SHIFTING TO A PALLIATIVE APPROACH IN LONG TERM CARE: WHAT DOES IT TAKE?

DR LEAH MACDONALD PALLIATIVE CARE PHYSICIAN, MEDICAL DIRECTOR
DELLA ROBERTS CLINICAL NURSE SPECIALIST
ISLAND HEALTH, PALLIATIVE & END OF LIFE CARE PROGRAM
Objectives

Understand LTC initiatives, tools and resources
Explore the evolving roles of specialist PC with LTC homes
Learn about the findings and lessons from the ‘Island experience’
Disclosures

No conflicts to disclose
LTC Context

- Complex care environment
- Resource constrained setting
- Direct care provision largely by care aids
- Common trajectories - frailty and organ failure
- Decreased length of stay over past years
Need for a palliative approach

“[There is] a lack of understanding around the language and definition about what is a palliative approach? You know, so often you’ll hear ah, clinicians talking about palliative care as final days and hours, so I think that was a gap in terms of education.”

-- A Project Team Member

“A palliative approach generally isn’t taken in residential care and often planning for these patients is reactive rather than proactive, and so these patients end up with unnecessary transitions at EOL”

– A Project Team Member
UK Gold Standards Framework
Care Homes

GSF accreditation for Care Homes since 2004

- Identification and planning tools
- Practice guidelines
- Educational workshops
- Local facilitator to identify patients in their final months of life, assess needs, provide care planning, improve communication, and educate and empower care staff.
  - Hewison, Badger, Clifford, & Thomas, 2009

Improved quality of experience & care
50% reduction in hospital deaths
Australian LTC Palliative Approach Initiative

Australian Residential Palliative Approach Competency Project
- Tailored education nurses and care assistants. ‘Link nurses’ provided on-site support.

Australian Institute of Health’s Palliative Approach Toolkit for residential aged care
- 3 education modules for direct care providers resources, advanced care planning, and clinical assessments
- Brochures

- Built staff confidence;
- Collaborative team-based approach offered better support to residents with complex needs;
- Assessment tools helpful to systematic documentation of subtle clinical changes or declines;
- Common palliative language empowered direct care providers. (Phillips et al, 2008)

Participating residents less likely to be inappropriately transferred to hospital (1.7% vs. 21.5%) (Reymond, Israel, & Charles, 2011)
Ontario –
Quality Palliative Care in LTC

5 year research to develop formal palliative care programs in LTC homes
- determined organizational readiness,
- identified a palliative champion or catalyst for change,
- created a palliative resource team, and
- involved direct care staff in development of a toolkit and other supports

Community capacity development model approach
Resulting in 4 LTC homes creating own palliative care programs
Vancouver Coastal – Daisy Project/EPAC

Comprehensive program - implemented in 48 care homes (2012-2017)
- Focus on early Identification
- Discuss goals of care
- Develop & implement comprehensive care plan
- Specific Education

2017 Canadian Foundation for Healthcare Improvement - Embedding Palliative Approaches to Care Spread Collaborative (EPAC - Residential Setting)

Improved end of life care at the care home, avoid unnecessary hospital transfers, supported clinicians

Identified as a CFHI demonstrated innovation
- 7 teams in 6 provinces/territories – Yukon, Alberta, Quebec, Ontario, New Brunswick, Newfoundland & Labrador
- 26 LTC homes
LTC Palliative Approach Initiatives
Common Ingredients & Outcomes

**Systematic integrated programs**
- Process of identifying residents
- Processes to support goals of care conversations
- Collaborative team approach
- Inclusion of care aids as essential ingredient
- Empowerment of staff through palliative care knowledge, skills & tools
- Better preparation for dying

**Common outcomes**
- Improved quality of experience and care of residents and families
- Increased goals of care conversations
- Increased staff confidence
- Improved team collaboration & communication
- Increased deaths of residents in the care home
- Fewer crisis hospital admissions & ER transfers
Pilot Partnership between Palliative Care & Long Term Care Programs with funding support by Specialist Services Committee (SSC)

Project Goals:

1. Embed a resident-centered palliative approach to care in 4 long term care facilities in Island Health in BC.

2. Improve the dying experience
   ◦ support residents dying in place
   ◦ improve the experience of team members in caring for the dying, and
   ◦ reduce ER visits and hospitalization for resident

