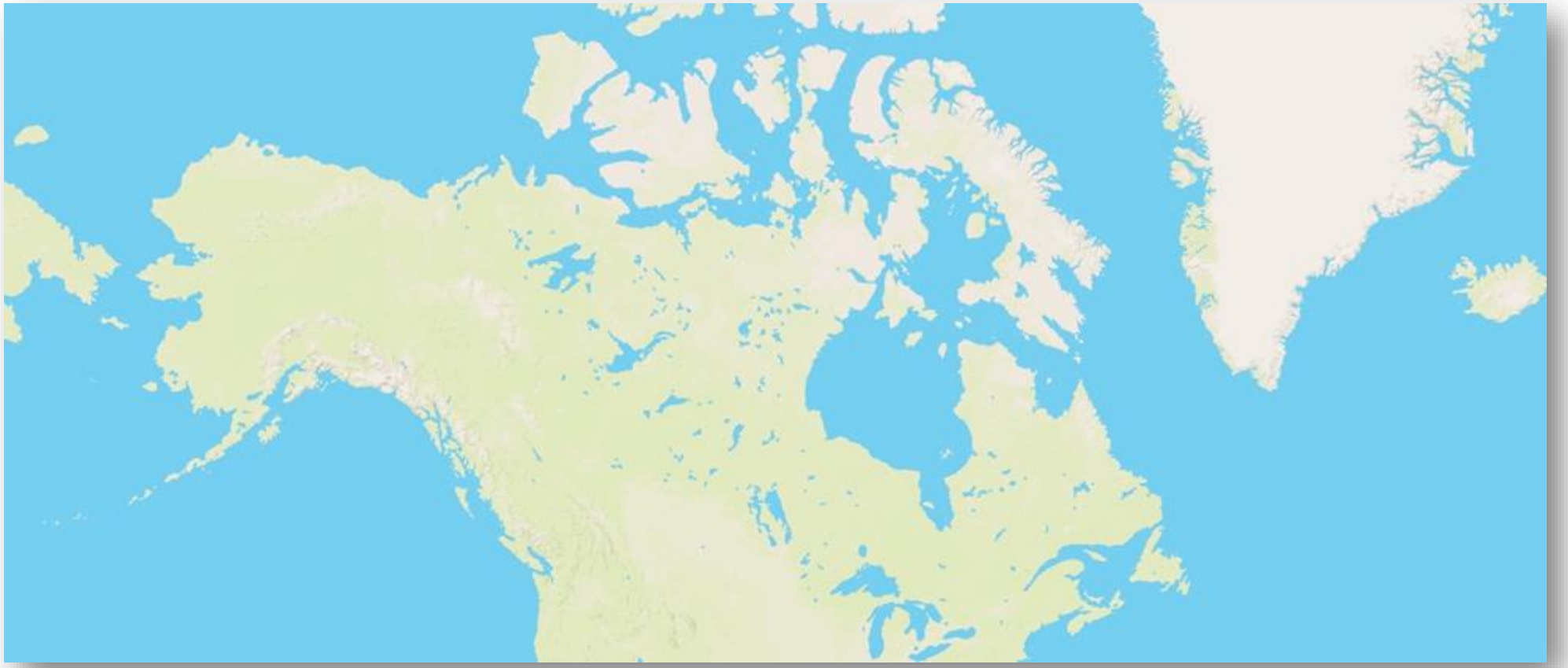
Community-Based Primary Palliative Care Community of Practice Series 4

Communication Part 2

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitator: Dr. Nadine Gebara
Guest Speakers: Dr. Tiffany Lee
Date: March 27, 2025

Territorial Honouring



The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness and their families.

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The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

LEAP Core

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Taught by local experts who are experienced palliative care clinicians and educators.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) who provides care for patients with life-threatening and progressive life-limiting illnesses.
- Accredited by the CFPC and Royal College.

