



Central East Palliative Pain and Symptom
Management Consultants

PALLIATIVE CARE & END OF LIFE CARE, THE SAME RIGHT?

January 2023

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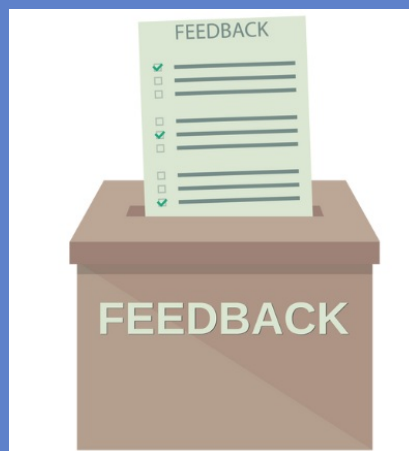
Palliative Care and End of Life Care, the Same Right??

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The information provided in this newsletter is for educational purposes only.

Resources

(click on pictures for PDF version)

Supportive and Palliative Care Indicators Tool (SPICTM)

The SPICTM is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admissions.
- Performance status is poor or deteriorating, with limited reversibility. (ie. The person stays in bed or in a chair for more than half the day).
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying conditions.
- The person (or family) asks for palliative care, chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer	Heart/vascular disease	Kidney disease
<ul style="list-style-type: none"> Functional ability deteriorating due to progressive cancer. Too frail for cancer treatment or treatment is for symptom control. 	<ul style="list-style-type: none"> Heart failure or extensive, untreatable coronary artery disease, with breathlessness or chest pain at rest or on minimal effort. 	<ul style="list-style-type: none"> Stage 4 or 5 chronic kidney disease (eGFR <30ml/min) with deteriorating health. Kidney failure complicating other life limiting conditions or treatments.
Dementia/ frailty	Respiratory disease	Liver disease
<ul style="list-style-type: none"> Unable to dress, walk or eat without help. Eating and drinking less; difficulty with swallowing. Urinary and faecal incontinence. Not able to communicate by speaking; little social interaction. Frequent falls; fractured femur. Recurrent febrile episodes or infections; aspiration pneumonia. 	<ul style="list-style-type: none"> Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations. Persistent hypoxia needing long term oxygen therapy. Has needed ventilation for respiratory failure or ventilation is contraindicated. 	<ul style="list-style-type: none"> Cirrhosis with one or more complications in the past year: <ul style="list-style-type: none"> clinically relevant ascites hepatic encephalopathy hepatorenal syndrome bacterial peritonitis recurrent variceal bleeds Liver transplant is not possible.
Neurological disease	Other conditions	Review current care and care planning.
<ul style="list-style-type: none"> Progressive deterioration in physical and/or cognitive function, despite optimal therapy. Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing. Recurrent aspiration pneumonia; breathless or respiratory failure. Persistent paralysis after stroke with significant loss of function and ongoing disability. 	<ul style="list-style-type: none"> Deteriorating with other conditions, multiple conditions and/or complications that are not reversible; best available treatment has a poor outcome. 	<ul style="list-style-type: none"> Review current treatment and medication to make sure the person receives optimal care; minimise polypharmacy. Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage. Agree a current and future care plan with the person and their family/people close to them. Support carers. Plan ahead early if loss of decision-making capacity is likely. Record, share, and review care plans.

SPICTM - October 2020

SPICTM

Why use the SPICTM?

SPICTM helps clinicians identify people with one or more general indicators of poor or deteriorating health and clinical signs of life-limiting conditions for assessment and care planning. SPICTM looks for changes in health status, burden of illness and increasing care needs. Integrate a holistic palliative care approach with best available treatment of underlying illnesses. Timely identification avoids harm and improves treatment and care of patients and families.

Using SPICTM to assess people's needs and plan care.

- Unplanned hospital admission, more clinic visits or a decline in health status: review current care, treatment and medication; discuss future options; plan for managing further deterioration.
- Poorly controlled symptoms: review and optimise available treatment of underlying conditions; stop medicines/treatments/benefits not of benefit; use effective palliative symptom control measures.
- People who are increasingly dependent on others due to deteriorating functional ability, physical frailty and/or mental health problems often need additional care and support.
- Complex symptoms or other patient/family needs: consider specialist palliative care review or involve another appropriate specialist or service.
- Assess decision-making capacity. Plan ahead if this will deteriorate. Record details of close family/friends, Power of Attorney or legal proxies. Involve in decision-making if capacity is impaired.
- Identify people who need proactive, coordinated care in the community from the primary care team and/or other community staff and services. Involve the local community. Support carers.
- Agree, record, share, and plan to review advanced anticipatory care plans (ACP); include plans for urgent/emergency care and treatment if the person's health deteriorates or care at home changes.