Research to evaluate the initiative – stream of SALTY

Seniors-Adding Life to Years

◦ Assess the impact of the QI project
◦ Identify the process/factors influencing successful implementation
Selection of Sites
Hiring of Link Nurses
Baseline Data

2015

2016

2017

2018

2019

Project Timeline

Link Nurses and PCP in facilities LEAP sessions for staff Co-design of practice support tools and processes such as Palliative Rounds

Introduction of draft practice support tools Data Collection 3 more LEAP sessions Physician engagement sessions

Finalization of Tools
Link Nurses finished on site
SIC Workshop for Residential Physicians
Engagement around Next Steps

SPREAD Adoption of approach and tools by LTC Program
Community of Practice Development of One Day Curriculum for LTC "teams"
PILOT PROJECT PROCESS SUMMARY

IDENTIFY

Early Identification Tool: Screen at admission, care conference, RAI review, change in performance status, after illness or hospitalization

Guide for Goals of Care Plan

Team Communication/Consensus

Letter to Family Physician: FP reviews and returns

Palliative Rounds: Patient discussed by Care Team, FP invited to contribute

Communication with Resident & Family

Conversation Guide for Care Team

Family Meeting Framework: FP in office or facility

“Living Well” Palliative Approach Brochure

DOCUMENTATION

Record Goals of Care and Serious Illness Conversations

Suggested Use of “ACP Notes & Conversations Form”

MOST

ONGOING INTEGRATION OF PALLIATIVE APPROACH

Ongoing conversations with families to prepare for change

Screening/Assessing Symptoms

Anticipatory Orders
Project Sites

1. Urban, owned & operated site, 72 beds
2. Urban, affiliate site, 217 beds
3. Rural, affiliate site, 160 beds
4. Rural, owned & operated site, 90 beds
5. Control site - Semi-rural, owned & operated, previously affiliate site, 75 beds
Project Resources

- Advisory steering committee – Palliative & LTC programs
- Palliative Care Specialist ‘Link Nurses’ one day a week at a site
- Palliative Care Physicians linked with each site
- Palliative Care Project team

- Education - Learning Essentials Approaches to Palliative Care (LEAP-LTC)(2 days)
Palliative approach framework

ADOPTS principles EARLY in the course of a person’s life-limiting condition

ADAPTS strategies to meet patient and family needs

EMBEDS practices into usual care in settings not specialized in palliative care
A Palliative Approach to care is not limited to last days. It is about providing comfort and quality care for all residents living with progressive life-limiting illness and their families.

Early integration of a palliative approach enhances quality of living.

**Key Messages**
- "We are here to support and care for you to the well until the end of your life."
- "Things are changing for you. This seems a good time for a family conference."
- "Your mom has more time now and thinking closer to the end of her life."
- "Your mom has changed more, and it’s in her dying time."
- "I’m sorry for your loss. We will miss your mom."

**PPS (Palliative Performance Status)**
- 50-40% in 5 years
- 40-30% in 4 months
- 30-20% in 8 weeks
- 20-10% in 7 days
- Death

**Integrate a Palliative Approach**
- Affirm goals of care
- Inform and guide
- Enhance symptom management
- Anticipate care needs

**Signs of Transition**
- Progressive weight loss
- Significant functional decline with limited reversibility
- Resident and family asking for palliative care or comfort measures only, treatment withdrawal or limitation
- Unplanned transfer(s) to ED or hospital admissions
- Extreme frailty
- Advanced dementia or other neurological disease, advanced cancer diagnosis, severe heart disease, severe respiratory disease
- Increasing fatigue, e.g. not wanting to be out of bed long
- Withdrawing socially, loss communicative
- Swallowing difficulties
- Eating and drinking less
- Fluctuating level of consciousness
- May not want any food or fluid
- Congested breathing
- Irregular breathing (apnoea apnoeic)
- Body temperature changes

**INCREASING FRAILTY**
- For frail people admitted to residential care, this is the last season of their lives.

**INCREASING MEDICAL AND FUNCTIONAL DECLINE**
- There are often signs a resident’s health is declining. Dying is possible at any time in the coming months.

**LAST WEEKS**
- Dependency and symptomatic increases. Death is now expected.

**ACTIVE DYING**
- Your mom has more time now and thinking closer to the end of her life.

**DEATH AND Bereavement**
- Acknowledge and review death
- Support grieving family
- Consider referral for bereavement support to local Hospice Society
Identification

Identify who is ‘sick enough to die’ versus ‘actively dying’.