Pallium Canada

LEAP CORE

Learn more about the course and topics covered by visiting

www.pallium.ca/course/leap-core

Objectives of this Series

After participating in this series, participants will be able to:

- Augment their primary-level palliative care skills with additional knowledge and expertise related to providing a palliative care approach.
- Connect with and learn from colleagues on how they are providing a palliative care approach.

Overview of Sessions

Session #	Session Title	Date/ Time
Session 1	Pain Management in the Delirious Patient	January 22, 2025 from 12 to 1pm ET
Session 2	Communication: Part 1	February 26, 2025 from 12 to 1pm ET
Session 3	Communication: Part 2	March 27, 2025 from 12 to 1pm ET
Session 4	Palliative Care for those Living with Dementia	April 23, 2025 from 12 to 1pm ET
Session 5	AYA	May 28, 2025 from 12 to 1pm ET
Session 6	Gastrointestinal Symptoms in Palliative Care	June 25, 2025 from 12 to 1pm ET
Session 7	Interventions for symptom management; tubes and drains	July 3, 2025 from 12 to 1pm ET
Session 8	Intimacy and Sexually in Advanced Serious Illness	August 27, 2025 from 12 to 1pm
Session 9	Tissue Donation at End of Life	September 24, 2025 from 12 to 1pm ET
Session 10	Supporting Caregivers	October 29, 2025 from 12 to 1pm ET

Welcome & Reminders

- Please introduce yourself in the chat! Let us know what province you are joining us from, your role and your work setting
- Your microphones are muted. There will be time during this session when you can unmute yourself for questions and discussion.
- You are welcome to use the chat function to ask questions and add comments throughout the session
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session
- This 1-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **10 Mainpro+** credits.

Disclosure

Relationship with Financial Sponsors:

Pallium Canada

- Not-for-profit
- Funded by Health Canada

Disclosure

This program has received financial support from:

- Health Canada in the form of a contribution program
- Generates funds to support operations and R&D from Pallium Pocketbook sales and course registration Fees

Facilitator/ Presenter:

- Dr. Nadine Gebara: Nothing to disclose
- Dr. Tiffany Lee: Nothing to disclose
- Julia Pinkney: Nothing to disclose

Disclosure

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content

Introductions

Facilitator:

Dr. Nadine Gebara, MD CCFP- PC
Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

Panelists:

Dr. Haley Draper, MD CCFP- PC
Clinical co-lead of this ECHO series
Palliative Care Physician at Toronto Western Hospital, University Health Network
Family Physician at Gold Standard Health, Annex

Dr. Roger Ghoche, MDCM CCFP-PC, MTS
Palliative Care and Rehabilitation Medicine, Mount Sinai Hospital-Montreal

Jill Tom, BSN CHPCN ©
Nurse Clinician for palliative Home Care
Mount Sinai Hospital, Montreal

Elisabeth Antifeau, RN, MScN, CHPCN(C), GNC(C)
Regional Clinical Nurse Specialist (CNS-C), Palliative End of Life Care
IH Regional Palliative End of Life Care Program
Pallium Canada Master Facilitator & Coach, Scientific Consultant

Thandi Briggs, RSW MSW
Care Coordinator, Integrated Palliative Care Program
Home and Community Care Support Services Toronto Central

Claudia Brown, RN BSN
Care Coordinator, Integrated Palliative Care Program
Home and Community Care Support Services Toronto Central

Rev. Jennifer Holtslander, SCP-Associate, MRE, BTh
Spiritual Care Provider

Introductions

Guest Speakers:

Julia Pinkney, RN, CHPCN(C)

Clinical Nurse Educator and Patient Care Coordinator at Abbotsford Regional Hospital and Cancer Centre, Fraser Health Authority

Julia Pinkney is a patient care coordinator and clinical nurse educator at the Palliative Complex Care Unit (PCCU) at Abbotsford Regional Hospital in British Columbia. Communication is a keystone in her role. She believes that creating space for effective communication is one of the most significant, yet underrated interventions that her team provides. The Abbotsford PCCU allows for discussions to occur in a safe space without pressure to make immediate decisions. Communication takes time but always improves patient and family outcomes!

