

Implementing a Palliative Approach to Care in Long Term Care:

An Implementation Guide and Resource Toolkit that aligns with the expanded Palliative Approach to Care requirements within the Fixing Long-Term Care Act, 2021 (FLTCA)

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Developed in collaboration by:

Ontario Health West Region Palliative Care Network

Palliative Pain and Symptom Management Consultants (West Region)

The Ontario Centres for Learning, Research and Innovation in Long-Term Care (CLRI)

The Strengthening a Palliative Approach in Long-term Care (SPA-LTC) team

Prevention of Error-based Transfers (POET) Project Team

**Content is adapted and adopted from the legacy Toronto Central LHIN's implementation guide (2018)*

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PURPOSE OF DOCUMENT:

As of April 11, 2022, the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 expand Palliative Care requirements from the previous *Long-Term Care Homes Act, 2007* (LTCHA).

The Palliative Approach to Care requirements under the FLTCA and its regulation reflect a shift in practice towards a broader, more inclusive and holistic approach to Palliative Care.

The purpose of this resource guide is to support a consistent and standardized approach to Implementing a Palliative Approach to care in Long Term Care that is in alignment with the Palliative Approach to Care requirements within the 'Fixing Long Term Care Act, 2021 (FLTCA)', within a geographical focus of the West Region of Ontario Health.

The palliative approach to care requirements under the FLTCA and O. Reg 246/22:

The FLTCA and its regulation expand a palliative approach to care requirements from the previous LTCHA.

1. The FLTCA adds a new right to the Residents' Bill of Rights that states that it is the right of every resident to be provided with care and services based on a ***palliative approach to care***.
2. The FLTCA also requires that every Licensee ensure that a resident's plan of care covers all aspects of care, including a ***palliative approach to care*** and that a resident is provided with care or services that integrate a palliative approach to care philosophy. Its regulation requires a Licensee to ensure that an interdisciplinary assessment of the resident's palliative care needs for their plan of care considers a resident's physical, emotional, psychological, social, cultural, and spiritual needs. Based on the assessment, a Licensee must ensure that an explanation of the palliative care options that are available to the resident is provided to the resident, the resident's substitute decision-maker, if any, and any other person or persons designated by the resident or their substitute decision-maker. These options must include, at a minimum, Quality of Life improvements, symptom management, psychosocial support, and end-of-Life care, if appropriate.
3. Before taking any action to assess a resident's needs, or provide care or provide services to a resident, a Licensee shall ensure the resident's ***consent*** is received.
4. A Licensee must comply with the requirements for programs respecting palliative care and the palliative care philosophy within six months after the coming into force of the applicable section of the regulation under the FLTCA.
5. In addition to the above, the regulation under the FLTCA updates palliative care training and removes the training exemption that was applicable under the LTCHA for persons such as medical directors and physicians.

This resource repository provides comprehensive, credible and relevant resources that can be utilized to build capacity at the regional, local, organizational and individual level.

Health Quality Ontario's, Palliative Care Standard Quality Statements are embedded throughout this document. Doing so assists Long-Term Care Homes (LTCHs) who may have Palliative Care as part of their Quality Improvement Plan (QIP).

WHO CAN USE THIS IMPLEMENTATION GUIDE AND TOOLKIT?

This resource repository was developed to be used by Long Term Care Home sector staff, organizations and providers; however, there may be information that is also valuable to individuals and volunteers.

LIMITATIONS OF THE DOCUMENT:

This is a **'living'** document that will be and can be updated regularly based on feedback received from end users. Please note, that the content is not peer reviewed and not to be utilized as a best practice style document, rather, it's intention is to assist LTCH staff in their ability to meet the required legislation changes and connect with local Subject Matter Experts for ongoing support.

HOW TO USE THIS DOCUMENT:

The document is divided into 3 sections, each section starts with content related to the section's theme, followed by a comprehensive list of resources, including hyperlinks. We suggest working closely with your local Subject Matter Experts that can assist in your utilization of this resource.

DEFINITIONS AND ABBREVIATIONS (used within this document)

Term	Abbreviation	Definition
Advance care planning	ACP	The purpose of ACP is to prepare people and their SDM(s) for decision-making in the future. While ACP can be for healthy people, it gets more and more important as people develop serious and progressive illness.
Goals of care conversations	GoC	Goals of care discussions are discussions in the context of a current illness about a person's values & goals leading up to a treatment or care decision. GoC conversations, aim is to align available treatment options with a person's goals.
Capacity		An individual is considered capable of consenting to a treatment if the individual is able to understand the information that is relevant to the decision, and appreciate the reasonably foreseeable consequences of a decision or lack of decision.
Health care consent	HCC	A health care provider is required to get informed consent from a capable person prior to a medical investigation or treatment. The health care provider must convey detailed information about the investigation/treatment as well as the benefits/risks before consent can be provided (written or verbal).
Substitute decision maker	SDM	An individual who makes health care decisions on behalf of an individual who is not capable of making decisions for themselves. The substitute decision maker is determined by a hierarchy in the Health Care Consent Act in Ontario law.
Power of attorney (for personal care)	POA	The person named in a "Power of Attorney for Personal Care" document that has provisions for health care. This individual has legal authority to make decisions on care for an incapable individual.
Individual (Resident) care conference or Family care conference	RCC FCC	Meetings held with an individual (if capable), family members, SDM/POA (if an individual is not capable) to discuss an individual's condition, to understand an individual's wishes and to develop a plan of care.
Comfort care rounds	CCR	A LTCH wide forum for staff and volunteers to discuss and reflect on deteriorating individuals, dying individuals or those who have recently died.
End-of-life	EoL	An Individual who is in their last hours to days of life.
Quality Improvement Plan	QIP	A Quality Improvement Plan is a public commitment to meet quality improvement goals.

SECTION 1: KEY CONCEPTS IN A PALLIATIVE APPROACH TO CARE

Note: This section covers 1, 2 and 3 of the Palliative Care Requirements (refer to pg. 3 above) within the FLTCA (2021):

INTRODUCTION

Increasingly over the last decade, individuals whom reside in long term care (LTC) homes have been found to have later stages of progressive illnesses with more complex and unstable health care needs. Nine out of 10 individuals have some form of cognitive impairment (Canadian Institute for Health Information 2016).

Research has shown a positive impact when a *palliative approach to care* is introduced early (Zimmermann, 2014). This approach begins from the time the individual is first diagnosed with a life-limiting illness. Earlier conversations about preferences for care have been associated with improved individual and caregiver satisfaction with communication and decision-making.

The following information is broken down into 4 components:

- A. What is a Palliative Approach to Care?
- B. The Palliative Approach to Care in LTC homes.
- C. Advance Care Planning and Goals of Care Conversations
- D. Consent, Capacity and Substitute Decision Makers.

