Section #3: Process of Change

This module will:

- Describe a model of change that supported the development and implementation of a palliative care program in long term care.
- Describe strategies that assisted the long term care homes with their change process.

Introduction

The Alliance was formed with the understanding that all parties (front line staff, management, community partners, and researchers) bring expertise and information to his/her practice. It was this philosophy that led to the development of a successful palliative care program framework and toolkit. The following module outlines points to consider/include when formalizing your palliative care program.

Roles within the Change Process

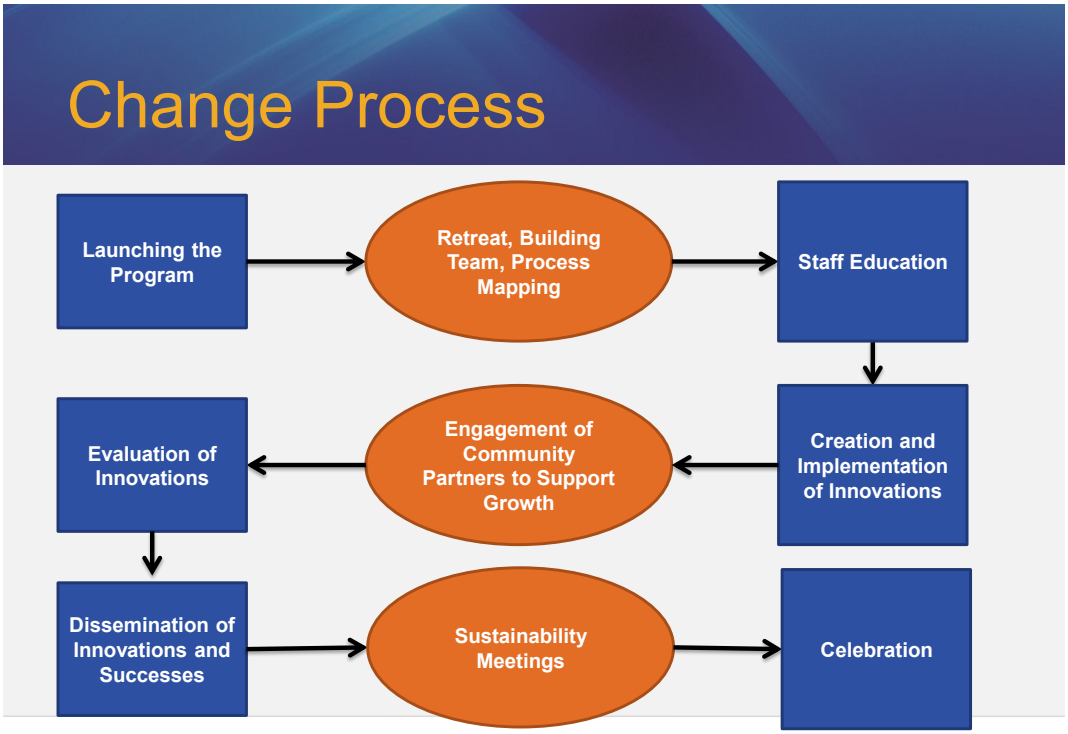
Champions within the change process are needed in order to support the process. It is recommended that a long term care home consider four types of roles:

- Sponsorship: administration within the long term care home showed support and placed the palliative care program and resource team development as a priority within the long term care home
- Facilitator: a staff member who was able to chair the palliative care team meetings and provided support for the Personal Support Worker leads
- Personal Support Worker leads: Personal Support Workers who were natural leaders within the home, who were respected amongst their peers, and had an interest in palliative care (see Personal Support Worker lead module)
- Core Resource Team: the interdisciplinary team that provided leadership on the palliative care program within the home (see Palliative Care Resource Team brochure)

The Change Process

In our work with the project sites it became clear that implementing a palliative care program within a long term care home would inspire culture change. As the culture change involved a bottom-up process that supported front line staff (resource team to guide the program implementation process) it was important to support the experience through implementation of the following components:

- launching the program
- retreat, building the team, and process mapping
- providing staff education
- creating and implementing innovations
- engaging community partners to support growth
- evaluating innovations
- disseminating innovations and sharing successes
- planning for sustainability
- hosting a final celebration



A Three Year Process

It was suggested that the process of change within each home would take approximately three years to complete. The following provides a breakdown of activities during each year of the process:

Year #1

Determining roles and responsibilities:

- People should be designated in the roles within the change process (Sponsor, Facilitator, Personal Support Worker lead, and Palliative Care Resource Team). Please note that staff members should not be appointed. For tips on finding Personal Support Worker leads please see Personal Support Worker lead toolkit. Consider using the same or similar application process with those wishing to join the palliative care resource team.

