Long-Term Care Quality Improvement (QI) Community of Practice (Ontario)

Moments That Matter: Empowering Long-Term-Care Teams to Recognize and Act with a Palliative Lens

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Host: Holly Finn, PMP

Presenter: Dr. Christine Jones, MD CCFP (PC)

Date: October 01, 2025

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.

Health Canada Santé Canada

Stay connected: www.echopalliative.com

Join a QI Workshop on Palliative Care in LTC

Registration is open for our free quality improvement and change management half-day virtual workshop: Aim Align Achieve Quality Palliative Care.
Aim, Align, Achieve Quality Palliative Care - Ontario Centres for Learning, Research, and Innovation in Long-Term Care

An introductory program on quality improvement and change management for the Ontario long-term care setting. An interactive program focused on implementation of a palliative approach to care, this class is for quality improvement and palliative care committees; physicians; quality improvement coordinators; best practice advocates; and everyone who wants to work on a person-centered approach to care that honors the humanity of residents, team members and families.

Wage support available for LTC homes as well as scholarships for physicians – see our site for details.

ONTARIO CLRI Centres for Learning, Research & Innovation in Long-Term Care

Santé Bruyère Health

Project ECHO Palliative Care - Canada BY Pallium Canada

Learning Essential Approaches to Palliative Care (LEAP)

Pallium Canada LEAP Learning Essential Approaches to Palliative Care

Pallium Canada's award-winning suite of LEAP courseware transforms health care practice through interprofessional and evidence-based palliative care training:

- Build the skills and confidence to deliver compassionate, patient-centred care.
- Developed and peer-reviewed by Canadian palliative care experts.
- Online, in-person or hybrid course delivery options.
- Earn annual learning credits and a nationally recognized certification.
- Backed by evidence and best practices.
- Practical, case-based learning with real-life scenarios.

Learn more at: pallium.ca/courses

Overall Learning Objectives of this COP

Upon participating in this COP, members should be able to:

- Describe how quality improvement methodologies can support successful integration of a palliative care approach in long-term care homes
- Describe relevant metrics, change ideas and lessons learned from quality improvement initiatives implemented by peers
- Recall case discussions that demonstrate strategies to address challenges to a palliative approach to care
- Recall how to access resources to support QI work

Overview of Sessions

Session #/ Title	Date/ Time
Session 1: Base Camp: Building a foundation in Palliative Care QI for your home	January 29, 2025 from 12 to 1pm ET
Session 2: Advancing Meaningful Conversations: Advance Care Planning and Goals of Care	April 22, 2025 from 12 to 1pm ET
Session 3: From Recognition to Relief: Enhancing Pain Management in Dementia through Quality Improvement	June 4, 2025 from 12 to 1pm ET
Session 4: Moments That Matter: Empowering Long-Term Care Teams to Recognize and Act with a Palliative Lens	October 1, 2025 from 12 to 1pm ET
Session 5: EDI Focus- Title TBC	November 26, 2025 from 12 to 1pm ET

Introductions

Host:

Holly Finn, PMP
Senior Manager, Program Delivery

Presenter:

Christine Jones MD, CCFP (PC)
Palliative Care Physician, Victoria BC
Medical Director, Victoria Hospice Society
Clinical Assistant Professor, University of British Columbia

Disclosures

Pallium Canada

- Pallium is a registered charitable organization

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

Host/ Presenters:

- Holly Finn: Senior Manager, Program Delivery at Pallium Canada.
- Dr. Christine Jones: Medical Director Victoria Hospice Society

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of program content.

