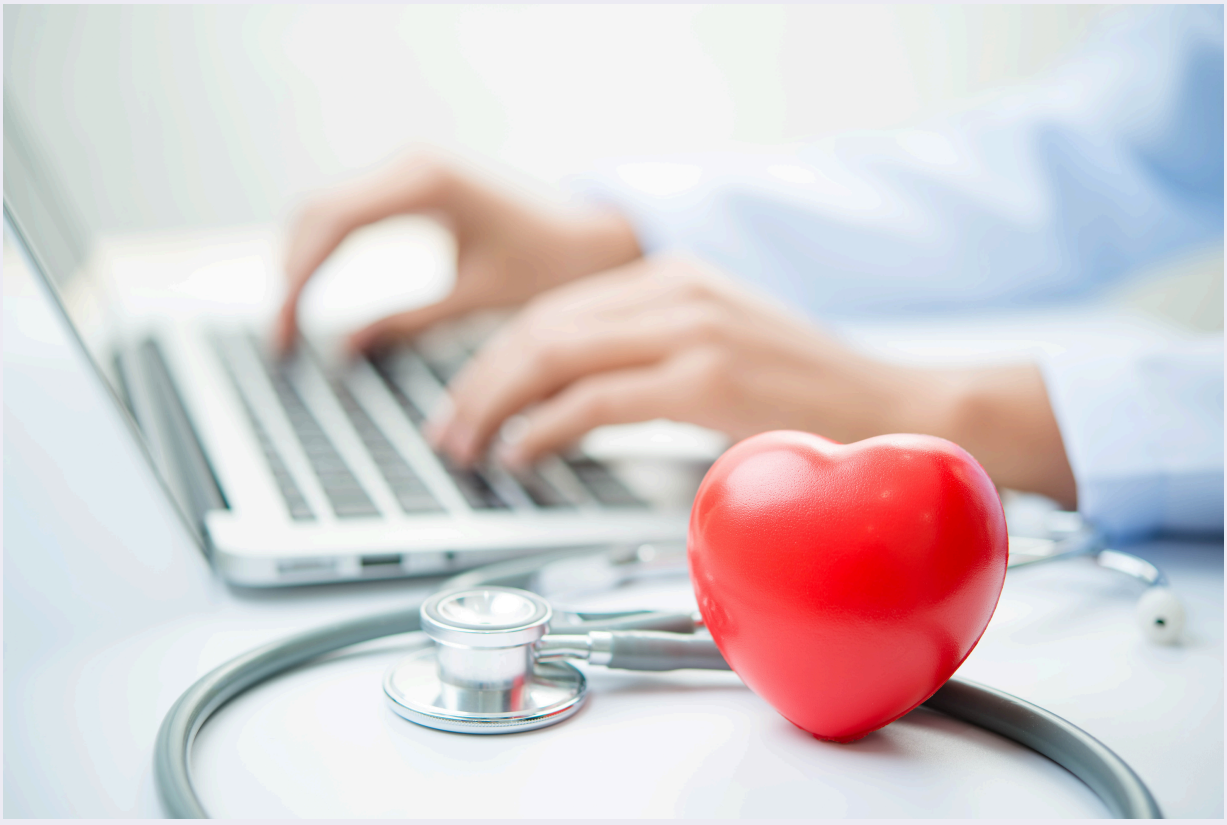
Sarnia-Lambton
ONTARIO HEALTH TEAM

Palliative Care Provider Toolkit

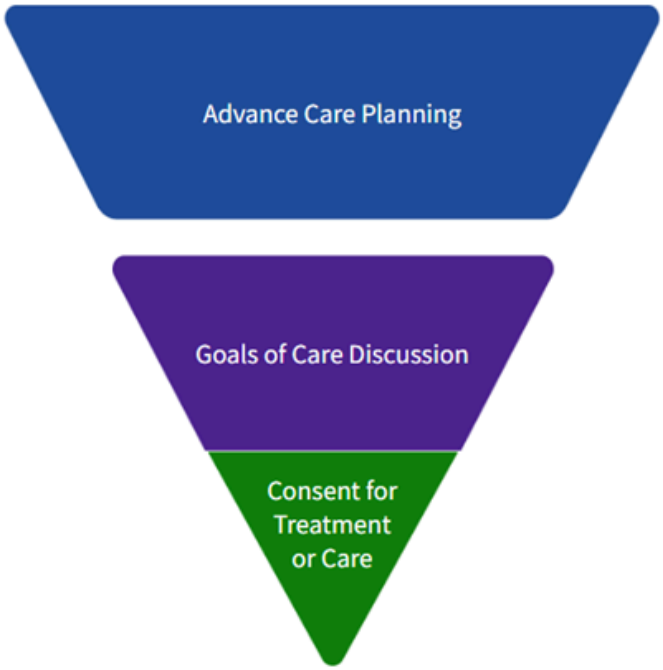
(Adapted from Hospice Palliative Care Ontario)



Advance Care Planning

Advance care planning (ACP) The purpose of ACP is to prepare people and their Substitute Decision Maker (SDM) for decision-making in the future. While ACP can be for healthy people, it gets more and more important as people develop serious illness.

