CHNC National Conference

Community Health Nursing and the Palliative Care Team

Stronger Relationships Equate Better Client Care

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Overview

- Definition of Palliative Care
- Delivery Models of Palliative Care
- Eastern Health's Community Palliative Care End of Life Program
- Role of the Advance Practice Nurse
- Improving Collaboration: Nurse "Leads"

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What is Palliative Care?

Palliative care aims to relieve suffering and improve the quality of *living* and *dying* in those patients diagnosed with progressive incurable illness.

Palliative Care addresses:

- Physical, psychological, social, and spiritual needs
- Loss, grief and bereavement
- Preparation for, and management of, self determined life closure and the dying process

A model to Guide Hospice Palliative Care: Canadian Hospice Palliative Care Association 2002.

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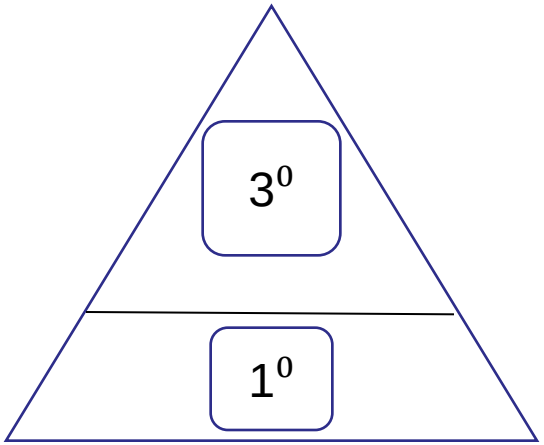
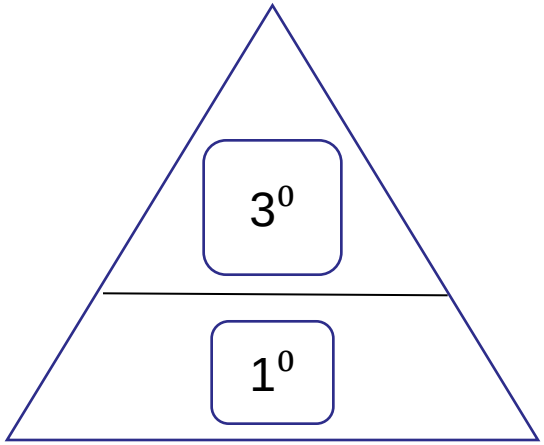
Primary Palliative Care: "Generalist"[1]

- Basic Management of pain and symptoms
- Basic management of depression and anxiety
- Basic Discussions about:
  - Prognosis
  - Goals of Treatment
  - Suffering
  - Code Status



Tertiary Palliative Care:"Specialist"[1,2]

- Management of refractory symptoms
- Management of complex depression, anxiety, grief and existential distress
- Assistance with conflict resolution re: goals of care or treatment
  - Within families
  - Between staff and families
  - Among treatment teams



Primary Palliative Care:[3-8]

Barriers:

- Lack of education/expertise
- Low numbers make it difficult to maintain proficiencies
- Lack of time/high workload
- Lack of access to/coordination with specialized PC
- Large geographic regions
- GPs ability to do home visits

Specialist Driven Services[1]

Drawbacks:

- Increase in demands soon outstrips resources
- Fragmenting of care
- Unintentional undermining of existing therapeutic relationships
- Removes sense of responsibility of all providers for basic symptom management and psychosocial support
- Costly

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2 parallel programs working together to provide Palliative Care in the community

Community Health Palliative Care End of Life Program

Generalist Model (1^0)

Palliative Care Consultation Team

Consultative Model (3^0)

Specialist advice provided on assessment and treatment, without necessarily assuming primary responsibility of care, negotiation of level of palliative care involvement

How do we make this interface work?

- Challenges?
- Solutions?

Palliative Care at Home

- In 20 years, almost 25% of our population will be 65 or older
- With increased age there is a decline in health and increase in disease
- More people wish to die at home
- Options for Palliation
  - 10 Bed Palliative care Unit located at Miller Center
  - Admission to Acute Care/LTC
  - Home

Background

- In September 2004 , an agreement was reached between the Federal Government Province's and Territories, referred to as the First Ministers Accord

- In December 2006 ,under the term “ Home Care Basket of Service” funding was approved for home care services.

