Long-Term Care Quality Improvement Community of Practice

Introduction to the QUIC Toolkit

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Presenters: Dr. Amit Arya & Holly Finn

Date: September 11th, 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.

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- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
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- Delivered online or in-person.
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- Accredited by CFPC for **26.5 Mainpro+ credits** (online) and **26.5 Mainpro+ credits** (in-person).

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Introductions

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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.

Welcome and Reminders

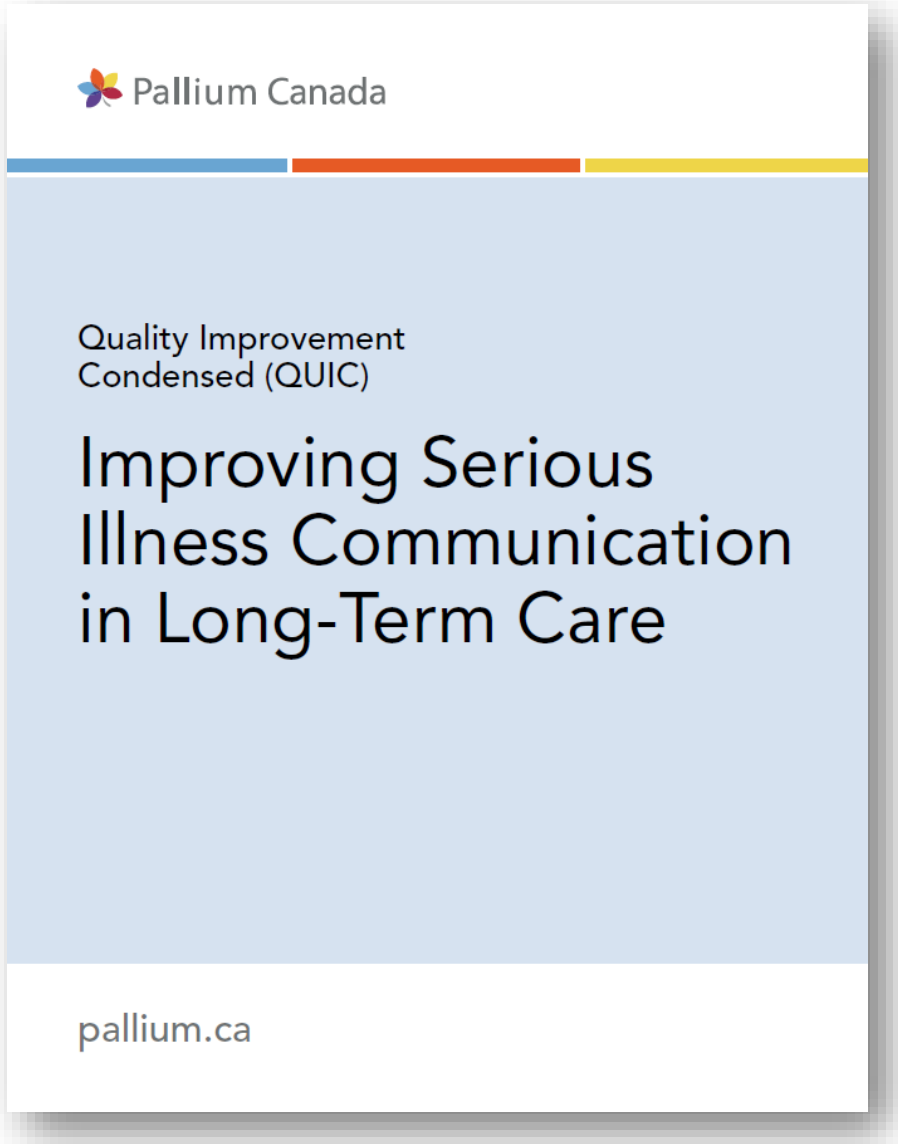
- Please introduce yourself in the chat! Let us know what province you are joining us from and what your role is in the Long-Term Care setting.
- Your microphones are muted. There will be time throughout this session for questions and discussion.
- You are welcome to use the chat function to ask questions, 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.

Our Goal for Today's Session:

- Provide a high-level overview of the Quality Improvement Condensed (QUIC) Toolkit Prototype
- Provide instructions on how you can provide your feedback on this prototype
- Discuss the ongoing needs of this Community of Practice and how we would like to move forward

About this Toolkit

- QUIC= Quality Improvement Condensed
- Part of a broader collection of QUICs
- Follows Model for Improvement framework from the Institute for Healthcare Improvement
- Aims to support those working in LTC homes to improve serious illness communication with Residents and their Caregivers
- Includes relevant examples and resources throughout
- Was developed with your support!