A. WHAT IS A PALLIATIVE APPROACH TO CARE?

A palliative approach to care is a focus on care that improves the **quality of life** of an individual who has a diagnosis of a life-limiting illness. It includes, but is not limited to, end-of-life care; see Figure 1.1 and Figure 1.2, which show the growing role for a palliative approach to care across the illness trajectory. A palliative approach to care:

- Offers a support system to help an individual live as actively as possible until death.
- Provides relief from pain and other distressing symptoms.
- Treats all active issues while preventing new issues from occurring.
- Includes investigations to characterize and manage distressing clinical complications.
- Helps the individual and their family prepare for and manage end-of-life choices and the dying process.
- Uses a team approach to address the needs of an individual and their family.
- Helps the family cope with loss and grief.
- Is applicable early in the course of illness in conjunction with other therapies that are intended to prolong life.

(World Health Organization, 2017)

Palliative Care-Enhanced Model

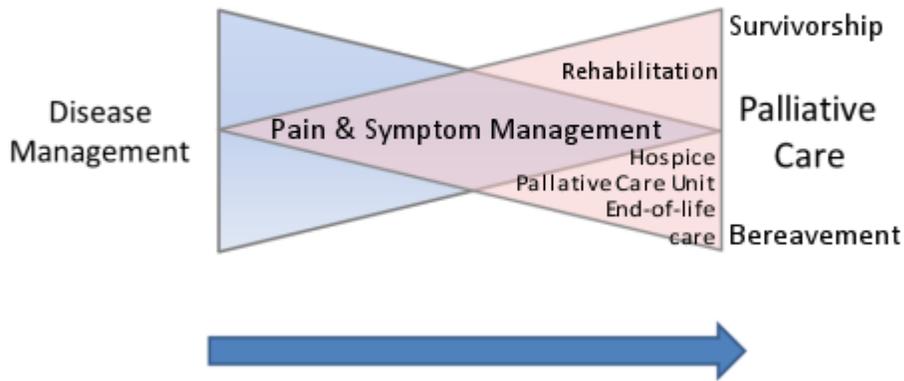


Figure 1.1: The Bow Tie Model of 21st Century Palliative Care, Dr. Pippa Hawley ([Canadian Virtual Hospice](#))

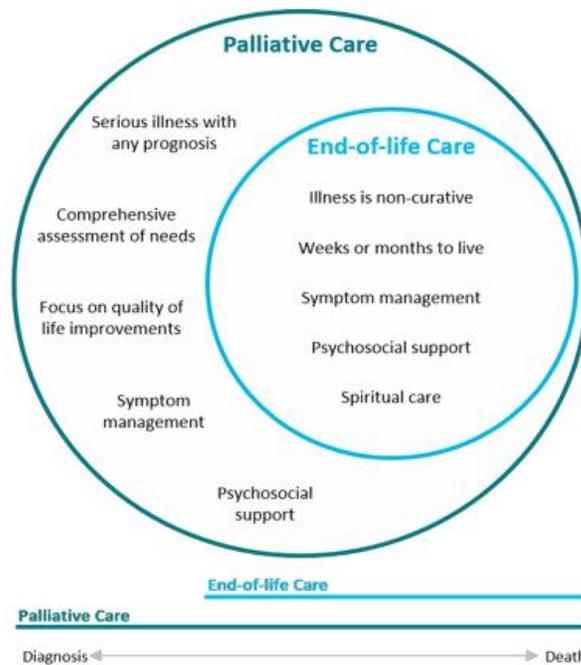


Figure 1.2: A shift in practice, A Palliative Approach to Care includes End of Life Care ([Ontario Provincial Framework for Palliative Care](#)).

Instead of focusing solely on End-of-life care, the definition of a palliative approach to care reflects the needed shift in practice towards a broader, more holistic approach that includes, but is not limited to, early identification of an individual who would benefit from a palliative approach to their care by encouraging earlier conversations about values and wishes to help prepare for end of life decision-making and end of life care.

Holistic and comprehensive assessments assist in determining the care and services an individual may need, this approach considers an individual's physical, psychological, social, linguistic, cultural, ethical and spiritual needs across the living-dying illness trajectory.

Canadian statistics show that 72% of deaths annually result from chronic life-limiting conditions such as organ failure, cancer, dementia, and frailty. Of these deaths, only a small portion will have access to palliative care services. Therefore, a palliative approach to care that is integrated across all care settings is essential to ensuring improved quality of life and end-of-life care.

B. THE PALLIATIVE APPROACH TO CARE IN LTC HOMES

Within a long-term care home, a palliative approach to care is **patient-centered** care that aims to relieve suffering and improve the quality of life for an individual and their family. A plan of care that has a palliative approach would address the physical, psychological, social, cultural, spiritual and practical issues of both the individual and family; it continues to provide support to the family into bereavement. A Palliative approach to care does not include 'deeming' an individual palliative or a medical order for Palliative Care, rather it is an approach to care that

There are 3 phases of a palliative approach to care in LTC (see Figure 1.3):

1. **Communicating about a palliative approach to care** focuses on early understanding of an individual's values, preferences for care that inform goals of care decisions via ongoing communication with the individual and their family as well as holistic care.
2. **Specialized palliative care services to manage declining health** is in place where LTC home staff can seek advice and support from palliative care specialists (e.g., nurses, physicians, others) and partners to manage complex issues related to an individual's deteriorating health. Palliative care specialist teams will not take over the care of the individual but will provide expert knowledge and advice on complex issues.
3. **End-of-life care** is appropriate when an individual is in the final days or weeks of life. Care decisions are reviewed more frequently and the focus is on the individual's immediate physical comfort as well as their emotional, social and spiritual needs and supporting the family.



Figure 1.3: 3 phases of a palliative approach to care in LTC

C. ADVANCE CARE PLANNING & GOALS OF CARE CONVERSATIONS

The purpose of advance care planning (ACP) is to describe an individual's wishes for future care, in case an occasion arises when they are not mentally capable to make these decisions themselves. ACP also involves clarification of the individual's substitute decision maker(s) (SDM(s)) and whether or not a Power of Attorney (POA) needs to be put in place (see Section 1D on SDM). Through the process of talking about wishes, values and beliefs with an individual, the SDM/POA is to be prepared for a future time when they may be called upon to make treatment decisions on an individual's behalf.

HQO Palliative Care Quality Statement

Advance care planning – Substitute Decision-Maker

People with a progressive, life-limiting illness know who their future decision-maker is. They engage in ongoing communication with their substitute decision-maker about their wishes, values, and beliefs so that the substitute decision-maker is empowered to participate in the health care consent process if required.

Statement #3 from
Palliative Care: Care for Adults with a Progressive, Life-Limiting Illness

Health Quality Ontario 2018

It is hoped that all individuals will have had these conversations with their SDM/POA before moving into a LTC home. Upon admission into a LTCH, there needs to be a shift in current practice, for residents who are capable, the goal is to engage them early in ACP conversations, while they are able to maintain capacity to independently express their own values and wishes for their care.

These conversations are defined as:

- **Goals of care (GoC) discussions** still center on the individual’s wishes and values, but emphasize the consideration of options for more immediate care when an individual is unwell.
- **Health care consent (HCC) or decision-making discussions** are conversations in which health care providers are required to get informed consent from a capable person prior to any care or treatment (or from the SDM/POA for an incapable person). HCC conversations must involve communication about the individual’s condition and all treatment options as well as a refusal of treatment. Once a reasonable summary of the risks, benefits, and possible side effects has been explained, the HCC conversation focuses on a decision regarding a proposed treatment or care plan based on an individual’s current condition.