Welcome and Reminders

- Please introduce yourself in the chat! Let us know your role is in the Long-Term Care setting.
- Your microphones are currently muted. There will be time throughout this session for questions and discussion, including breakout rooms
- You are welcome to use the chat function to ask questions, if you have any comments or are having technical difficulties
- The open discussions following the presentation will NOT be recorded.
- Take comfort in knowing this is a safe space to share your thoughts and stories.
- Remember not to disclose any Personal Health Information (PHI) during the session

Agenda for today's session

- Case presentation introduced
- Sharing of Victoria QI project and tools
- Breakout Groups
- Return to large group for sharing take home tools

Moments That Matter: Empowering Long-Term Care Teams to Recognize and Act with a Palliative Lens

A quality improvement approach to better end-of-life care

Thank you to our project participants!

- Pilot Project Physician Lead Medical Director, Palliative and End of Life Care Program, Island Health
- Palliative Care Specialist Physician Team
- Dr. Christine Jones – PC Physician Lead for Victoria
- Dr. Valorie Masuda – PC Physician Lead for Duncan
- Dr. Marlene van der Weyde – PC Physican Lead for Parksville
- Dr. Christian Wiens – PC, Geriatric Psych Specialist Physician, Advisor Palliative Care Specialist Nurses
- Jamie Linstead RN CHPCN (C) - PC Specialist Nurse, Victoria
- Della Roberts CNS CHPCN (C) - Education and Research Advisor to Project Charlotte
- Robinson RN MN CHPCN (C) - PC Specialist Nurse, Duncan and Parksville Pilot Project Management
- Barbara Power MSW - Pilot Project Coordinator and Manager SSC125 - Improving End-of-Life Outcomes in Residential Care Facilities: a palliative approach to care 13 Program-level Support for Pilot Project
- Jill Gerke MA – Regional Program Manager, Palliative and End of Life Care Program

George

- 84-year-old retired teacher
  - Widowed from wife of 45 years, Jean
  - Newly admitted to long term care
  - Daughter Janet, representative and visits every few weeks
- Admitting Diagnosis-
  - frailty, heart disease, renal disease, moderate dementia
- PPS 50% CFS 6 approaching 7
  - Mobilizes with walker, but struggles
  - Help with dressing, toileting,
  - Can feeds self
  - Can still, inconsistently recognize his family
  - Socially engaged

How do we

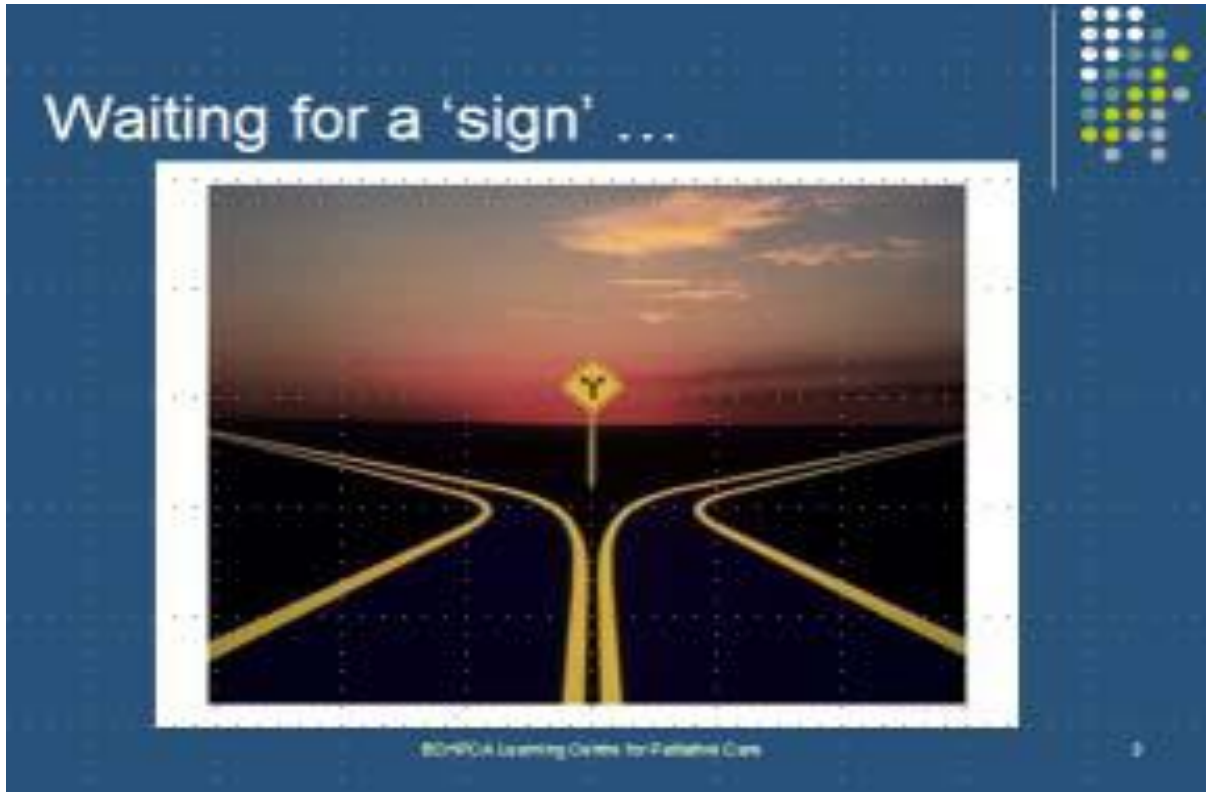
“Transition”

