WHOLE COMMUNITY PALLIATIVE CARE ROUNDS GUIDELINE SEPTEMBER 2018

PRINTED copies of the Guideline may not be the most recent version.
The ***OFFICIAL*** version is available on the InsideNet.

1.0 PURPOSE

Inter-professional Whole Community Palliative Care rounds are a regular, local communication method that facilitates a whole care-continuum discussion about person and family centered care needs, and which may otherwise become fragmented by sector and discipline. It enables the inter-professional team to collaborate on a weekly basis to offer their collective clinical expertise and knowledge to address the immediate palliative needs of persons and families brought forward for consultation.

The goal of Whole Community Palliative Care Rounds is for the palliative team (defined locally as the circle of care) to work collaboratively to review the current goals of care, discuss any difficult physical or biopsychosocial/spiritual presenting symptoms, and to make recommendations about care management approaches, care plan revisions designed to improve quality of care and decrease suffering in alignment with the individual's goals of care. Timely communication back to principle and primary health providers (if not in direct attendance during rounds) is essential.

Collaborative inter-professional Palliative Care Rounds are an excellent forum and safe place to acknowledge and recognise the multiple and valuable skill sets required to give excellent, benchmark Palliative Care. It synthesizes new knowledge from inter-professional sharing, builds synergy, team spirit and facilitates improved quality care and better team engagement.

2.0 GUIDELINE

2.1 MEMBERSHIP:

Recommended membership of the Inter-professional Palliative Care Rounds Team[1] includes (but is not limited to);

- Nursing Leadership
- PCC/RCC/RN/RPN
- Medical Palliative Leader (Palliative Physician/General Practitioner/Nurse Practitioner).
- Aboriginal Health Partner
- Community Paramedics
- Dietitian
- Health Care Providers working in First Nations communities
- Hospice Volunteer Coordinator
- Music Therapist
- Pharmacist (Community or IH)
- PT/OT/RT
- Social Worker
- Spiritual Health Professional
- Other participants per referral as needed e.g. Chronic Disease Management Programs, Clinical Ethics.

[1] Not all members of the recommended inter-professional Palliative Care Rounds team may exist in smaller rural and remote communities

2.2 STRUCTURE:

Structure ensures proper attention is paid to the focus of the rounds. Key concepts are:

- The Facilitator role for rounds will be assigned (this may be permanent or rotating)
- Select team members from multiple disciplines who help meet the goals of the rounds.
- Not all palliative persons need to be reviewed in weekly rounds. See 2.4.

2.3 ROLES AND RESPONSIBILITIES:

Rounds Facilitator roles and responsibilities are;

- Coordinate the team
- Ensure all members are aware of the purpose and goals of palliative rounds and the guideline expectations
- Ensure the inter-professional rounds start and end on time
- Manage the local palliative registry through Meditech data sources or a local spreadsheet
- Ensure documentation completed and follow-up occurs**. SEE APPENDICES** (Palliative Rounds Record Form # 821285 and/or Palliative Tracking Record Form # 821299)
- Coordinate the implementation of standard documentation tools for the inter-professional team to use for rounds. **SEE APPENDICES**
- Respond and/or invite external health professional teams to join palliative rounds when they have identified concerns, symptom burden and/or quality of life issues for persons who may not yet be registered to the Interior Health Palliative Program for consultation

Local teams may choose to rotate the assigned leadership

All participants are expected to participate in the active discussion, bringing their professional lens, current and relevant information for contribution to inform the team and plan of care, and take round outcomes back to their workplace setting for follow-up, care planning and action.

2.4 REFERRING PERSONS FOR PRESENTATION AT WEEKLY ROUNDS:

- **The focus for weekly rounds is to address the palliative needs of persons and families who:**
  - Present with transitioning or unstable physical symptoms e.g. ESAS-r 4 or greater
  - Current management and care plan is ineffective
  - Present with psychosocial, emotional, spiritual health or financial care needs that are complicated and require an inter-professional problem solving approach
  - Are transitioning between sectors of care and require planning and communication from a whole community approach
- When the persons needs have been satisfactorily met by palliative rounding, their name may be deleted from the weekly rounds unless there is a change in their condition requiring further inter-professional review
- Clinicians in the community may pre-emptively inform the palliative rounds team of individuals whose condition is changing and may need palliative review.