(Speak Up Ontario,2016)



Figure 1.4: [IMPROVING PERSON-CENTRED CONVERSATIONS](#)

D. CONSENT, CAPACITY AND SUBSTITUTE DECISION MAKERS

Health care providers have a legal and ethical duty to obtain informed consent from an individual:

- Before the start of care or treatment.
- After communication with the individual about the individual's condition, treatment options, and the risks, benefits, side effects, alternatives and what would happen if care were refused.
- On admission to a LTC home, personal assistance services within the home as well as informed decisions about treatments.
- When planning for care, whether the plans include immediate care options or setting goals for future care.
- If they are determined to be mentally capable to make decisions.

(Advocacy Centre for the Elderly, 2016)

DETERMINING CAPACITY

The health practitioner who is proposing the plan of treatment is responsible for determining whether the individual is mentally **capable to give consent**; they do not have to be a capacity assessor. If a plan of treatment is proposed to the individual, one health practitioner may determine the individual's capacity on behalf of all the health practitioners involved in the plan. An individual is considered capable of consenting to a treatment if the individual is able to:

- a) "Understand" the information that is relevant to making this decision about this treatment, and
- b) "Appreciate" the reasonably foreseeable consequences of a decision or lack of decision.

(Ontario's Health Care Consent Act, 1996)

Mental capacity can fluctuate and should be assessed with each new decision (for further information see Section 1 resources). If the individual is determined to be not mentally capable to consent to the particular treatment, then the health practitioner must turn to the individual's SDM/POA, who gives or refuses to give informed consent on behalf of the individual. In an emergency, if the individual is mentally incapable or unable to communicate and a delay would put the individual at risk, health practitioners in this circumstance do not need consent in order to treat but they must follow any known wishes of the individual with respect to treatment.

ROLE OF THE SUBSTITUTE DECISION MAKER

An individual's SDM is defined by a prescribed hierarchy in the Health Care Consent Act in Ontario law (see Figure 1.5 for a summary). If an individual does not want the person outlined in this hierarchy to act as their SDM, then a Power of Attorney for Personal Care with authority for health care (POA) needs to be put in place to support this choice.

Substitute Decision Maker Hierarchy

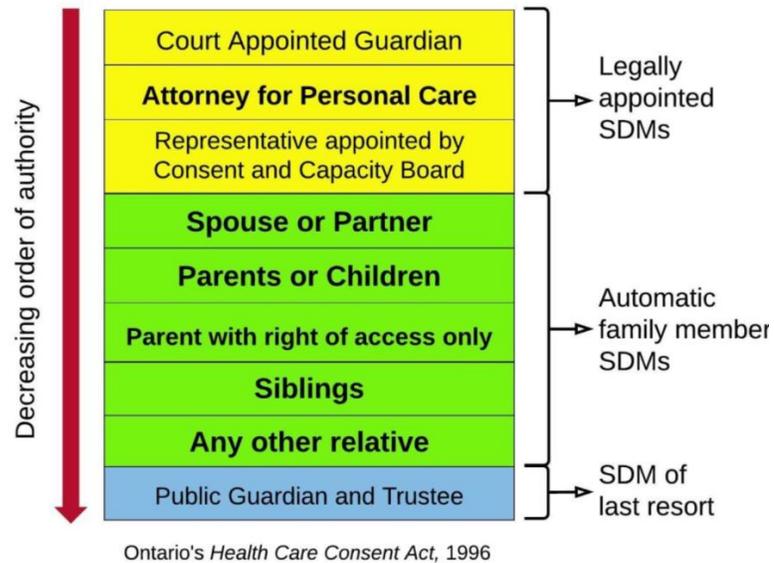


Figure 1.5: From: [A CLINICIAN'S GUIDE TO SUBSTITUTE DECISION MAKING](#)

If the individual is not mentally capable, then their SDM/POA makes treatment decisions based on:

1. **Individual's expressed wishes:** Whether the individual established their wishes before admission to the home via ACP or in a GoC conversation upon admission, this information can guide the SDM/POA to act as the individual would. This information about the individual's preferences for care may have been expressed either in writing or verbally (when the individual was mentally capable).
2. **"Best interests"** of the individual as defined in the *Health Care Consent Act* and including:
 - Values and beliefs that the SDM/POA knows that the incapable individual held and believes that he or she would still act on if they could.
 - Whether treatment is likely to improve the individual's condition or to prevent the condition from deteriorating and whether condition is likely to improve or remain the same without the treatment.
 - Whether there are less restrictive or less intrusive treatment options.
 - If the benefit of the treatment outweighs the risk of harm.

(Advocacy Centre for the Elderly, 2013)

SECTION 1 RESOURCES

Section	Resources
<p>Section 1A:</p> <p>What is a palliative approach to care?</p> <p>Early Identification tools</p>	<ol style="list-style-type: none"> 1. Canadian Hospice Palliative Care Fact sheet: https://www.chpca.ca/about-hpc/ 2. Ontario Palliative Care Network. Key palliative care concepts and terms: https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/KEY_PALLIATIVE_CARE_CONCEPTS_AND_TERMS.pdf 3. Ontario Palliative Care Network, Tools to Support Early Identification for Palliative Care. 4. Gold Standards Framework Early Identification tool, Central Regional Palliative Care Network. 5. Dr. Atul Gawande on Aging, Dying and "Being Mortal" (Video): https://www.youtube.com/watch?v=VRkr09ZMI3w 6. The Model to Guide Hospice Palliative Care
<p>Section 1B:</p> <p>The Palliative Approach to Care in LTC homes</p>	<ol style="list-style-type: none"> 1. Palliative care in LTC (Palliative Alliance): http://www.palliativealliance.ca/assets/files/Module_2_Draft.pdf 2. Shift your care to a palliative approach (iPANEL) video: https://www.youtube.com/watch?v=sABo3gZoAcM&t 3. End of life in LTC facilities (Video): http://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Support/Support/The+Gallery/illness+and+Caregiving/Romayne+Gallagher+End+of+life+in+long+term+care+facilities.aspx
<p>Section 1C:</p> <p>Advance Care Planning and Goals of care Conversations, Person Centered Decision Making</p>	<ol style="list-style-type: none"> 1. HQO Palliative Care Quality Statement #3: http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Palliative-Care/Quality-Statement-3-Advance-Care-Planning-Substitute-Decision-Maker 2. Speak Up Ontario: https://www.advancecareplanning.ca/resource/ontario/ 3. A Clinician's Guide to ACP: https://www.pcdm.ca/acp/clinician-primer 4. Crucial conversations (Virtual Hospice): http://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Support/Support/The+Gallery/Decisions/Romayne+Gallagher+Crucial+conversations.aspx#video_content_details 5. Serious Illness Conversation Guide 6. Serious Illness Conversation Guide training opportunities 7. ACP and dementia: https://www.hindawi.com/journals/nrp/2014/875897/abs/ 8. Nurses' role in Advance Care Planning 9. LTC Advance Care Planning Education Modules

