...in nurses’ words

I’m just back from holidays and there’s a small tower of charts on my desk along with a ton of emails and phone messages. Among the charts there’s a new admission for ‘medication management’. The intake notes say this 76 year old man had a recent hospital stay for his heart failure. It’s evident he’s having a hard time remembering his meds, and so, has been referred to me for a visit. I’m to assess his capacity to manage his meds and put in whatever supports I can to help him manage at home.

Although the referral is for medication management, I’m concerned with the heart failure diagnosis. This is a chronic progressive illness and this man’s health will deteriorate over time. I want to do more than just sort out a medication strategy. I plan to ask him some of these questions:

• What is your understanding of heart failure?
• Which symptoms bother you most and what practical problems is heart failure creating for you?
• What does quality of life mean to you and what has provided the most meaning in your life?
• Are there family members who need to know what is going on?
• Has faith been important to you at specific times of your life?


Asking these questions allows me to address the referral, and get to the heart of the matter—how has his life been affected by this illness, and how does he want to proceed. I am frustrated that we don’t have great systems in place for sharing this information. A note in his chart won’t be at the hospital the next time he ends up in the ER, and electronic health records aren’t ready yet. For now I’ll fax his GP and talk with the home care team involved. It’s a place to start supporting this man in accordance with his needs and goals… using a palliative approach.

Home Care Nurse
One way to start the conversation is with the following statements:

- I am concerned about your overall health.
- Tell me how the past year has been going.
- Has anyone spoken to you in the past about what to expect from your disease and the kinds of treatments you would or would not want when you get really sick?
- Do you have a living will or advance directive, or do you know what these terms mean?

Advance Care planning (ACP) plays an important role in improving patient care at the end of life. However, many patients and families identify end of life planning and communication as an area in need of improvement. Barriers pertaining to identification, communication, and documentation prevent patients from receiving the benefits of ACP and these need to be resolved.

A recent study examined patients’ ACP activities before hospitalization, preferences for care from the perspective of patients and family members, and measured the translation between patients’ expressed preferences for care and staff documentation of those preferences in the medical record. Findings revealed that 48% of patients had completed an advance care plan, and 73% had formally named a surrogate decision maker for health care. However, of patients who had discussed their wishes, only 30% had done so with the family physician and 55% with any member of the healthcare team. Shockingly, in cases where preferences were documented, more than 2/3 were not consistent with the patients’ expressed preferences. The majority of patients and family members had discussed their preferences for EOL care prior to hospitalization, but ACP communication between patients or family members and the healthcare team appears to have been ineffective. Systems to ensure communication of ACP preferences across the healthcare system need to be put into place.

Another study suggests that ACP discussions can be triggered by a stay in hospital. This timing may hold particular advantages as a stay signals changes in illness trajectory, and surrogate decision makers are often present to share in discussions. This review, published in CMAJ, identifies a number of strategies that healthcare professionals can use for discussing goals of care with patients whom are identified as being at high risk of dying. See the articles cited below for more information about tools that can be used in ACP and suggested questions and statements for conversation around goals of care.

An iPANEL undergraduate experience: William Harding

This summer, TVN (Technology Evaluation in the Elderly), provided me with the valuable opportunity to work with the iPANEL team under the supervision of Dr. Rick Sawatzky at Trinity Western University. I was able to contribute to many iPANEL projects; within these projects I assisted research staff with article retrieval, database management, and coding. I also helped to create a flow diagram that provided a comprehensive overview of one of the project’s major phases. Throughout this experience I had the valuable opportunity to collaborate with iPANEL team members on data interpretation, presentation, and dissemination. A significant amount of my time was spent writing code so that modifiable, multi-layered graphs could be generated from the provincial survey data for the health authority reports.

In addition to my involvement with the projects; I was given the chance to interact with the team themselves—by participating in face-to-face investigator meetings, and several iPANEL Webinars. This privilege allowed me to develop interdisciplinary contacts, teamwork skills, and observe how researchers, clinicians, and health administrators work together within the healthcare community. My eyes have been opened to the opportunities and challenges in research, knowledge translation, and policy formation. I would like to thank the iPANEL team, especially Rick, Kelli, Carolyn, Sheryl, Elisabeth, Gweneth, and Ami, for their continual support, encouragement and insight.

THINKING OUTSIDE THE BOX

Thinking-outside-the-box meetings provide 3 hr sessions with iPANEL team members and affiliates to facilitate discussions around our research findings with front line nurses, care aides, leaders, and other health care providers from all sectors of care. What does this research mean to you, as a practitioner, and how may it impact your practice? More info and how to register can be found under PUBLICATIONS & PRESENTATIONS on the iPANEL website.

- NOVEMBER 28 | A Palliative Approach to Care: Would your patients benefit? Facilitated by Dr. Kelli Stajduhar. Island Health – Central/North Island

WEBINARS

Webinars are generally a 40 minute presentation followed by a 20 minute collaborative dialogue with the goals of informing both research and practice. All webinars are the 4th Tuesday of the month from 1400-1500 PST (unless otherwise indicated). To join you must register with InspireNet (www.inspirenet.ca) and join our iPANEL action team.

- NOVEMBER 26 | An example of a dynamic research and practice partnership: What makes iPANEL tick? Presented by Dr. Kelli Stajduhar
- JANUARY 28 | Knowledge Translation of a Palliative Approach. Presented by Dr. Sheryl Reimer-Kirkham
Integrated knowledge translation: Examining a collaborative knowledge translation approach

Principal Investigators: Sheryl Reimer-Kirkham, Gweneth Doane, Elisabeth Antifeau
Co-investigators: Barb Pesut, Pat Porterfield, Kelli Stajduhar, Della Roberts, Nicole Wikjord
Research Staff: Elizabeth Causton, Marie Cochrane

This two-year MSFHR-funded knowledge translation (KT) demonstration project is designed to develop and test a model for effective, collaborative and integrated knowledge translation processes. Our aim is to translate what we know about identifying clients with chronic life-limiting illnesses who would benefit from a palliative approach into everyday practice. Building on the relationship between academic, administrative and clinical stakeholders, the primary KT strategy involves participatory action cycles in 3 health authorities at 1 residential and 2 acute care sites. Local champions, co-facilitators and working groups made up of staff at each site are developing synergies around the unit-specific KT initiatives. With the support of the Knowledge Broker, Elizabeth Causton, these working groups are designing demonstration projects that are simple, concrete, and sustainable. All sites are actively involved in KT that reflects the care planning aspect of a palliative approach. Both acute sites are focused on strategies around Advanced Care Planning (ACP), while the residential site has focused their efforts on improving nurses’ skills related to the use of existing resident assessment tools, which will become the foundation of soon-to-be-implemented Plan of Care meetings.

Based on preliminary findings, knowledge translation is not a straightforward, linear process at any of the sites; rather it reflects the profound influence of timing, collective capacity for change, and the recurring presence of practice issues affecting energy levels and morale. Given these factors, the current initiatives have been developed over time and often involved creative ideas which were then re-worked by site-specific realities of practice. Organizational support and alignment with other initiatives have also proven to be integral to successful knowledge translation. A project colloquium will be held in February 2014 to share the findings.

FOUR THINGS YOU SHOULD KNOW ABOUT iPANEL

1. Three quarters of the British Columbians who die, do so without being identified as people who could benefit from the services associated with palliative care.
2. Through research we create new knowledge about how nurses can further integrate palliative philosophies and services into non-specialized settings which provide end-of-life care.
3. Our research is informed by and informs clinical practice.
4. Our ultimate goal is to advance the further integration of the palliative approach into every care setting.