HOSPICE PETERBOROUGH

SCARBOROUGH CENTRE FOR HEALTHY COMMUNITIES

VON Durham Hospice Services

CE PALLIATIVE PAIN AND SYMPTOM MANAGEMENT CONSULTANTS

Navigating Difficult Conversations

December 2022

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CE PPSMC's Present:

NAVIGATING DIFFICULT CONVERSATIONS

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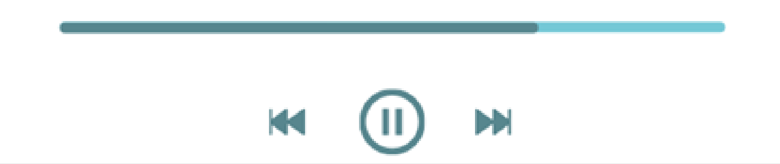
October 2022

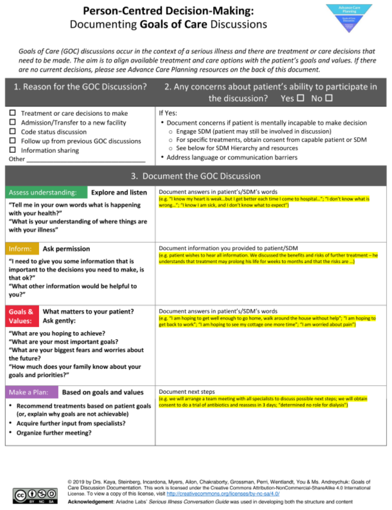


Click HERE for the online evaluation in order to receive your certificate of attendance.

Click HERE to download the slide deck used in this presentation.

Resources

(click on pictures for PDF version)



Person-Centred Decision-Making:
Documenting **Goals of Care** Discussions

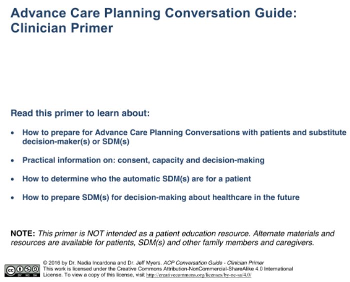
Goals of Care (GOC) discussions occur in the context of a serious illness and there are treatment or care decisions that need to be made. The aim is to align available treatment and care options with the patient's goals and values. If there are no current decisions, please see Advance Care Planning resources on the back of this document.

1. Reason for the GOC Discussion?	2. Any concerns about patient's ability to participate in the discussion? Yes ☐ No ☐
☐ Treatment or care decisions to make ☐ Admission/Transfer to a new facility ☐ Code status discussion ☐ Follow up from previous GOC discussions ☐ Information sharing Other ____________	If Yes: • Document concerns if patient is mentally incapable to make decision ○ Engage SDM (patient may still be involved in discussion) ○ For specific treatments, obtain consent from capable patient or SDM ○ See below for SDM Hierarchy and resources • Address language or communication barriers

3. Document the GOC Discussion	
Assess understanding: **Explore and listen** **"Tell me in your own words what is happening with your health?"** **"What is your understanding of where things are with your illness"**	Document answers in patient's/SDM's words (e.g. "I know my heart is weak...but I get better each time I come to hospital..."; "I don't know what is wrong..."; "I know I am sick, and I don't know what to expect")
Inform: **Ask permission** **"I need to give you some information that is important to the decisions you need to make, is that ok?"** **"What other information would be helpful to you?"**	Document information you provided to patient/SDM (e.g. patient wishes to hear all information. We discussed the benefits and risks of further treatment – he understands that treatment may prolong his life for weeks to months and that the risks are ...)
Goals & Values: **What matters to your patient? Ask gently:** **"What are you hoping to achieve?** **"What are your most important goals?** **"What are your biggest fears and worries about the future?** **"How much does your family know about your goals and priorities?"**	Document answers in patient's/SDM's words (e.g. "I am hoping to get well enough to go home, walk around the house without help"; "I am hoping to get back to work"; "I am hoping to see my cottage one more time"; "I am worried about pain")
Make a Plan: **Based on goals and values** • **Recommend treatments based on patient goals (or, explain why goals are not achievable)** • **Acquire further input from specialists?** • **Organize further meeting?**	Document next steps (e.g. we will arrange a team meeting with all specialists to discuss possible next steps; we will obtain consent to do a trial of antibiotics and reassess in 3 days; "determined no role for dialysis")