Who is at a high risk of dying?
Whose condition has changed?

Identify routine times for screening:

- Daily huddles
- At change in condition
- Before care conferences
- On hospital return
- On admission to LTC

Early Identification Tool

What factors support the care teams impression that the resident is in their last months of life? (check all that are relevant)

- Progressive weight loss (greater than 10% in 6 months)
- Progressive, irreversible functional decline
- Resident or family asking for palliative care or comfort measures only, treatment withdrawal or limitation
- Unplanned transfers to hospital
- Extreme frailty (e.g. persistent pressure ulcers, recurrent infections, delirium, persistent swallowing difficulties, falls)
- Advanced dementia or other neurological disease (e.g. full assistance needed with all activities of daily living, incontinence, unable to communicate effectively, poor oral intake, swallowing difficulties, recurrent UTIs, aspiration pneumonia)
- Advanced cancer diagnosis
- Severe heart disease (e.g. breathlessness or chest pain at rest or with minimal exertion)
- Severe respiratory disease (e.g. breathless at rest or with minimal exertion, on oxygen therapy in place, recurrent hospitalizations)
- Advanced illness of any cause with progressive function decline or poorly controlled symptoms

Criteria adapted from Supportive and Palliative Care Indicators Tool (SPICT) www.spict.org.uk and
“*The Gold Standards Framework Prognostic Indicator Guidance”
Identification

ID occurred at average of 6.6 weeks before death

“The team is still doing the, using the early identification tool and you know, having discussions about whether residents are, you know, at risk of dying in the next six months, so that we can identify those people that might benefit from perhaps a different focus in their, in their approach to care.”

-- LTC Manager at Pilot Site
## Palliative Approach

### Actions

**Identification**
- Revisiting goals of care
- Care planning

### Guide for Goals of Care Plan

**DOMAINS OF CARE** | **GOALS** | **ACTIONS** | **INITIALS**
--- | --- | --- | ---
**Early Identification** | Ensure coordinated team-based support is initiated when residents are identified as in greater need of a palliative approach to care | 
- Complete "Early Identification Tool" as a care team and place on resident's chart
- Share information about identification with MRP (form letter)
- Communicate to entire care team that resident has been identified | 

**Information Sharing and Being a Guide to Family** | Ensure that the family and resident (as appropriate) have opportunity to discuss the anticipated illness course and the benefits of a palliative approach to care to inform their care plan | 
- Identify a care team member to speak honestly and sensitively with family and resident (as appropriate) about changes the care team has noted
- Document conversations, including wishes or concerns, on the Advance Care Planning Notes and Conversation Form (or equivalent) kept in Greensleeve of a resident's chart
- Encourage family to make an appointment with the resident's doctor to discuss anticipated illness course, prognosis and MOST
- For families with more concerns or questions suggest a larger family meeting with RN, SW and MRP
- Provide ongoing check-ins with family | 

**Confirming Goals of care** | Ensure that care provided is in keeping with resident's wishes and values, and is medically appropriate | 
- Revisit "Medical Orders for Scope of Treatment" (MOST) given changing condition
- If MOST designation appears inconsistent with condition notify MRP and encourage family to make an appointment to revisit MOST | 

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*Improving End-of-Life Outcomes in Residential Care Facilities Pilot Project*

November 2014
“a lot of it grew from those initial education sessions when you saw where the interest was in conversation strategies”

Ask, Tell, Ask
<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>SCRIPT QUESTIONS / Sample Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASK</strong> share information about changes</td>
<td>Now that we have talked ...</td>
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<tr>
<td><strong>EXPLORE</strong> what is most important, the concerns</td>
<td>Q: What is most important to you at this moment?</td>
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<tr>
<td></td>
<td>Q: What hopes and concerns do you have?</td>
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<tr>
<td><strong>Outline</strong> next steps</td>
<td>– I will write all this down and let the rest of the care team know so we are all on the same page.</td>
</tr>
<tr>
<td><strong>Record</strong> Advance Care Plan (ACP) notes and conversation, and fax to physician (MRP); attach progress notes if needed</td>
<td>– I will (the nurse will) connect with the doctor and ask about changing some of the medications. We can reconnect next week. Does that sound OK?</td>
</tr>
<tr>
<td><strong>Share</strong> with team including physician</td>
<td>– I think it is important to make an appointment with your doctor and have a good discussion about what to expect and the plan of medical care.</td>
</tr>
<tr>
<td><strong>Update</strong> care plan</td>
<td>– ACP notes and conversations example:</td>
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<td></td>
<td>“Discussed recent changes in condition with family. Family wishes to have medical information and review plan of care. Asked family to make appointment with GP.”</td>
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**GOALS OF CARE**

