Improving Essential Conversations in Long-Term Care

Introduction to the QUIC Toolkit

Project ECHO Palliative Care - Canada BY Pallium Canada

WORLD QUALITY WEEK 2023 CQI | IRCA

Presenters: Dr. Amit Arya, Elizabeth Wojtowicz & Holly Finn

Date: November 9, 2023

Territorial Honouring

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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Introductions

Presenters

Dr. Amit Arya, MD, CCFP (PC), FCFP
Medical Director, Specialist Palliative Care in Long Term Care Outreach Team, Kensington Gardens, Toronto
University of Toronto
Assistant Clinical Professor, Division of Palliative Care, Faculty of Health Sciences,
McMaster University

Elizabeth Wojtowicz, NP
Director of Clinical Practice, Thrive Group – Idlewyld Manor LTC
Nurse Practitioner

Holly Finn, PMP
Senior Manager of Program Delivery
Pallium Canada

Support Team

Diana Vincze
Palliative Care ECHO Project Manager, Pallium Canada

Aliya Mamdeen
Program Delivery Officer, Pallium Canada

Disclosure

This program has received financial support from:

- Health Canada in the form of a contribution program.
- Generates funds to support operations and R&D 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.
- Elizabeth Wojtowicz: no conflicts of interest to disclose.

Welcome & Reminders

- Use the chat function to introduce yourself and to add comments throughout
- For questions, use the Q&A function to be addressed by presenters at the end of the presentation.
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session.

Introduction to the QUIC Toolkit

About this Toolkit

- This Quality Improvement Condensed (QUIC) toolkit is 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 essential conversations with Residents and their Substitute Decision Makers
- Includes relevant examples and resources throughout
- Developed with the support of the Long-Term Care Quality Improvement Community of Practice
- Available free of cost at https://www.pallium.ca/palliative-care-resources/

Terminology

- Essential Conversations: Conversations that aim to align medical care and treatment with patients' values, goals, priorities and preferences
- Many terms can be used to describe the varying aspects of essential conversations (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