from a

Palliative Approach

to

End of Life Care?



Back to George…

The Health Care Aid noticed the following….

- Beginning to spend more time in bed
- Reduced Intake
- Mobility changing-had a few falls
- Some pressure sores
- Losing weight
- Withdrawn

Tool #1
Trigger Tool

Palliative Approach in Long Term Care QI Project

A PALLIATIVE APPROACH TO CARE

Early Identification Tool

There are often signs that a resident's health is declining and they are at higher risk of dying. Being attuned to these signs allows health care providers to better inform and guide residents and their families in this final season of their life. **What factors support the care team's impression that the resident is at risk of dying in the coming months?**

CHECK ALL THE FACTORS THAT ARE RELEVENT FOR THE RESIDENT

- ☐ Progressive weight loss (greater than 10% in 6 months)
- ☐ Progressive, irreversible functional decline
- ☐ Resident or family asking for comfort measures only, treatment withdrawal or limitation
- ☐ Unplanned transfers to Emergency Department or hospital admissions
- ☐ Extreme frailty (e.g. persistent pressure ulcers, recurrent infections, delirium, persistent swallowing difficulties, falls)
- ☐ Advanced dementia or other neurological disease (e.g. unable to dress, walk or eat without help, incontinence, unable to communicate verbally, eating and drinking less, swallowing difficulties, recurrent UTI, 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, recurrent hospitalizations)
- ☐ Advanced illness of any cause with progressive function decline or poorly controlled symptoms

☐ Resident **NOT "identified"** at this time,
to be reviewed on this date: _____

☐ Resident **"identified"** at this time,
date of Identification: _____

Signature: _____

Tool # 2 Comfort Care Rounds

Discuss patient's who have been identified by the trigger tool

Plan for Action

Support Education for Staff as needed

CHECK ALL THE FACTORS THAT ARE RELEVENT FOR THE RESIDENT

- [x] Progressive weight loss (greater than 10% in 6 months)
- [x] Progressive, irreversible functional decline
- [ ] Resident or family asking for comfort measures only, treatment withdrawal or limitation
- [x] Unplanned transfers to Emergency Department or hospital admissions
- [x] Extreme frailty (e.g. persistent pressure ulcers, recurrent infections, delirium, persistent swallowing difficulties, falls)
- [x] Advanced dementia or other neurological disease (e.g. unable to dress, walk or eat without help, incontinence, unable to communicate verbally, eating and drinking less, swallowing difficulties, recurrent UTI, 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, recurrent hospitalizations)
- [ ] Advanced illness of any cause with progressive function decline or poorly controlled symptoms