A Note on Terminology

- Many terms can be used to describe the varying aspects of serious illness communication (e.g., Goals of Care Discussions, Advance Care Planning, Consent for treatment etc.)
- The *Prepare or Decide* framework can help to avoid confusion between the terms

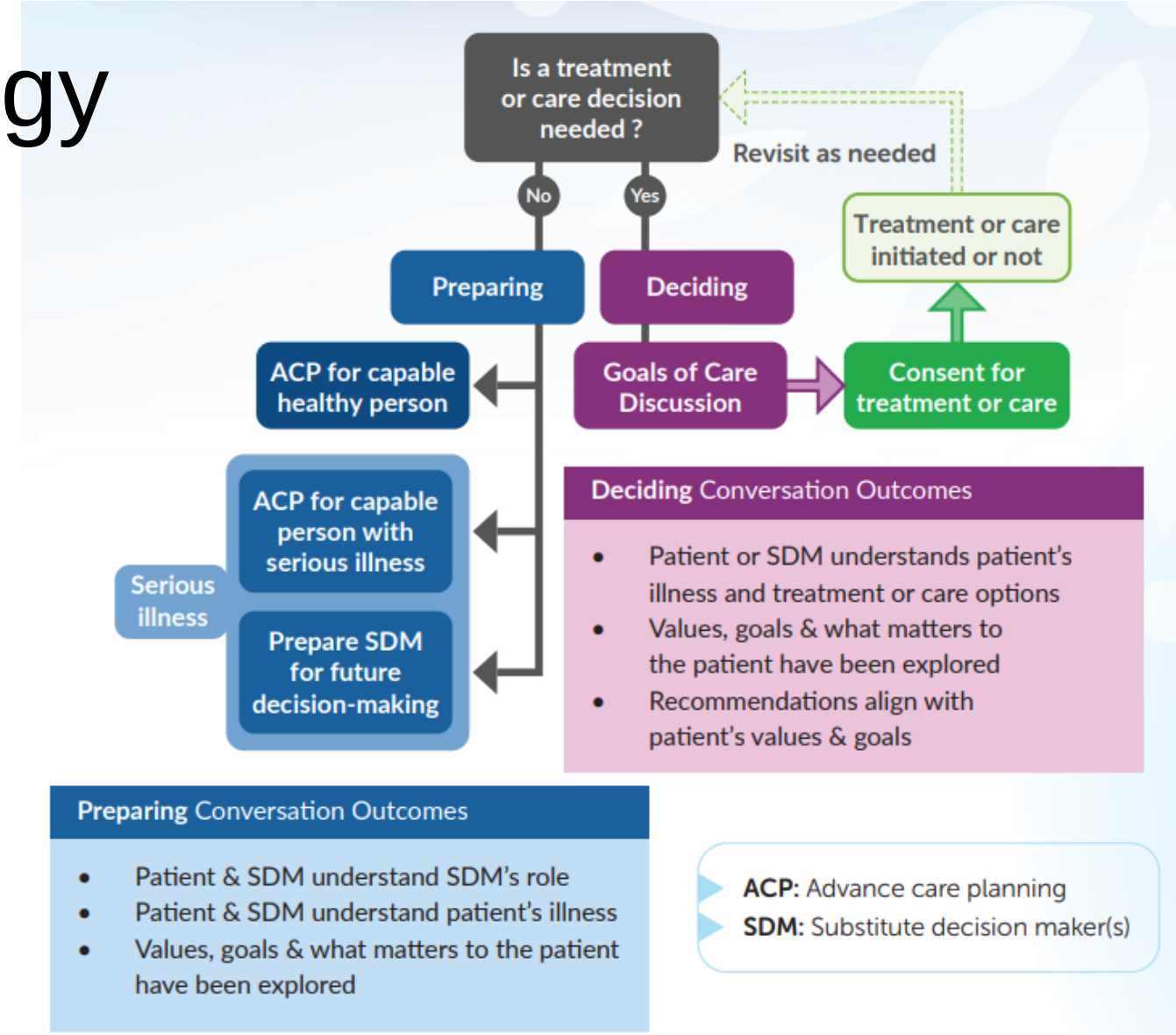


Image Source: https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/questions-ask-yourself-make-difficult-conversations-about-serious-illness-easier/questions-ask-en.pdf