<table>
<thead>
<tr>
<th>CLARIFY GOALS OF CARE (as appropriate)</th>
<th>Also refer to Conversation Guide on page 2 of MOST</th>
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<tbody>
<tr>
<td><strong>Answer questions as they are raised</strong></td>
<td><strong>FAMILY QUESTIONS:</strong> How much time do they have? Are they dying?</td>
</tr>
<tr>
<td><strong>Use the same approach:</strong> <strong>ASK - TELL - ASK</strong></td>
<td><strong>ASK</strong> - What is your sense? What are you expecting?</td>
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<td></td>
<td><strong>TELL</strong> - You could be right. Often we aren't able to predict how much time, but we can see that she frail enough and change could happen at any time. This could be her dying time.</td>
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<tr>
<td></td>
<td><strong>ASK</strong> - Is that what you expected to hear? Does that make sense to you?</td>
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<tr>
<td></td>
<td><strong>FAMILY QUESTION:</strong> Should their family member still go to hospital?</td>
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<tr>
<td></td>
<td><strong>ASK</strong> - What are you thinking? How do you think they would benefit from going to the hospital? What would you hope from your mom going to hospital?</td>
</tr>
<tr>
<td></td>
<td><strong>TELL</strong> - It is so important to discuss your worries and hopes. We can care for your mom here, focusing on her comfort. For what she now needs, we have the care available.</td>
</tr>
<tr>
<td></td>
<td><strong>ASK</strong> - It sounds like you have more questions? Do you want to talk about this with your mom's doctor? Could you make an appointment?</td>
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# CONVERSATION GUIDE for LONG TERM CARE TEAM

Responding to a resident and/or family's concerns regarding a resident's condition

## CONVERSATION - LISTENING MORE THAN TALKING

Elements of conversation often take place over many small conversations and do not need to happen in one long session.

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<tr>
<th>STEPS</th>
<th>DESCRIPTION</th>
<th>SCRIPT QUESTIONS / Sample Statements</th>
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| 1 INITIATE discussion | Validate the resident and/or family's emotion  
Pause and make eye contact, sit down, use gentle touch (if there is permission)  
Use simple, clear language to acknowledge the emotion  
Avoid unwarranted reassurance or changing the topic | S: “I can see that you're upset about changes you're noticing in your mom's health.”  
S: “It sounds like you are worried about your mom.”  
S: “That must be upsetting for you.” |
| 2 ASK the resident and family | Seek to gain a deeper understanding of their concerns and what is important to them.  
ASK “Tell me more”  
ASK “What is important to your mom? To you?” | Q: Can you tell me more about what your concerns are?  
Q: Have you noticed any other changes?  
Q: What do I need to know about your loved one to provide the best possible care? |
| 3 TELL | Share your observations of the resident.  
This could include: eating, amount of sleep/rest, change in level of support for ADL’s, participation in activities | S: “Yes, your mom has only been eating about half of her meals.”  
S: “Your mom has been asking to go back to bed and prefers to lie down after being awake for about an hour.”  
S: “Your mom is declining invitations to attend/participate in activities she used to enjoy.” |
“a family needed to be talked to ... and I said ‘do you want me to come up and give you support’ and she goes, ‘no, I think I’ll be okay, I have the conversation sheet’... so (the conversation sheet) gave her the strength to try and do that on her own and have that communication with the family which all along was difficult (for her). I asked her later on and I spoke with the family as well and ah, it was a very good interaction. She did really, really well and that’s where she got her strength from.”

- Pilot Site LTC Manager
Established Palliative Rounds

Setting aside regular time for focus on palliative approach – signals clear organizational valuing, support & permission

“The one thing that I think has been really valuable for the staff have been the palliative rounds... where the physician, the palliative physician is there, the palliative coordinator and then the care aides are there, the nurses are there, and other staff, support staff and those one hour meetings once a month have been really good.”
- LTC Clinical Nurse Leader

“We talk about what went well, what didn’t go so well, how things can be improved next time, what it felt like emotionally to care for these patients.”
-- LTC Clinical Nurse Leader
# Framework for a Palliative Approach Family Meeting in Residential Care

Best practice supports ongoing “goals of care” conversations beginning with residential care admission and at regular care conference. Evidence supports that families have specific information needs when their loved one is in their final months of life.