Acknowledgement: Ariadne Labs' *Serious Illness Conversation Guide* was used in developing both the structure and content

Person Centered Decision Making - Documenting Goals of Care Discussions



Advance Care Planning Conversation Guide:
Clinician Primer

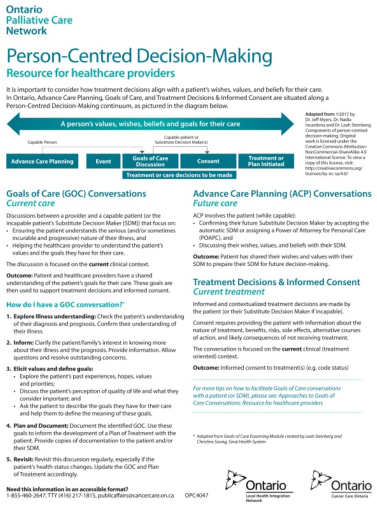
Read this primer to learn about:

- **How to prepare for Advance Care Planning Conversations with patients and substitute decision-maker(s) or SDM(s)**
- **Practical information on: consent, capacity and decision-making**
- **How to determine who the automatic SDM(s) are for a patient**
- **How to prepare SDM(s) for decision-making about healthcare in the future**

NOTE: *This primer is NOT intended as a patient education resource. Alternate materials and resources are available for patients, SDM(s) and other family members and caregivers.*

Your copy should address 3 key questions: Who am I writing for? (Audience) Why should they care? (Benefit) What do I want them to do here? (Call-to-Action)

Create a great offer by adding words like "free" "personalized" "complimentary" or "customized." A sense of urgency often helps readers take an action, so think about inserting phrases like "for a limited time only" or "only 7 remaining"!



Ontario
Palliative Care
Network

Person-Centred Decision-Making
Resource for healthcare providers

It is important to consider how treatment decisions align with a patient's wishes, values, and beliefs for their care. In Ontario, Advance Care Planning, Goals of Care, and Treatment Decisions & Informed Consent are situated along a Person-Centred Decision-Making continuum, as pictured in the diagram below.

Adapted from: ©2017 by Dr. Jeff Myers, Dr. Nadia Incardona and Dr. Leah Steinberg. Components of person-centred decision-making. Original work is licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International license. To view a copy of this license, visit: http://creativecommons.org/licenses/by-nc-sa/4.0/

Goals of Care (GOC) Conversations
Current care

Discussions between a provider and a capable patient (or the incapable patient's Substitute Decision Maker [SDM]) that focus on:

- Ensuring the patient understands the serious (and/or sometimes incurable and progressive) nature of their illness, and
- Helping the healthcare provider to understand the patient's values and the goals they have for their care.

The discussion is focused on the **current** clinical context.

Outcome: Patient and healthcare providers have a shared understanding of the patient's goals for their care. These goals are then used to support treatment decisions and informed consent.

How do I have a GOC conversation?*

1. **Explore Illness understanding:** Check the patient's understanding of their diagnosis and prognosis. Confirm their understanding of their illness.
2. **Inform:** Clarify the patient/family's interest in knowing more about their illness and the prognosis. Provide information. Allow questions and resolve outstanding concerns.
3. **Elicit values and define goals:**
   - Explore the patient's past experiences, hopes, values and priorities;
   - Discuss the patient's perception of quality of life and what they consider important; and
   - Ask the patient to describe the goals they have for their care and help them to define the meaning of these goals.
4. **Plan and Document:** Document the identified GOC. Use these goals to inform the development of a Plan of Treatment with the patient. Provide copies of documentation to the patient and/or their SDM.
5. **Revisit:** Revisit this discussion regularly, especially if the patient's health status changes. Update the GOC and Plan of Treatment accordingly.

Advance Care Planning (ACP) Conversations
Future care

ACP involves the patient (while capable):

- Confirming their future Substitute Decision Maker by accepting the automatic SDM or assigning a Power of Attorney for Personal Care (POAPC), and
- Discussing their wishes, values, and beliefs with their SDM.