2.5 PREPARING FOR WEEKLY ROUNDS:

- Manage and update the local registry of people on the palliative program or with identified palliative needs
- The presenting clinician will briefly introduce the person's condition and care issues, relying on nursing notes, reports, verbal handover. E.g. physical/psychosocial, family and spiritual health issues.
- Succinct information of the person and their palliative status can include:
  - Brief demographic overview
  - Physician/Nurse Practitioner

- Palliative Program admission date
- Diagnosis
- Prognosis if known
- PPSV2
- Trending of current clinical information e.g. PPSV2, ESAS-r
- Focus of concern

2.6 PROCESS:

- Facilitator briefly communicates deaths that occurred since last week's rounds
- Facilitator asks each health care provider for their succinct report, introducing the person and the care focus issue then leads to a solution-based inter-professional discussion.
- . Team members who do not have direct care responsibilities of the person and their family may also add their professional expertise to the discussion (see Circle of Care)
- Ensure new or proposed changes to an existing Plan of Care are communicated **[SEE APPENDIX A Palliative Rounds Record Form # 821285]** to relevant members of the care team physician/clinician/person/family as appropriate.
- The Plan of Care is communicated to the MRP (Physician/Nurse Practitioner) by either: fax, discussed in person or by phone (**this step is essential where the Physician/Nurse Practitioner is not the palliative physician**). **SEE APPENDIX B** (Physician/Nurse Practitioner Communication Sheet Form #821298)
- Medical suggestions made by the Medical Palliative Leader will be communicated by them directly to the Physician/Nurse Practitioner who will make further decisions around new orders for processing.

2.7 LOGISTICS

- Designated space for regular inter-professional Palliative rounds needs to be established as ideally health care providers should meet face to face.
- Alternatively, clinicians and inter-professional team members can participate by calling in to a set teleconference line and code (with Polycom available if possible).
- A reoccurring Outlook calendar meeting invitation for weekly Palliative Rounds may be issued to all participants. It will be the responsibility of each care sector (acute care, community, home health, long term care) to plan their own process/reminder system to attend.

2.8 DOCUMENTATION

- The outcomes from discussion in weekly Palliative rounding should be documented on the Palliative Rounds Record (Form # 821285) **SEE APPENDIX A** and/or Palliative Rounds Tracking Record (Form # 821299) **SEE APPENDIX C.**
- The responsibility for documentation rests with each sector's reporting clinician including communication back to program staff, person and family.

2.9 CONFIDENTIALITY

- Health Care Providers participating in Palliative Rounds are deemed to be within the 'Circle of Care': **APPENDIX E**
  - In the context of caring and presenting persons with palliative needs from any sector (community, long term care or acute) in "whole community" palliative rounds, the person's "circle of care" should include, whenever reasonable and possible, IH inter-professional providers and external healthcare partners, such as hospice coordinators, community pharmacists, P3 partners, health care providers working in First Nations communities, community paramedics etc.
  - Information about the person can be shared in this circle as long as it's for the

purpose of contributing to the healthcare plan and meeting the service needs for that person and his/her family/support network.

- Questions arising regarding confidentiality from members of the public to health care providers should be answered with integrity with reference made to the Form 807248 Caring for Your Information (hyperlink) brochure.

3.0 REFERENCES

AR0400 – PRIVACY AND MANAGEMENT OF CONFIDENTIAL INFORMATION (Interior Health Administrative Policy Manual)

Freedom of Information and Protection of Privacy Act, Retrieved from: http://www.bclaws.ca/Recon/document/ID/freeside/96165_03#section33.2, May 12, 2018

4.0 DEVELOPED BY [November 2017]

Vicki Kennedy, Regional Clinical Nurse Specialist, Palliative Care
Elisabeth Antifeau, Regional Clinical Nurse Specialist, Palliative Care
Dr. Alan Nixon, Regional Medical Director, Palliative Care

5.0 REVISED BY

6.0 REVIEWED BY

- 19 December, 2017 – 9 January, 2018 – HCIS Administrators, Managers, Clinicians, various Physicians
- 26 January, 2018 – 16 February, 2018 – HCIS Administrators, Managers, Clinicians, various Physicians

7.0 APPROVED BY [May 2018]

Interior Health Palliative Care Steering Committee

Please provide a list of keywords to aid in searching for this tool:

Whole Community Palliative Rounding
Palliative Rounds
Palliative Team Rounds
Circle of Care

APPENDICES

APPENDIX A: IHA Palliative Rounds Record (Form #821285)
APPENDIX B: Physician/Nurse Practitioner Communication (Form #821298)
APPENDIX C: Palliative Rounds Tracking Record (Form #821299)
APPENDIX D: Definitions
APPENDIX E: Circle of Care Memo

APPENDIX A:
IHA – Palliative Care
Palliative Rounds Record

Date: _____
Location: _____

Admission Date:	Allergies:(**SEE ADR RECORD)**
Diagnosis:	
PPSV2 on Admission:	
EOL Respite Symptom Management *(circle all that apply)*	
Pertinent Background and Goals of Care:	

Weekly Rounds Progress Note				
Date	**PPSV2**	**Focus/Need/Symptom**	**Action/Follow-Up** ***(includes communicating back to family and care team)***	**Team Member Responsible/Date Resolved**

