FIVE STEPS OF THE SPA-LTC TOOLKIT

SPA-LTC

Strengthening a Palliative Approach in Long-Term Care

| ORGANIZATIONAL DEVELOPMENT

Introduction

The goal of this brief guide is to give you an overview of the the 5 steps of the SPA-LTC toolkit and how it informs and supports you to move ahead as an organization. The steps involved are as follows:

Step 1(a)	Identifying which facilities to start with
Step 1(b)	Build local palliative champion teams to initiate change
Step 2	Conduct a self assessment of a palliative approach in current care delivery in each facility
Step 3	Plan local education and coaching approaches to support staff to shift care
Step 4	Optimize internal and external consultation resources and services to support staff in complex care situations
Step 5	Develop a plan for continuously strengthening a palliative approach as part of the culture of care

Step one (a)

Identifying which facilities to start with

Now is a good time to start thinking about which of the facilities in your organization would **benefit from a palliative approach**. Reflect on the various facilities within your organization and consider the following questions:

- Are some facilities using this approach to care already and doing it well?
- Are other facilities in your organization needing added support to achieve this goal?
- Which facility may have the strongest readiness and capacity for change?
- Which facility is in greatest need for practice or culture change?
- How will you find this information out?
- Who can you speak with to accurately "find the pulse" of these issues in current facility practice?

Self-Assessment Checklist

The Quality Palliative Care in Long-Term Care: Self-Assessment Checklist in the SPA-LTC toolkit is a useful tool to consider as an organizational 'snap shot' of current state of palliative approach. The first and third pages of this tool are focused at an organizational level, with page one examining the organizational context for palliative care.

The third page identifies Performance criteria for your consideration.

The second page of this tool (Process of Care Delivery) should be completed by local facilities to describe elements of a palliative approach as it is or is not embedded into Resident daily care.

The second page can be completed later in the implementation within selected facilities. Discuss this checklist within your Leadership Advisory Team. Do you have consensus about current state in your organization?

Choosing an implementation approach

Once you have determined a better assessment of organization and facility need, discuss what your chosen approach to implementing this initiative might look like.

Perhaps your team wishes to start with a few ‘early adopter’ facilities and then progressively implement with local learnings to all facilities within your organization? Or would you consider rolling out the palliative approach plan across all sites at the same time to gain momentum and coordination?

Once you have completed this step, it is time to think about the teams you wish to engage with at those identified facilities.

Step one (b)

Build local palliative champion teams to initiate change

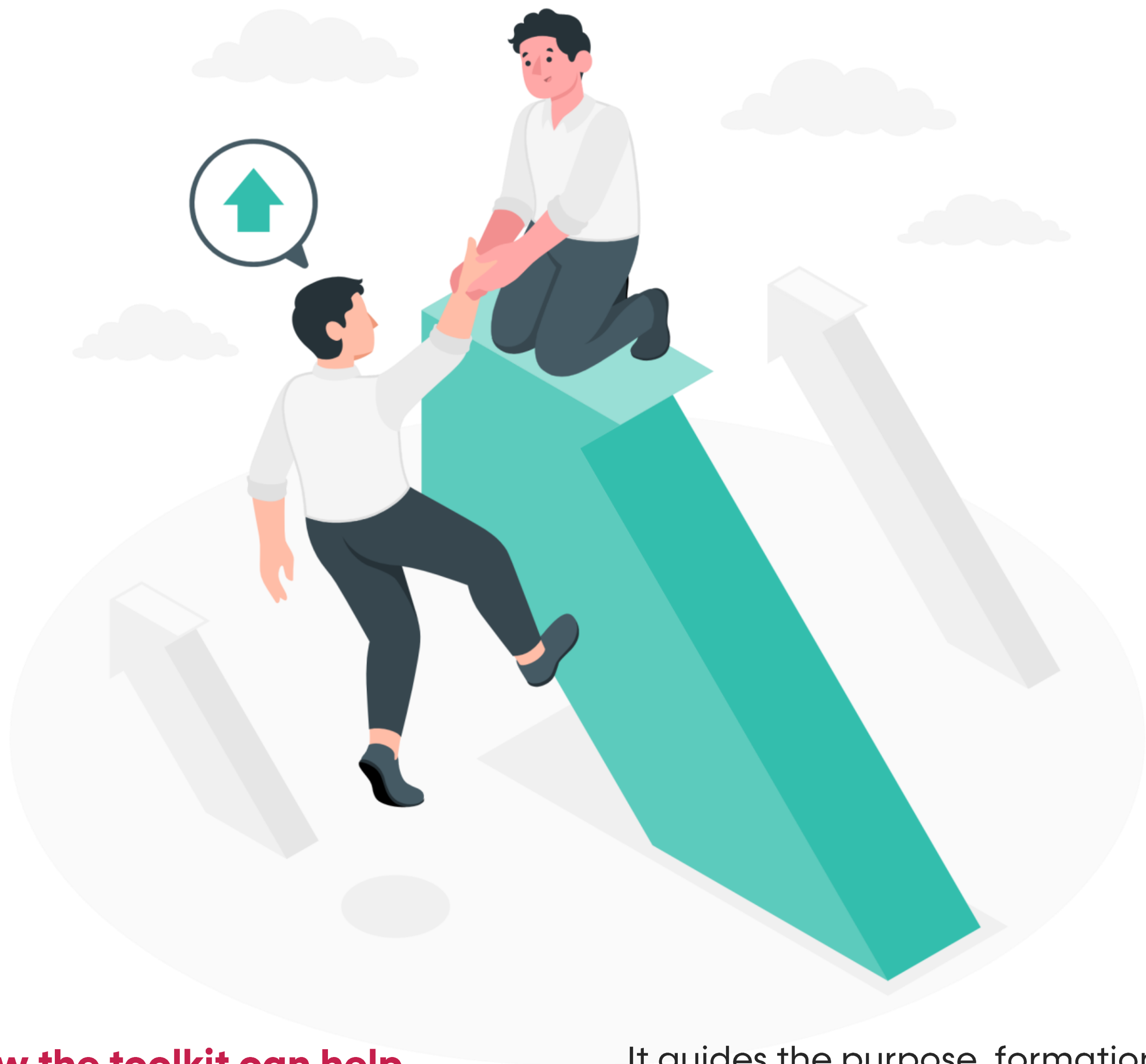
A key step in the SPA LTC Toolkit is to build effective **local palliative champion teams** to shift organizational and local cultural practices.