Outcome: Patient has shared their wishes and values with their SDM to prepare their SDM for future decision-making.

Treatment Decisions & Informed Consent
Current treatment

Informed and contextualized treatment decisions are made by the patient (or their Substitute Decision Maker if incapable).

Consent requires providing the patient with information about the nature of treatment, benefits, risks, side effects, alternative courses of action, and likely consequences of not receiving treatment.

The conversation is focused on the **current** clinical (treatment oriented) context.

Outcome: Informed consent to treatment(s) (e.g. code status)

For more tips on how to facilitate Goals of Care conversations with a patient (or SDM), please see: Approaches to Goals of Care Conversations: Resource for healthcare providers

* *Adapted from Goals of Care ELearning Module created by Leah Steinberg and Christine Soong, Sinai Health System*

Need this information in an accessible format?
1-855-460-2647, TTY (416) 217-1815, publicaffairs@cancercare.on.ca OPC4047

Ontario Local Health Integration Network
Ontario Cancer Care Ontario

OPCN - Person Centered Decision Making. Resource for Healthcare Providers

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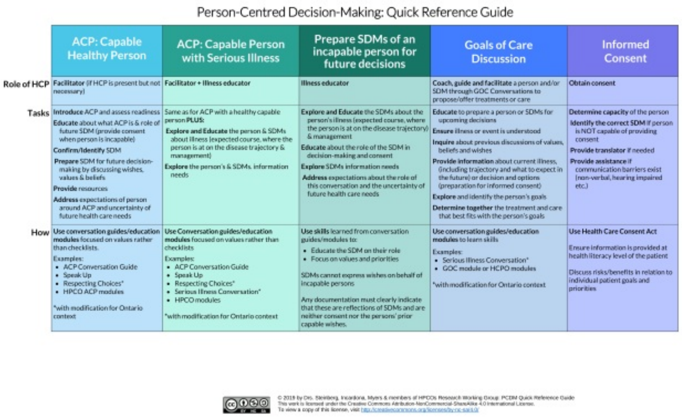
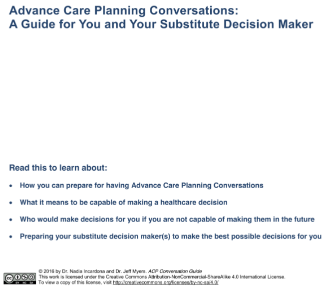


Person-Centred Decision-Making: Quick Reference Guide

	ACP: Capable Healthy Person	ACP: Capable Person with Serious Illness	Prepare SDMs of an incapable person for future decisions	Goals of Care Discussion	Informed Consent
Role of HCP	**Facilitator** (If HCP is present but not necessary)	**Facilitator + Illness educator**	**Illness educator**	**Coach, guide and facilitate** a person and/or SDM through GOC Conversations to propose/offer treatments or care	**Obtain consent**
Tasks	**Introduce** ACP and assess readiness **Educate** about what ACP is & role of future SDM (provide consent when person is incapable) **Confirm/Identify** SDM **Prepare** SDM for future decision-making by discussing wishes, values & beliefs **Provide** resources **Address** expectations of person around ACP and uncertainty of future health care needs	Same as for ACP with a healthy capable person **PLUS:** **Explore and Educate** the person & SDMs about illness (expected course, where the person is at on the disease trajectory & management) **Explore** the person's & SDMs. information needs	**Explore and Educate** the SDMs about the person's illness (expected course, where the person is at on the disease trajectory) & management **Educate** about the role of the SDM in decision-making and consent **Explore** SDMs information needs **Address** expectations about the role of this conversation and the uncertainty of future health care needs	**Educate** to prepare a person or SDMs for upcoming decisions **Ensure** illness or event is understood **Inquire** about previous discussions of values, beliefs and wishes **Provide information** about current illness, (including trajectory and what to expect in the future) or decision and options (preparation for informed consent) **Explore** and identify the person's goals **Determine together** the treatment and care that best fits with the person's goals	**Determine capacity** of the person **Identify the correct SDM** if person is NOT capable of providing consent **Provide translator** if needed **Provide assistance** if communication barriers exist (non-verbal, hearing impaired etc.)
How	**Use conversation guides/education modules** focused on values rather than checklists. Examples: • ACP Conversation Guide • Speak Up • Respecting Choices* • HPCO ACP modules *with modification for Ontario context	**Use Conversation guides/education modules** focused on values rather than checklists Examples: • ACP Conversation Guide • Speak Up • Respecting Choices* • Serious Illness Conversation* • HPCO modules *with modification for Ontario context	**Use skills** learned from conversation guides/modules to: • Educate the SDM on their role • Focus on values and priorities SDMs cannot express wishes on behalf of incapable persons Any documentation must clearly indicate that these are reflections of SDMs and are neither consent nor the persons' prior capable wishes.	**Use conversation guides/education modules** to learn skills Examples: • Serious Illness Conversation* • GOC module or HCPO modules *with modification for Ontario context	**Use Health Care Consent Act** Ensure information is provided at health literacy level of the patient Discuss risks/benefits in relation to individual patient goals and priorities