<p>Section 1D: Consent, Capacity and Substitute Decision Makers</p>	<ol style="list-style-type: none">1. College of Nurses of Ontario (2017). Practice Guideline: Consent https://www.cno.org/globalassets/docs/policy/41020_consent.pdf2. A Clinicians Guide to Substitute Decision Making: https://www.pcdm.ca/acp/clinicians-guide-for-substitute-decision-making3. Registered Nurses' Association of Ontario (RNAO) welcomes you to the second edition of the Long-Term Care Best Practices Toolkit: https://ltctoolkit.rnao.ca/
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SECTION 2: MENTORSHIP, EDUCATION & SUPPORT TO BUILD COMPETENCY AND CAPACITY

Note: This section covers how to build competency in providing palliative care through education, mentorship and research project opportunities, doing so will aid in meeting all the Palliative Care Requirements (refer to pg. 3 above) within the FLTCA (2021):

OVERVIEW

This section of the guide focuses on **how to build competency and enhance capacity** that will help to establish a foundation for a comprehensive palliative care program within a LTC home.

This section is divided into 2 categories:

- A. Building Capacity
- B. Connecting with Specialized Palliative Care Services and Providers

A. BUILDING CAPACITY

The importance of providing education and skills training that focuses on a palliative approach to care is paramount for LTC homes. This should be established as a formalized component, integrated into the home's annual education plan. This education plan should also include ad hoc in-house sessions as areas of need are identified.

There are 3 key areas where LTCH's could focus educational efforts:

1. **Ensuring Palliative Care Competency:** education opportunities for staff to enhance their Palliative Care knowledge by completing recommended Palliative Care Education sessions and training opportunities.
 - a. Many LTC staff members already have foundational knowledge of a palliative approach to care including GoC conversations, assessment of a deteriorating individual, End-of-life care, and psychosocial support of individuals and families including loss, grief and bereavement. The goal is to strengthen this knowledge and to build in-house expertise by enhancing competency, allowing teams to be able to have the conversations throughout the person's journey.
2. **Targeted Palliative Care Education:** Have a Champion(s) within the LTCH who's role is to support facility-wide Palliative Care education to all LTCH staff and volunteers, ensure this champion is well connected with the Palliative Pain and Symptom Management Consultants (PPSMCs).
 - a. There are many educational and mentorship programs and individuals that support localized needs-based education for all staff (i.e. pain management education for RN/RPNs or end-of-life education for volunteers), with additional education and support attained from external partners.

3. **Integrate and embed training into orientation:** All new staff and volunteers receive education and training during their orientation that focuses on the Palliative Care Competencies for generalist and specialist level providers (see OPCN Competency Framework in resource section).
- a. LTCH’s should aim to support ongoing palliative care education for staff, volunteers and individuals and families, especially orientation for new employees. The Palliative Care Competency Framework and self-assessment tool can be used to support and guide orientation (see Section 2 references).

HQO Palliative Care Quality Statement

Education for Health Care Providers and Volunteers

People receive palliative care from health care providers and volunteers who possess the appropriate knowledge and skills to deliver high quality palliative care.

Statement #13 from
Palliative Care: Care for Adults with a Progressive, Life-Limiting Illness

PALLIATIVE CARE EDUCATION, MENTORSHIP and RESEARCH OPPORTUNITIES:

The following courses may be helpful for champions and LTCH staff to enhance their palliative care knowledge, build competency and capacity.

Connect with your local PPSMC or Nurse Led Outreach Team (NLOT) for more information about educational and mentorship opportunities

LEAP – Learning Essential Approaches to Palliative Care offered by Pallium Canada	
<ul style="list-style-type: none"> Course for health care professionals providing learners with the essential, basic competencies of the palliative approach to care 	<ul style="list-style-type: none"> Has LTC dedicated course CME accredited Organizations can host a course for their team at their location 2-day commitment Cost associated – group discounts available
Strengthening A Palliative Approach in Long Term Care: Resource Library – SPA LTC ; https://spaltc.ca/registration/	
<ul style="list-style-type: none"> Strengthening a Palliative Approach in Long-term Care (SPA-LTC) is about making sure that people with life-limiting illnesses have more opportunities to experience a high quality of life from the moment they enter long-term care to the day of their death. 	<ul style="list-style-type: none"> Palliative Approach to Care e-learning modules Simple and free to access

Essentials in Hospice and Palliative Care	
<ul style="list-style-type: none"> Textbooks with additional online resources For Nurses (RNs and RPNs) and PSWs and other front-line staff and volunteers to assist with gaining the skills, knowledge and attitudes for integrating a palliative approach to care 	<ul style="list-style-type: none"> Self-paced text and workbook based Capacity to do alone or with a group supported by an instructor Cost of textbooks
Education offered by the Palliative Pain and Symptom Management Consultants:	
<ul style="list-style-type: none"> Fundamentals of Palliative Care: Course for interdisciplinary health care providers and hospice volunteers with standardized curriculum based on A Model to Guide Hospice Palliative Care from the Canadian Hospice Palliative Care Association. 	<ul style="list-style-type: none"> Core course with opportunity to take additional courses on advanced skills 3 in class sessions (offered virtually as well). Offered by the PPSMC's Cost
<ul style="list-style-type: none"> Comprehensive Advanced Palliative Care Education (CAPCE) Program: Detailed information found here: https://www.palliativecareswo.ca/programs-CAPCE.html 	<ul style="list-style-type: none"> Prerequisites for CAPCE program: <ul style="list-style-type: none"> Fundamentals (Core) Fundamentals (Enhanced) Both Fundamentals programs must have been completed within the last seven (7) years (2015-2022).
<ul style="list-style-type: none"> Advanced Palliative Practice Skills (APPS) Designed for PSWs & Health Care Aides who have an interest in enhancing their knowledge and skills related to palliative and end-of-life care. APPS builds upon the Fundamentals of Hospice Palliative Care Program, and focuses on the PSWs scope of practice in alignment with the <u>OPCN Palliative Care Competency Framework</u> 	<ul style="list-style-type: none"> 8 week course with 3 classroom sessions Offered by PPSMCs
<ul style="list-style-type: none"> Essential Pain Management using a Palliative Approach (EPM) EPM is designed to benefit and appeal to all classes of nurses who care for adults living with life-threatening or life-limiting illnesses. The EPM course aims to equip nurses with a foundational knowledge base and skills around pain management, from a palliative care approach, that can be applied to your practice. The focus of this course is on the pharmacological management of pain and is aligned with the <u>OPCN Palliative Care Competency Framework</u> 	<ul style="list-style-type: none"> Self-directed course format with one mandatory coaching session; suggested completion time 6 weeks Multiple coaching session opportunities to meet individual learning needs and goals Offered by PPSMCs
Additional Learning:	
Connect with Local PPSMC for other education opportunities	https://www.palliativecareswo.ca/programs-consolidated-list.html https://acclaimhealth.ca/programs/palliative-care-consultation/ https://hpconnection.ca/consultation/

	https://www.hnhbhealthline.ca/displayService.aspx?id=188259 http://www.hpceducation.ca/home/consultation https://hpcconnection.ca/education/courses/ww-hpc-courses/ https://hpcconnection.ca/ltc-training/
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LTCH RESEARCH PROJECT SUMMARY & CONTACTS:

