Establishing a Palliative Care Program in Long-Term Care

Feb. 22, 2017
3 – 4 p.m. ET

Reflection for Today’s Program

Prayer for Caregivers in the Face of Disparities

Today we pray for persons serving in Catholic health ministry, those women and men who are called to be aware of the chasm in health care today. May they have eyes open to the disparity in care that results in worse outcomes for persons who are made vulnerable because they are unjustly kept outside the mainstream of community life.

May they act for justice, and bring comfort and healing to those persons who do not sit at the table today. Let them advocate for those on the margins of society, and promote and defend human dignity.

God, our creator, we give you thanks for all the blessings of this life, especially for the gift of each other and our work. Every person is a treasure, every life a sacred gift. Through our work we strive to diminish the chasm of disparity and bring about greater justice and equity. We ask your blessing on our gathering today and on all those in our communities who need our care, attention and focus.

Amen.
Establishing a Formalized Palliative Care Program in Long-term Care

Your Speakers for Today’s Program

Sr. M. Peter Lillian Di Maria
Director
Avila Institute of Gerontology

Joan Murphy, MSW, LICSW
Director of Social Services
St. Patrick’s Manor

Geraldine Gracey, RN, BA, CRRN
Clinical Instructor
St. Patrick’s Manor

Cha Webinar
February 22, 2017
The Program

- **Education** – Comprehensive and ongoing training for staff on palliative care
- **Assessment** – We have developed streamlined tools for the evaluation of all types of resident pain
- **Teamwork** – Different levels of staff working together for the best solutions for each resident
- **Reevaluation** – Flexibility and willingness to make changes as residents’ needs change

Education

- Training is the most important aspect of implementing a Palliative Care Program
- It is essential that **all** staff be trained in the principals of palliative care and pain management—not just physical pain but all five domains of pain.*
- Education must be ongoing

* The five domains of pain used in our palliative care program were first identified by Dr. Michael Brescia, Executive Medical Director of Calvary Hospital in Bronx, N.Y.
Education

Our curriculum focuses on the importance of:

- Identifying and managing different types of pain
- Being an advocate for the residents
- Each resident’s culture and faith traditions
- An interdisciplinary approach to resident care
- Understanding the mission

Implementation Guidebook

Implementing Palliative Care: Implementation Guide Book produced by the Avila Institute of Gerontology, in collaboration with the Carmelite Sisters for the Aged and Infirm and the Nursing End of Life Consortium, provides:

- Information on establishing a Palliative Care Program
- An overview of the five domains of pain
- Assessment tools to evaluate pain
- Processes for operating the program
- Guidance on sustaining a quality program
The Palliative Care Steering Committee

The first step is the establishment of a Palliative Care Steering Committee which will oversee all aspects of the Palliative Care Program. It will include some combination of:

- Nursing Staff
- Medical Directors
- Administration
- Social Services
- Pastoral Care

The Palliative Care Steering Committee

The Palliative Care Steering Committee oversees all aspects of the Palliative Care Program. This committee:

- Provides education to staff
- Establishes Unit Teams
- Develops policies and procedures
- Assures assessments are completed and appropriate interventions are put in place
- Oversees evaluation of the program to assure quality and effectiveness
- Creates environment of compassionate healing
Establishing a Formalized Palliative Care Program in Long-term Care

**Palliative Care**

Facilitate monthly meetings with Unit Nurse Managers and Social Workers

- Discuss concerns
- Entertain possible solutions
- Highlight successes of the program
- Encourage discussion about the essence and value of Palliative Care

**Palliative Care Unit Teams**

Each floor/unit has its own interdisciplinary Palliative Care Unit Team. In addition to nursing (including nursing assistants), social services, and pastoral care, it includes recreation, therapists, psychologists, support services, residents and their families.

The unit teams are chosen by the Palliative Care Steering Committee.
Palliative Care Unit Teams

The Palliative Care Unit Team has a coordinator and meets weekly to:

- Assure every resident is assessed for the five domains of pain
- Develop interventions for pain
- Educate families and residents as to what they can expect in the disease process
- Coordinate with hospice care for dying residents
- Report back to Steering Committee Chairperson

Pain Assessment

Every resident must be assessed for all five domains of pain upon admission (and at change of condition as appropriate).