Dr. Tiffany Lee, MD, MSc, FRCPC

Palliative Care Physician at Abbotsford Regional Hospital and Cancer Centre, Fraser Health Authority

Dr. Tiffany Lee is a palliative care and intensive care physician working at the Abbotsford Regional Hospital and the University Hospital of Northern BC, in British Columbia. She completed her Internal Medicine residency at the University of Saskatchewan, and her Critical Care and Palliative Care training at the University of Toronto. She holds a Master's degree in Health Sciences education and is passionate about learning and teaching communication skills! When not at work, she's probably planning a camping trip or, more likely, eating snacks on her couch.

Communication Part 2

Objectives

1) **Learn an approach to understanding a patient's hopes and values as a tool to help guide treatment decisions and end of life planning.**

2) **Discuss interdisciplinary team communication in complex palliative care cases**

3) **Learn an approach to having code status conversations with patients and families**

Goals-of-care don't *only* pertain to CPR and resuscitative interventions (but we'll talk about that too!)

Agenda

- Review of Communication 1
- MAP
  - Mapping values
  - Aligning with patients
  - Planning and offering recommendations
- Case 1: patient with a complex wound
- Case 2: patient with severe dyspnea
- Case vignettes 3: Don’t dodge the D words

Use the REMAP tool when addressing goals of care!

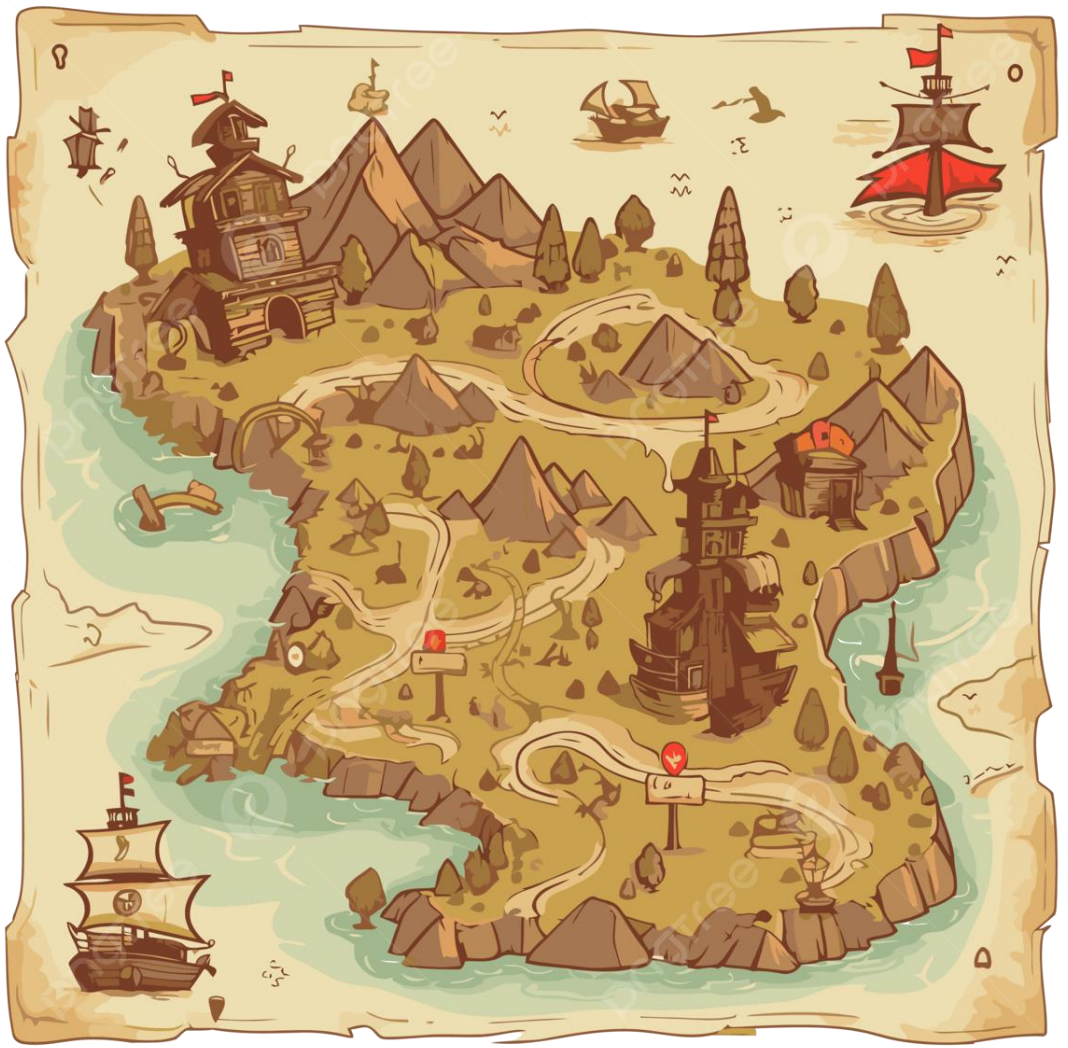
R Reframe why the status quo isn't working.