Person Centered Decision Making Quick Reference Guide



Advance Care Planning Conversations:
A Guide for You and Your Substitute Decision Maker

Read this to learn about:

- **How you can prepare for having Advance Care Planning Conversations**
- **What it means to be capable of making a healthcare decision**
- **Who would make decisions for you if you are not capable of making them in the future**
- **Preparing your substitute decision maker(s) to make the best possible decisions for you**

ACP Conversation Guide - Public

Central East Palliative Pain and Symptom Management Consultants

December Educational Opportunities:

For consultation support or education requests:

Brenda Derdaele, RN, CHPCN (C)
Palliative Pain & Symptom Management Consultant
Durham Region

Email Me

Erin Newman-Waller, RN, BScN, CHPCN(C)
Palliative Pain & Symptom Management Consultant
Peterborough Hospice

Email Me

Gwen Cleveland, RN, BScN, MEd, CHPCN(C)
Palliative Pain & Symptom Management Consultant Scarborough

Email Me

Topic:

Lunch and Learn

- Wednesday, December 7
- 12-1pm

Lunch & Learn Registration

Coffee and Palliative Care

- Thursday, December 8
- 3-4pm

Coffee & Care Registration

Durham Region PPSMC Educational Hub

PDF Version of Newsletter

Central East Palliative Care Educational Opportunities

- Fundamentals in Hospice Palliative Care
- Enhanced Fundamentals in Hospice Palliative Care
- Advanced Palliative Practice Skills (APPS)
- Comprehensive Advanced Palliative Care Education

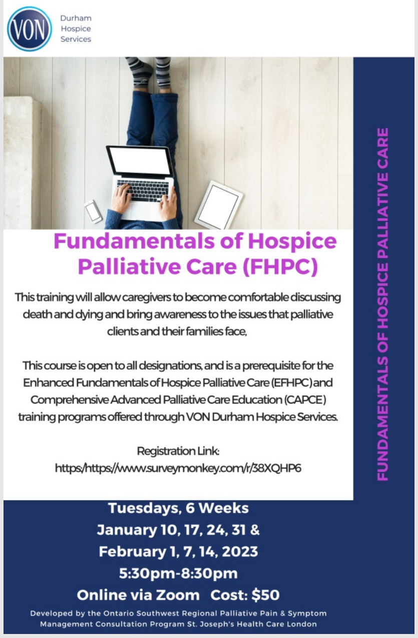
Click Photo's for PDF Version

VON Durham Hospice Services

SCARBOROUGH CENTRE FOR HEALTHY COMMUNITIES

HOSPICE PETERBOROUGH

For information about Palliative Education offered by SCHC, go to



Durham Hospice Services

Fundamentals of Hospice Palliative Care (FHPC)

This training will allow caregivers to become comfortable discussing death and dying and bring awareness to the issues that palliative clients and their families face,

