Palliative Approach to Care

Accountability Report

February 2018

Vancouver Coastal Health
Promoting wellness. Ensuring care.

VGH UBC hospital foundation

Key Milestones

Regional

VCH called the project that resulted from the generous philanthropy of Robert and Greta Ho the "**Integrating a Palliative Approach by having Conversations Early**" or **iPACE project**. It involved hiring seven palliative care specialists:

Regional Project Manager
Nadya Repin
(February 2017)

Vancouver Community Clinical Practice Leader
Ingrid See
(April 2017)

Vancouver Community Clinical Nurse Educator
Sarah Lau
(July 2017)

Richmond End-of-Life Leader
Umilla Stead
(July 2017)

Coastal End-of-Life Leader
Katerina Velecky
(September 2017)

Costal End-of-Life Leader & EPAIRS
Jane Webley
(February 2017)

Vancouver Acute End-of-Life Leader
Dara Lewis
(February 2018)

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33 **Nurse Practitioners** trained and identified as champions

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Goals of Care conversation resources translated into four languages

Two training sessions held with Provincial Language Services, a Provincial Health Services Authority organization that provides interpreting services to BC Health Authorities so they can better serve their linguistically and culturally diverse clients, including refugees.

Partnership with Langara College Nursing Students

Key Milestones

Vancouver Community: Home Health

22 **training sessions** delivered

154 **staff trained** in Workshop #1 – Identification

125 **staff trained** in Workshop #2 – Goals of Care conversations

Appox. 72% **of home health staff at targeted sites trained** in Workshops #1 and #2

13 **champions and five palliative care Resource Nurses** were trained

59 **hours of on-site mentoring and coaching** have been provided and five joint visits have been conducted by the team lead and educator

Key Milestones

Richmond

Phase 1: Home Support, Home Health, Primary Care Home, Quick Response Team/ED iCARE, Chronic Disease Management Nurses, Social Work

20 **training sessions** delivered

176 **staff trained** in Workshop #1 – Identification

58 **staff trained** in Workshop #1 – Goals of Care conversations

3 **champions** trained

Collaborated with cultural engagement and palliative care project (funded by a donor gift through the Richmond Hospital Foundation) to engage 12 community organizations on discussions about palliative care and cultural considerations

Key Milestones

Coastal

Phase 1: Community Services and Home Support

Current state and needs assessment complete

2 **staff focus group** sessions conducted

Residential Care

Embedding a Palliative Approach to Care in Residential Care Settings (EPAIRS)

100% **of 48 facilities trained** across Vancouver, Richmond and Coastal

32% **reduction in number of death in acute care** comparing Q2 from 2014/15 to 2017/18

36% **reduction in acute bed days (unplanned admissions)** in the last three months of life comparing Q2 from 2014/15 to 2017/18

Embedding a Palliative Approach to Care across the Continuum

VCH has a comprehensive plan to benefit palliative care patients and families, as well as the health care system overall. This plan contains five Strategic Elements in support of the fundamental goals of a palliative approach to care.

Goal 1:

Create system capacity to deliver timely, coordinated End-of-Life care in the community

Element 1: Implement a palliative approach to care
Element 2: Double hospice capacity by 2020
Element 3: Improve residential* and at-home palliative care

Goal 2:

Develop End-of-Life clinical people capacity, guidelines, education & resources

Element 4: Increase capacity and competency in the palliative approach to care

Goal 3:

Develop and report on End-of-Life performance measures

Element 5: Develop metrics to monitor and report on quality and system performance

> "Health related concerns can be very tough to have with the families. With more appropriate information it can be easier to have palliative care discussion with the client."

Create system capacity to deliver timely, coordinated End-of-Life care in the community

Strategic Element 1:
Implement a Palliative Approach to Care

- Professional practice and End-of-Life Practice Lead are standardizing VCH policies around End-of-Life across the region and embedding a palliative approach to care in them (e.g. notification of death).

- VCH received one-time funding from the Ministry of Health for End-of-Life care that has been allocated to the development of a regional approach to End-of-Life education that promotes consistency and accessibility, with emphasis on education being available to staff in rural and remote locations.

- VCH adopted the BC Centre for Palliative Care symptom guidelines, which are best practice guidelines established by a collaboration of the BC Centre for Palliative Care, Fraser Health, First Nations Health Authority, Interior Health, Island Health, Providence Health, Northern Health and VCH.

- VCH is working with Professional Practice to ensure existing clinical practice guidelines align.

- VCH is participating in the development of a provincial palliative and End-of-Life care policy.

- End-of-Life Practice Lead joined the technical committee of the Health Standards Organization (i.e. Accreditation Canada) to develop the first palliative and End-of-Life standards for the organization.

- Implementation of a palliative care registry in Richmond.

- In parallel, a number of strategic palliative approaches to care initiatives are being led by physicians across VCH.