- Who are the inter-professional staff within the facility who you identify as passionate and engaged in palliative care?
- Who brings leadership skills, interpersonal and communication skills and is a staff member of influence with others?

These are important considerations to guide the selection of a local facility palliative champion team.

Note that this person may not be in an official or recognized position of authority in the facility.

But they should be a well regarded and respected staff member who holds power, persuasion and influence with others they work with.



How the toolkit can help

The SPA LTC toolkit can help you shift from identifying to organizing a local palliative champion team.

Check out the suggested **SPA-LTC Terms of Reference** that can be used as a template to guide the development and initial forming of the team.

It guides the purpose, formation and structure of taking a team-based approach to this work.

There is also a useful **Palliative Champion Team Meeting Agenda and Minutes Template** that can be used to stay focused and organized.

Step two

Conduct a self assessment of a palliative approach in current care delivery in each facility

The local Palliative Champion Team can begin by **taking a measure of their current state** of using a palliative approach in care.

A self-assessment is an important first step that allows all members of the team to recognize current strengths and also identify areas to build on.

The SPA-LTC toolkit provides facilities with a quality improvement self assessment tool called **Quality Palliative Care in Long-term Care: Self Assessment Checklist**. The local Palliative Champion team can use page 2 of this tool to conduct the facility self assessment.

This checklist has been developed to assess whether key structural, process, and outcome components are present in a given long-term care facility.

This checklist can be used in conjunction with the "Model for Quality Palliative Care in Long-Term Care" to assist organizations to perform self-audits to monitor progress toward best practice in providing quality palliative care in long-term care facilities.

Step three

Plan local education and coaching approaches to support staff to shift care

As local Palliative Champion teams in each facility begin to make a plan that will assist their teams to adapt, adopt and embed a palliative approach to Resident Care, they will need to identify the resources and methods that will provide staff with education, coaching and mentoring.

Resources and approaches

There are many SPA-LTC resources and approaches that can help staff understand and implement a palliative approach to care in their daily work.

Some of these may include:

- Learning about and implementing **Comfort Care Rounds** as part of a defined regular practice;
- **SPA-LTC Health Care Worker (HCW) Palliative Education Program (PEP)** – a free online course for HCW and other staff
- Planned learning events using **Case Scenarios** (e.g. once per week or month) to discuss in a team meeting or post as a group or team activity to be solved over a few weeks.
- **Reflective Debriefing in Long-term Care** (supporting people and practice through facilitated group sessions)

Other educational sources

There are several other sources of education that support learning about a Palliative Approach to Care. Some of these resources for you to explore are to the right.

Links to these alternative courses are provided for you to explore content, curricula and costs.

- Pallium Canada's LEAP (Learning Essentials to Palliative Care), which has several courseware renditions, including **LEAP Long-term Care** and **LEAP Personal Support Worker (PSW)** as well as many more **courses** and palliative **learning resources**
- PACE for PSWs
- **Hospice Palliative Care Ontario (HCPO) Learning Portal**
- **All-In Palliative Care: The Team Approach in LTC**

Step four

Optimize internal and external consultation resources and services to support staff in complex care situations

No organization or facility will be fully independent and have the internal resources, knowledge and abilities to use a palliative approach for all Residents with palliative needs.