## STEPS

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<th>EXAMPLES TO CONSIDER</th>
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<tbody>
<tr>
<td>1. PRE-MEETING</td>
<td><strong>Review</strong> medical history and prognostic indicators. <strong>Gather</strong> collateral history from care team about recent changes in the resident’s status. <strong>Coordinate</strong> medical opinions from relevant specialists. <strong>Review</strong> advance care planning documents. <strong>Determine</strong> what is medically appropriate. <strong>Identify</strong> substitute decision maker(s) as required. <strong>Consider</strong> using a pre-meeting questionnaire to help identify areas of concern to the resident and family. <strong>Determine</strong> the goals for the palliative care focused family meeting.</td>
<td><strong>Ask yourself:</strong> What interventions will improve or worsen function, longevity and quality of life? What are the main concerns for the resident and family at the moment? What questions would the family like answered at the meeting?</td>
</tr>
<tr>
<td>2. INTRODUCTIONS</td>
<td><strong>Review</strong> planned goals of the conversation. <strong>Build</strong> rapport with resident* and the family.</td>
<td>*Residents should be included in family meetings when they are capable and wish to be present. I know about your (your mom’s) medical situation. Tell me something more about you (her) as a person.</td>
</tr>
<tr>
<td>3. ASK THE FAMILY</td>
<td><strong>Assess</strong> understanding of current status and prognosis. <strong>Ask</strong> about the resident’s function and quality of life over last 3 to 6 months. <strong>Ask</strong> about what is important to the resident.</td>
<td>*What do you understand is happening with your mom’s health? Tell me about how the last 3 months have been for your mom. Have there been changes or trends? What is most important to your mom now? What is most important to you?</td>
</tr>
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| 4     | SHARE INFORMATION | - Provide a brief summary of current medical situation.  
|       |              | - Clarify prognosis while acknowledging there is some uncertainty.  
|       |              | - Do not avoid words like “dying” and “death”.  
|       |              | - Share Information about changes to expect in the coming weeks or months, tailored to resident’s specific diagnosis.  
| 5     | MAKE A RECOMMENDATION | - Make a recommendation when you believe there is one preferred medical decision based on the facts and your knowledge of the resident’s wishes.  
|       |              | - Avoid questions like: “What would you like us to do?”  
| 6     | TRANSFORM GOALS INTO THE MEDICAL PLAN | - Revisit the current goals of care including MOST status.  
|       |              | - Review the current care plan including medications, tests, and procedures to decide which are helping to meet the current goals and which are not beneficial.  
|       |              | - Key areas for discussion often include ongoing hospitalizations, use of antibiotics, transfusions, and artificial fluids and food.  
|       |              | - Respond to family’s concern about dehydration and decreased intake of food.  
| 7     | CHECK-IN | - Confirm understanding of the conversation.  
|       |              | - Ask if family has questions or concerns, worries or fears.  
|       |              | - Acknowledge emotions and empathize.  
|       |              | - Provide reassurance about the ability of residential care team to look after resident through end of life.  
|       |              | - Infections and fever are not uncommon for people at the end of life.  
|       |              | - If treatment and care are focused on comfort, antibiotics may not be necessary.  
|       |              | - We can support a natural, comfortable death.  
|       |              | - A decrease in water and food intake is the body’s natural “winding down” process. Artificial fluids and feeding often result in decreased comfort for the individual. Fluid can accumulate in the lungs, legs, and skin for example.  
|       |              | - I want to reassure you that excellent care can be provided for your mom here at this facility.  
|       |              | - As things change, we will continue to care for your mom and manage pain and other symptoms that may develop.  

Update MOST (Medical Orders for Scope of Treatment) form as necessary.  
Document other information where it will be easily accessible to inform the facility team and covering physicians.  
(For example, the Island Health “ACP Notes and Conversation” form can be used.)

3. Adapted from the Serious Illness Care Goals Conversation Guide © 2015 Ariadne Labs A Joint Center for Health Systems Innovation (www.ariadanelabs.org)  
A Palliative Approach to Care
Information for Residents and Families

Living well
A palliative approach to care focuses on what quality of life means to you now and in the future. It is most beneficial when started early.

