A growing expertise in people skills, chronic illnesses, palliation and an understanding of how families “let go” of their loved one are integral to the palliative approach. It therefore makes sense that a palliative approach can only be cultivated by deliberately creating conditions for ongoing clinical learning for both individuals and teams. How can this clinical learning take place?

When exploring a palliative approach to care within the residential care program at Mount St Joseph (MSJ), we focused on interdisciplinary clinical decision makers who can have the often lonely job of making sense of clinical situations in order to provide support, understandable interpretation and daily leadership to care aides and families.

Our exploration began when a Quality of Care review of a specific case uncovered that clinicians were unwittingly working towards conflicting goals. This discovery highlighted how the MSJ team lacked protected time to develop an evolving team understanding of a resident’s illness or a family’s process. They decided to try meeting every morning for no longer than 15-20 minutes, specifically for this purpose. Later experience told them to focus these meetings only on residents they worried about most, to make sense of the resident’s clinical status and family’s situation, and to assess interventions from the previous day. Consulting staff such as a palliative care consultation team (POCT) nurse or a CNS could drop in to encourage fresh thinking and to introduce concepts to further the team’s understanding.

When clinicians think together, they get a slight observational distance from their own thoughts and feelings. It helps them refocus on the resident and family. These strategies allow the team to own the clinical problem together rather than to struggle individually. In my estimation, this strategy worked; our care aides told us at evaluation that they and the residents’ families seemed better prepared for death.

-Tilly Schalkwyk, CNS
Integrating a palliative approach to care

On October 5, 2015 an interprofessional education day, “Integrating a Palliative Approach to Care,” was held at Vancouver General Hospital, organized by its palliative and clinical education program teams. Over 200 clinicians gathered in the Paetzold Auditorium while others tuned in via webcast across VCH and from other health authorities to learn more about providing the best care they can to patients with chronic life limiting illnesses. Links to the recorded webcasts are available on the iPANEL website.¹

The daylong event was organized by the palliative and clinical education programs at Vancouver General Hospital and was supported by VGH & UBC Hospital Foundation, VGH Palliative Care Program, VGH School of Nursing Alumane Building Society/Association In-House Education Fund, and the BC Centre for Palliative Care.

The day reflected the need for more widespread use of a palliative approach to care, which aims to help people live well throughout their life-limiting illness until death. This is supported in the recently released joint position statement from the Canadian Nurses’ Association: “The palliative approach and the role of the nurse.”² The palliative approach honours people’s values and health care wishes by promoting autonomy, dignity, control and shared decision-making.

Dr Kelli Stadjuhar began the day describing what is meant by a palliative approach to care. Approximately 40% of deaths in British Columbia occur in acute care, where the patient’s quality of life is often compromised due to time pressures and communication breakdown between team members. The complexity and uncertainty of patients’ illnesses often hinder the team in making a coordinated care plan. Dr Stadjuhar encouraged participants to adopt the foundational principles of palliative care, to adapt this knowledge and expertise to the care of all patients with life-limiting illness trajectories, and to embed this adapted knowledge into the delivery of care across different healthcare sectors and professions.

Clinical experts Dr John Duncan, Kaillie Kangro and Dr Pippa Hawley spoke about ways to integrate a palliative approach into care for renal and cancer patients, including the development of new pathways and new ways of thinking. Breaking away from the specialist model where palliative

Volunteers helped make the day a success!
care is seen as the program to which a patient is referred when all else fails, they described embedding the principles of palliative care earlier in disease trajectories, concurrent with disease management.

Understanding the trajectories of life-limiting illnesses and providing comfort by effectively managing symptoms is fundamental to a palliative approach. Clinical nurse specialist Maureen Shaw emphasized the life-limiting nature of dementia and how to provide a palliative approach, and also spoke to the management of delirium.

Dr Wendy Yeomans, medical director of the palliative program at VGH, provided an overview of pain management. The audience soon learned that “the first order of kinetics” was the premise of many of the options discussed related to opioid route and dose.

Dr Shalini Nayar, a physician with the VGH palliative program, presented a case of dyspnea and walked through the assessment and management plan with the participants. Dr Greg Egan, pharmacist, discussed the various pathways one should consider when treating nausea and vomiting in order to choose the most effective anti-emetic. Jill Longhurst, physiotherapist, and Yin Case, occupational therapist from the palliative program, discussed the importance of function to the quality of life of patients and their families and the role of rehabilitation to support patients within a palliative approach to care.

Throughout the day, the audience indicated their support of this approach to care, but many expressed apprehension as to how to change, particularly in relation to communication with patients and families about their illnesses and goals of care. This was expertly addressed by the final speaker, Dr. Doris Barwich, who discussed advance care planning and goals of care conversations.

The participants’ interest and commitment to learning about how to integrate a palliative approach to care across all sectors made this an inspiring event. We hope that this will be an annual event to share our common goal of providing the best we can in patient care!

— Elizabeth Beddard-Huber, CNS
A palliative approach in home and community care

“What might a palliative approach look like in home and community care?” Clinical consults in specialist hospice palliative care practice have changed from predominantly people with malignant diagnoses to also include those living with chronic life-limiting conditions such as dementia, lung and heart disease.

Community clients may transition from home to emergency rooms and acute care and back home. A hospital physician deems a 90 year old male with a long history of dementia and urinary tract infections “palliative” because the daughter agreed she would no longer bring her father to hospital if he developed further infections and wanted comfort care only. The case manager knows the client has a private caregiver 5 days/week and that long term care provides a 24-hour live-in caregiver on the weekends, for which the daughter pays. Community providers interpret “deemed palliative” to mean that home support on the weekends is now free. The daughter also enquires about her dad being entitled to get “free” home support care since he is “palliative”. Community providers ask, “Does this client with a non-malignant illness qualify for hospice palliative care services?” More appropriately, these clients will benefit from a palliative approach rather than a focus on “palliative” service eligibility.

To deliver a palliative approach community providers must have knowledge that progressive, life-limiting conditions are terminal illnesses from which clients will die. After diagnosis, the palliative approach focuses on open conversations about the person’s illness trajectory, and on understanding and establishing goals of care for the client and family, including advance care planning and treatments, psychosocial and spiritual supports, as well as assessment and management of symptom distress. By identifying clients with chronic conditions and by not delaying conversations and goal-setting until the end stages of an illness, home and community providers will improve the quality of care for all clients and families at the end of life. Not all clients require specialized palliative services, nor do all clients require acute care admissions if not their goal of care. Community clients and families require a palliative approach for chronic life-limiting conditions.

— Barbara McLeod, CNS

FOOT NOTES | PAGE 1
2. MSJ residents are cared for by consistent interdisciplinary teams that emphasizes relationship-based care.

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.