Palliative care can be complex and is widely recognized as a 'team sport'. Our individualized care is more robust and effective when we consult with experts both within and external to our organization for the purposes of building the best possible care plan to meet Resident and Family needs.

Pause and reflect about your internal and external environments and think about who supports the staff.

- Do you have local or external experts and leaders in palliative care for consult purposes?
- How can they be reached? What is their availability (weekends? After hours?)
- How are staff supported in complex situations outside of a Monday to Friday business mode

Resident care needs are 24/7 and may require consultation services in the after hours.

Practice support and consultation

Consultation services can look variable depending on what is needed and what is available.

Local Health Authorities may extend consultation services across organizational lines to include contracted partners. This might be a consultation line for physicians or nurses to do a phone consult, or a palliative group who can be reached by calling the switchboard of your local hospital.

Do you have Clinical Nurse Specialists or Nurse Practitioners available in your larger system of care?

Both of these types of **Advanced Practice Nurses** have a specialized body of nursing that can support the complex care of Residents/Families and the entire inter-professional team in your facility.

What do you have in your local of external resources to support facility care?

Practice support and consultation may also be targeted to the Professional who often has a deeper working knowledge about particular Resident care needs.

For example, identifying who staff can call for information about medications (Pharmacist), medical supplies and equipment that supports enhanced comfort (Occupational and Physiotherapists), social and family supports (Social Worker), family supports (Hospice volunteers) and spiritual guidance for people in crisis (Spiritual Advisor).

When facility staff know not only when to consult but who to reach out to for added knowledge to enhance the care plan, they are able to delivery a higher quality of care to meet Resident needs.

Step five

Develop a plan for continuously strengthening a palliative approach as part of the culture of care

As your local palliative champion teams implement their planned care events, education and strategies to support the staff**, it is important to embed some of these planned strategies into a monthly or regular routine**, so it becomes the new local norm of "how we do our work".

For example, weekly comfort care rounds held for 20 minutes as a rapid staff clinical huddle can ensure that Resident care plans are current and up-to-date and everyone is aware of Resident changes and coordinated new care plan approaches. Facilitated reflective debriefing can be an implemented strategy that is routinely held for every complicated death in that facility.

Continuing to build competency and confidence to adopt, adapt and embed a palliative approach to care in Long-term care requires staff to further grow and strive to enhance their knowledge and skills. Offering regularly scheduled topical or thematic palliative education based on recent clinical experiences provides timely learning for everyone.

SPA-LTC offers a wide range of **podcasts** that can be accessed by staff along with videos, including one about **Spiritual Care**. The "**Polish Your Practice**" series is available free online and engages the entire team into case-based scenarios for Long-term care.

Supports for communication

SPA-LTC offers a number of supports for great communication with Residents and Families. The **Illness Trajectory Complementary Communication Guide** is a suitable resource for all staff members to understand how best to communicate the changes they see in Residents as their illness advances.

Additionally, Serious Illness Conversation workshops and the use of **Serious Illness Conversation Guides and Tip Sheets** can also assist all members of the team to feel more comfortable and confident in speaking with the Resident and Family about what is important to them. These Tip Sheets assist staff to inquire about wishes and preferences for care as residents experience ongoing health changes and changing abilities, so that meaningful quality of life can be achieved.

Families may be unfamiliar with the term of "Palliative Approach" and be frightened that it indicates their loved one is dying. This is a wonderful opportunity to explore their understanding and fears and assure them that a Palliative Approach focuses on symptom comfort while living with advancing illness, and quality of life. There are some excellent family brochures in the **Palliative Care Toolkit – SPA LTC** that can be used to help families gain a better understanding and appreciation of a palliative approach, as well as include them as an active member in the Resident's care.

Aligning the vision

Do you recall the list of initial ideas and strategies that your Leadership Advisory Team generated when clarifying and aligning the Vision for change?

This is where it's a good idea to revisit those ideas and think about **how you might embed those values into larger organizational operations to better support facility-based change.** When the organizational vision and values are grounded into the very culture you are endeavouring to change, it becomes part of sustainable change.

For example, when it is embedded into the very language of job postings and in hiring new staff, it signals to prospective employees that this knowledge and abilities is important, expected and supported by your organization.

You might review and update new employee orientation to ensure they receive education about a palliative approach. The **SPA-LTC Health Care Worker Palliative Education Program** is an excellent and free online resource to support new and existing staff to gain those competencies.

When a palliative approach is also overtly included in staff performance it sends a message to staff that **this is expected and their contributions in this area are valued**. Remember, organizational culture describes an organization's "way of being" that influences and guides its employees to interpret how the everyday reality of work is expected, necessary, created and sustained.

A palliative approach in Long-term Care can also **become part of your organizational "brand" and identity.** Articulating this approach and philosophy to care is something to visibly share (e.g., brochures, advertisements) and communicate with the public to inform existing and new families that you are an organization that values and strives to provide person-centred care that focuses on comfort and quality of life for all Residents.