- Referrals came from acute care, hospitals, palliative care , community Health Nurses and physicians

Generalist Model of Care

- Community Health Nurses are responsible for all community referrals for their own district.
- All CHN's are expected to care for palliative and end of life clients referred to their district.
- Learning Essential Approach to Palliative Care (LEAP) 2 day training was initially provided to all staff
- New Staff are given orientation session to Palliative End of Life Program at initial orientation.

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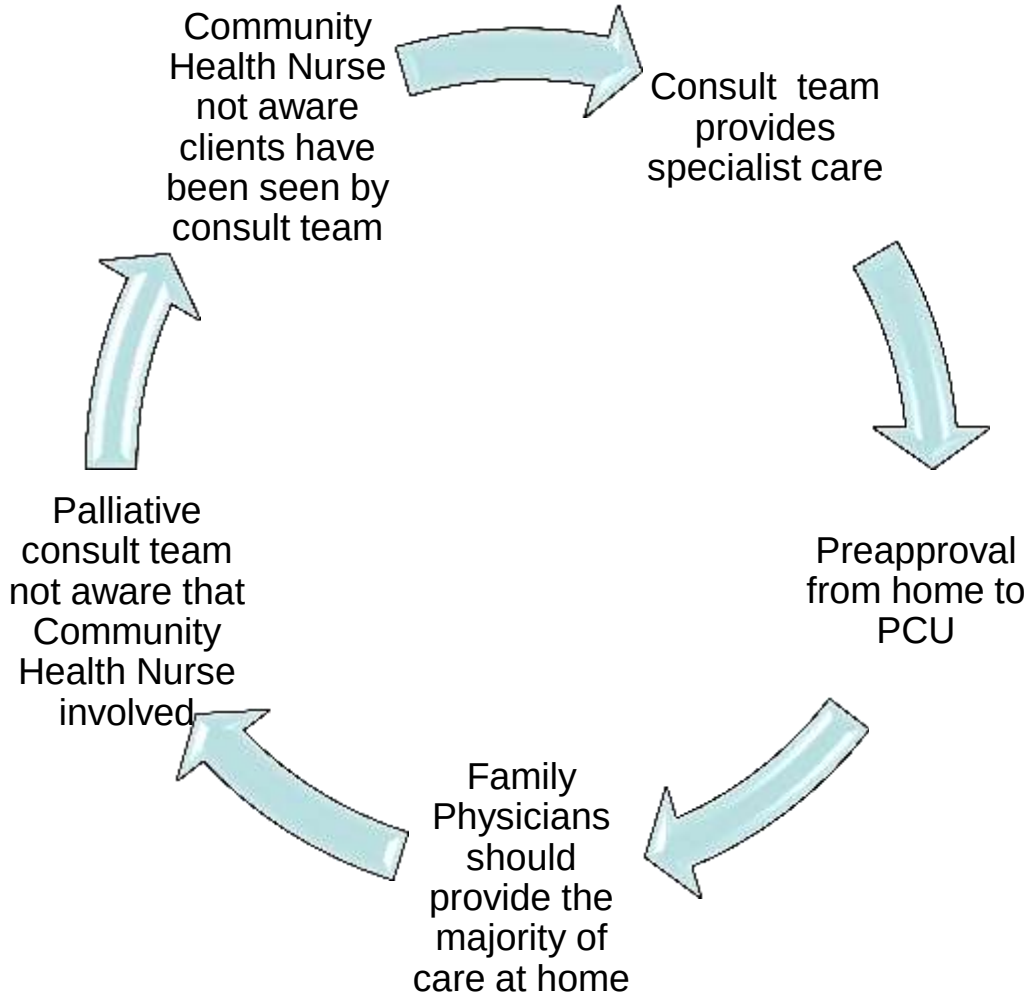
Concerns with Generalist Model

- Inexperience and Lack of Exposure
- Comfort level of Nurses
- Additional pressures and time consuming nature of palliative clients makes case management difficult
- Building and maintaining inter-professional relationships with the Palliative Consult Team is challenging

Issues of Transitions of Care Settings



Challenges to Shared Care [9]

- Necessitated specialized competencies in PC
- Showing respect for other competencies
- More efficient communication between care settings
- Accessibility, quality and continuity of care
- Need for proactive planning
- Clear distribution of tasks