It is active treatment to ensure that pain and other symptoms are well managed to help you live well.

A palliative approach to care also provides social, emotional and spiritual support to you and your family.

Preparation
Recognizing that changes in condition will continue to occur, we can help you plan for those transitions and talk about how we can care for you here. By learning and communicating what is most important to you, what your goals, values and wishes are, everyone can be prepared and on the same page.

Things to think about:
- What does quality of life mean to me?
- What gives my life value?
- What are my biggest fears/worries about the future?
- What are my goals/wishes?
- What do I understand about my health conditions and changes I could expect?

Conversation
Engage in conversations with your physician/nurse practitioner and care team in the long-term care home where you live.

We welcome the opportunity to learn more about what is important to you and your family, and address any concerns you may have.

Questions you may want to ask:
- What is the current state of my/my loved one’s medical condition(s)?
- What changes might I/we anticipate?
- What treatment options are available?
- What are the pros and cons of treatment options?

A Palliative Approach to care is not limited to last days. It is about providing comfort and quality care for all residents living with progressive life-limiting illness and their families.
Trends towards decreased ED and hospital admissions in last 90 days of life.

Trend towards more residents dying in place compared to control sites.

Tools co-created with LTC and Specialty Palliative care, refined with PDSA cycles

Increased confidence and comfort amongst LTC staff around identification and EOL communication

Positive word of mouth amongst LTC sites

Support of LTC Program leadership for adoption and spread

Support of Palliative & End of Life Care Program leadership
Spread and Sustainability

**Sept 2018**
LTC recommends a Palliative Approach be implemented across all sites

**Community of Practice**
Received toolkit
Meet monthly via teleconference to discuss tools, challenges, share successes, Q&A.

**One day PA curriculum**
Attended by team from sites
Palliative Approach philosophy and focus on communication

**Further Improvements to Toolkit**
Conversation Guide for HCAs
Information for Patient and Families

**Train-the-Trainer session**
7 LTC CNEs & 2 Palliative Care Consult Nurses

**Physician leaders engaged to update Care Conference Guidelines**
(HPF funding)

**October 2019**
Phase 2 sites join Community of Practice
Education sessions for each Geo

LTC homes that have participated as a Community of Practice member in phase 1 or currently enrolled in phase 2:
- Owned and Operated 12/18 (66.7%)
- Affiliate 18/40 (45%)
- Overall 30/58 (51.7%)
Key Findings
1. Context matters

• Organizational Readiness – matching needs & capacities
• Site leadership support & champions are key drivers
  • “if management doesn’t endorse and support the pieces that I was trying to do, the staff are going to say why should I bother?”
  • RN/LPN “they want to see it spread and want to be champions within the greater system”
• Need for Education/Training
  • “lack of educational opportunities for every level from the health care aide up.”
  • “they are so hungry for the education, but they’re just trying to do the basics in care”
• Staff turnover influences team-approach to care and practice innovation
  • “barriers would be that there’s high staff turnover so that we educate and support... and then start all over again.”
• Time - a pervasive all encompassing theme; time to adopt/adapt/embed
Other Key findings

2. Education alone is not sufficient
3. Tools alone are not sufficient
4. Integrated practices within setting processes and documentation is key
5. Sustainability depends on integration
6. When Medical Director attended education and supported integration of tools together with Clinical nursing leadership – strong use & integration
The specialist palliative care role in LTC

QI project reality

- Care for active dying is part of the culture of care and norm of LTC
- There are opportunities to improve symptom management, but support for the clinical staff in LTC with care and conversations was the greatest identified need.

PC specialist have a role:

- shifting our view to broader application of PA during consultations
- supporting LTC clinicians with conversation skills and gaining confidence – education/tools
- presence in LTC such as at rounds, lends credibility and support for LTC clinicians
- low barrier PC consultation – direct connect to PC nurse

Palliative programs have a role in:

- Being a partner in system development and sustainment
- Advocating for LTC palliative approach systematic program and support
Summary

**Palliative approach is a concept** readily understood by LTC staff

Tools **specific to the setting & education** are essential, but not enough

**Champion / ownership / integration** into usual care is key

**Communication** was the most substantial issue and is where the greatest change can happen.

**Context** must be considered for a palliative approach to become part of usual care & local ownership is essential

**Medical director & physician practice can be a difference maker**