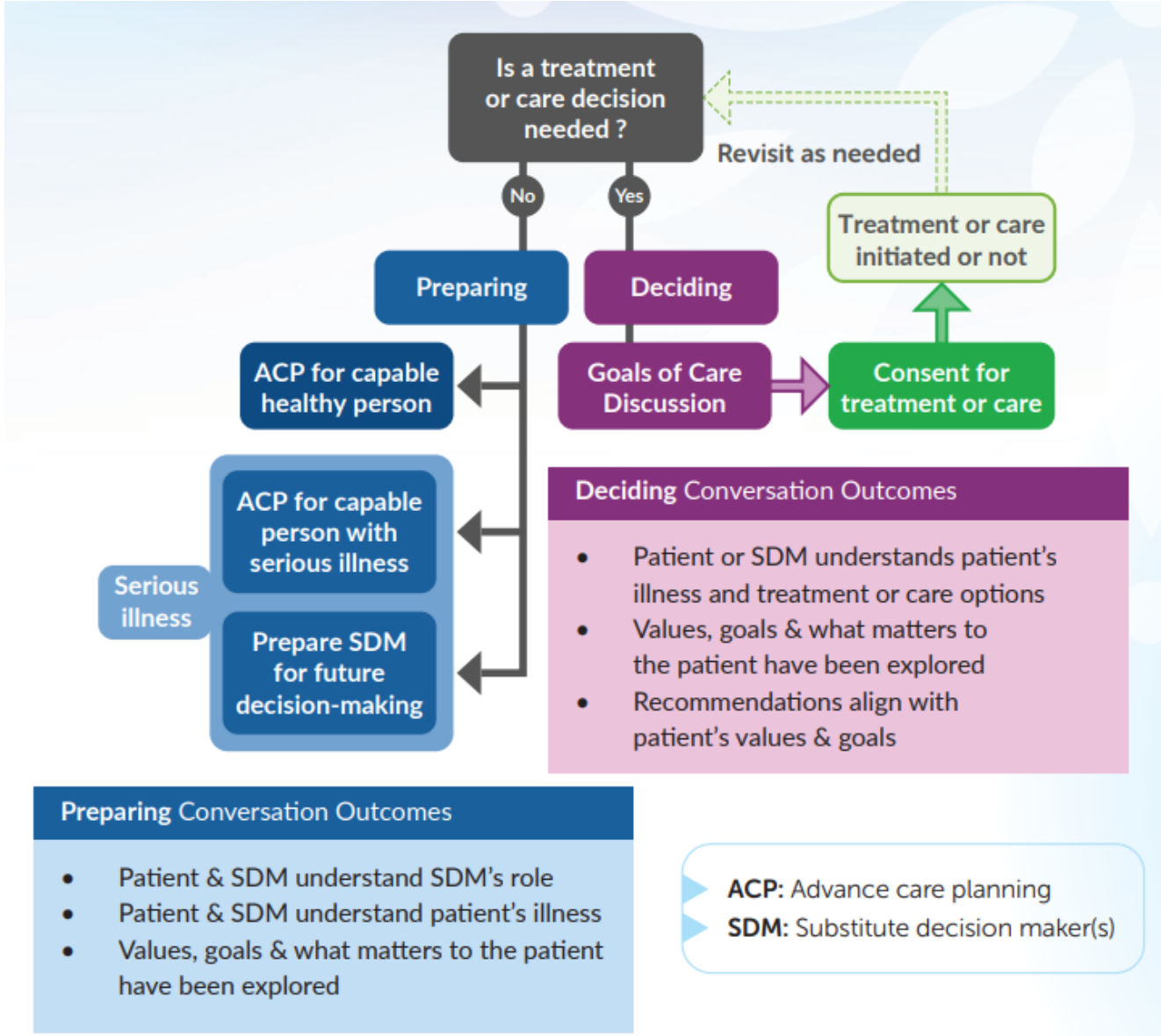

Image Source: https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/questions-ask-yourself-make-difficult-conversations-about-serious-illness-easier/questions-ask-en.pdf

Why this QUIC Matters

- Essential conversations associated with improved end-of-life care for residents as well as reduced stress, depression and anxiety for their surviving loved ones[1,2]
- These conversations are not happening early enough, often enough and often only scratch the surface
- It's never too early for essential conversations about one's serious illness, but it can be too late
- This toolkit was designed to give long-term care homes the tools and resources to optimize the frequency and quality of these important conversations

[1] Wright, Alexi A et al. "Associations between end-of life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment." JAMA vol. 300,14 (2008): 1665-73. doi:10.1001/jama.300.14.1665.

[2] Zhang, Baohui et al. "Health care costs in the last week of life: associations with end-of life conversations." Archives of internal medicine vol. 169,5 (2009): 480-8. doi:10.1001/archinternmed.2008.587.


KEEP
CALM
AND
TAKE ONE STEP AT
A TIME
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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 practitioners, administrators, and directors of care to make a more sweeping change.

Ask: Who can help me with this?

- Consider one or two colleagues who might have an interest in this. They may be clinical or administrative.

Have an informal chat with the colleagues you've identified

- Explore this QUIC together to start thinking about how to implement improvements in your practice.
- Consider if this type of project makes sense in your long-term care home and what you hope to accomplish.

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 confirms the need to improve essential conversations in your long-term 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 most residents in your home would likely benefit from a palliative care approach already. If you would like to look at a more targeted sample, you could search for residents who have had hospital transfers, 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. For example, if there was a transfer back from the hospital or a new treatment initiated (e.g., antibiotics, X-ray), did an essential conversation take place? It is recommended to check how many residents have had an essential conversation at least two times per year.
- In cases where you come across a goals of care conversation or advance care planning that has taken place, check to see if the conversation went beyond a DNR and DNH discussion. Were common future complications of the underlying disease discussed (e.g., falls, aspiration, infection)? Was a palliative care plan proposed? Was there a plan to treat the underlying disease or complication in the long-term care setting with the resources available?

Check sheet (prospective)

- Prepare a simple check sheet such as a 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.

Case reflections

- Reflect on a case, or multiple cases, of residents in your practice with a serious illness whose end-of-life care could have been better.
- Using a resident safety approach, review the cases and reflect if earlier, more frequent, or deeper goals of care discussions could have made a difference. Use these cases to inform the improvement opportunity.

Table 2: Sample check sheet

Chart #	Recent transfer back from hospital or new treatment?	Did a GOC conversation take place?	What was discussed as part of this conversation?
234532	Yes	Yes	DNR, DNH
324325	No	N/A	N/A
342132	Yes	No	N/A

STEP 3: GET PEOPLE ON BOARD

The following steps are recommended:

- Ensure leadership is on board by getting sign off on a project charter. (See **Resource 1**)
- Determine who will be the project lead(s) who will help to keep things moving forward. Ideally, you can pair a clinical lead with an administrative lead.
- Form a project team that is representative of those who could potentially impact, or be impacted, by this initiative. Ensure you are incorporating a variety of perspectives.
- This team will be involved in understanding what the issue is, preparing for the change and implementing the change.
- Start building awareness about this issue across your organization and communicate information that will spark a desire for colleagues to want to be a part of this change. People often need to hear the message multiple times and in a variety of ways before it can take a hold. (See **Resource 1** for communication templates)

Resources

RESOURCE 1: TEMPLATES

Project charter/plan templates

- The **QUIC project charter/plan template** can initially be used 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 these **email templates** for customizable templates to 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.
- **Sample PDSA cycle worksheets.**
- **PDSA cycle template.**

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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

Work breakdown:
- Take a deeper dive:
  - Identify root causes of the problem.
  - Determine readiness for change.
  - Reflect on barriers and facilitators.
  - Identify stakeholders.
- Prepare for change.
  - Develop problem statement.
  - Develop AIM statement.
  - Decide what to measure.
  - Come up with change ideas.
- Plan, Do, Study and Act.