Research/Project Name:	Website:	Contacts:	Info:
<p>All-In Palliative Care: The Team Approach to LTC</p> <p>From: The Ontario Centres for Learning, Research and Innovation in Long-Term Care (CLRI) at Bruyère</p>	https://clri-ltc.ca/resource/all-in-palliativecare/	<p>Angelina Filip AFilip@bruyere.org</p> <p>Andrea Katz AKatz@bruyere.org</p>	<p>An 8-hour virtual training program to help your team build confidence in communicating about and strengthening resident-centered palliative care.</p> <p>Funded: Tuition for 5-10 participating team members; 10 hours of backfill wage support for 5-10 participating team members</p>
<p>Strengthening a Palliative Approach in Long-Term Care (SPA-LTC)</p>	<p>https://spa-ltc.ca/</p> <p>https://spa-ltc.ca/resource-library/</p>	<p>Dr. Sharon Kaasalainen kaasal@mcmaster.ca</p> <p>Sally Shaw burtens@mcmaster.ca</p>	<p>The SPA-LTC program provides needed resources to family members, health care providers and researchers across Canada to stimulate improved care for all LTC residents, especially the most vulnerable. These resources are developed to integrate evidence-and equity-based approaches to palliative care at both practice and policy levels.</p>
<p>Prevention of Error based transfers (PoET)</p>	<p>https://www.poetproject.ca/pssp/</p>	<p>Dr. Jill Oliver Jill.Oliver@williamoslerhs.ca</p>	<p>PoET supports long-term care homes to bring habits and practices more closely in line with Ontario’s Health Care Consent Act. When a home launches PoET, a PoET Spread Leader will work with staff to identify changes to test, and then support staff in making, measuring, and sustaining those changes.</p> <ul style="list-style-type: none"> - PoET-related changes homes might make include (but are not limited to): - Discontinuing the use of the “Level of Care” form - Inviting residents to all care conferences - Reviewing advance care planning documents on admission - Informing residents of their right to appeal a finding of incapacity - Ensuring that consent is obtained from the right person

B. CONNECTING WITH SPECIALIZED SERVICES

Palliative Pain and Symptom Management Consultants (PPSMCs)	
<ul style="list-style-type: none"> - Help to facilitate initial implementation of a palliative care approach - Provide staff training and education - Help guide case-based discussions and facilitate Comfort Care Round discussions - Provide outreach support 	Palliative Care Consultants Network (PCCN) Website https://pccnetwork.ca/where-we-are/
Nurse Led Outreach Team (NLOT)	
<ul style="list-style-type: none"> - Assist with wound care, hydration, antibiotics, falls and fractures with the goal of reducing ER wait times, hospital length of stay, and ALC use while providing excellent care for all LTC individuals - Will do weekly proactive rounds and target individuals who need extra care/support - Help to facilitate and implement the advance care plans that have been developed by families when an individual returns to LTC after a hospital admission 	
Specialist Palliative Care Physicians	
<ul style="list-style-type: none"> - Referral for complex palliative issues for an individual or a resource for LTC physicians (i.e. pain and other symptoms) - Regional home visiting palliative care physician groups can support direct patient care - E-Consult: An e-Consult allows requesting clinicians to engage in a secure, electronic dialogue with specialists to manage patient care, without the need for a face-to-face visit. E-Consults may avoid the need to refer a patient to a specialist for diagnosis and 	Physicians need to request/order palliative physician consult. RN can arrange and complete consultation form with family/individual approval. Specialist recommendations require LTC physician written approval. Ontario Telemedicine Network

SECTION 2 RESOURCES

Section	Resources
<p>Section 2A: Building Capacity</p>	<ol style="list-style-type: none"> 1. Ontario Palliative Care Competency Framework: https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/2021-01/OPCNCompetencyFramework.pdf 2. Self-Assessment Tool: Application of the competency framework  Self AssessmentTool Fin: 3. HQO Palliative Care Quality Statement #13 http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Palliative-Care/Quality-Statement-13-Education-for-Health-Care-Providers-and-Volunteers 4. LEAP – Learning Essential Approaches to Palliative Care offered by Pallium Canada https://pallium.ca/work-with-us/ 5. Contact Your local PPSMC for educational courses such as PPSCM Website: https://pccnetwork.ca/where-we-are/ , general info: https://pccnetwork.ca/work-of-pccn/ 6. Hospice Palliative Care Ontario (HPCO) http://www.hpcoco.ca/ltc/ 7. Strengthening a Palliative Approach in Long-Term Care (SPA-LTC): https://spaltc.ca/ 8. SPA LTC Resource Library: https://spaltc.ca/resource-library/ 9. Prevention of Error based transfers (PoET): https://www.poetproject.ca/pssp/ 10. All-In Palliative Care: The Team Approach to LTC: https://clri-ltc.ca/resource/all-in-palliativecare/ 11. Quality Palliative Care in Long-Term Care: Self-Assessment Checklist: http://www.palliativealliance.ca/assets/files/Alliance_Reources/Self-Assessment_Oct._2012.pdf
<p>Section 2B: Connecting with specialized services</p>	<ol style="list-style-type: none"> 1. Connect with your local Palliative Pain and Symptom Management Consultant (PPSMC): https://pccnetwork.ca/where-we-are/ 2. To connect with your local palliative care outreach team ask your PPSMC or consider contact Home and Community Care Support Services: http://healthcareathome.ca/

SECTION 3: IMPLEMENTING A PALLIATIVE APPROACH TO CARE

Note: This section covers 1, 2 and 3 of the Palliative Care Requirements (refer to pg. 3 above) within the FLTCA (2021):

OVERVIEW

This part of the guide focuses on initiating and sustaining **conversations with individuals and families** to understand the physical, psychological, social, spiritual and practical issues of both the individual and family.