E Expect emotion and empathize.

M Map the future.

A Align with the patient's values.

P Plan medical treatments that match patient values.



Map: The VALUES mnemonic

- **Vital goals**
  - Knowing this news, what are things that feel most important?
  - When thinking about the future, what would you like to prioritize?
- **Activities**
  - When thinking about the next weeks to months, what would you like to be doing?
- **Limits**
  - What would good quality of life look like? What would unacceptable quality of life look like?
- **Uncertainties/worries**
  - When thinking about the future, what worries you?
  - After hearing this news, what are the big concerns that come to mind?
- **Experience with illness**
  - Tell me about the time ___ was seriously ill or died? Did that impact your thoughts on healthcare?
  - Tell me about the last time in hospital. Would you have wanted things to go differently?
- **Strengths/supports**
  - What gives you strength?
  - What supports have you had through this illness?

What do I need to know about you as a person to take good care of you?

What else?

Align statement

Here's what I'm hearing about what is important…

Did I get that right?

Plan: offer a recommendation

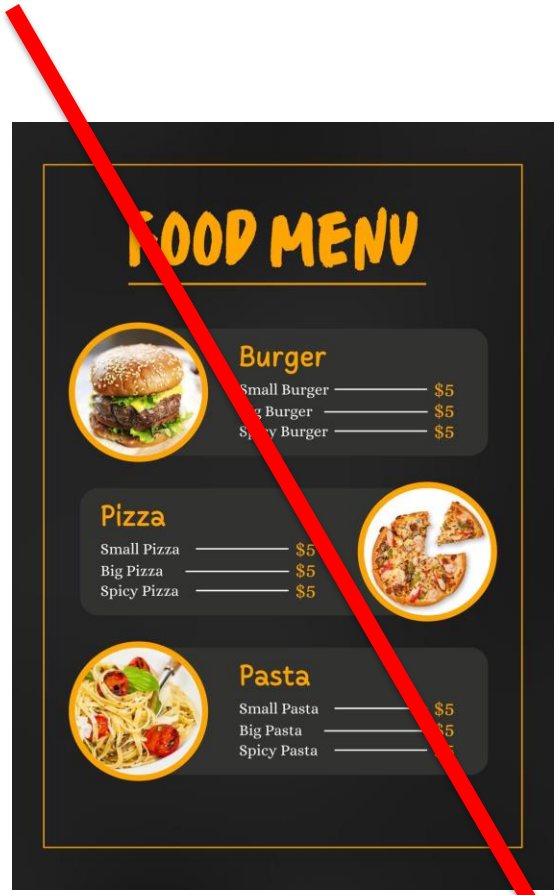
ALIGN first, don't jump in with a recommendation

Ask permission

- "May I make a recommendation based on what I've heard?"