The Advance Practice Nurse/NP[10-12]

- Clinical leadership roles to provide intermediate level of care to bridge the gaps in services between specialists and generalists, reducing fragmented delivery of care

- Complimentary to, not competitive with physicians and generalist nurses
  - Clinical consultants – diagnosis, prescribing and making appropriate referrals
  - Case Management – assessing specific needs and coordinating referrals/services
  - Leadership
  - Educators
  - Researchers

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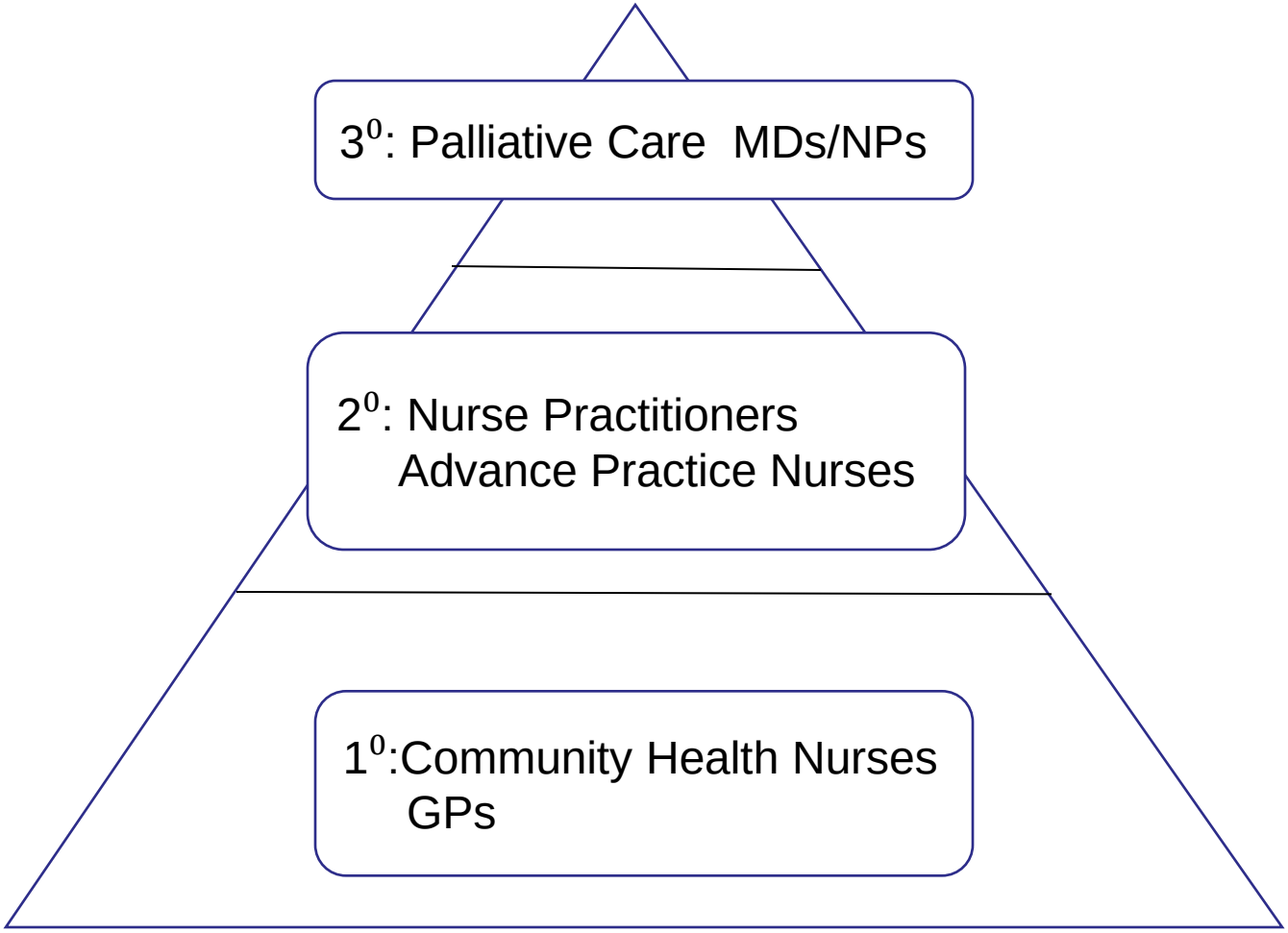