Strategic Element 2:
Increase hospice capacity by 2020

- In 2017/18 VCH opened 13 new community hospice beds. Five of the new hospice beds opened on the North Shore in January 2017 and eight hospice beds opened in Vancouver in May 2017.
- Additional hospice beds are planned to open between 2018 and 2020.

Strategic Element 3:
Improve residential and at-home palliative care

- VCH expands and monitors the ongoing implementation of the Embedding a Palliative Approach to Care in Residential Settings (EPAIRS) project.

- From October to December 2017, 17 update training sessions were delivered to 275 residential care staff, volunteers and students. VCH also completed training for all residential care physicians in Coastal.

- The lead for EPAIRS regularly attends family and residential councils to deliver education, as well as meeting with other stakeholder groups. The lead has provided education to approximately 30 palliative volunteers and works with the Lions Gate Hospital and Squamish Hospice Societies. The lead provides education through Capilano University to care aids and rehabilitation assistants.

- The EPAIRS project has been featured at several conferences, including the BC Care Providers conference at Whistler in April, the Canadian Foundation for Healthcare Improvement conference at Toronto in June and the Canadian Hospice Palliative Care Association Conference at Ottawa in September.

- VCH is working with the Canadian Foundation for Healthcare Improvement to expand EPAIRS to other health authorities across Canada.

- Ongoing monitoring of results and trends at EPAIRS sites shows:

    - 32% (n=22) reduction in number of deaths in acute care comparing Q2 from 14/15 to 17/18
    - 18% (n=10) reduction compared to Q2 16/17
    - 36% (n-422) reduction in acute bed days (unplanned admissions) in last 3 months of life comparing Q2 of 17/18 with Q2 14/15
    - Reduction in acute bed days from Q2 last year = 275 days (27%)

Develop End-of-Life capacity, guidelines, education and resources

Strategic Element 4:

Increase clinical capacity and competency in the Palliative Approach to Care

This element is critical to the successful implementation of a palliative approach to care system wide. Education and training are the start to a culture shift that VCH is passionate about and dedicated to. VCH called the project that resulted from the generous philanthropy of Robert and Greta Ho the "**Integrating a Palliative Approach by having Conversations Early**" or **iPACE project**. With philanthropy, VCH hired specialized palliative care clinical leads in each of VCH's Communities of Care, Vancouver, Richmond and Coastal (North Shore and coastal communities).

VCH experienced some challenges hiring. The combination of skills and experience necessary for the role is highly specialized with a limited pool of applicants. To expand our recruitment options, we diversified our hiring approach by developing a new job description that extended the opportunity to clinicians with a nursing background as well as other allied professionals such as Social Workers and Occupational Therapists. VCH is pleased with the interdisciplinary team of leads we have hired because they have all demonstrated a passionate drive and commitment to palliative care and patient-centered care. The combination of experience, skills and backgrounds has allowed our team to learn from each other, to leverage each other's strengths and to benefit from a diversity of backgrounds and approaches as we begin implementation. The diverse professional backgrounds of the team has also been received positively by our staff as the mix of professionals is reflective of the staffing of our healthcare teams.

1. Regional Project Manager, Nadya Repin (February 2017)
2. Vancouver Community Clinical Practice Leader, Ingrid See (April 2017)
3. Vancouver Community Clinical Nurse Educator, Sarah Lau (July 2017)
4. Richmond End-of-Life Leader, Umilla Stead (July 2017)
5. Coastal End-of-Life Leader, Katerina Velecky (September 2017)
6. Coastal End-of-Life-Leader & EPAIRS, Jane Webley (February 2017)
7. Vancouver Acute End-of-Life Leader, Dara Lewis (February 2018)

VCH-Wide Work

The team and numerous internal stakeholders developed a shared framework that defined the vision and goals of the iPACE project as implementation planning began and as the team began to communicate to VCH leadership and staff about the upcoming education and coaching/mentorship opportunities.

VISION: Enable a culture shift to embed a palliative approach to care in services so that after three years healthcare providers across the continuum of care are confident and competent to:

1. **Identify** individuals with a serious illness who may benefit from a palliative approach to care
2. Have **conversations** about their serious illness and goals of care with individuals and their families
3. Ensure consistent **documentation** of their serious illness and goals of care conversations
4. Make certain that client's wishes and goals of care are **respected**
5. Ensure **sustainability** of project after funding ends

From these guiding principles, each Community of Care chose the tools they would use to implement and support each goal. Many communities chose to implement the serious illness conversation guide to support staff having goals of care conversations. Seven team members and future champions attended Serious Illness Guide training provided by the BC Center for Palliative Care in May 2017.

Team leads were recruited in phases from April to September 2017. They worked with the project manager to conduct needs assessments, stakeholder engagement, communication strategies, and to develop appropriate training and resource materials and education sessions for staff to become confident and competent in identification and in having goals of care conversations. Project phases were defined over the three years of funding and clinical teams and units were identified for each phase.