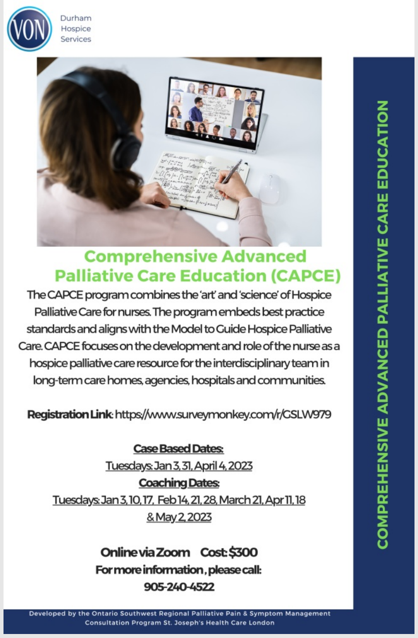
This course is open to all designations, and is a prerequisite for the Enhanced Fundamentals of Hospice Palliative Care (EFHPC) and Comprehensive Advanced Palliative Care Education (CAPCE) training programs offered through VON Durham Hospice Services.

Registration Link:
https/https//www.surveymonkey.com/r/38XQHP6

Tuesdays, 6 Weeks
January 10, 17, 24, 31 &
February 1, 7, 14, 2023
5:30pm-8:30pm
Online via Zoom Cost: $50

Developed by the Ontario Southwest Regional Palliative Pain & Symptom Management Consultation Program St. Joseph's Health Care London

FUNDAMENTALS OF HOSPICE PALLIATIVE CARE



Durham Hospice Services

Comprehensive Advanced Palliative Care Education (CAPCE)

The CAPCE program combines the 'art' and 'science' of Hospice Palliative Care for nurses. The program embeds best practice standards and aligns with the Model to Guide Hospice Palliative Care. CAPCE focuses on the development and role of the nurse as a hospice palliative care resource for the interdisciplinary team in long-term care homes, agencies, hospitals and communities.

Registration Link: https://www.surveymonkey.com/r/GSLW979

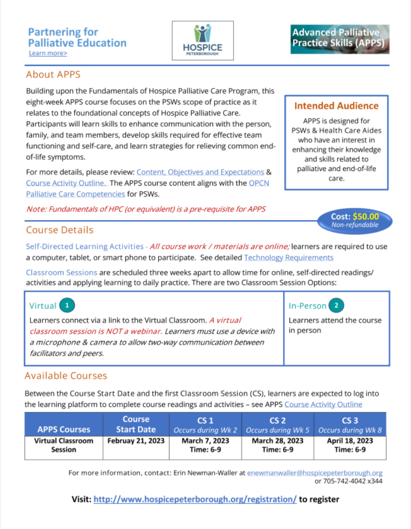
Case Based Dates:
Tuesdays: Jan 3, 31, April 4, 2023
Coaching Dates:
Tuesdays: Jan 3, 10, 17, Feb 14, 21, 28, March 21, Apr 11, 18 & May 2, 2023

Online via Zoom Cost: $300
For more information , please call:
905-240-4522

Developed by the Ontario Southwest Regional Palliative Pain & Symptom Management Consultation Program St. Joseph's Health Care London

COMPREHENSIVE ADVANCED PALLIATIVE CARE EDUCATION

https://schcontario.ca/programs/health-services/palliative-education/



Partnering for Palliative Education
Learn more>

HOSPICE PETERBOROUGH

Advanced Palliative Practice Skills (APPS)

About APPS

Building upon the Fundamentals of Hospice Palliative Care Program, this eight-week APPS course focuses on the PSWs scope of practice as it relates to the foundational concepts of Hospice Palliative Care. Participants will learn skills to enhance communication with the person, family, and team members, develop skills required for effective team functioning and self-care, and learn strategies for relieving common end-of-life symptoms.

For more details, please review: Content, Objectives and Expectations & Course Activity Outline. The APPS course content aligns with the OPCN Palliative Care Competencies for PSWs.

Note: Fundamentals of HPC (or equivalent) is a pre-requisite for APPS

Intended Audience

APPS is designed for PSWs & Health Care Aides who have an interest in enhancing their knowledge and skills related to palliative and end-of-life care.