Talking about future care planning

REDMAP FRAMEWORK

- REDMAP FRAMEWORK:
 - RED: Review current care and medication to make sure the person receives optimal care; minimise polypharmacy.
 - MAP: Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
 - FRAME: Agree a current and future care plan with the person and their family/people close to them. Support carers.
 - WORK: Plan ahead early if loss of decision-making capacity is likely.
- Talk about:
 - Benefits, harms and costs of hospital admission, outpatient visits, tests and treatments (eg. IV antibiotics/chemo; surgery; cancer treatments; interventions for heart or kidney disease; tube feeding; oxygen/ventilation).
 - Treatments that will not work or have a poor outcome for this person (eg. cardiopulmonary resuscitation)
 - Choosing legal proxy decision-makers in case the person's decision-making capacity is lost in the future.
 - What a person would like; anything they do not want.
 - Help and support for family/ informal carers.

Tips on starting conversations about deteriorating health

- I wish we had a treatment for... Could we talk about what we can do if that's not possible?
- I am glad you feel better and I hope you will stay well, but I am worried that you could get ill again...
- Can we talk about how we manage not knowing exactly what will happen and when?
- If you get less well in the future, what would be important for you? What would she say about this?
- Some people want to talk about whether to go to hospital or be at home if they are seriously ill...

www.spic.org.uk Nov 2021

Cancer Care Ontario

Action Cancer Ontario

Edmonton Symptom Assessment System (revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness (Tiredness = lack of energy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness (Drowsiness = feeling sleepy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression (Depression = feeling sad)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety (Anxiety = feeling nervous)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing (Wellbeing = how you feel overall)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
Other Problem (for example constipation)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible

ESAS-R
Revised, November 2015

Completed by (check one):
 Patient
 Family caregiver
 Health care professional caregiver
 Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

Supportive and Palliative Indicators Tool (SPICTM)

Guide on how to use SPICTM

Edmonton Symptom Assessment Scale

Early Identification and Prognostic Indicators

Guidance for clinicians to support earlier identification of patients nearing the end of life and who could benefit from a hospice palliative

Mississauga Palliative Care Network www.mhpcn.net

Why is it important to identify people nearing the end of life?

About 15% of the population dies each year. Although some deaths are unexpected, many more in fact can be predicted. This is inherently difficult, but if we were better able to predict people in the final year of life, whatever their diagnosis, there is good evidence that they are more likely to receive well-coordinated, high-quality care.

The Early Identification and Prognostic Indicator Guide aims to help family physicians, specialist physicians and nurse practitioners in earlier identification of those patients nearing the end of life who could benefit from a palliative care approach to care.

The tool has been adapted from the Gold Standards Framework (GSF) Prognostic Indicator Guidance tool developed by the GSF Centre in the UK. The UK has been using the tool along with a comprehensive education program to support GPs, care homes and general hospital staff in identifying patients and placing them on a register to help trigger specific support.

Varying Disease Trajectories

Three triggers that suggest that patients could benefit from a palliative care approach

- The Surprise Question: "Would you be surprised if the patient were to die in the next year?"
- General indicators of decline: deterioration, advanced disease, decreased response to treatment, decline for no further disease-modifying treatment.
- Specific clinical indicators related to organ conditions.

Definition of Palliative Care

Palliative care is a philosophy of care that aims to relieve suffering and improve the quality of living and dying. It tries to help individuals and families to:

- Address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears.
- Prepare for and manage self-determined life closure and the dying process.
- Cope with loss and grief during the illness and bereavement.
- Treat all active issues.
- Prevent new issues from occurring.
- Promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization.

10/23, 9:43 AM Palliative Prognostic Index (PPI)

Palliative Prognostic Index (PPI)

Predicts survival in terminally ill patients based on five criteria.

1 **Palliative Performance Scale**
10-20 (+4)
30-50 (+2.5)
>60 (0)

2 **Oral Intake**
Severely Reduced (< mouthfuls) (+2.5)
Moderately Reduced (> mouthfuls) (+1)
Normal (0)

3 **Oedema**
Present (+1)
Absent (0)

4 **Dyspnoea at rest**
Present (+3.5)
Absent (0)

5 **Delirium**
Present (+4)
Absent (0)

Calculate Reset

Early Identification and Prognostic Indicators Guide

Palliative Prognostic Index (PPI)

Victoria Hospice Society

Palliative Performance Scale (PPSv2) version 2

PPS Level	Activities	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal or reduced	Full
80%	Full	Normal activity with Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Occasional assistance necessary	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full
50%	Mainly Self-Care	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Drowsy
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to None	Full or Drowsy
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma
0%	Death				< 2 Confusion

