discharge planning
      6. Bereavement care
  - c) Regularly reviews and adjusts the plan of care throughout the illness trajectory to compensate for changes in the person's and/or the family's status, needs and choices

6. Engages in **care delivery** to the extent that she/he:
  - a) Assesses the learning aspirations and needs of formal and informal care team members relative to skill sets required to deliver the chosen therapeutic options
  - b) Documents that care is aimed at meeting the goals of the person and that the person, family and extended support network are at the heart of the team.
  - c) Identifies team members who will provide leadership, coordination, facilitation and support; a particularly important process when potential conflict is identified
  - d) Organizes learning strategies to meet the aspirations and needs of caregivers enabling them to be competent and confident in providing care
  - e) Identifies community resources including secondary level hospice palliative care consultants and demonstrates knowledge of how to access services
  - f) Develops a written plan of care
  - g) Ensures that mechanisms are in place to communicate the plan of care and information among all caregivers and across all settings of care
  - h) Regularly reviews care delivery and adjusts approaches to compensate for changes in the person's and his or her family's status and choices
  
7. **Confirms** understanding and satisfaction of the treatment plan to the extent that she/he:
  - a) Documents the person's and his or her family's understanding of the disease process and the expected course of the illness
  - b) Documents the level of satisfaction in relation to the plan of care and the delivery of care
  - c) Determines the perceived complexity of the treatment regime and documents concerns, questions and issues raised
  - d) Determines and documents the expressed level of stress
  - e) Determines and documents the ability of formal and informal care providers to participate in the plan of care
  - f) Documents the effects of therapeutic interventions and advocates for further intervention when goals and expectations are not met
  
8. Serves as a **Resource Professional** sharing knowledge by engaging in the following activities:
  - a) Identifies gaps in care delivery both at the bedside and within the organization and considers strategies in response to identified gaps and needs
  - b) Communicates organizational gaps and issues and possible problem solving strategies to management in an effort to enhance delivery of hospice palliative care within the organization
  - c) Collaborates with peers in problem solving and development of an individualized plan of care that responds to the identified needs of the person / family
  - d) Champions hospice palliative care within the organization
  - e) Advocates for improved delivery of hospice palliative care services within the
  - f) organization

**Appendix A: Framework for the Development of Hospice Palliative Care Expertise**

Palliative Care Expertise	Expectations	Relevant Education Opportunities
<p style="text-align: center;"><b>Primary Formal Caregivers</b></p> <p style="text-align: center;">↓</p> <p>Front line staff / volunteers with some knowledge of hospice palliative care.</p> <p>E.g. physician, nurse, volunteer, social worker, pharmacy, clergy, etc.</p> <p><b>Qualifications:</b> Fundamentals or equivalency recommended</p>	<p>Manage disease Identify Issues Provide core competencies Advocate for patient and family</p>	<p>The Fundamentals of Hospice Palliative Care Palliative Pain and Symptom Management for Nurses Advanced Palliative Care Course for Support Workers Conferences and In-services Discipline Specific Sessions Other</p>
<p style="text-align: center;"><b>Resource Professionals</b></p> <p style="text-align: center;">↓</p> <p>All settings E.g. physician, nurse, social worker, pharmacy, clergy, etc.</p> <p><b>Qualifications:</b> Advanced level hospice palliative care knowledge and skill; member of an acute care hospital palliative program/long term care home/agency or has been designated as a hospice palliative care resource professional within the organization.</p>	<p>Demonstrate proficiency in core concepts Promote and champion hospice palliative care within their role and work setting Assist mentors and peers in identifying issues and problem solving Advocate for best possible care for patients and families</p>	<p>Comprehensive Advanced Palliative Care Education (<b>CAPCE</b>) Ian Anderson Continuing Education Program in End-of-Life Care Canadian Association of Pastoral Practice and Education Other</p>
<p style="text-align: center;"><b>Secondary Consultants/ Educators</b></p> <p style="text-align: center;">↓</p> <p><b>District:</b> Experienced members of a designated hospice palliative care team / unit / program employed on a full time or part time basis in palliative care and associated with a secondary or tertiary level facility. Regional Palliative Pain and Symptom Consultants / Educators</p> <p><b>Qualifications:</b> Discipline specific certification in hospice palliative care or equivalency in knowledge, skill and experience.</p> <p><b>Minimum requirement:</b> Comprehensive Advanced Palliative Care Education (<b>CAPCE</b>) for nurses or discipline specific Ian Anderson Program in End-of-Life Care modules</p> <p><b>Regional:</b> Experienced member of a designated hospice palliative care team / unit / program in a large urban centre employed exclusively or primarily in Palliative Care.</p> <p><b>Qualifications:</b> Discipline specific certification in Hospice Palliative Care or equivalency in knowledge, skill and experience.</p>	<p><b>District:</b> Support formal primary providers and resource professionals in all settings Consult on difficult to manage cases Educate primary providers and resource professionals Advocate at district and regional program development level</p> <p><b>Regional:</b> Support secondary consultants and educators working at the district level Advocate at district and regional program development level</p>	<p>Comprehensive Advanced Palliative Care Education (<b>CAPCE</b>) RNAO Advanced Practice Nurse Fellowship in Palliative Care Physician Fellowship Canadian Association of Pastoral Practice and Education Supervisory Level CHPCN (C) Other</p>
<p style="text-align: center;"><b>Tertiary Care Consultants/Educators</b></p> <p style="text-align: center;">↓</p> <p>Expert practitioners and researchers in hospice palliative care with teaching responsibilities in a university.</p>	<p>Consult on difficult to manage cases Educate and train secondary and tertiary experts and develop advocacy strategies Design and conduct research</p>	