Launching palliative care as an organizational priority:

- With program support from management, launching the project in the homes involves a focused effort to include staff, residents, families and community partners.
- This may act as an integral event to determine interest and commitment from staff to be on the palliative care resource team.
- In order to facilitate a bottom up capacity development approach, opportunities for information gathering from staff, residents and their families became a top priority. The enthusiasm and dedication to palliative care and resident centered care within the home is harnessed best by first hearing from these stakeholders.

Building an interprofessional resource team

- An interprofessional resource team should include representation from all departments.
- The resource team needs a clear mission and unified language and a vision for change (please see Palliative Care Resource Team Brochure).

Palliative care resource team retreat

A significant positive step forward in the project was realized through the arrangement of a facilitated full day staff retreat. The retreat was an opportunity to engage staff to decide on details regarding their palliative care program. In this retreat, staff members were encouraged to clarify:

- Goals of the palliative care program
- Mission and values
- Areas of focus
- Resources required for implementation
- Membership of palliative care resource team
- A communication strategy for new initiatives and programs

The facilitated retreat agenda included;

- time to review a summary of relevant research information;
- time to hear from family members of palliative residents sharing personal experience;
- and opportunity to brainstorm about program categories.

At the end of the day, the group was able to reach consensus on all the above areas.

A significant portion of the retreat day's discussion concerned the role of the resource team. Again information was pulled from various sources (literature, responses to previous questionnaires) to provide a context for discussion. This information helped spark a meaningful conversation about the role of the resource team. A palliative care resource team can provide a structure in the organization that supports the successful development and delivery of a palliative care program. The team can:

- mentor other Staff / Families
- provide emotional support for Staff/ Families/ Residents
- raise awareness of internal and external palliative care training/education opportunities
- seek clarification on a residents health status after a hospital transfer
- educate / provide palliative care information to Residents and Families
- provide input into guidelines / policies and procedures
- advocate for a palliative approach to care for Residents and Families

As seen in the activities above, palliative care resource teams **are not** clinical teams. It is the responsibility of all staff to provide palliative and end-of-life care in long term care, however, this team can provide leadership in palliative care initiatives and quality improvement efforts. For more information on the retreat process or to view a sample agenda please view the Retreat module.

Process mapping

A process map according to Health Quality Ontario is a "flowchart that outlines all the different steps in a process, for example all the steps that a LTC home takes to deliver a particular kind of service." In this case, LTC staff created a process map of care delivery for a resident from admission until death. This included bereavement care of staff, families, and other residents. The completion of the process map along with the organizational self-assessment audit tool helped the staff determine palliative care priorities. For more information regarding process mapping please view the process mapping module.

Determining annual palliative care priorities:

Identifying palliative care priorities for your home is important. The palliative care resource team and management team need to understand the current status of palliative care delivery within the home. This can be done by reviewing the home's current conditions which include:

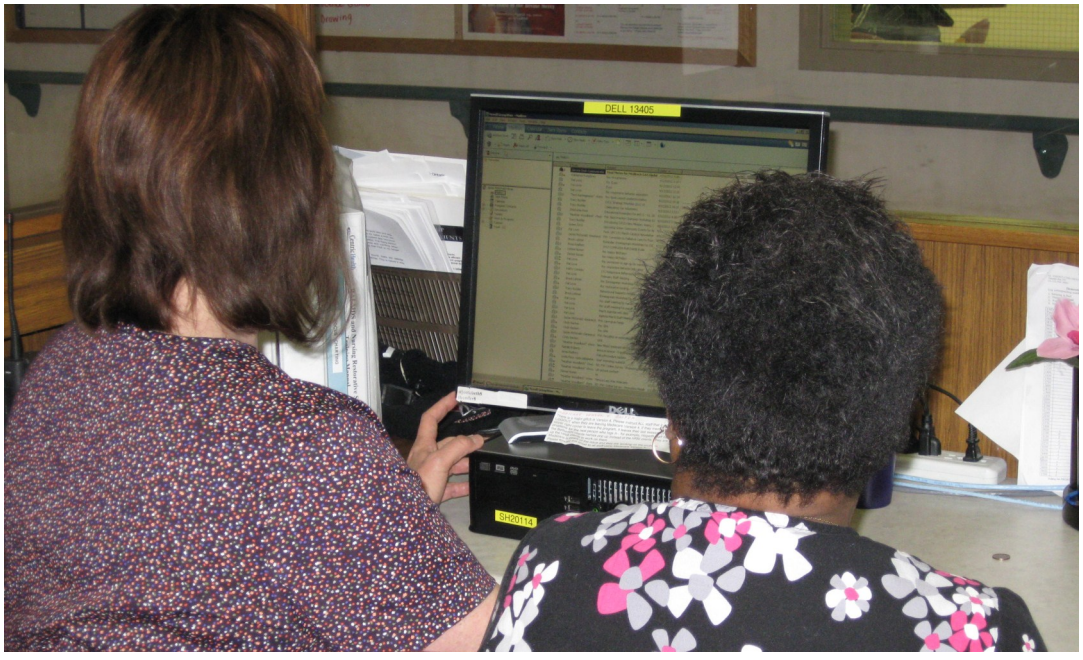
- Having sufficient infrastructure (service, staff, resources)
- Using a collaborative team approach
- A vision exists to improve the care of dying people
- A desire to empower and influence change