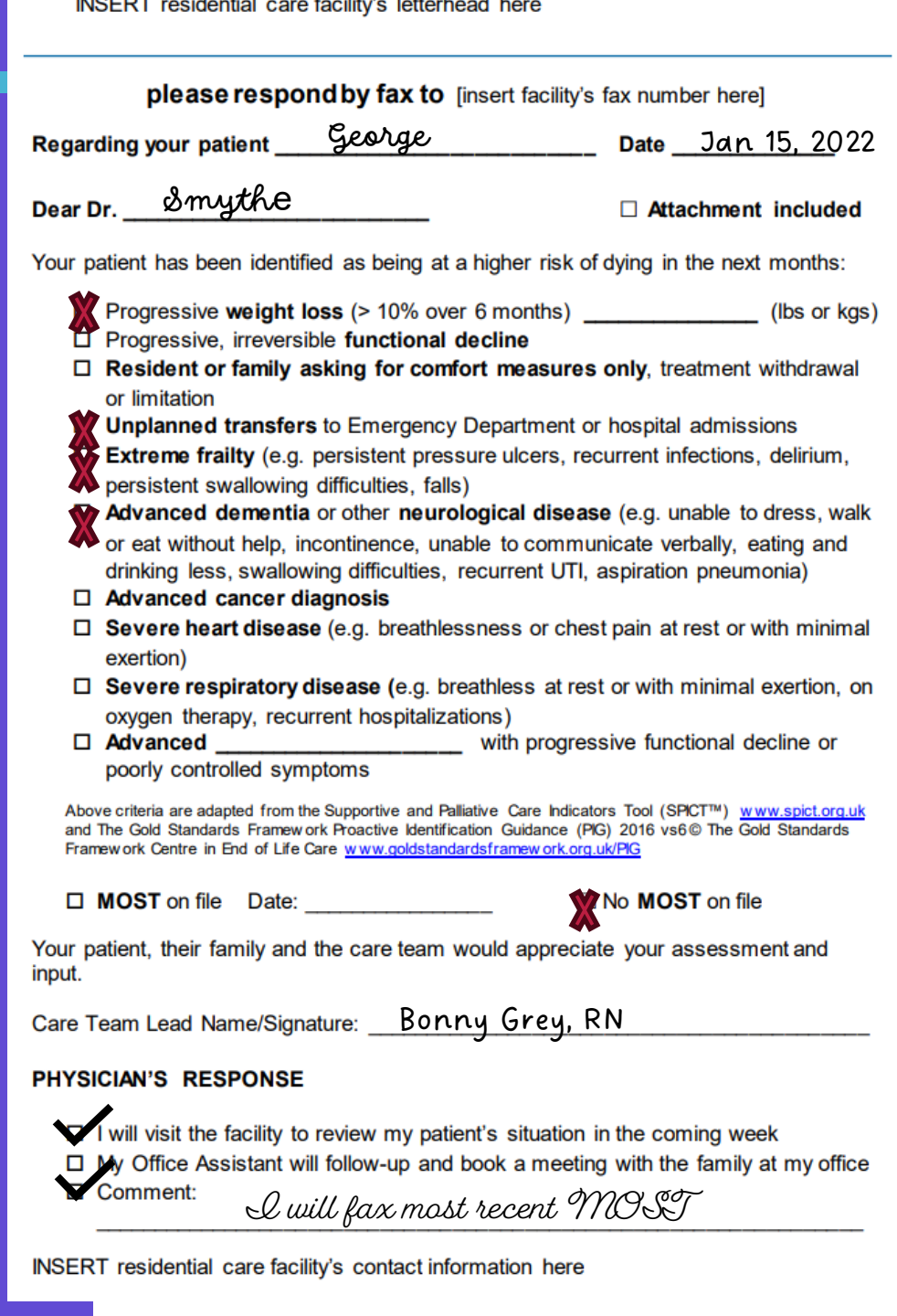
---

- [ ] Resident **NOT "identified"** at this time,
  to be reviewed on this date: _____
- [x] Resident **"identified"** at this time,
  date of Identification: _____