Why this QUIC Matters

- Serious illness communication is important
  - Advance Care Planning promotes person-centred care
  - Goals of Care discussions associated with improved end-of-life care for residents and reduced stress, depression and anxiety for caregivers
- This communication is not happening early enough, often enough and sometimes only scratches the surface
  - Goals of care discussions should be part of every clinical encounter involving decisions such as starting antibiotics, initiating opioids for symptom management or considering whether to transfer to hospital
  - We are missing the mark when serious illness communication only touches on DNR and DNH orders


KEEP
CALM
AND
TAKE ONE STEP AT
A TIME
KeepCalmAndPosters.com

QUIC Steps

STEP 1: GET STARTED

Ask: Is this something I want to do in one area of the home or in the entire long-term care home?

- Sometimes you may need to start small and then highlight your successes to inspire medical directors, attending physicians/nurse practitioner's, administrators and directors of care to make a more sweeping change.

Ask: Who can help me with this?

- This may be one or two colleagues. Can be from different professions and/or administrative team.

Have an infor colleagues yo

- Explore this thinking ab improveme
- Consider if sense in yo and what y

STEP 2: DOES THIS APPLY TO US?

Consider one or two of the following:

- Chart audit (See **Resource 3**)
- A check sheet (See **Resource 3**)
- Case reflections (See **Resource 3**)

- If this confi illness com care home, proceed to the next step.

RESOURCE 3: CONFIRMING THE NEED

Chart Audit

- This strategy involves reviewing a sample of charts. A randomized sample will likely suffice as almost all residents in your home would likely benefit from a palliative care approach. Or if you would like to look at a more targeted sample, you could do a search for residents who have had hospital transfers, or a Palliative Performance Scale (PPS) completed in their chart or consider reviewing a list of residents and asking yourself the surprise question (See Resource 2).
- When reviewing these charts, check to see how often these conversations are happening or when they are happening. For example, if there was a transfer back from the hospital or a new treatment initiated (e.g., antibiotics, X-ray) did a goals of care conversation take place? It is recommended to check to see how many residents had a goals of care conversation at least two times per year.
- In cases where you come across a goals of care conversation that has taken place, check to see if the conversation went beyond a DNR and DNH discussion. Was a palliative care plan proposed? Was there a plan to treat the underlying disease in the long-term care setting with the resources available?

Check Sheet (prospective)

- Prepare a simple check sheet (paper-based, word document or excel document).
- For every resident with a serious or advanced illness that you see over the next one to two months — determine a time frame that is most realistic — add them to the list and complete the columns.
- Use the results to confirm or exclude an improvement opportunity.

Table 1: Sample check sheet

Chart #	Recent transfer back from hospital and/or new treatment?	Did a GOC conversation take place?	What was discussed as part of this conversation?
234532	Yes	Yes	DNR, DNH
32432	No	N/A	N/A
342132	Yes	No	N/A

STEP 3: GET PEOPLE ON BOARD

The following steps are recommended:

- Ensure leadership is onboard by getting sign off on a project charter (see **Resource 1**).
- Determine who will be the project lead(s) who will help keep things moving forward. Consider pairing a clinical lead with an administrative lead.
- Form a project team that is representative of those who could potentially impact, or be impacted, by t
are incorporating
This team will be

QUIC – Project charter/Plan template

Project Name	
Organization Name	
Date Charter Created	
Date Last Modified	

Project Description
What is the problem (remember to include any learnings you've gathered when identifying the need in Step 2)? Why does this issue matter? What are the overarching goals of this project?

Scope

Schedule

Phase	Tasks/ *Milestones*	Start Date	End Date	Status
Initiation	Receive sign off from key stakeholders			
Planning	Take a deeper dive			
	Prepare for change			
Implementation	PDSA Cycle #1			
	PDSA Cycle #2			
	PDSA Cycle #3			
Closing	Review Lessons Learned			
	Celebrate!			

RESOURCE 1: TEMPLATES

Project charter/plan templates

- The **project charter/plan template** can initially be used as a project charter to get leadership on board.
- Once the project has gotten started, this template can evolve into a detailed project plan, summarizing key decisions (e.g., AIM statement, measures identified).

Communication templates

- Communicating your quality improvement initiative is an important part in determining the success of your project.
- Access the **E-mail templates** and **poster templates** for customizable templates can help you spread the word about your quality improvement project.