A recommendation is not a menu

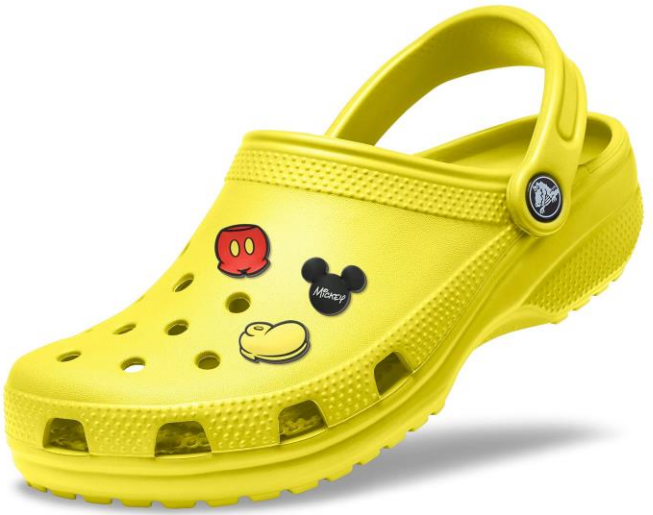
- Describe what we WILL do before what we WILL NOT do
- "We want to do things that will **HELP** , **NOT HURT**"
- Once there is agreement, make explicit how decision will be document e.g. MOST form in BC



Case based discussion

Case 1: patient with a complex wound

- Woman in her late 40's with metastatic endometrial cancer, no more cancer-directed therapy
- Stayed in our unit for 5 months until EOL- starting PPS low 40%
- Previous cervical cordotomy 6 months prior, now escalating neuropathic pain once again
- Massive gluteal wound, entero-cutaneous fistulae, osteomyelitis
- Patient has a very devoted parent who has been primary caregiver for >6 years of patient's cancer journey



Patient's parent is insistent on being present at every wound change. Expressing mistrust in nursing care.

Patient has been insistent on receiving all care in a recliner. Nursing team is concerned about safety and logistics of multiple dressing changes per day.

At end-of-life, she receives continuous palliative sedation. Due to massive doses of medications patient is tolerant to, she is receiving >80 mL/h of fluid. Family and team concerned this is prolonging dying and increasing secretions.

Case 2: patient with severe dyspnea

- Woman in her 50's with metastatic breast cancer, no more cancer directed therapy
- Several weeks of escalating cough and dyspnea at home
- In ER, high-flow nasal O2 increases from 50% to 92% to maintain sats >88%
- Patient transferred to PCCU

- Goals:
  - Very hopeful that treating concurrent pneumonia will improve her situation
  - Wants to prioritize time with family
  - Believes in the power of prayer, deriving strength from Bible study and visits with pastor
  - Patient and family want her to be awake as possible

Patient's children and spouse are worried that medications are "making her too drowsy". Request that hydromorphone be discontinued entirely.

Nursing team members feel morally distressed that she is experiencing "undue suffering" from dyspnea. They feel uncomfortable about using lower hydromorphone CSCI dose during the day. They advocate for continuous palliative sedation.

Case 3: ICU on-call vignettes (a true story)

78 yo M with metastatic prostate ca- extensive bone and lymph node mets.

- EMS arrived → unconscious, in PEA arrest
- In ER- ROSC achieved x3, ICU consulted
- BP 68/30… and falling…on norepinephrine and epinephrine infusions
- Loses pulse again

80 yo F with metastatic breast ca- innumerable lung mets. Med onc appointment the day prior where she expressed interest in hospice care.

- EMS called for intractable nausea and vomiting
- Appeared moribund in ER. "No code status available" from chart or family MD.
- Patient intubated, central line inserted, high-dose vasopressors started → ICU called.

74 yo M with metastatic laryngeal ca, mediastinal lymphadenopathy compressing bilateral mainstem bronchi.

- Double-lumen tube inserted through stoma in OR. ICU called to facilitate palliative radiation

References

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Questions and discussion

Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- Join us for our next session on April 23, 2025, from 12-1pm ET for **Palliative Care for those Living with Dementia.**

Thank You

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