Signature: Bonny Grey

Tool #3
Letter to MRP

Palliative Approach in Long Term Care QI Project



INSERT residential care facility's letterhead here

please respond by fax to [insert facility's fax number here]

Regarding your patient George **Date** Jan 15, 2022

Dear Dr. Smythe ☐ **Attachment included**

Your patient has been identified as being at a higher risk of dying in the next months:

- [X] Progressive **weight loss** (> 10% over 6 months) _____ (lbs or kgs)
- [ ] Progressive, irreversible **functional decline**
- [ ] **Resident or family asking for comfort measures only**, treatment withdrawal or limitation
- [X] **Unplanned transfers** to Emergency Department or hospital admissions
- [X] **Extreme frailty** (e.g. persistent pressure ulcers, recurrent infections, delirium, persistent swallowing difficulties, falls)
- [X] **Advanced dementia** or other **neurological disease** (e.g. unable to dress, walk or eat without help, incontinence, unable to communicate verbally, eating and drinking less, swallowing difficulties, recurrent UTI, 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, recurrent hospitalizations)
- [ ] **Advanced** _____ with progressive functional decline or poorly controlled symptoms

Above criteria are adapted from the Supportive and Palliative Care Indicators Tool (SPICT™) www.spict.org.uk and The Gold Standards Framework Proactive Identification Guidance (PIG) 2016 vs6 © The Gold Standards Framework Centre in End of Life Care www.goldstandardsframework.org.uk/PIG

☐ **MOST** on file Date: _____ [X] No **MOST** on file

Your patient, their family and the care team would appreciate your assessment and input.

Care Team Lead Name/Signature: Bonny Grey, RN

PHYSICIAN'S RESPONSE

- [✓] I will visit the facility to review my patient's situation in the coming week
- [ ] My Office Assistant will follow-up and book a meeting with the family at my office
- [✓] Comment: I will fax most recent MOST

