Long-Term Care Quality Improvement Community of Practice

Exploring Change ideas to Improve Goals of Care Conversations

Presenters: Dr. Amit Arya & Holly Finn

Date: April 17th, 2023

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

Stay connected: www.echopalliative.com

LEAP Long-Term Care

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Case studies contextualized to the long-term care setting.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) working in long-term care and nursing homes.
- Accredited by CFPC for **26.5 Mainpro+ credits** (online) and **26.5 Mainpro+ credits** (in-person).

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-long-term-care

About this Community of Practice (COP)

Who is it for

- Administrators and clinicians from across Canada who work in the Long-Term Care setting who have a desire to continuously improve they deliver a palliative approach to residents and their close ones

Main goals

- To identify palliative-care related QI opportunities in the Long-Term Care setting
- To develop Quality Improvement Toolkits as a resource for those who wish to implement these kinds of projects
- To support teams who are implementing these quality improvement initiatives

Introductions

Dr. Amit Arya, MD, CCFP (PC), FCFP
Palliative Care Lead, Kensington Health, Toronto
Lecturer, Division of Palliative Care, Department of Family & Community Medicine, University of Toronto
Assistant Clinical Professor, Division of Palliative Care, Faculty of Health Sciences, McMaster University

Holly Finn, PMP
Senior Manager of Program Delivery
Pallium Canada

Conflict of Interest

This program has received financial support from:

- Health Canada: in the form of a contribution program
- Pallium Canada: a non-profit that generates funds to support operations, research and development from Pallium Pocketbook sales and course registration Fees

Presenter Disclosures

- Holly Finn: employed by Pallium Canada.
- Dr. Amit Arya: no conflicts of interest to disclose.

Meet the rest of our core team!

Dr. Sharon Kaasalainen, RN PhD
Professor & Gladys Sharpe Chair in Nursing
McMaster University

Bev Faubert
Registered Nurse, Ontario

Shannon Fogarasi
Social Worker, Ontario

Gloria Nickels
Personal Support Worker, Ontario

Julie Weir
CEO, New Brunswick Association of Nursing Homes,
New Brunswick

Elizabeth Wojtowicz
Nurse Practitioner, Ontario

Gita Rafiree
Registered Nurse, British Columbia

Welcome and Reminders

- Please introduce yourself in the chat! Let us know what province you are joining us from and what your role is in the Long-Term Care setting.
- Your microphones are muted. There will be time during this session for questions and discussion.
- You are welcome to use the chat function to ask questions, if you have any comments or are having technical difficulties, but also please also feel free to raise your hand!
- This session is being recorded- this recording and a copy of the slides will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session.

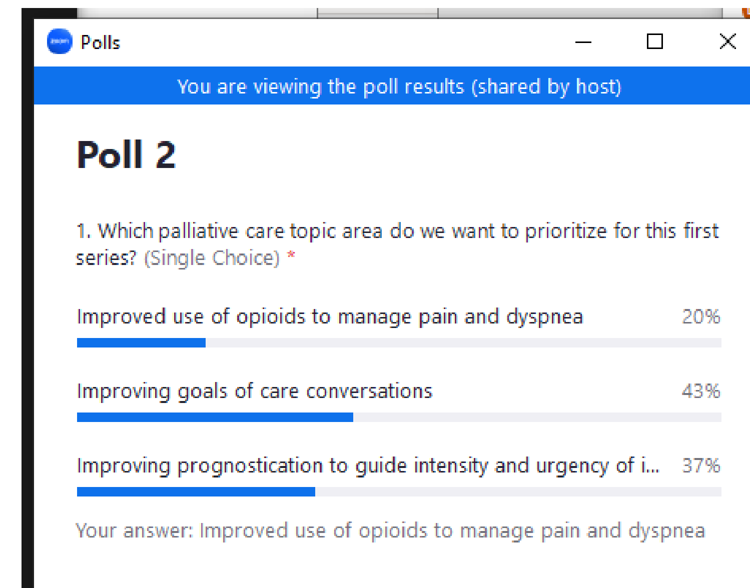
Agenda for Today’s Session

- Overview of what we’ve worked on so far
- Brainstorming Activity: Change ideas to improve Goals of Care Discussions in Long-Term Care
- Next steps