Out of scope:
Assumptions:
Constraints:

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			

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QUIC – Email templates

TEMPLATE #1

When you're approaching the "Step 3: Engaging Stakeholders" phase in the QUIC process, use the following email template. These email templates can be modified and updated to fit the language of your organization.

Subject line: QI project to improve essential conversations launching soon!

Dear [Recipient's Name],

We're excited to introduce our quality improvement project at [Your Long-Term Care Home Name], aimed at improving the care and quality of life for our residents and their families.

Following the "Improving Essential Conversations in Long-Term Care," QUIC guide by the Palliative Care ECHO Project, we've identified a need for better discussions about serious illness, as evidenced by [insert findings from Step 2 of the QUIC: Does this apply to us? (e.g., a recent chart audit at our LTC home, showed that only _% from a randomized sample had had a goals of care discussion after being transferred back from hospital.)]

Improving these essential conversations with our residents and their caregivers will ensure our care and treatment we're providing aligns with our residents' values, goals, priorities, and preferences.

We are in the early stages of this project and need your help. We are looking for [insert approx. number of team members you are looking for] interprofessional team members to join us. As a team member, you will:

- Participate in <<describe frequency - weekly, biweekly, monthly, etc.>> project meetings.
- Share insights and feedback on root causes, performance measures, goals, and change ideas.
- Support the implementation of change ideas through iterative Plan, Do, Study, Act (PDSA) cycles.

This project is set to start on [start date] and will run for [duration]. For those not on the project team, we will make to sure to keep you updated on the project's progress through regular communications and updates.

If you have any questions, suggestions, or would like to be part of the project team, please feel free to reach out to [Project Leader's Name], our Project Leader, at [Project Leader's Email].

Thank you for your dedication to our residents and our caring community.

Sincerely,

STEP 4: A DEEPER DIVE

Ask: What are the root causes of the problem?

- When undertaking QI work, it is important to understand the root causes of the problem at hand; otherwise, you run the risk of finding solutions that don't address the actual root causes.
- Several simple tools are available to help diagnose and understand the problem(s) and its contributing factors. (See **Resource 4**)

Ask: Are we ready to make a change?

- You probably have a general sense of whether or not your long-term care home is ready to make a change in how they communicate with residents and their caregivers around serious illness.
- There are organization readiness assessment tools — such as the **Quality Palliative Care in Long-Term Care: Self-Assessment Checklist** — that can help you to determine readiness for change.
- Perhaps you will find that you are ready to make a change, but the rest of your long-term care home is not ready. If this is the case, you may need to implement changes in your own practice first. If you are successful in your efforts, you may inspire the rest of your team to make changes as well!

Ask: What can help us get there?

- Consider what would help you succeed in making positive changes, including resources or tools that already exist. (See **Resource 5** for examples)

Ask: What could block or hinder us?

- Inevitably, you will run into challenges when trying to change the way people work. Consider what barriers might come up and how you will mitigate these barriers. (See **Resource 6** for examples)

Ask: Who are our project stakeholders?

- In project management, a key area of focus is stakeholder management, which involves the identification of anyone who could be impacted by or have an impact on your project.
- Consider who your stakeholders are for this project and consider what engagement strategies would work best for each of them. (See **Resource 7** for examples)

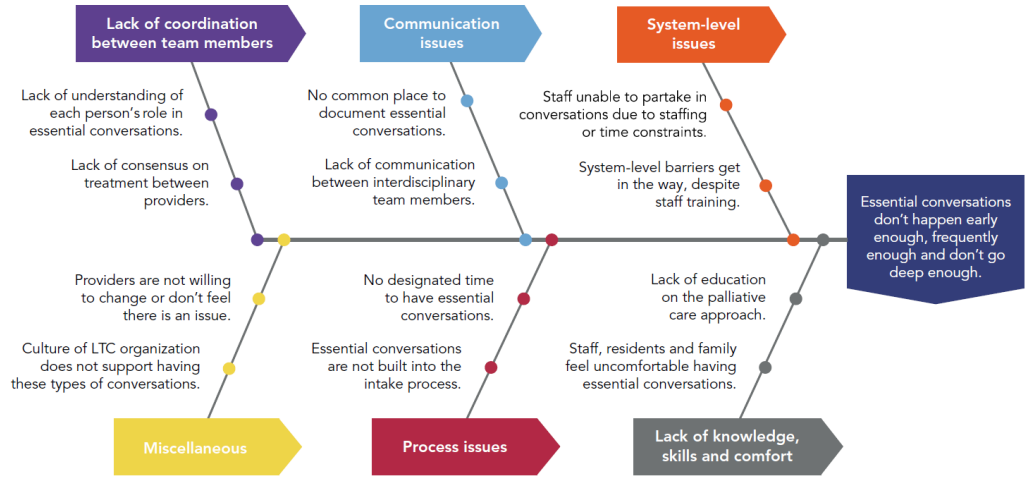
RESOURCE 4: ROOT CAUSE ANALYSIS

Fishbone (or Ishikawa) diagram

- A fishbone diagram is an organizational tool that helps teams to understand and display the many causes contributing to a certain issue.
- Below is an example of a fishbone diagram that is relevant to serious illness conversation communication.