This section is broken down into 3 categories:

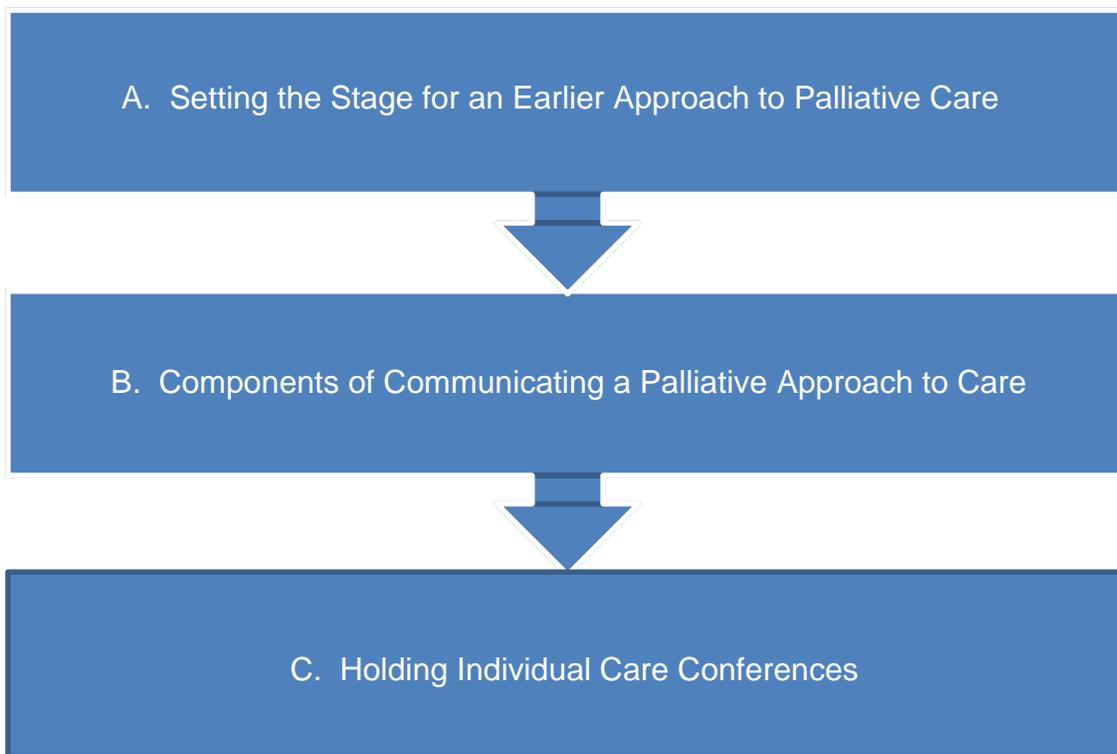


Figure 3.1: Organization and information in section 3

A. SETTING THE STAGE FOR AN EARLIER APPROACH TO PALLIATIVE CARE

Trusting and respectful relationships are the basis for a palliative approach to care; they create a foundation which can be relied on if care and treatment decisions need to be made in the future (Advance Care Planning / Goals of Care Conversations etc.). Using a “Person-Centred” approach helps to build healthy relationships within your LTC home. Each individual is unique; to ensure a person-centered approach is being adhered to, it important to deliver culturally competent care. Culturally competent care is defined as care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles,

beliefs, attitudes, and behaviors. You will find additional resources within Section 3's resource list that support cultural competence, inclusion and diversity.

To foster healthy relationships, staff and clinicians should:

- Allow individuals to define their dignity.
- Make compassion part of every interaction, by making direct eye-contact with individuals and addressing them by name with kindness.
- Facilitate and support their spiritual and/or psychological journey.
- Allow each individual to feel valued as a person, for their conversation, sense of humor or personality.
- Support the individual's desire for autonomy by helping individuals to make their own choices whenever possible.
- Assist with health, hygiene and personal matters in sensitive and individualized ways.
- Eliminate any language or routines that might make individuals feel that they are a burden.
- Refrain from talking about individuals in front of others.
- Listen to each individual's concerns and work with them to enhance safety and comfort.
- Respect each individual's personal space and their need for privacy.
- Enable individuals to complain without fear of repercussions.

Not only do these measures build better relationships, but they also promote dignity and they have been shown to reduce anxiety and depression in individuals.

Shortly after moving into a LTC home, an individual can be introduced to a palliative approach to care. Depending on their health status, this may be simply providing an introductory pamphlet on decision making, advance care planning and goals of care discussions. An earlier introduction of a palliative approach to care in LTC homes can lead to a better quality of life for the individual. Early identification of palliative care needs and early conversations about an individual's wishes can improve individual and caregiver satisfaction with communication and decision-making.

Earlier introduction to a Palliative Approach to care may mean:

- LTCH staff would initiate goals of discussions as soon as an individual is admitted into a LTCH, GoC discussions would be revisited regularly with the individual, family and health care team. This would include having clear discussions about an individual's life-limiting illness and care needs.
- LTCH staff would ensure the identity of the SDM has been clarified with the individual and that the individual is educated about their role and responsibilities.
- Providing information and resources like the Advance Care Planning resources and workbooks to facilitate further discussion between the individual and SDM/POA (see Section 3B Resources).
- LTCH's should have a clear policy identifying staff responsible for GoC discussions and SDM/POA documentation. This policy should include how often this

information should be reviewed (i.e. Every 6 months and/or when an individual's condition changes).

- LTCH staff members discuss a palliative care plan with the individual if they have symptom needs or their condition is declining.

*Note: Include family members that the individual has identified in these discussions.

B. COMPONENTS OF COMMUNICATING A PALLIATIVE APPROACH TO CARE

“The single biggest problem in communication is the illusion that it has taken place.”

Advance Care Planning is a process of reflection and communication. It allows individuals who are well to reflect on their values and consider what care they would want in the future if they were to become unwell. It also encourages individuals to know who their SDM is or identify a POA – the person who will speak and act for them if they are unable to speak for themselves.

HQO Palliative Care Quality Statement

Goals of Care Discussions and Consent

People with identified palliative care needs or their substitute decision makers have discussions with their interdisciplinary health care team about their goals of care to help inform their health care decisions. These values based discussions focus on ensuring an accurate understanding of both the illness and treatment options so the person or their substitute decision-maker has the information they need to give or refuse consent to treatment.

Statement #4 from
Palliative Care: Care for Adults with a Progressive, Life-Limiting Illness

When an individual is admitted to LTC, the conversations shift to focus on the goals of care (GoC) during this admission. Having conversations early with the individual, the SDM/POA and the health care team is critical to honouring each individual's choices about treatment or changes to the focus of care. The ultimate goal is to enable more individuals to have timely access to the integrated palliative approach to care and support throughout the illness trajectory.

COMMUNICATION STRATEGIES

Having simple strategies to help introduce a conversation around GoC for an individual and their family assists to normalize the conversation for everyone. The image to the right (Figure 3.2) provides examples of phrases or approaches that help staff to open the conversation and feel comfortable with the response.

It is helpful to employ positive non-verbal communication tools, such as arranging for a private space, having comfortable seating that allows you to look directly at the individual and their family members, and clearing adequate time in your calendar so that the conversation isn't rushed. Remember to be present, authentic and individual-centered in your focus.

Additional tools to support advance care planning and goals of care conversations can be found within Section 3 resources.

INFORMATION ABOUT CARDIO PULMONARY RESUSCITATION (CPR)

CPR is an important component of GoC conversations, especially if an individual's condition is declining. It is important for staff to be comfortable discussing CPR with individuals and family members. Although CPR alone should never be the sole focus of a GoC conversation, it is important information to have in order for staff to obtain informed consent (see section 1D on informed consent) and to support decisions around a possible hospital transfer as the individual's condition declines. Staff members should be ready to answer their questions about why it is needed, how it works, and whether it is likely to be successful, particularly in relation to an individual's specific health status.