Overview of What We’ve Worked on So Far

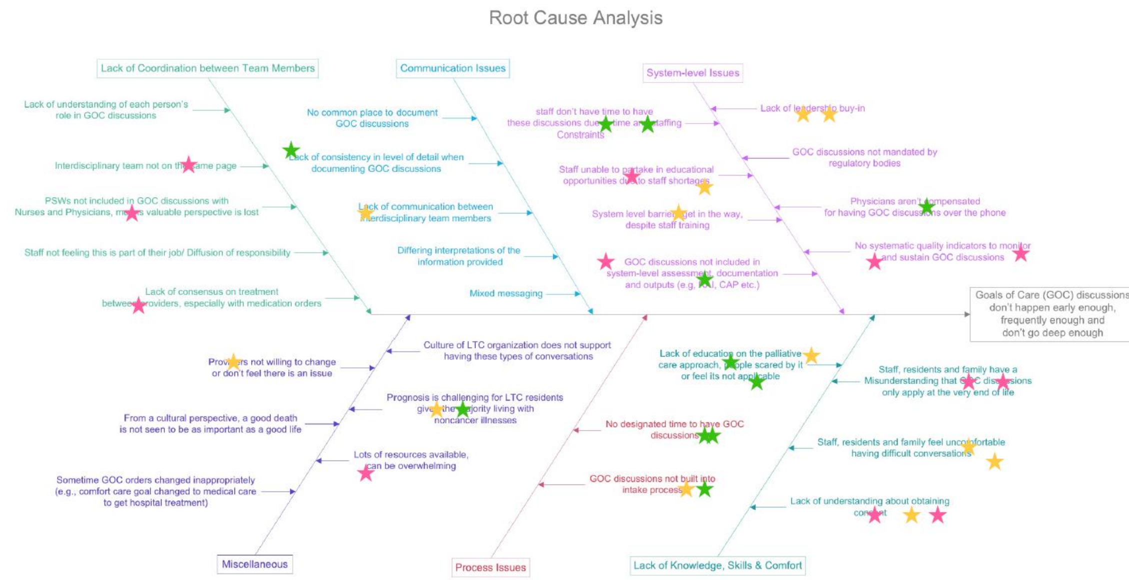
Selection of our first QI Opportunity

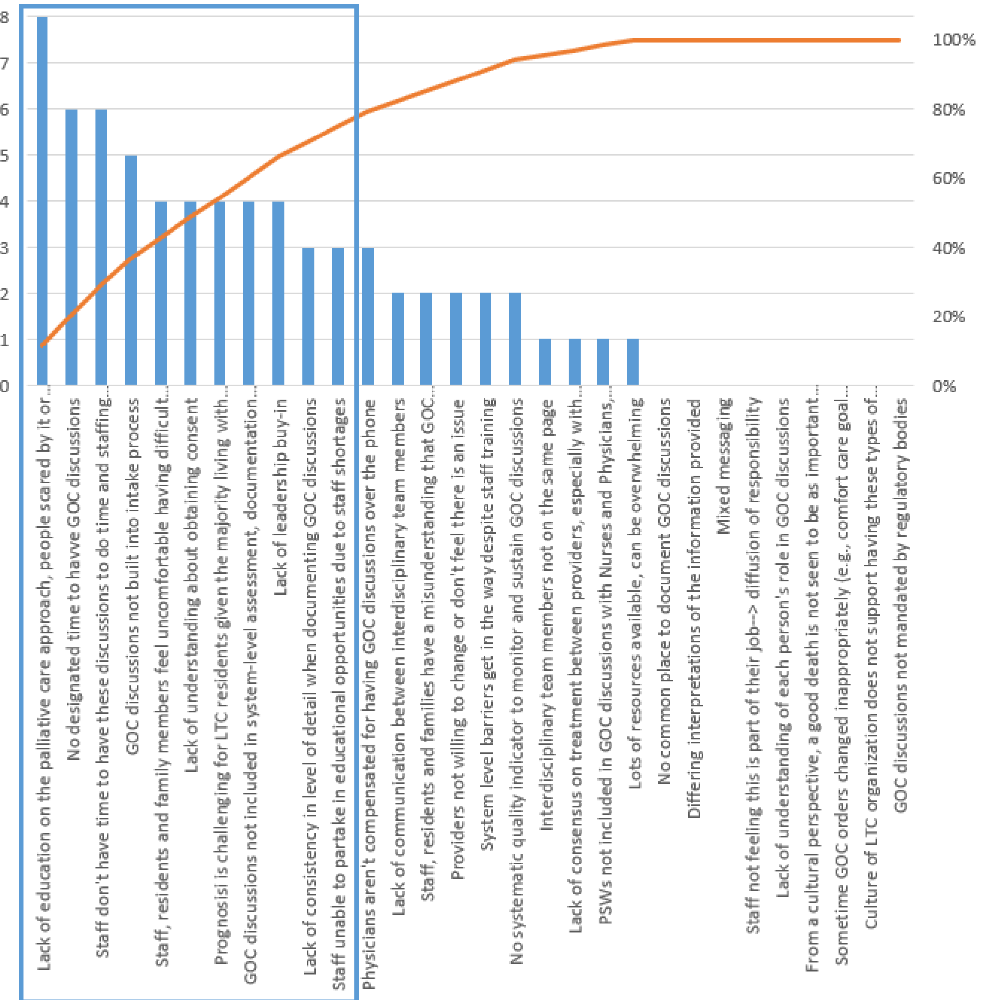
- Initial brainstorm by core group
- Broader COP voted on their top choice: Improving Goals of Care Conversations