The alignment of documentation of goals of care conversations across multiple systems, care settings and regions is ongoing work for the team. Goals of care conversations documented in the community health record (PARIS) and the primary care record (EMR) will be available to view in the provincial reader CareConnect as of February 2018. Documentation of goals of care conversations has been built into the new acute care documentation system, rolling out over the next few years.

In November 2017 the team trained 33 VCH Nurse Practitioners in identification and goals of care conversations. Several of them volunteered as champions for the work moving forward and offered to provide ongoing coaching and mentoring to their colleagues.

The serious illness conversation guide and family communication guide was translated into the four languages most commonly requested for translation services across VCH, including Chinese, Punjabi, Farsi and Arabic. In conjunction with translating the materials, our team held two training sessions with Provincial Language Services in September and October 2017 to instruct them in the principles of palliative care, the use of the tool and to provide a forum to brainstorm solutions to complications arising from the challenges of communicating across different languages. An online module will be developed to provide future training.

The team created an intranet site in order to ensure staff has access to all the education materials and additional resources, and this is updated regularly.

Develop and report on End-of-Life performance measures

Strategic Element 5:
Identify and report on key performance indicators

VCH agreed to capture feedback about the experience of care at End-of-Life is challenging given the nature of the timing of the care. At present, VCH has variable methods of gathering this feedback, such as surveys at specific sites or letters written and sent in by family members. Exploring and developing compassionate methods for capturing this important information are a current focus of VCH's overall plan. VCH is at a stage where the Health Authority is able to report on some key metrics.

> "I see the absolute value in using this to guide conversations for goals of care"

Key Targets

The evaluation framework and project metrics for iPACE were finalized in July 2017. Key metrics for reporting, current to end of December 2017, include:

1. Number of staff training sessions completed

- Training began in Vancouver community in September, Richmond in October, and has not begun in Coastal or Acute.
- As of December 2017, across VCH 40 sessions have been completed with 451 interprofessional staff attending

This initiative is about building capacity and empowering frontline staff who have traditionally not been trained in the palliative approach to care. The lack of skills resulted in less than ideal circumstances for some patients. For example, Jane Webley encountered a client in residential care with advanced dementia, the client couldn't speak for herself and was often very distressed. She developed pneumonia and the physician indicated to the husband that they could either continue to treat the client in residential care, or move them to the hospital where she would have access to more treatment options. The husband was quite distressed and seeing this, care staff calling in Jane to have a conversation with him. The husband immediately confided in Jane that his wife hadn't wanted any of this care, she hadn't wanted to prolong her suffering, but the husband didn't know what to do because they impression he had from the physician was that treatment was the only option, and at no time did anyone ask what he or his wife wanted their care at End-of-Life to be like

Richmond staff pre-workshop surveys showed that staff on average felt 6.5/10 confident and 6.7/10 competent to have goals of care conversations. Post-workshops surveys saw these numbers increase to 7.0 and 7.3 respectively. Course evaluations show that course objectives were clear and interest in the topic increased (4.7/5). Understanding of the topics covered was clearly conveyed (4.3/5) and the practical application and group discussion was understood and valued by staff (4.3/5). Overwhelmingly staff had their learning needs met and said that this education was useful in their daily practice.

For Vancouver Community staff pre-workshop surveys showed that staff felt on average 5.9/10 confident and competent to have goals of care conversations. Post-workshop surveys saw these numbers rise to 6.8/10. Course evaluations average 4.1/5 for practical application of education.

One staff commented that the training helped realize that palliative approach to care could be discussed with a client earlier than she had been doing, and she identified two clients on her caseload who would benefit from a palliative approach to care and began discussions with them both. Another staff commented "I will be supporting clinicians to implement and develop these care plans [from goals of care conversations]. This topic is completely relevant to our clients and align with my values of patient care."

2. Number of mentorship and coaching relationships established

- 33 Regional Nurse Practitioners
- Vancouver Community
  - 13 champions trained at four Community Health Centres plus 5 palliative care resource nurses
  - 59 hours of on-site mentoring and coaching have been provided and 5 joint visits have been conducted by the team lead and educator.
- Richmond
  - 3 champions identified and trained

3. Partnerships established with not-for-profit service providers that augment VCH's educational efforts for patients, families and the wider community – partnerships are key to extending the reach of the initiative and strengthening the necessary tie needed for sustainability

- Provincial Language Services
- Partnered with the Richmond Cultural Diversity Engagement Project, funded by a donor gift through the Richmond Hospital Foundation
  - Alzheimer Society, Richmond Centre for Disability, Tzu Chi Foundation, India Cultural Centre of Canada, Chinese Christian Mission, SUCCESS and MILAP Group
- In June the Richmond team lead and regional project manager attended the Richmond Patient Reference Group and introduced the iPACE project and solicited feedback
- The Vancouver Community nurse educator attended the Regional Lung Cancer Patient summit, delivered in both English and Cantonese, on November 8. She presented to the community participants about what community resources are available to them, how our clinicians work together to deliver care, what participants can do to prepare in advance for changing health conditions, what a palliative approach to care means and an introduction to the serious illness conversation guide.
- Ongoing community partnerships from the EPAIRS project include residential care family councils, hospice societies and volunteer organizations
- Relationships have been established with Capilano and Langara nursing programs.