INSERT residential care facility's contact information here

Today's Date: _____

Guide for Goals of Care

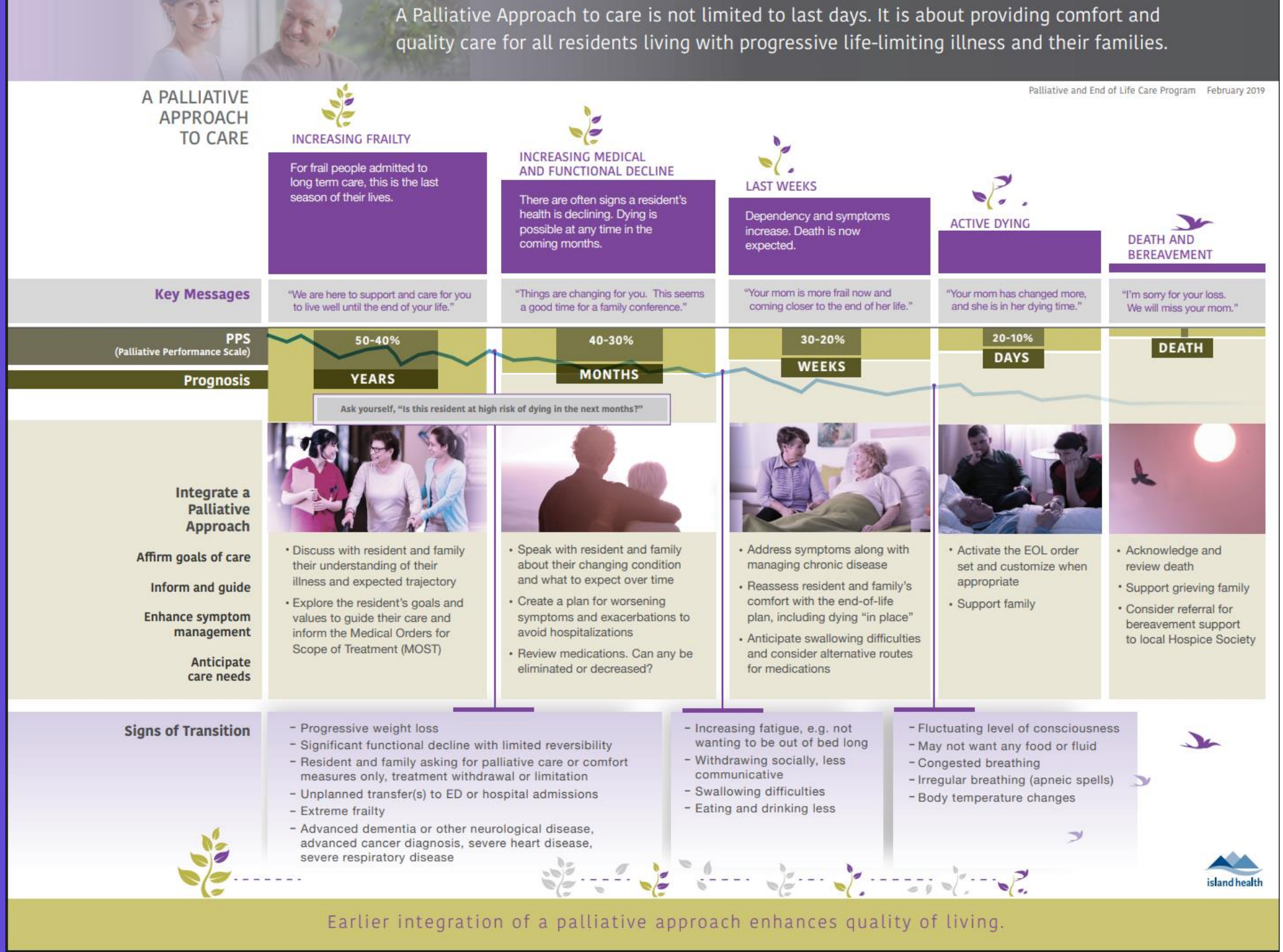
(following identification of resident for palliative approach to care)

DOMAINS OF CARE	GOALS	ACTIONS
Early Identification	Ensure coordinated team-based support is initiated when resident is identified as in greater need of a palliative approach to care	☒ Complete "Early Identification Tool" ☒ Notify MRP if resident is identified (send form letter if used by this facility) ☒ Communicate to care team that resident has been identified
Information Sharing and Being a Guide to Family	Ensure that the family/ resident have opportunity to discuss the anticipated illness course and the benefits of a palliative approach to care to inform their care plan	☒ Choose a care team member to speak with family/resident about changes the care team has noted ☐ Document wishes and 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 ☐ Consider a family meeting with care team 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) ☐ If MOST designation appears inconsistent with condition notify MRP and encourage family to make an appointment to revisit MOST

Tool #4.
ACTION PLAN

island health

Tool #5
Facility Poster



George's Health Care Aid noticed George….

- When daughter next visited
  - RN walked then through the poster, and identified where George was on his transition path
- The Family Doc was not available, so the family met with the social worker
  - Reaffirmed goals of care
  - Care at the facility, even if reversible conditions occurred
    - Symptom management in facility
    - Gentle comfort feeding
- MRP returned form
  - Goals of care conversations supported MOST M1
  - Dying time in the facility
    - No abx
    - Any hip fracture supported symptomatically at facility
- MRN checked in more often with health care aids
  - Their comfort, their observations, their concerns
  - Supported use of the conversation guide (our next tool)

Tool #5
ASK-TELL-ASK Conversation Tool for Staff- with SCRIPTS,

For Nurses and Social Workers

CONVERSATION GUIDE for LONG TERM CARE TEAM

A resident's increasing frailty has been identified and the early identification tool for a palliative approach to care has been completed.

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.