FIGURE E: FISHBONE DIAGRAM

(CLICK TO ENLARGE FOR A MORE IN-DEPTH EXAMPLE)



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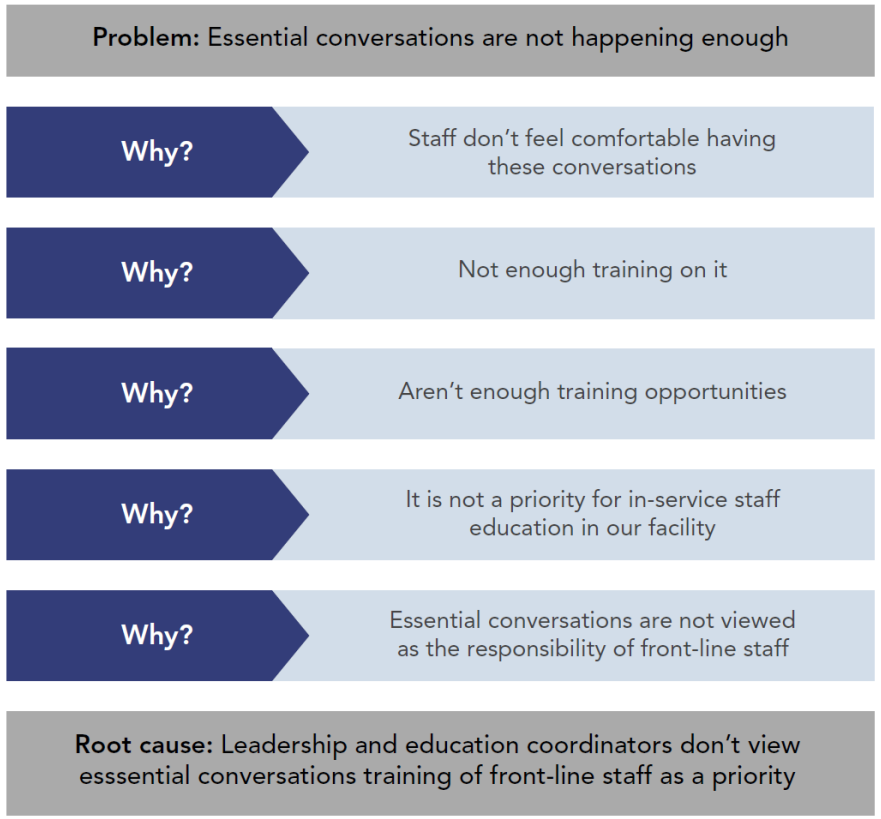
The five whys

- The five whys is a brainstorming method where the team repeatedly asks the question "Why" until the root cause of a problem is identified.
- **Figure G** shows an example of the five whys in action.

FIGURE G: EXAMPLE OF THE FIVE WHYS



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Process Mapping

- A process map is a visual representation of the steps in a given process. According to IHI, "understanding the process as it currently operates is an important step in developing ideas about how to improve it."
- By working with your team to map out a process in detail, you may be surprised at what you learn. You may uncover assumptions you held about the process that are incorrect, root causes you hadn't thought of and much more.

FIGURE H: A CURRENT STATE PROCESS MAP

This is a **current state** process map that was created before making any quality improvement changes. After creating this map, the team identified that a more inter-professional approach was needed. They also determined that waiting six weeks to have a care conference was too long for some residents.

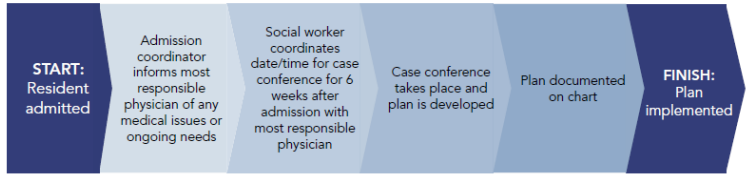
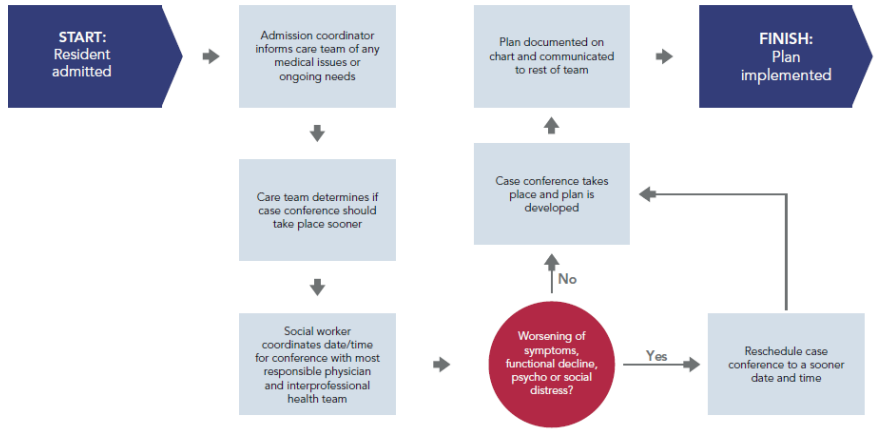


FIGURE I: A FUTURE STATE PROCESS MAP

Working together, the project team developed a **future state** process map that they felt would address the issues identified in the current process. Their first PDSA cycle focused on implementing this new process.