One way to help you understand your organization's current conditions is to use an organization self-assessment tool. By utilizing the self-assessment tool you are able to identify the *barrier, gaps,* and *enablers* that your organization will need to address when developing and delivering your palliative care program.

Enabler: ***a resource or function that supports development/ delivery of your program***

Gap: ***a resource or function that does not exist and is needed to develop/deliver your program***

Barrier: ***a resource or function that does not allow for the development of your program***



Using the Organizational Self-Assessment Tool

Please see the Quality Palliative Care in Long Term Care Organizational Self– Assessment module for an example self-assessment. When completing the self-assessment please consider that the assessment tool:

- was created for internal completion not for an external evaluation
- should be completed as an interdisciplinary team and not by one individual
- will require one hour to complete especially if there are mixed opinions within the group
- will help to identify areas that are strong and areas that the team would make a priority to change.

The follow highlights a list of benefits found through the use of the self-assessment tool:

- provided an opportunity to identify gaps in the palliative care program and areas of strength and capacity
- guided the development of programs and policies
- when used regularly, was an ongoing evaluation of the program
- helped determine organizational palliative care priorities

Year #2

Ongoing staff education

Staff education was a crucial part of the process. A major focus was providing personal support workers with opportunities for, education, empowering and articulating their scope of practice in providing palliative care to residents and families. Palliative and end-of-life care education should be provided on orientation and annually. The team should receive education on how to identify signs and symptoms of impending death, communicating with families, advance care planning, care planning, informed consent and capacity, substitute decision makers' role, pain management, and understanding the roles and scopes of practice of all members of the multidisciplinary team. It is important that all staff, families, and residents have a common definition and understanding for palliative care, end-of-life care, care planning and advance care planning.

Creating and implementing interventions

Monthly meetings between the sponsor, lead PSWs, & facilitator

Once priorities were determined it was important that the sponsor, lead Personal Support Workers and facilitator met monthly to discuss:

- the priorities setout by the palliative care resource team
- implementation of the different initiatives
- barriers and enablers to initiatives
- next steps within the palliative care program development
- sustainability of resources and innovations

Engaging community partners

National, provincial, and local community partners were recruited to support the homes with their program development. Community partnerships enhanced skill sets of staff, provided additional expertise and helped to offer more services, helped to provide a palliative care focus at an organizational level, and mentored long term care homes on clinical tools and best practices. Some examples of community partnerships include: hospice units, pain and symptom management consultants, hospice volunteers, Alzheimer Societies, nurse led outreach programs, multicultural and multifaith groups, churches, music programs, schools, local counselling centres and the medical community. Homes may also want to formalize partnerships with provincial and national organizations such as the Canadian Virtual Hospice, the Canadian Hospice Palliative Care Association, and the National Initiative for the Care of the Elderly as they provide valuable information to support staff, residents and families with end-of-life issues.

Year #3

Sharing the programs success

Sharing information about the program development and initiatives within the homes was a key component that kept staff engaged in palliative care. The Alliance findings indicated that encouraging communication around palliative care helped to remove the silent culture that surrounded death and dying. There were many barriers that the resource team wanted to explore such as a lack of formal communication processes regarding palliative care, the structure of the long term care home and how information is shared between departments and shifts.

Sharing the success of the program also occured outside of the home. It was important for the resource team to share success with other long term care homes and share suggestions for possible palliative care innovations.

Ongoing evaluation and sustainability

At this point in the process the foundation for the program was complete. A framework for Palliative Care in LTC was an outcome of the process along with a self-assessment tool. The self- assessment tool was used to evaluate the LTC homes palliative care program and identified program strengths and areas to improve. It was important to sustain and continue to grow the program. At the end of three years the resource team had a full day retreat to review successes during the development process, and were able to review what innovations had been started, completed and were still in progress. The group determined priorities for the coming term, and management attended the retreat to acknowledge achievements and identify ways they could support sustaining the program.

Celebrating

A final and significant step in the change process was the celebration. As stated in the beginning, developing palliative care is more than the addition of a new program, it requires a change in culture and care philosophy. The celebration activity included administration, staff, residents, families, community partners and researchers. During this time, the management and resource team highlighted the significant changes, success stories and the plan for sustaining the palliative care program.