Key regional metrics for 2017/18 included:

1. Reduction of hospital deaths of clients known to community programs by 5%[1]

- In Q1 of 2017, 43.8% of clients known to community had hospital deaths, by Q1 of 2018 this number was reduced to 38.3%

2. Reduction of days spent in acute care in the last six months of life by 2.5% [2]

- In Q1 of 2017, an average of 16.8 days were spent in acute in the last six months of life, by Q1 of 2018 this number was reduced to 16.5

Additional metrics VCH intends to report:

1. 100 percent of Home Health staff trained in End-of-Life competencies

Vancouver: 50% of home health staff trained in identification; 40% in goals of care conversations

- Richmond: 94% of home health staff trained in identification; 43% in goals of care conversations
- Coastal: Implementation 2019

2. PCRC and DAISY (now called EPAIRS) implemented across all residential care sites in VCH

- 100% of 48 residential care sites implemented
  - 30 Vancouver sites (completed 3rd quarter 2017)
  - 5 Richmond sites (completed 3rd quarter 2017)
  - 13 Coastal sites (completed 2nd quarter 2016)

3. Implementation of two community education forums on the topic of Goals of Care and the Palliative Approach to Care in collaboration with community partners

- Targeted for 2018/19

[1] This is a measure of quality care as it indicates proactive care planning and support to die in a place of choice which is often home or a homelike setting.
[2] This demonstrates we are identifying people earlier as needing a palliative approach and proactive care planning to enable individuals to live out their final days in their home/community environment.

4. Increase the number of clients registered with the Palliative Benefits Program demonstrating improvements in the earlier identification of those requiring a Palliative Approach to Care.

Note: VCH is working with the Ministry of Health to ensure the latter can provide VCH with this data.

- Ongoing
- Increase choice and access for well-supported home deaths, including home, hospice, and residential care in the community, as measured by:
    - Increase in the number of individuals transitioning to hospice from their home as opposed to acute care (demonstrates improved planning and timely access).
        - For 2017 the average percent of individuals transferring from community to hospice was 36.7%, for 2018 (first 8 periods) this was 40.9%.
    - Increase number of nursing hours provided in the home (shift care) in the last weeks of life to support a quality home death experience.
        - For 2017 (periods 1 to 3) the average number of nursing hours per day in the last month of life was 25.4, for 2018 (periods 1 to 3) it was 25.
    - Decrease in individuals transferring from residential care to acute care in the last 3 months of life.
        - Average emergency department visits per residential care client in the last 3 months of life decreased from 0.59 in 2017-Q1 to 0.48 in 2017-Q4.

> **"It is always valuable to start conversations about how we can care for people, help them feel valued and respected and increase their quality of life."**

Upcoming Plans for Strategic Element 4

- Working group to develop regional education plan, iPACE to be major component
- Business case to modify CareConnect to collect all end-of-life client information and documentation in one view
- Align end-of-life policies into one coherent structure and update to embed a palliative approach to care
- Mentor two semesters of Langara nursing students to work on developing education for acute care and coastal rural settings and to develop evaluation framework for short-term quality improvement
- Discussion and alignment with VCH aboriginal health to ensure population needs are met
- Collaborating with Vancouver acute to design outreach and education to facilitate goals of care conversations with specialized populations (i.e. disability groups)

> **"[The education was] useful because End-of-Life discussions I believe are very important. Talking is empowering not traumatizing. It can prepare clients and families for what they hesitate to talk about in general. Discussions can allow people to do or plan things that they think they might not have the time to do."**

VCH's Palliative Approach to Care Leads
Left to right: Umilla Stead, Sarah Lau, Ingrid See, Nadya Repin, Katerina Velecky

Thank You

We cannot thank you enough for your generous contribution and visionary gift. We know the challenges change can bring yet we know better the profound impact it can have on improving care. With your investment, we are able to drive practice changes across care settings and disciplines to roll out a new and standard approach in palliative care. Providing health care teams with this important education and continued guidance benefits patients, clients, residents and families tremendously, and helps all of us have better conversations about the complexities of death and dying. We are very grateful to you for investing in an initiative that aims to positively affect the lives of people faced with life limiting illness for generations to come. Thank you.

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