- The Palliative Care Program Implementation Guide provides assessment forms and guiding questions for four of the domains of pain: emotional, psychiatric, spiritual and familial
- There are multiple physical pain assessment tools available and already in use in each facility
The Palliative Care Plan (PCP)

Each resident will have a Palliative Care Plan (PCP). It is developed by the unit team using the Palliative Care Unit Team Worksheet as follows:

- Team reviews diagnosis, resident profile, completed assessment tool(s)
- Team discusses most pressing concern
- Team proposes interventions and an implementation plan

The Palliative Care Plan (PCP)

- Team reviews effectiveness of new interventions weekly
- When deemed effective, they become part of the PCP
- PCPs are reviewed at every care plan meeting for efficacy
The Palliative Care Plan (PCP)

Specific Palliative Care Plan
- Reflects the five domains of pain
- Goals of care as evidenced by resident, family and staff
- Reviewed quarterly at Care Plan meeting

Culture Change
- Implementation Schedule
- Resident Profile Completed within Seven Days
- Pain Assessment Upon Admission
- Psychiatric, Emotional, Spiritual, and Familial
- Palliative Care Plan 7 – 14 Days (MDS)
- Advanced Directives
- Initial Care Plan Meeting Held within 14-21 Days upon Admission
Culture Change

Palliative Care Meeting

- Begin with prayer
- Discuss reason for care plan meeting
- Rotate leader between Nursing and Social Service
- Bring Computer and PC Notebook
- Read Profile
- Discuss concerns
- Complete worksheet
- Update Care Plan and Care Card
- Construct IPN note
- Review MOLST

Steering Committee

Created a Resident Profile Prototype

- Social History
- Preferences
- Medical concerns
- Information Storage
  - Care tracker
  - Social Service section of chart
Culture Change

Palliative Care Notebook
- Unit team meetings documentation
- Reference source for evidence of resident concerns and resolutions

Unit Coordinator/Unit Manager
- Establish comforting and healing environment
- Educator and Mentor
- Ensure compliance with Assessments

Culture Change

Post Meeting
- Address resident on 24-hour log citing interventions
- Continue on 24-hour log for three days
- Discuss resident at shift report
- Discuss resident at Facility morning report
- Follow up on proposed interventions
SUSTAINING A PALLIATIVE CARE PROGRAM
Importance of Steering Committee

Sustaining the Program

There are three components in sustaining a Palliative Care Program:

- Education
- Evaluation
- Continual Improvement
Sustaining the Program

**Education**

- Complete training for all new staff
- Refresher courses with updated material for current staff
- Development of best practices within the unit teams to be shared with other teams
- Specific discipline training (allow other disciplines to attend to enhance interdisciplinary effectiveness.)

**Evaluation** – Evaluate Palliative Care Program effectiveness

- Get feedback and troubleshoot with staff
- Track key measures
- Use focus groups and surveys to evaluate the program
- The residents’ input is essential
- The family and caregivers’ observations are critical
Sustaining the Program

Continual Improvement

- Use feedback from evaluation tools to maintain and improve the quality of care
- Maintain a constant cycle of evaluation and improvement

Education

- Family Night on two occasions – Sr. Peter as guest speaker
- Care Plan Conferences to introduce terms
- Instructional Brochure – Massachusetts State version adapted by the Avila Institute
- Letter to families
- One unit selected and trained in interdisciplinary approach
- Facility wide education at mandatory in-services
## Culture Change

### Admissions Department
- Introduce basic concepts of Palliative Care
- Provide SPM Brochure
- Enroll resident and family in appreciation for program

### Admission to Resident Care Unit
- Resident and family meeting with Unit Nurse Manager and Social Worker for initial discussion of Palliative Care

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## Culture Change

### Ongoing proposals
- Continue to use Palliative Care terms whenever possible
- Identify types of pain in resident conversations
- Discuss with resident transitioning to "End of Life Palliative Care"
- Reinforce principles with family and in staff education
- Keep the conversation going about bringing Joy to every resident's life
- Make it a mission to discover what individual residents care about
Culture Change

- November designated Palliative Care Month
- Frame of reference change from medical model to joyful living model
- Quality Assurance

“[Palliative care], is an expression of the properly human attitude of taking care of one another, especially of those who suffer. It bears witness that the human person is always precious, even if marked by age and sickness.”
— Pope Francis
QUESTIONS