PDSA worksheets

- A PDSA cycle is a useful tool for documenting and testing out change ideas.
- See **PDSA Cycle #1** and **PDSA Cycle #2** for sample worksheets.

STEP 4: A DEEPER DIVE

Ask: What are the root causes o

- When undertaking QI work, it
to understand the root causes
problem at hand; otherwise, y
the risk of finding solutions tha
address the actual root causes

- Several simple tools are availa
diagnose and understand the problem(s) and its contributing factors. (See **Resource 4**)

Ask: Are we ready to make a change?

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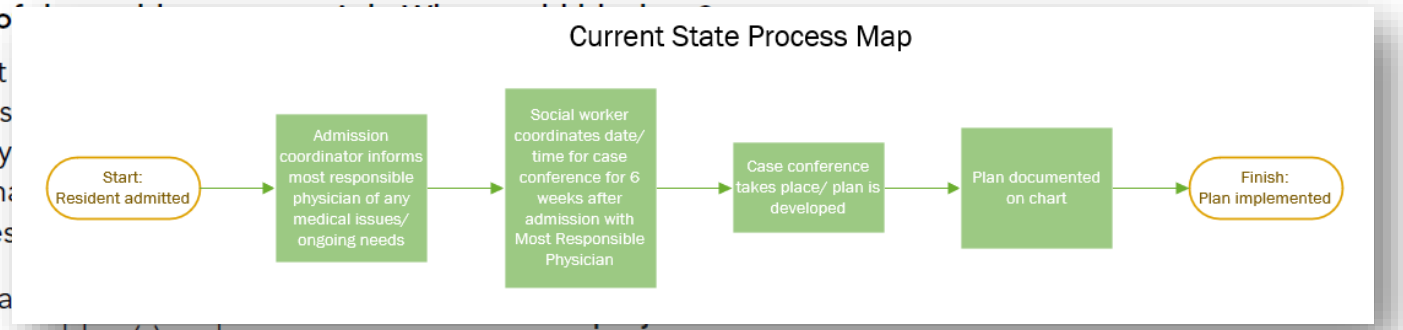
(See **Resource 4A** for examples)



- In project management, a key area of focus is stakeholder management, which involves the identification of anyone who could be impa

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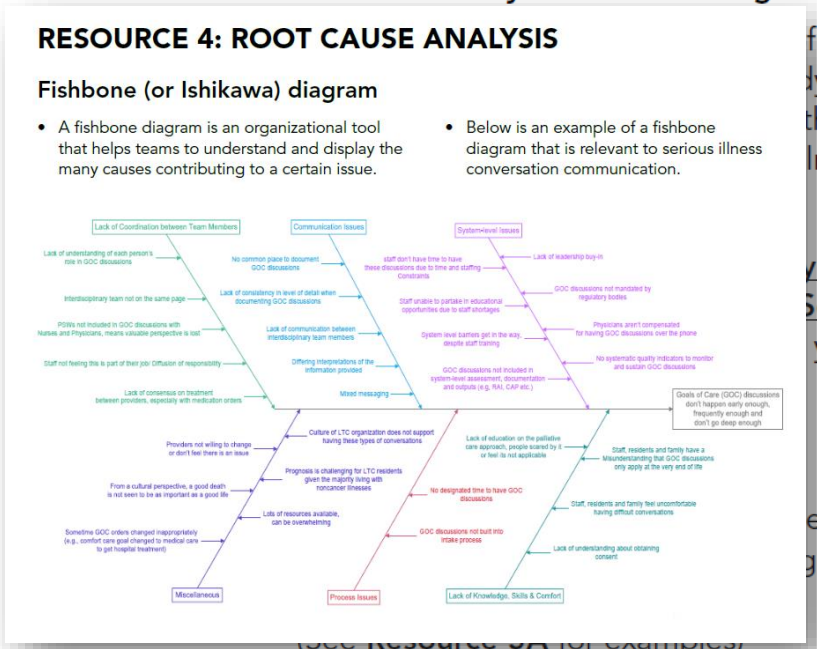


STEP 5: PREPARE FOR THE CHANGE

What are we trying to accomplish?