STEPS	DESCRIPTION	SCRIPT QUESTIONS / Sample Statements
1 INITIATE discussion	**Contact** the resident and/or family **Ask** permission for discussing change **Gather information** from the team about the specific changes identified **Plan** what you will say to the resident and/or family	**Q:** I'd like to talk with you about the changes in your mom's health. Is that OK? **Q:** Have you been noticing change? What changes have you been noticing?
2 ASK the resident and family	**Ask** the resident and/or family what their thoughts are about the resident's current status **Ask** the resident and/or family about what is important to them	**Q:** What do you understand about what is happening for your mom, with her illness? **Q:** What is most important to your mom now? What is most important to you?
3 TELL share information about changes	**Ask** permission to share information **Share information** on current status; include changes staff have seen, the increasing frailty, and that more change could happen at any time **Give information** in a straightforward way **Use words** the resident and family will understand Use "I **wish**...", "I **worry**...", "I **wonder**..." strategy	**Q:** Is it okay if I tell you the changes the care team has been seeing? As you noticed, your mom is sleeping more and doesn't go to activities. She is also eating less and has lost 5 pounds over the last 2 months. She is more irritable and is in more pain when moving. These changes are all part of what we expect as someone becomes more frail and ... ... they become less able to fight off a cold or infection ... they are moving toward the end of life ... life is getting shorter ... I **wish** things were different. I **worry** time is getting shorter. I **wonder** if we could talk about how we can provide care for your mom at this time

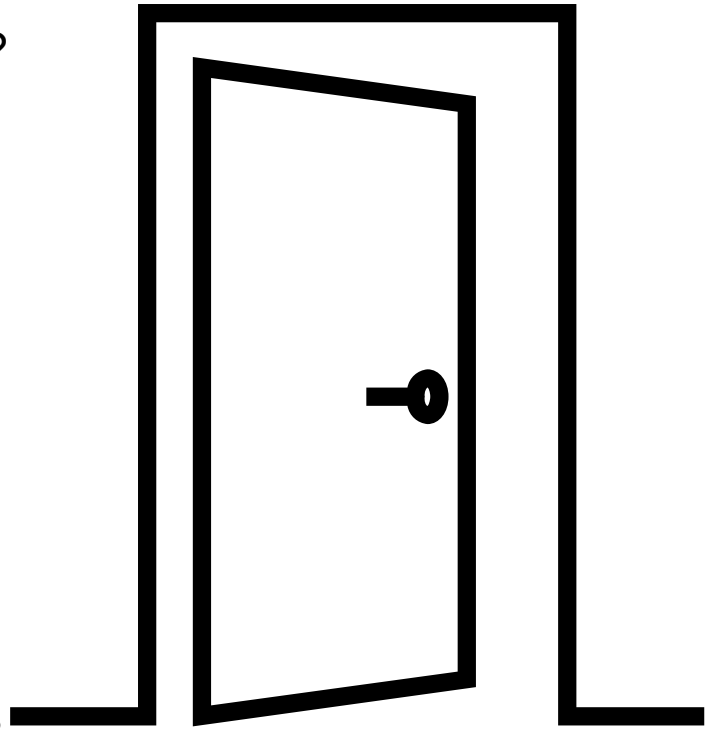
Breakout Rooms

Tools for Identifying a Palliative Approach

What ways does your facility identify people who are approaching end of life?
What works well? What could be improved?

Which of the tools most resonates with you? Or….What surprised you?

- *The Identification Tool?*
- *Comfort Care Rounds Tool?*
- *Action Plan?*
- *Large Poster for Awareness and Reinforcement?*
- *Letter to family Physician (with a clear ask)*
- *Conversation Tool?*



What is one thing you might take home today to your teams and perhaps try to implement?

Session Wrap Up

- Please fill out the feedback survey following the session! Link has been added into the chat.
- Join us for our final session that will be held on **November 26, 2025 from 12 to 1pm ET**
- A copy of these slides will be emailed to registrants within the next week.
- Thank you for your participation!

Thank You

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