Serious Illness Conversation Guide

CLINICIAN STEPS

- Set up**
 - Thinking in advance
 - Is this okay?
 - Combined approach
 - Benefit for patient/family
 - No decisions today
- Guide** (right column)
- Summarize and confirm**
- Act**
 - Affirm commitment
 - Make recommendations to patient
 - Document conversation
 - Provide patient with Family Communication Guide

CONVERSATION GUIDE

Understanding	What is your understanding now of where you are with your illness?
Information preferences	How much information about what is likely to be ahead with your illness would you like from me? <small>FOR EXAMPLE: Some patients like to know about time, others like to know what to expect, others like to know both.</small>
Prognosis	Share prognosis, tailored to information preferences
Goals	If your health situation worsens, what are your most important goals?
Fears / Worries	What are your biggest fears and worries about the future with your health?
Function	What abilities are so critical to your life that you can't imagine living without them?
Trade-offs	If you become sicker, how much are you willing to go through for the possibility of gaining more time?
Family	How much does your family know about your priorities and wishes? <small>(Suggest bringing family and/or health care agent to next visit to discuss together)</small>

Figure 3.2: Serious Illness Conversation Guide

FAQ #1: Why is it important to discuss CPR status?

- Not only can unexpected events occur that stop the heart from beating, but as a chronic illness progresses, there is an increased likelihood that the heart may stop due to the individual’s terminal condition.

FAQ #2: What happens during CPR?

- It is important for individuals and families to understand the extent of what happens during CPR especially when transferred to a hospital so that they can make an informed decision as to whether they would want it. The process can be very traumatic and this should be understood. See Section 3B Resources for link to Speak Up resource on CPR that details the process.

FAQ #3: How well does CPR work?

- It is important for individuals and families to understand that CPR is successful in restarting someone’s heart in only in a small portion of the population. Please see figure 3.2 for a representation of its success rates.
- At best, the individual might return to their previous baseline; CPR will not improve the condition that caused the heart to stop.
- Even if successful, many individuals will have an altered health status and continued functional decline

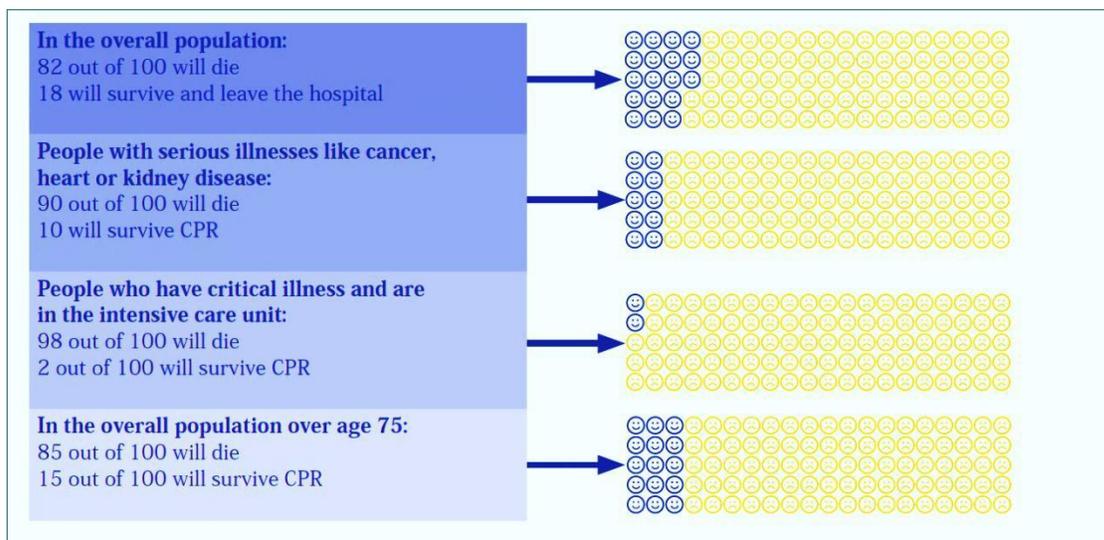


Figure 3.3 Graphic illustrating the effectiveness of CPR in the general population (Caret Canadian Researchers at the End of Life Network 2017)

INFORMATION ABOUT SETTING AND PLACE OF DEATH

HQO Palliative Care Quality Statement

Setting of Care and Place of Death

People with identified palliative care needs, their substitute decision-maker, their family, and their caregivers have ongoing discussions with their health care professionals about their preferred setting of care and place of death.

Statement #11 from
Palliative Care: Care for Adults with a Progressive, Life-Limiting Illness

Health Quality Ontario 2018

In 2016, 61% of deaths in Canada occurred in acute care hospitals (Statistics Canada. 2016). However, most individuals express a preference to die at home, either their own home or in the community (in long term care or a hospice), provided that high quality care can be assured, and families are not burdened. There is clearly a discrepancy between where people die and where they wish to die.

This mismatch might be addressed by asking and recording an individual's preferred place of death. It is important to also capture an individual's preferences for:

- Faith, spiritual, religious and pastoral rites.
- Cultural observances or family traditions.
- Any personal requests or wishes that might be accommodated without their care being compromised.

C. HOLDING INDIVIDUAL CARE CONFERENCES (Resident and Family Caregivers)

HQO Palliative Care Quality Statement

Individualized, Person-Centred Care Plan

People with identified palliative care needs collaborate with their primary care provider and other health care professionals to develop an individualized, person-centred care plan that is reviewed and updated regularly.

Statement #5 from
Palliative Care: Care for Adults with a Progressive, Life-Limiting Illness

Health Quality Ontario 2018

Resident care conferences (RCCs) are meetings held with an individual, family members, SDM/POA to help discuss an individual's condition, to understand an individual's wishes and to develop a plan of care. Regular RCCs should be held in addition to the admission and annual care

conferences. If an individual is capable of making decisions, then staff should consult them on who they would want at the RCC to share information and support their decision making.

RCC's are designed to help an individual and their family to:

- Support and understand an individual's values, goals and preferences for care as the first steps in any care planning and decision making.
- Support an individual and their family to better understand the individual's health status and current or future care decisions.
- Consider the possible sites for care and services available in each (e.g. LTC, home, hospital).
- Share information and develop a partnership in care.
- Facilitate conversation with an individual and their family, to provide information about what may be expected if the individual's condition changes.
- Provide the opportunity for more in-depth conversation of symptoms and concerns, to discuss possible management strategies or involvement of external specialist(s).
- To establish family meetings as a norm, so that if the individual's health declines and a meeting is required, a precedent has been established.

CONSIDERATIONS:

- **Preparations:** If you are feeling uncertain about how this RCC will proceed, consider holding a 'mock' RCC with support from members of the Palliative Committee.
- **Be clear about why you are meeting:** Early in an individual's care, the purpose is to understand the individual's values and wishes for care. Later in an individual's care, the purpose may be around goals for end-of-life care. Recognize that this can still be an emotional and difficult conversation for some family members.
- **Attendees:** Invite key health care professionals involved with the individual's care. Generally, this will be the individual's attending physician, dietician, personal support worker, recreation therapist and nurse. Include a professional interpreter if required.
- **Appoint a coordinator:** One person should take responsibility for scheduling and coordination. Ideally, this person should also act as the primary contact point for the key family member(s).
- **Invitations:** Contact the primary family member(s) and provide an overview of the purpose of the care conference; offer to convene at a mutually acceptable time; advise them that the meeting time will be confirmed once other attendees are arranged.
- **Accommodations:** A comfortable room free of interruptions, with a comfortable seating arrangement is recommended. If resources allow, offer to conduct the meeting by videoconference via the Ontario Telemedicine Network. Ensure you have a contact number, and an alternate number (mobile).