Summarise your problem

- A problem statement clearly defines what is currently not working well and what the effect is on quality.
- **Example:** Staff in our long-term care home are frustrated when serious illness conversations occur without providing information about prognosis. This leads to uninformed decision making.
- **Example:** We are not having serious illness conversations with residents and caregivers early enough or often enough at our long-term care home. This is resulting in increased hospital transfers, and diagnostic tests or procedures that may not provide a benefit.

Develop an AIM STATEMENT

- An aim statement helps us to better understand what we are trying to accomplish by answering the "what," "by how much" and "by when." Aim statements should be SMART (Specific, Measurable, Actionable, Relevant and Timebound).
- **Example:** By April 2024, we aim to have had at least two in-depth serious illness conversations documented in 80% of residents' charts.
- **Example:** By March 2024, we aim to have had goals of care discussions with 60% of residents and caregivers who have been transferred back from hospital or had a new treatment initiated.

How will we know it is an improvement?

It is important to determine what you are going to measure so that your team will know whether or not you have made an improveme

Usually, three types of measures are used in a QI pro examples of these three types of measures — see R

Process measures

- By tracking process measures, we can ensure tha doing the things that we want to be doing.
- **Example:** Percentage of residents and caregivers discussion with their care provider(s) following a t initiation of a new treatment (e.g., antibiotics, X-r

Outcome measures

- Tracking outcome measures helps us to understa the change is having the intended impact.
- **Example:** Percentage of residents with identified palliative care needs (or their caregivers) who state that discussions with a healthcare professional about their serious illness helped them to make treatment decisions.[2]

Balance measures

- Balance measures help us to determine if the change we've implemented has led to any unintended consequences (whether good or bad).
- **Example:** Number of staff, residents and caregivers reporting increased levels of distress after having these conversations.

RESOURCE 8A: MEASURES TO TRACK CHANGE

Measures

(Examples. Develop further to best suit your practice)

Process Measures

- Percentage of residents with identified palliative care needs who have documented serious illness conversations with a healthcare professional documented in their medical record.[2]
- Average number of serious illness conversations taking place per resident per year.
- Percentage of residents who have had at least one serious illness conversation involving more than simply DNR and DNH (e.g., plan for future infections, fall, aspiration) in the past year.

Outcomes Measures

- Percentage of residents with identified palliative care needs (or their caregivers) who reported that discussions about serious illness with a healthcare professional happened at the right time.[2]
- Number of hospitalizations for individuals who could have received end-of-life care in the long-term care home such as the number of preventable hospitalizations.
- Percentage of staff reporting to feel somewhat or very comfortable in having conversations with residents and their families about end-of-life decision-making and other care decisions.

Balance Measures

- Number of workload complaints.
- Number of complaints about staff working out of their scope of practice in relation to this project.

Sample root causes	Sample change ideas
Lack of interprofessional collaboration	• Hold staff pre-briefs and debriefs around care conferences. Consider including PSWs in these conversations. • Hold interprofessional huddles following the death of a resident. Consider what went well and opportunities for improvement. • Enact policies and procedures that help to break down hierarchies between professions. • Develop a standardized way for PSWs or care aides to document what they've learned regarding resident's values and wishes. • Clarify the roles and responsibilities of each team member.
Not built into the current workflow/systems	• Ensure serious illness conversations are scheduled at a minimum twice a year, but also with any change in status, and prior to and before hospital transfer, at end-of-life. • Schedule serious illness conversations as part of intake process, considering when would be the right time for each individual and adjust as needed if things change in the meantime. • Think of ways to incorporate serious illness conversations more informally. It doesn't have to be all or nothing! • Create and implement a "template" in the residents' chart to help guide these conversations. • Find ways to build in serious illness conversations within other chronic disease conversations. • Build in electronic triggers through electronic medical record, especially for NPs or MDs to lead these discussions at the ideal times.
Lack of time	• Review daily routines to determine how daily time is being utilized and if there are opportunities to adjust how much time is spent on certain activities. • Ask for support from palliative care nursing consultants if this is an available resource.

Screening tools to trigger Serious Illness Communication

Palliative Performance Scale (PPS)

- The Palliative Performance Scale (PPS) is a reliable and validated tool that is used for assessing a patient's functional performance.
- It has been translated into as many as 17 languages

The Surprise Question

- The Surprise question promotes the initiation of a palliative care approach earlier on
- For any patient with a serious illness, ask, "Would I be surprised if this patient died within the next 6–12 months?" If the answer to the question is "No," then a palliative care approach should be activated if it has not yet been activated.
- Not designed to be used as a prognostic tool.