STEP 5: PREPARE FOR THE CHANGE

What are we trying to accomplish?

Summarize 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 essential conversations occur without providing information about the prognosis. This leads to uninformed decision making.
- **Example:** We are not having essential 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 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 essential conversations documented in 80% of residents' charts.
- **Example:** By March 2024, we aim to have had essential conversations with 60% of residents and caregivers who have been transferred back from hospital or had a new treatment initiated.

Image source: https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/aim-statements

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 improvement after implementing changes.

QI is a flexible framework that enables you to select measures that make the most sense for your home. You can get really specific or keep things broad.

Usually, three types of measures are used in a QI project. The following are examples of these three types of measures — see **Resource 8a** for more.

Process measures

- By tracking process measures, we can ensure that we are doing the things that we want to be doing.
- **Example:** Percentage of residents and caregivers who had a conversation about prognosis — an important component of essential conversations — with their care provider(s) following a transfer back from hospital or initiation of a new treatment (e.g., antibiotics, X-ray) within the past month.
- **Example:** Number of staff who have received training on essential conversations (e.g., using the Serious Illness Conversation Guide©).

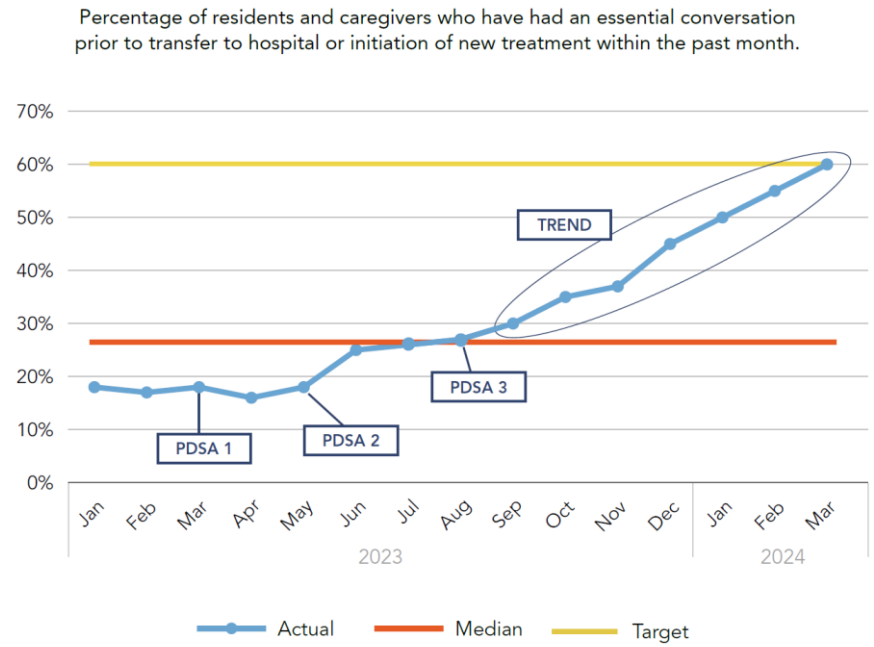
Outcome measures

- Tracking outcome measures helps us to understand if the change is having the intended impact.
- **Example:** Percentage of residents, or their caregivers, who state that discussions with a health care 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.

FIGURE J: SAMPLE RUN CHART



What changes can we make?

It is important to acknowledge that macro- (policy, population and government changes to improve care) level changes are also required. While discussing these changes and how to advocate for them are largely beyond the scope of this project, some of the changes which policymakers and governments should consider to improve essential conversations with residents in long-term care would include:

- Improving funding to address long-standing staff shortages.
- Ensuring that all health workers in long-term care have mandatory training in the palliative care approach, including how to communicate with residents and their substitute decision makers about serious illness.
- Ensuring that essential conversations are included in systems-level assessments (e.g., RAI) and are documented well.

Below are some examples of change ideas focus on the micro- (improving health worker skills to improve care for individual patients) and meso- (improving care at the community and organization levels) level — see **Resource 9** for more.