HOLDING THE RCC:

1. Introduction
 - Thank everyone for attending and introduce everyone.
 - Review meeting's purpose.
2. Determine what the individual/family already knows:
 - Ask about the past 1-6 months—what do they understand about the individual's health and why this meeting has been arranged.
3. Review current health status
 - Using the individual's desire for information as a guide, review current clinical status, prognosis and treatment options.
4. Discuss Goals of Care (Use SICG)
 - If the individual is capable: Confirm that the individual knows who their SDM is (or has identified a POA). Ask the individual about their wishes for care.
 - If the individual is not capable: Ask the SDM/POA and family members if they have questions or concerns about the treatment plan or about how the care team can better support the individual.
5. Wrap-up:
 - Summarize consensus, disagreements, decisions & plan.
 - Identify family spokesperson for ongoing communication.
 - Document key issues and action plans.
 - Establish a plan to revisit the care plan and GoC regularly.
 - Circulate the document to the care team involved. If requested, prepare one for the individual and/or their POA

SECTION 3 RESOURCES

Section	Resources
<p>Section 3A: Components of Communicating a Palliative Approach to Care</p>	<ol style="list-style-type: none"> 1. Ontario Palliative Care Network’s Palliative Care Toolkit (includes hyperlinks to best-practice tools from around the world to support health care providers with palliative care delivery using a 3 step model – Identification, Assessment and Plan and Manage): https://www.ontariopalliativecarenetwork.ca/resources/palliative-care-toolkit 2. HQO Palliative Care Quality Statement #4 http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Palliative-Care/Quality-Statement-4-Goals-of-Care-Discussions-and-Consent 3. Living my culture (videos): http://livingmyculture.ca/culture/ 4. Cultural beliefs (PC Network of Wisconsin): https://www.mypcnw.org/blank-g562m 5. 5 steps at Speak Up: http://www.advancecareplanningpei.ca/what-is-advance-care-planning/ 6. Dignity in Care: https://dignityincare.ca/en/ 7. ACP at Speak Up: http://www.makingmywishesknown.ca/ 8. Serious illness conversation guide (Dana Farber): https://www.talkaboutwhatmatters.org/documents/Providers/PSJH-Serious-Illness- Conversation-Guide.pdf 9. CPR decision aid from Speak Up: https://www.advancecareplanning.ca/wp-content/uploads/2020/06/ACP-CPR-Tool_FINAL-web.pdf 10. What is right for you at the end of life (Speak Up Video): https://www.youtube.com/watch?v=2SBg26XpOYI 11. CPR at Speak Up: http://www.advancecareplanning.ca/resource/cpr-decision-aids/ 12. ACP and dementia: https://spaltc.ca/lessons/acp-in-persons-living-with-dementia/ 13. Spiritual Care within a Palliative approach in LTC: https://www.youtube.com/watch?v=tlr91ffbHJw 14. HQO Palliative Care Quality Statement #11 http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Palliative-Care/Quality-Statement-11-Setting-of-Care-and-Place-of-Death 15. HQO Palliative Care Quality Statement #5 http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Palliative-Care/Quality-Statement-5-Individualized-Person-Centred-Care-Plan 16. Resuscitation: A Decision Making

<p>Section 3B: Equity, Inclusion, Diversity and Anti-Racism (EIDAR) resources</p>	<p>Below is a list of selected resources on equity, inclusion, diversity, anti-racism and health equity. This is not an exhaustive list but rather a starting point.</p> <p>Equity and Inclusion Resources</p> <ul style="list-style-type: none"> • Land Acknowledgement Guide • National Indigenous History Month Background (png) <ul style="list-style-type: none"> • Reversed Background (png) • Belonging: A conversation about Equity Diversity and Inclusion • The Urgency of Intersectionality - Kimberlé Crenshaw (video) • The Real Work of Being an Ally • Beyond Diversity: An LGBT Best Practice Guide for Employers • Creating a Trans-Inclusive Workplace • How to Do Better with Gender on Surveys (pdf) • Ontario Health - Gender-Inclusive Language Guidelines • Ontario Health - Indigenous Terminology Guideline 2021 • FAQ on Pronouns • OH Pride Background (png) <ul style="list-style-type: none"> • Reversed Background (png) • How-to Guide: Inclusive Meetings • 4 Ways to Improve your Company's Disability-Inclusion Practices • What is Disability Justice? <p>Anti-Racism Resources</p> <ul style="list-style-type: none"> • Black History Month 2022: Corporate Toolkit • An open source list of resources to deepen anti-racism work • There have always been two Canadas. In this reckoning on racism, both must stand together for Indigenous people now • Indigenous experiences with racism and its impacts • Data Standards for the Identification and Monitoring of Systemic Racism • Being human with your teams during global cultural transformation • White Privilege: Unpacking the Invisible Knapsack • Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis <p>Health Equity Resources</p> <ul style="list-style-type: none"> • Institute for Healthcare Improvement Health Equity Resources • Wellesley Institute: Socio-demographic data and equity in health services in Ontario: building on strong foundations • Including Disability in all Health Equity Efforts: An Urgent Call to Action • National Collaborating Centre for Determinants of Health Resource Library: <u>Whiteness and Health Equity</u> and <u>Racism and Health Equity</u>. • How Racism Makes Us Sick (video) • Black Health Alliance: A community-led registered charity working to improve the health and well-being of Black communities in Canada • Black Experiences in Health Care Symposium 2020 Report and Executive Summary • The Health Effects of Anti-Black Racism • Resources from the National Collaborating Centre for Indigenous Health • Resources from the Indigenous Cancer Care Unit • Indigenous Primary Health Care Council Resources • LGBT2SQ Health Resource Library - Rainbow Health Ontario
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SUMMARY

The Palliative Approach to Care requirements under the FLTCA (2021) and its regulation respond to the diverse and often complex needs of individuals who reside in Long-term care homes across Ontario. These requirements align with the Ontario Provincial Framework for Palliative Care, which reflects the shift in practice towards a broader, more holistic approach to Palliative Care.

At the outset, it is important to note that a licensee must ensure that the rights of residents in the Residents' Bill of Rights are fully respected and promoted. In addition, the Residents' Bill of Rights and the fundamental principle of the FLTCA is to be applied when interpreting the FLTCA and anything required or permitted under it, such as the Palliative Approach to Care requirements.

LTCH's are encouraged to fully utilize the resources within this document, along with the highly recommended connections with Subject Matter Experts (i.e. PPSMC's, etc.). Building strong relationships with subject matter experts will aid in the successful implementation of the FLTCA recommendations, in addition, these Subject Matter Experts will provide ongoing mentorship and education that will help to ensure High Quality Palliative Approaches to Care are being delivered.