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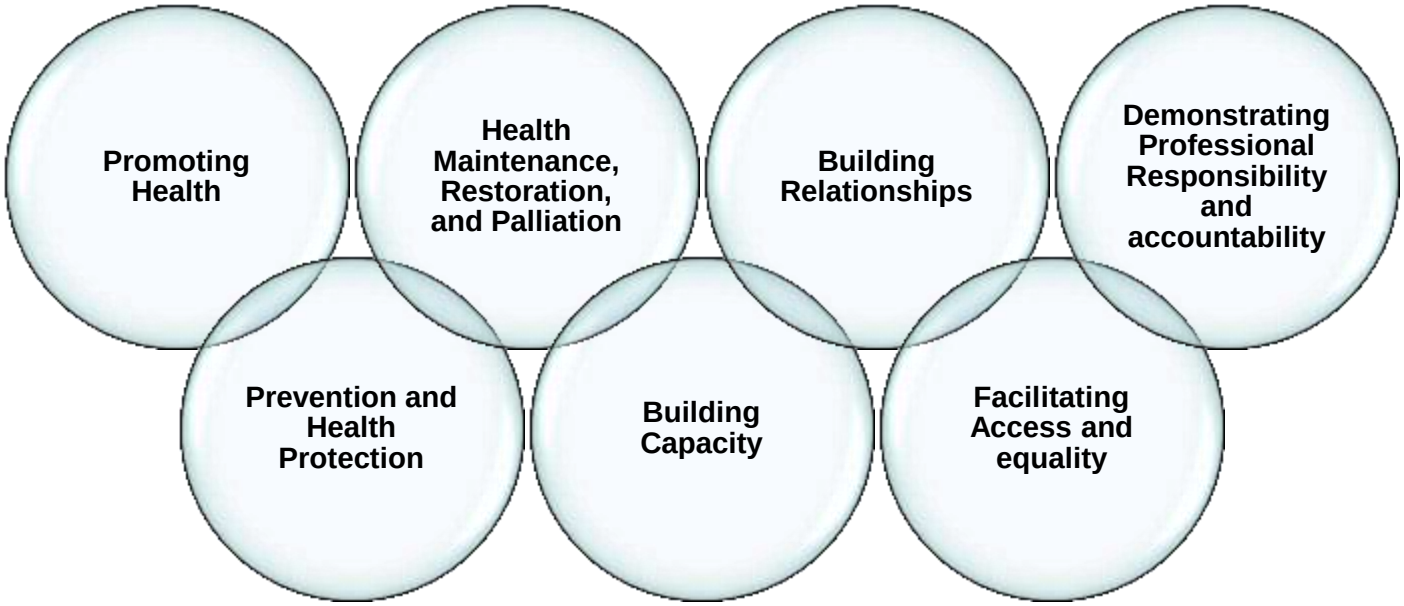
Canadian Community Health Nursing Standards of Practice



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Goals of New Model

- Improve the quality care of the service provided to palliative care clients
- Increase knowledge and skill set of CHN
- Enhance and strengthen the capacity of the whole nursing team
- Improve communication with Palliative Care Consult Team

Palliative Leads Model

- CHNs will continue to carry their own district and receive their own referrals
- Palliative referrals will be shared between the district and lead nurse. *A home visit is required for all new referrals*
- With this model the palliative lead will receive some additional training
- The palliative lead will be the resource person for the team to begin building capacity for the entire team

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Palliative Leads Model

- District nurse will follow the client with regular consultation with the palliative lead
- Assessment and screening tools to be completed on admission and on a regular basis
- Discuss options of preapproval to PCU and or plan of EOL at home
- Do Not Resuscitate discussions to be initiated
- Palliative Lead may see more EOL clients and be the resource Nurse for the zone

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Palliative Care Consult Team

- Coordinate joint home visits
- Improve communication regarding client care issues
- To provide education to maintain specific palliative care skill set
- Increase access to telephone advice

Summary

- Models of palliative care should integrate specialist expertise with primary/generalist community services
- Shared care teams are a more sustainable model and greatly increase competence, access to care and home death planning
- Partnership is enhanced with good communication and clear delineation of roles amongst providers

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Building Capacity Together

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