Gold Standards Framework

Supportive Palliative Care Indicators Tool (SPICT)

- The Supportive and Palliative Care Indicators Tool (SPICT) is derived from the Gold Standards Framework (GSF) prognostication tool (UK)
- Consists of a single page that includes general (i.e., weight loss, hospital admissions) and broad specific disease indicators (i.e., breathlessness at rest for heart and respiratory disease).
- Includes an assessment approach.
- Can be applied across all care settings.
- Not disease specific.

Clinical Frailty Scale

- A 9-point scale that quantifies frailty based on function in individual patients.
- It is complemented by a visual chart to assist with the classification of frailty.
- Higher scores indicate increased frailty and associated risks.

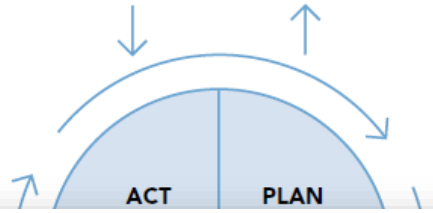
Prognostication tools

RESPECT: Risk Evaluation for Support: Predictions for Elder-life in the Community Tool

- A newly developed electronic prognostic algorithm.
- Since it uses data routinely collected in home care, it can be used to identify all individuals within home care populations who are at risk of clinical decline and may benefit from palliative care.

STEP 6: PLAN, DO, STUDY AND ACT (P)

- A Plan-Do-Study-Act (PDSA) Cycle is a useful tool for documenting and testing out change ideas.
- Sometimes, more than one PDSA cycles are needed. Ma
small changes and tweaks after each cycle and test.



Working through the steps

(*See* Resources 1 for a PDSA template and sample PDSA v

Stage	Steps to take (*modify to your practice*
Plan	• Start by planning hov • Be sure to engage th
Do	• Implement your plan • Observe and keep n • Collect data — keep
Study	• Analyze what happe • Compare the data to • Summarize what you learned. • Keep the whole team informed with periodic reporting of the results as they come in.
Act	• Determine whether this is a change worth maintaining or if modifications are needed (adopt, adapt or abandon).

QUIC – PDSA template

PDSA Cycle # 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 and by who?

STEP 7: CELEBRATE

STEP 8: SUSTAIN

Plan for sustainability from the offset.

- Strategies include forced functions for periodic monitoring and reporting of performance (e.g., periodic audit charts).

What will help for sustainability:

- Periodic reminders (email or mention at team meetings monthly or quarterly).
- Mentions at QI huddles.
- Periodic monitoring (quick audit or check sheet).
- Periodic reporting.

CELEBRATE the improvement's birthday every year!

SHARE YOUR QI LEARNINGS (SUCCESSES OR FAILURES)

- When an improvement has successfully been made, **CELEBRATE!**
- Find a fun way to announce the achievement and to celebrate it. Thank everyone who was involved and give yourselves a pat on the back.

SHARE YOUR STORY AND LEARNINGS WITH OTHERS

- The lessons we learned are important, whether one succeeds, fails, or continues to try.
- Share your QI work with Pallium and consider getting involved in one of the Palliative Care ECHO Project's Quality

Your Feedback is Welcome!

- A prototype of this QUIC toolkit will be circulated to members of this Community of Practice within this next week
- We would greatly appreciate your input. We will provide a link to capture your feedback. The deadline for submissions is October 11th, 2023.
- We plan to showcase the **finalized version of this toolkit** in a national ECHO session that is taking place on **World Quality Day taking place on November 9th, 2023.**

Future Directions for this COP

- When we established this Community of Practice, our main goals were to:
  - Identify palliative-care related QI opportunities in the Long-Term Care setting
  - Develop Quality Improvement Toolkits and provide peer support to teams who decide to embark on quality improvement initiatives in their homes
- Do you have an interest in starting a QI project around serious illness communication in your home?
- Do you feel this COP could be a source of support for you on your QI Journey?
- Are there other areas of interest that you think this COP could be helpful for?

Next Steps

- Please fill out our feedback survey, a link has been added to the chat!
- Within the next week, we will send out a copy of these slides, along with a recording of today's discussion and a copy of the QUIC prototype to members of this group.
- Please do not distribute the prototype more broadly as it is very rough!
- Please do provide us with your feedback via the link that will be provided to you.
- Join us for the final reveal on November 9th 2023.
- Stay tuned for more information on future plans for this COP.

Thank You

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