Flexing Your Core: the Palliative Workout ECHO

Domain 5: Care Planning & Collaborative Practice

Nov 5th, 2024

AGENDA ITEM	NOTES
Introductions, Objectives	Session Facilitator: Leanne Drumheller, MSW **Learning objectives:** 1. Identify the importance of determining a person's goals for their care at end of life 2. Identify key elements of anticipatory care planning
Session Key Points and discussion	**Advance Care Planning:** • Formalized and written down through a variety of approaches: My Voice, Rep Agreement and Enduring Power of Attorney • MOST (Medical Order for Scope of Treatment) – used in BC Intro to **Advance Care Planning** Video: **https://youtu.be/5CioB8TAvi0?si=JaWh77o5pra3Zgcr** • Conversation starters: **How well do you know me?** **Goals of Care** Identifying a person's goals of care is a key aspect in any area of patient care. When palliative goals of care are not considered, the person's quality of life can be negatively affected. Discussion: How have you found these types of conversations? • Asking 'what's important to you today?' helps to broach these conversations. And is something you can revisit as health status changes. • Sometimes pts can get defensive, and it puts a barrier in the relationship up (especially when they aren't ready to have the conversation). Other times it can build more rapport and trust because they needed someone to help them figure out how to start thinking about these important care decisions. • Asking permission to have these conversations may help with defensiveness to talk about • Different care settings will have routine and regular evaluations and check-ins on goals of care for pts/clients/residents.

	Discussion: difference between Advance care planning (ACP) and anticipatory care planning? • ACP: thinking about your values, beliefs and wishes for future health and personal care, and sharing them with people you trust (encouraged to do early on and review often). It can include choosing who would make care decisions for you if you cannot • Anticipatory care planning – when health in decline, further along in disease process. Clinician initiated process taking patient's goals of care and any advance care planning they have done. Important for care team to think ahead, educate family, pts, carers of what we may anticipate with changes in health and have conversations about managing symptom, etc. Important for all care providers to contribute to these conversations and ensure properly documented. **Resources:** • Peter & Joe – series of videos (YouTube link) showing how Advance Care Planning Conversations can make a big difference. • 'My Voice' - Advanced Care Planning guide - request this be available in your office to offer to clients/patients. https://www2.gov.bc.ca/assets/gov/people/seniors/health-safety/pdf/myvoice-advancecareplanningguide.pdf **Case Study discussion** Michael, a 76 year old man with colon cancer is rushed to the ED for urgent pain and symptom management. His condition worsens rapidly and he becomes non-responsive. Joanne, Michael's wife of 12 years is present as is his son and daughter from a previous marriage. The admitting physician attends the bedside and speaks with the family regarding a plan of care. The adult children disagree with Joanne's perspective on how Michael would like to be treated. 1) What issues do you anticipate could happen for Michael? • Improper treatment for the patient, traumatic for family • Increased frustration, possibly increased pain (more or less interventions) • Conflict with children, family riffs 2) What questions do you want to ask Michael's family? • Who is his substitute decision maker (SDM)? • does he have an advance care directive? • How much do they understand about his condition and care wishes?

	3) Which members of the health care team would you want to bring into the care planning discussion? • Counsellor to help family navigate through conflict and concerns • Include social worker • Nurse • Ethics team perhaps (maybe done for the road for more complex considerations) • Physician or Nurse Practitioner (primary care provider for Michael) • Spiritual care • Team members who can speak to and explain what is going on with Michael 4) How might the care team offer a multidisciplinary approach to care planning? • Help inform family what is going on from all areas of his care. Help with the family's decisions making and try to help them navigate conflict and being on the same page for his care • Educate the family on options, perspectives and considerations depending on how far along his cancer is **Considerations for care plan** Is it: • Dynamic: able to shift and respond to changing circumstances and health status. Engaging members of the multidisciplinary team for perspectives and anticipatory planning • Person-centered: Ideally driven by the wishes of the patient, or family/TSDM in consultation with the care team if the patient is unable and there is no ACP. • Proactive: Anticipating the possible progression of changes and having early conversations with patients and families on what to expect. Predetermining goals in anticipation of circumstances changing quickly • Shared: Available for the multidisciplinary care team and patient/family/TSDM to access and alter in the face of new information or a changing condition. Entered into the care setting/health region's electronic charting system.
Next session info	Next Flexing Your Core ECHO Session: ***Domain 6: Loss, Grief, Bereavement*** **Nov 12th 9am-10am PDT. Register here!** **Other upcoming ECHO sessions listed here**