Cost: $50.00
Non-refundable

Course Details

Self-Directed Learning Activities - *All course work / materials are online;* learners are required to use a computer, tablet, or smart phone to participate. See detailed Technology Requirements

Classroom Sessions are scheduled three weeks apart to allow time for online, self-directed readings/activities and applying learning to daily practice. There are two Classroom Session Options:

Virtual ①
Learners connect via a link to the Virtual Classroom. *A virtual classroom session is NOT a webinar. Learners must use a device with a microphone & camera to allow two-way communication between facilitators and peers.*

In-Person ②
Learners attend the course in person

Available Courses

Between the Course Start Date and the first Classroom Session (CS), learners are expected to log into the learning platform to complete course readings and activities – see APPS Course Activity Outline

APPS Courses	Course Start Date	CS 1 *Occurs during Wk 2*	CS 2 *Occurs during Wk 5*	CS 3 *Occurs during Wk 8*
Virtual Classroom Session	**Februay 21, 2023**	**March 7, 2023** **Time: 6-9**	**March 28, 2023** **Time: 6-9**	**April 18, 2023** **Time: 6-9**

For more information, contact: Erin Newman-Waller at enewmanwaller@hospicepeterborough.org or 705-742-4042 x344

Visit: http://www.hospicepeterborough.org/registration/ to register

FUNDAMENTALS 2023

Fundamentals Core education is a certificate program for ALL health care providers and volunteers who wish to enhance knowledge and develop capacity related to hospice palliative care.

Fundamentals ENHANCED education is intended for Nurse Practitioners (NPs), Registered Nurses (RNs), and Registered Practical Nurses (RPNs) with an interest in developing his/her/their capacity related to hospice palliative care in a clinical setting. NPs, RNs and RPNs must take the core Fundamentals program prior to taking the Enhanced Fundamentals program. Both the Fundamentals CORE and ENHANCED session are a prerequisite for the CAPCE program.

Fundamentals eligibility:
· Health care provider or volunteer caring for people with a progressive, life-limiting illness
· Access to an internet-enabled computer
· Knowledge of basic computer programs

Included in the core curriculum:
- An 11 chapter program guide
- 8 e-learning modules
- 2 peer-to-peer exchanges (learning debriefs)
- 1 reflective activity
- 3 group learning sessions*
- 1 (one) additional online group learning session for the ENHANCED program that is mandatory for all RPNs, RNs, NPs wishing to go one to take CAPCE in the future.

**learning may be conducted in-person, virtual or a blended delivery depending COVID guidelines and/or restrictions*

Cost:$50

Winter session
January 12, February 2, February 16, **Enhanced** March 2 from 6-9pm

Spring sessions
Session 1: April 20, May 11, May 25, **Enhanced** June 8 from 6-9pm
Session 2: April 25, May 16, May 30, **Enhanced** June 13 from 9am-12pm

Fall sessions
Session 1: September 14, October 5, October 19, **Enhanced** November 2 from 6-9pm
Session 2: September 19, October 10, October 24, **Enhanced** November 7 from 9-12pm

Registration now open for all sessions at
http://www.hospicepeterborough.org/registration/

For more information please contact
Erin Newman-Waller at 705-868-8126 or
email: enewmanwaller@hospicepeterborough.org

CAPCE dates to come.......

Durham Hospice Services

Please help VON Durham Hospice Services support our Palliative Community.

We offer:
- Hospice Volunteer supports
- Patient & Caregiver support groups
- Care Navigation
- Supportive Care Counselling
- Grief & Bereavement support
- Community Education

Visit our Website | vondurham.org

VON Durham Referral Form

Hospice Peterborough offers:
- Hospice Volunteer supports
- Patient & Caregiver support groups
- Nurse Navigation
- Supportive Care Counselling

hospicepeterborough.org

- Grief & Bereavement support
- Community Education
- Hospice Residence

HOSPICE
PETERBOROUGH

Referral Form

SCARBOROUGH
CENTRE FOR
HEALTHY
COMMUNITIES

SCHC provides comprehensive, focused health programs and services to improve the holistic overall health and well-being for our community.

Through the operation of 42 distinct and integrated services across 10 sites that work together to improve the health of the Scarborough community, SCHC provides medical assistance through clinics, has a growing youth program, and offers many social support programs, including a food bank.

Go to https://https://schcontario.ca// to learn more about SCHC.

Thanks to Oak Ridges Hospice for their ongoing support and exemplary end-of-life care. If you are interested in a tour or making a referral, please visit their website for more information.

Visit their Website | Oak Ridges Hospice

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