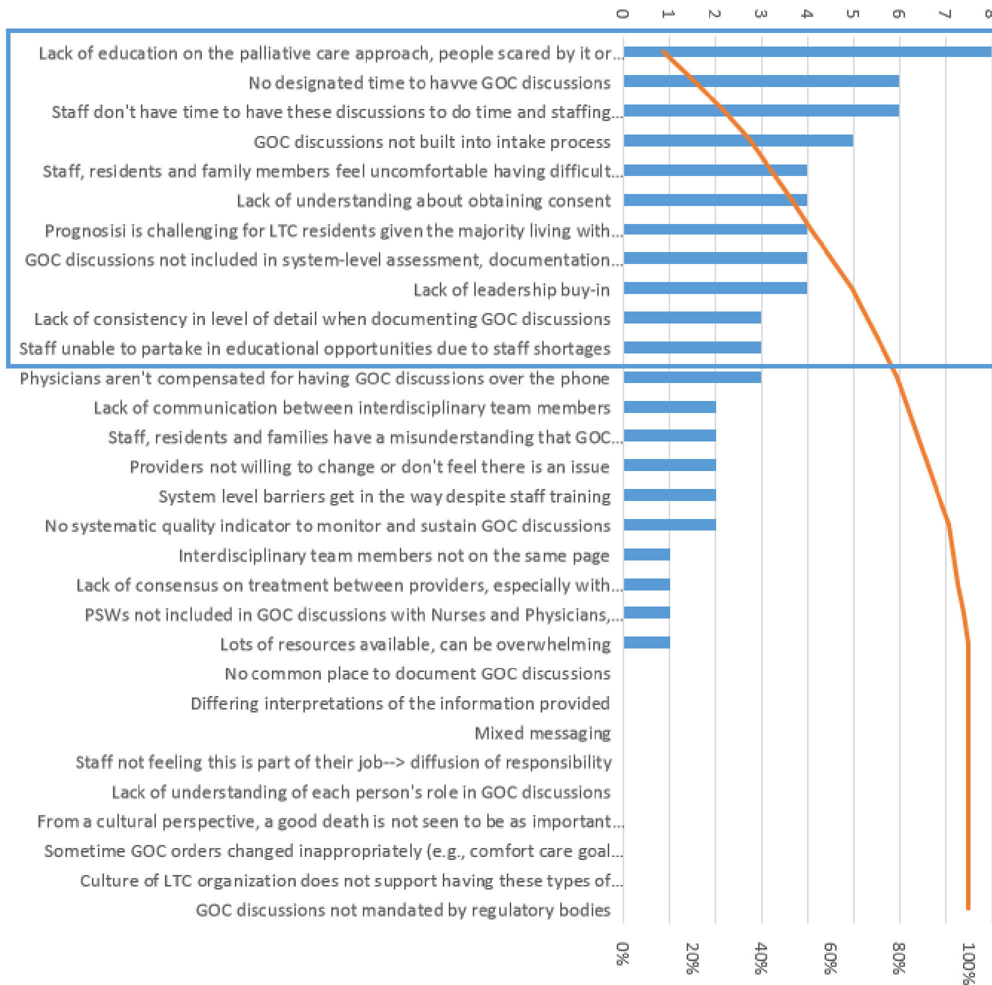
Identification of Root Causes

Prioritization of Root Causes





Prioritization of Root Causes



Root Cause	Sample Change ideas
Lack of education on the Palliative care approach (leading to lack of comfort, skills and knowledge when it comes to having goals of care conversations	• Mandatory LEAP Training for all new staff • Mandatory Training for all staff in use of the Serious Illness Conversation Guide
Lack of time to have goals of care conversations	• Senior management to work with staff and physician team to create time for nurses and PSWs to participate in care conferences
Not built into current workflow	• Ensure goals of care conversations are included as part of intake process (depends on the condition of the resident and family wishes?) • Ensure goals of care conversations are scheduled at a minimum twice a year, but also with any change in status, and prior to and before hospital transfer, and at end of life
Challenges in prognosis	• Obtain data from the RESPECT tool for each resident prior to formal care conferences
Lack of consistency in level of detail when documenting Goals of Care discussions	• Discussing a potential treatment plan for future complications e.g. infection, fall, aspiration • Discussing risks of hospitalization

Brainstorming Activity: Change ideas to improve Goals of Care Discussions in Long-Term Care

Root Cause	Change ideas
Lack of education on the Palliative care approach (leading to lack of comfort, skills and knowledge when it comes to having goals of care conversations	• Mandatory LEAP Training for all new staff • Mandatory Training for all staff in use of the Serious Illness Conversation Guide • Tap into palliative care consultants! • Mentorship opportunities from PPSMCs (in Ontario) and other palliative experts in the local areas- their role is to help build capacity in the region • Add this education as part of orientation for new staff and have an annual refresher for all staff • Have community of practice at care home level or regional level to sustain the education • Need to inspire people that the palliative care approach is a team approach, everyone's responsibility, to get them to buy in to the education itself • Ensuring staff are paid or backfilled for getting this education • Make tools and resources available to people (e.g. posters in staff room) • Huddles after death- debriefing after case conferences, transfers- promote teamwork, cross collaboration • Include family educations (brochures, 1-pagers) • Toolkits to tackle distress both for families and staff • Resident/ family education at family/ resident council • We need to practice, I think part of these discussions are our team members are afraid/not comfortable.
Lack of time to have goals of care conversations	• Senior management to work with staff and physician team to create time for nurses and PSWs to participate in care conferences • These conversations can be done on the fly (doesn't need to be all or nothing) • Having a "template" so that even staff that don't feel very confident in the discussion can know what to address when the chance to have goals of care conversations arise • I know this isn't about palliative but we have been reviewing our daily routines to determine how we are utilizing our daily time • Work as a team to open the conversation with the patient