Table 1: Examples of micro- and meso- level change ideas

Sample root causes	Sample change ideas
Lack of education on the palliative care approach	• Provide education and resources to residents and caregivers regarding the palliative care approach and different aspects of serious illness communication.
Lack of interprofessional collaboration	• Hold interprofessional huddles following the death of a resident, in particular for difficult cases. Consider what went well and opportunities for improvement.
Not built into the current workflow or systems	• Schedule serious illness conversations as part of intake process. Consider when would be the right time for each individual and adjust as needed if things change in the meantime.

Screening tools to trigger essential conversations

Palliative Performance Scale (PPS)

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

The Surprise Question

- The Surprise Question promotes the initiation of a palliative care approach earlier on.
- For any resident with a serious illness, ask, "would I be surprised if this resident 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

- Practical guide for clinicians enabling earlier recognition of decline for residents considered to be in their final year/s of life, enabling better assessment of their needs and planning care in line with their needs and wishes.
- See the Gold Standards Framework here.

Supportive Palliative Care Indicators Tool (SPICT)

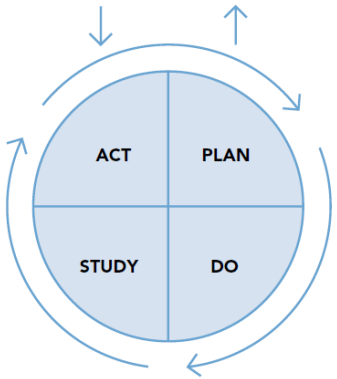
- The Supportive and Palliative Care Indicators Tool (SPICT) is derived from the Gold Standards Framework (GSF) prognostication tool (UK).
- Consists of a single page that includes general (i.e., weight loss, hospital admissions) and broad specific disease indicators (i.e., breathlessness at rest for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

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.
- See the Clinical Frailty Scale here.

STEP 6: PLAN, DO, STUDY AND ACT

- 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. Make small changes and tweaks after each cycle and test.



Working through the steps

(See **Resource 1** for a PDSA template and sample PDSA worksheets)

Stage	Steps to take *(modify to your practice realities and context)*
Plan	• Start by planning how to test a change. • Be sure to engage the whole team and involve them in the work.
Do	• Implement your plan and pilot the change. • Observe and keep notes. • Collect data — keep it simple, this is not research!
Study	• Analyze what happened when the change was implemented. • Compare the data to predictions. • 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). • If you decide to adapt, make a small tweak or a big change and repeat the PDSA cycle. • If you decide to abandon, do not proceed with implementing this change idea and keep in mind lessons learned. • If you decide to adopt, proceed to Step 7.

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QUIC – PDSA template

PDSA CYCLE #1

Plan		
What change do we want to test out?		
Scope and timelines		
What do we predict will happen?		
What could hinder us vs. help us?	Barriers or facilitators	Mitigation/en
What steps are needed to implement this change?	What	When

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QUIC – Sample PDSA cycle worksheets

PDSA CYCLE #1

Plan			
What change do we want to test out?	Train staff on how to use the Serious Illness Conversation Guide.		
Scope and timelines	Provide training to physicians, nurse practitioners, physician assistants, social workers, RNs and RPNs by May 15, 2024.		
What do we predict will happen?	After receiving this training, staff will feel more comfortable having essential conversations, which will result in these conversations taking place more often.		
What could hinder us vs. help us?	Barriers or facilitators	Mitigation/enhancement strategies	
	Unable to get coverage for staff to attend training	- Booking training at a time when the fewest staff are scheduled for vacation. - Stagger training into 2 different cohorts.	
What steps are needed to implement this change?	What	When	Who is responsible?
	Schedule Serious Illness Conversation training sessions.	By October 6, 2024	Janet
	Provide registration instructions to eligible staff	By October 29, 2024	Janet
	Cohort A to take training	December 2024	Staff
	Cohort B to take training	January 2025	Staff
How will we measure if this change is successful?	Measure description	Type of measure	How will this be measured and by who?
	Percentage of residents and caregivers who had an essential conversation with their care	Primary process measure	Run chart/Emily

STEP 7: CELEBRATE

- 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 yourself a pat on the back.

STEP 8: SUSTAIN

- Sustainability is achieved when new ways of working and improved outcomes become the norm ... and stay the norm!
- But we are only human and slippage can occur … so keep working at it.

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:

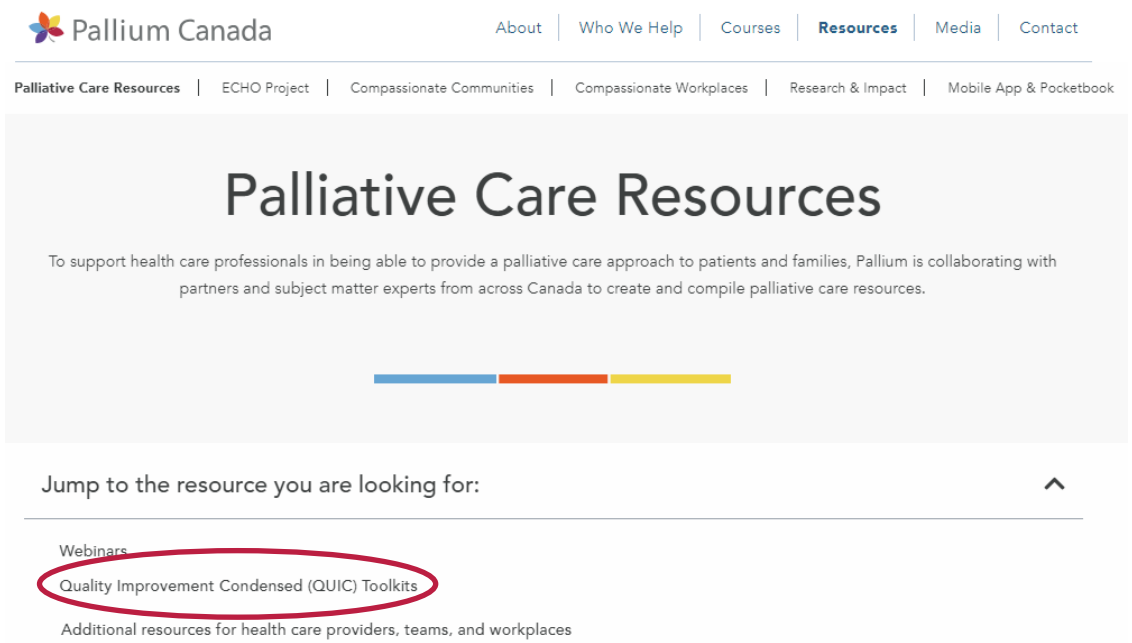
- Periodic reminders (email or mention at team meetings monthly or quarterly).
- Mentions at QI huddles.
- Periodic monitoring (quick audit or check sheet).
- Periodic reporting.