Instructions for Use of PPS (see also definition of terms)

- PPS scores are determined by recording functionality at each level to find a "best fit" for the patient which is then assigned as the PPS's score.
- Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the appropriate evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, "leftward" columns (columns to the left of any specific column) are "stronger" determinants and generally take precedence over others.
 - Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious and with good intake would be scored at PPS 60%.
 - Example 2: A patient who has become anorectic and quadriplegic requiring total care would be PPS 10%, although the patient may be oriented in a substantial period (perhaps even daily) to at 30%, the score is 10% because he or she would no longer be able to do any work or to do any activity if seen for the caregivers providing total care including Mitternachts.
 - Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40% or 50% when he or she is not in total care.
- PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a "best fit" decision. Choosing a "best fit" value of PPS 45%, for example, is not correct. The combination of clinical judgement and leftward precedence is used to determine whether 40% or 50% is the more accurate score for that patient.
- PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for hospital assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

Copyright © 2001 Victoria Hospice Society

10/23, 9:43 AM Clinical Frailty Scale - Geriatric Medicine Research - Dalhousie University

Geriatric Medicine Research

Home - Our Tools - Our Tools

Clinical Frailty Scale

CLINICAL FRAILTY SCALE

1 **VERY FIRM** People who are robust, active, energetic and motivated. They tend to receive regularly scheduled care and are rarely in the ER for their care.

2 **FIRMLY** People who have the entire disease spectrum but are less fit than category 1. They do not receive care from a geriatrician, but often need regularly scheduled beyond routine walking.

3 **MORBIDLY** People who are frail and have several chronic conditions but are still ambulatory, self-sufficiently independent, but often need regularly scheduled care beyond routine walking.

4 **UNFIT** People who often have moderate chronic conditions and need help with walking, shopping, transportation, housework, typically, and daily personal care.

5 **FRAGILE** People who are frail and have moderate chronic conditions and need help with walking, shopping, transportation, housework, typically, and daily personal care.

6 **MODERATELY FRAGILE** People who need help with all outside activities and who frequently have trouble with walking and shopping and who often need help with dressing.

7 **COMPLETELY FRAGILE** Completely dependent for personal care and transportation of all. Significant disability with walking and shopping.

8 **VERY FRAGILE** Completely dependent for personal care and transportation of all. Significant disability with walking and shopping.

9 **TERMINALLY FRAGILE** Approaching the end of life. This category applies to people with life expectancy of months, who are not ambulatory with walking and shopping. (Only in the very latest stages of illness, if people are still conscious and able to walk.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty is assessed by the degree of dementia. People with mild dementia are scored as "very firm" or "firmly". People with moderate dementia are scored as "morbidity" or "unfit". People with severe dementia are scored as "frail" or "moderately frail". People with very severe dementia are scored as "very frail" or "terminally frail".

The Clinical Frailty Scale (CFS) was introduced in the second clinical examination of the Canadian Study of Health and Aging (CSHA) as a way to summarize the overall level of fitness or frailty of an older adult after they had been evaluated by an experienced clinician (Rockwood et al., 2005).

Palliative Performance Scale (PPS)

Clinical Frailty Scale

More resources can be found at:

<https://www.ontariopalliativecarenetwork.ca/resources/palliative-care-toolkit>

Central East Palliative Pain and Symptom Management Consultants

For consultation support or education requests:

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

brenda.derdaele@von.ca

December Educational Opportunities:

Topic: MAID - Medical Assistance in Dying

Lunch and Learn

- Wednesday, January 11/2023
- 12-1pm

Lunch & Learn Registration

Coffee and Palliative Care

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

enewmanwaller@hospicepeterborough.org

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

gccleveland@schcontario.ca

- Thursday, January 12/2023
- 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



For information about Palliative Education offered by SCHC, go to

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

Partnering for Palliative Education Learners

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.

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 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 Learners attend the course in person.
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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	CS 2	CS 3
Virtual Classroom Session	February 21, 2023	Overlapping 3/1 & 2 March 2, 2023 Time: 6-9	Overlapping 1/5 & 5 March 28, 2023 Time: 6-9	Overlapping 3/8 & 8 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 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://www.surveymonkey.com/r/58XQHP6>

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

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 on to take CAPCE in the future.

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

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

Cost: \$50



Fundamentals of Hospice Palliative Care (FHPC)

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Registration Link <https://www.surveymonkey.com/r/XCQNT9J>

Thursdays, 6 Weeks

February 2, 9, 16, 23 &

March 2, 9 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



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/CSLW979>

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

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
- Grief & Bereavement support
- Community Education
- [Hospice Residence](#)



hospicepeterborough.org

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://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



. | ., ., . Canada

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