Weekly Rounds Progress Notes				
Date	**PPSV2**	**Focus/Need/Symptom**	**Action/Follow-Up** ***(includes communicating back to family and care team)***	**Team Member Responsible/Date Resolved**

Patient Label

APPENDIX B:

PALLIATIVE ROUNDS
PHYSICIAN/NURSE PRACTITIONER COMMUNICATION

DATE OF ROUNDS: _____

DATE SENT: _____ **FAX:** _____

Dear Physician/Nurse Practitioner_____

Your patient _____**was reviewed in weekly Palliative Rounds today.**

PATIENT INFORMATION:

ISSUE DISCUSSED AT ROUNDS:

SUGGESTIONS:

NAME: _____

SIGNATURE: _____

DESIGNATION: _____ **CONTACT NUMBER:** _____

PLEASE WRITE PHYSICIAN/NURSE PRACTITIONER ORDERS, IF REQUIRED, ON THE ATTACHED ORDER SHEET

Suggestions Noted – New Orders Attached: **Yes** ☐ **No** ☐

Physician/Nurse Practitioner Signature: _____

APPENDIX C:

PALLIATIVE ROUNDS TRACKING RECORD

Facility

Location

Date of Rounds

NAME	HOSPICE/ ACUTE/ COMMUNITY	Symptom/Issue of Concern	Date Recognised/Assessed	Date Resolved

APPENDIX D:

DEFINITIONS

WHOLE COMMUNITY: Whole community is inter-professional health care team members and external partners engaging collaboratively to assess, understand and meet the needs of people with palliative needs in an efficient and effective way.

PALLIATIVE NEEDS: Consider the palliative care needs of all persons with advancing, life-limiting illnesses, such as malignant and non-malignant diagnoses. This includes any diagnosis of cancer or end-stage organ failure including motor neuron disease, dementia, frailty, congestive heart failure, chronic obstructive pulmonary disease, chronic renal failure etc. Palliative needs are identified when active symptoms present with increasing disability, functional decline, frequent hospitalisation and/or deconditioning, and/or decreasing benefit from prescribed therapies resulting in reports of increased suffering and quality of life concerns.

CIRCLE OF CARE: See Tony Yip's email

PRESENTING CLINICIAN: The presenting clinician is the clinician with the most current and available knowledge of issues highlighting the need for a whole community approach to problem solve.

FACILITATOR: Facilitator is the clinician coordinating rounds on a regular weekly basis and communication to whole community palliative rounds membership.

MRP: Most Responsible Provider

RN: Registered Nurse

RPN: Registered Psychiatric Nurse

PCC: Patient Care Coordinator

RCC: Residential Care Coordinator

PT: Physiotherapist

OT: Occupational Therapist

RT: Respiratory Therapist

ESAS-r: Edmonton Symptom Assessment System revised

PPSV2: Palliative Performance Scale

APPENDIX E:

Date: May 9, 2018
To: IH Palliative Rounding Teams
From: Karyn Morash and Tony Yip Re: Circle of Care – Palliative Rounding

The term “circle of care” is commonly used to describe a group of internal and external health care providers supporting a specific person. Interior Health (IH) operates under the Freedom of Information and Protection of Privacy Act (FIPPA) and shares personal information within a circle of care based on an implied consent model that we establish via IH standard notification signage posted at all points of registration and admission in IH facilities.

Rounding practice and the definition of inter-professional care teams are evolving. A person’s circle of care may include IH acute, community and allied staff as well as external partners such as: hospice coordinators; Aboriginal care provider partners; community pharmacists; spiritual care providers; P3 long term care partners; and others. IH staff can and should share information about the person with members of this circle of care as long as it is for the purpose of contributing to their health care plan and meeting the service needs for them and their family. Remember to share with the external partners only the amount of information necessary and appropriate to enable them to provide their speciality care for the person.

Some health care professionals may be hesitant to bring external partners into a person’s circle of care citing privacy legislation. In addition to obtaining implied consent, FIPPA also supports IH employees sharing relevant information about an IH person amongst a broader inter-professional health care team:

Section 33.2(a) of FIPPA addresses the disclosure (i.e. sharing) of personal information for a consistent purpose. As health care practice evolves and public bodies rely increasingly on working collaboratively with external partners to collectively meet the health and service needs of persons, it becomes necessary for organizations to share information that is authorized, relevant and deemed necessary with those partners in order to plan and deliver integrated care and related services.

In summary, within the context of community palliative rounding, IH employees may share a person’s personal and medical information with inter-professional health care teams and external partners to the extent necessary to provide individuals with care and treatment, without their express consent.

For more information please visit the InsideNet to review Policy AR0400 – Privacy and Management of Confidential Information.