Root Cause	Change ideas

Not built into current workflow	• Ensure goals of care conversations are included as part of intake process (depends on the condition of the resident and family wishes?)
	• Tend to have post admission conferences 6 weeks after
	• Need buy-in from leadership
	• Ensure goals of care conversations are scheduled at a minimum twice a year, but also with any change in status, and prior to and before hospital transfer, and at end of life
	• Pre-admission package, identify
	• Review at any major changes
	• Guild in GOC within other chronic disease conversations
	• Electronic trigger through EMR, especially for NP or MD to lead that discussion at the ideal times
	• Consider when is the right time
	    • When first admitted it might be too fast
	    • GOC conversations are built in to our current flow. We don't require buy in from the leadership team. We have this implemented at the point of care including the RN/RPN, PSW team as well as the Interprofessional team

Challenges in prognosis	• Obtain data from the RESPECT tool for each resident prior to formal care conferences, can help guide health care team • Illness trajectories • Clinical frailty scale, combine all, diff ways of displaying/ sharing information

Root Cause	Change ideas
Lack of consistency in level of detail when documenting Goals of Care discussions (convo just focuses on DNR, hospitilization status)	• Discussing a potential treatment plan for future complications e.g. infection, fall, aspiration • Discussing risks of hospitalization • Depends on documentation system, can create template, but each home would dhave to make that on their own. Would be good • Look at sample • Include spiritual health assessments, look at beliefs, culture, beliefs, • Important to involve the family, can't leave it too late

Next Steps

Quality Improvement Condensed (QUIC) Toolkit

- Core team will continue to work on QUIC prototype, incorporating feedback from today's session

Sample Aim Statements

- By March 2023, we are aiming to have had GOC discussions documented in 80% of residents' charts.

Sample Quality Measures

Type	Indicator
Process Measures	• % of residents with identified palliative care needs who have documented discussions with a health care professional about their goals of care in their medical record* • # of goals of care discussions taking place per resident per year • % of residents who have had at least 1 goals of care discussion involving more than DNR and DNH (e.g., plan for future infections, falls, aspiration etc.)
Outcome measures	• % of residents with identified palliative care needs (or their caregivers) who state that discussions with a health care professional about their goals of care helped them to make treatment decisions* • % of residents with identified palliative care needs (or their caregivers) who state that discussions about goals of care with a healthcare professional happened at the right time* • # of preventable hospitalizations
Balance Measures	• Level of distress of staff, residents and caregivers in having more frequent goals of care discussions • # workload complains

*Source: HQO- https://www.hqontario.ca/portals/0/documents/evidence/quality-standards/qs-palliative-care-clinical-guide-en.pdf

PDSA Cycle Template

PDSA # 1				
Plan	What change do we want to test out?			
	Scope & Timelines			
	What do we predict will happen?			
	What could block us vs. help us?	Barriers or Facilitators	Mitigation/ Enhancement strategies	
	What steps are needed to implement this change?	What	When	Who is responsible?
	How will we measure if this change was successful?	Measure Description	Type of measure	How will this be measured & by who?
Do	What happened when you implemented the change?			
Study	What happened when this change was implemented? Compare the data to your predictions			
	What were the lessons learned?			
Act	Is this a change worth maintaining?			

Project ECHO Palliative Care - Canada BY Pallium Canada

Session Wrap Up

- Please fill out the feedback survey following the session! Link has been added into the chat.
- A recording of this session and a copy of these slides will be emailed to registrants within the next week.
- We hope to see you again at our next session taking place on **September 11th, 2023.**
- Thank you for your participation!

Project ECHO Palliative Care - Canada BY Pallium Canada

Thank You

Stay Connected
www.echopalliative.com