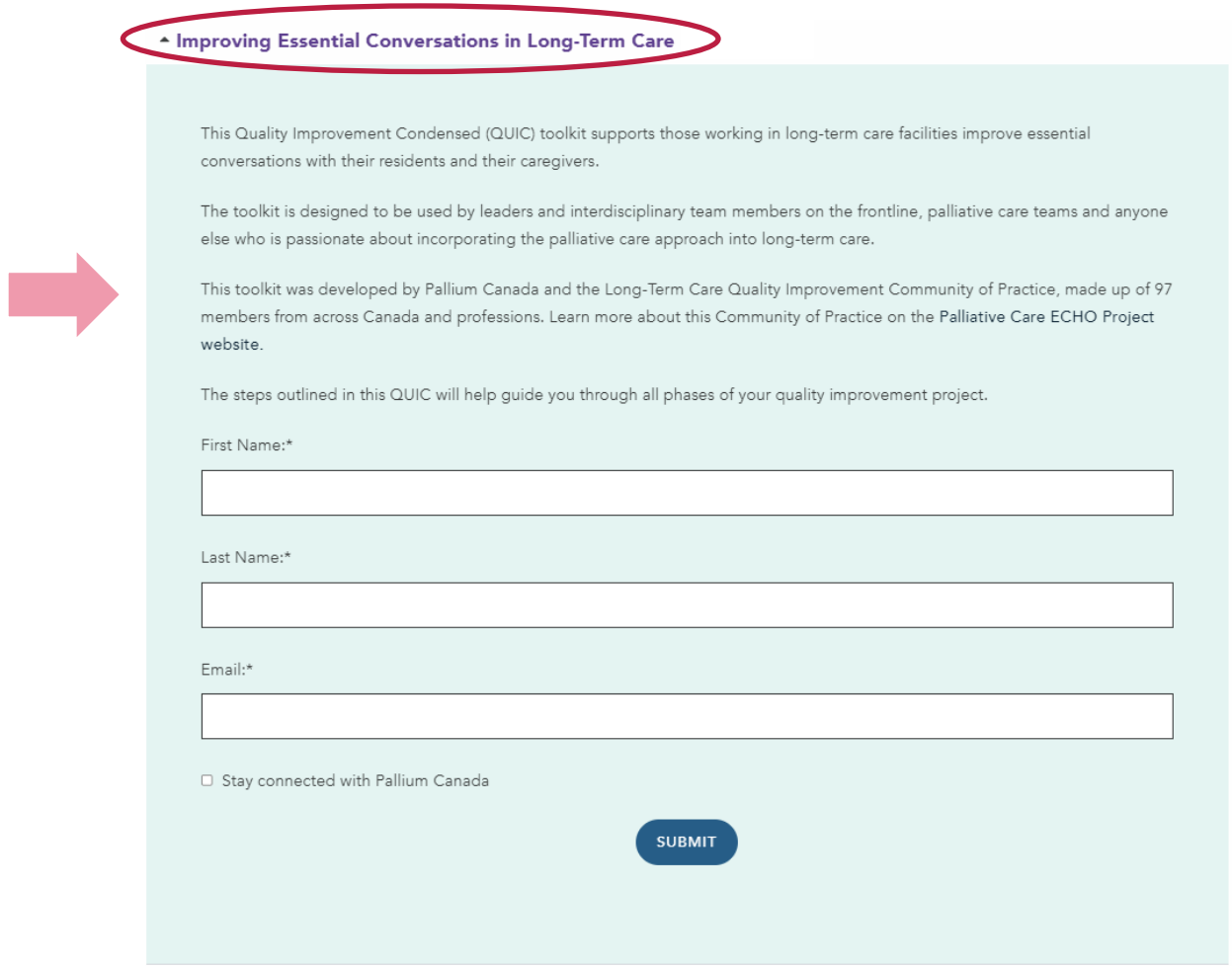
SHARE YOUR STORY AND LEARNINGS WITH OTHERS

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

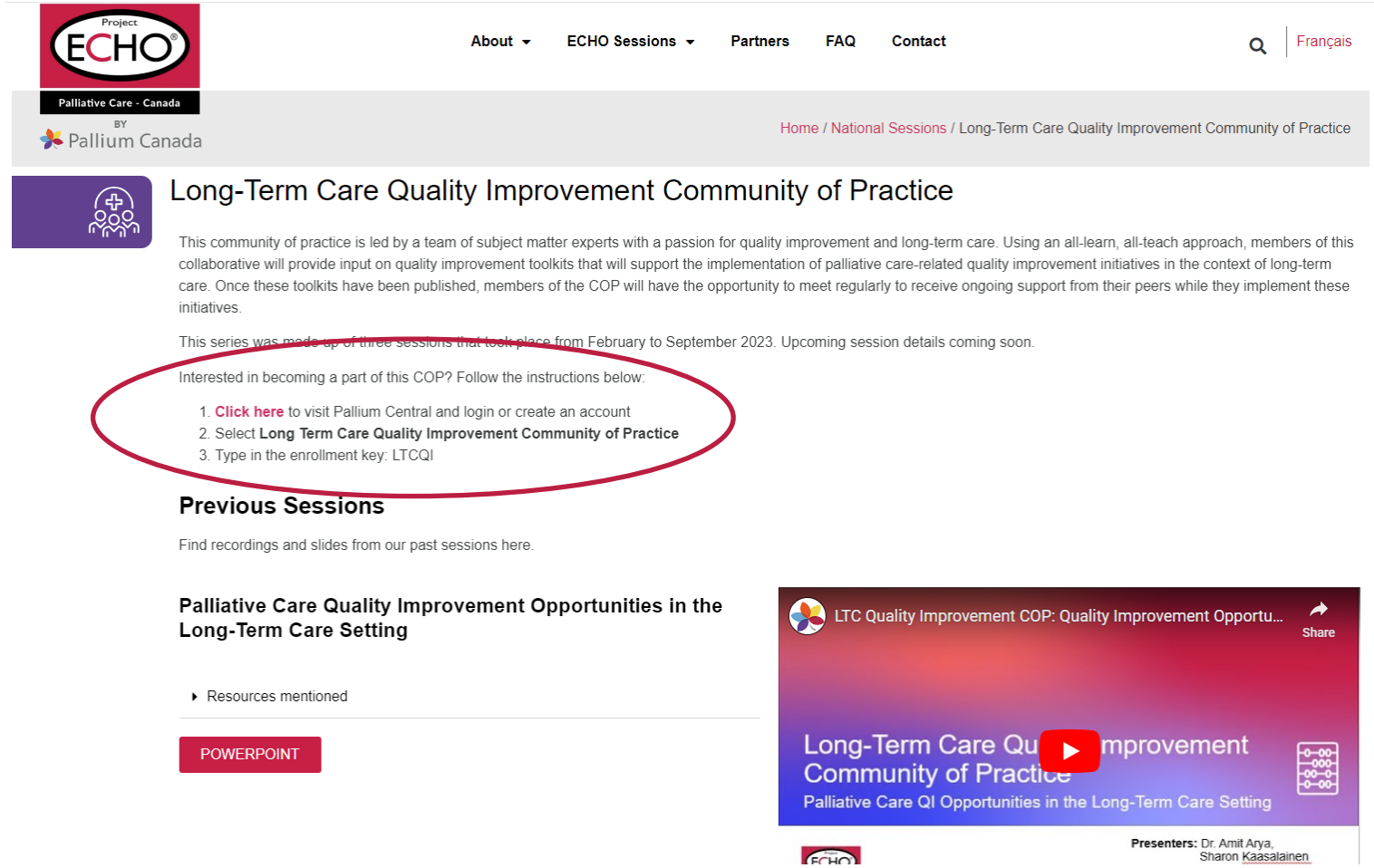
  Contact **echo@pallium.ca** or visit **echopalliative.ca** if this would be of interest to you.

How to access the QUIC





Join the Long-Term Care QI Community of Practice!



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Questions and Discussion

Session Wrap Up

- Thank you for joining us!
- Please fill out the feedback survey following the session—a link has been added into the chat

Thank You

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