Goals of care discussions (GOCD) and consent happen when treatment or care decisions are needed. Good ACP helps people and their SDMs be prepared to make decisions.



Advance Care Planning

- Conversations to confirm a person's substitute decision-maker (SDM) and prepare that SDM for future decision-making
- Focus on values and what's important to the person
- ACP is not consent for future care

Goals Of Care Discussion

- Discussions in the context of a current illness about a person's values & goals leading up to a treatment or care decision
- Aim is to align available treatment options with a person's goals

Consent For Treatment Or Care

- Conversation a healthcare provider must have with a person or their SDM prior to initiation of any treatment or personal care
- SDM only acts when the person lacks capacity for that decision

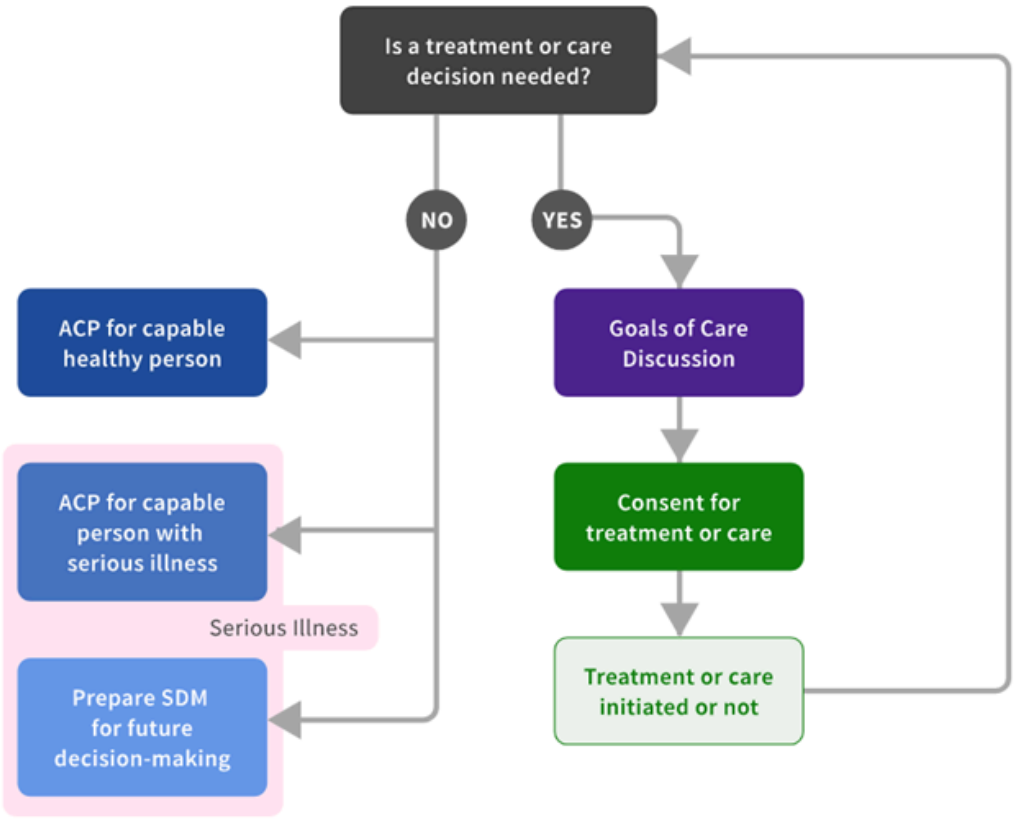
Identifying the Right Conversation

Starting ACP Conversations: Assessing Readiness

Choose the right moment to check in and offer to talk about future care. Ask simple, open-ended questions like:

- "Do you feel informed about your illness and what to expect?"
- "How are you coping with your health changes?"
- "How is your family managing with these changes?"

ACP is a flexible, ongoing process—revisit it as health needs evolve.



RESOURCES

Hospice Palliative Care Ontario

- **Assessing the patient's readiness for ACP Conversations:** https://www.pcdm.ca/acp/clinician-primer/stages-of-change-model

Building Triggers Into Your Practice

Consider discussing illness understanding and exploring interest in advance care planning when your patient:

- Has been diagnosed with a serious illness or experienced a significant health event
- Is being discharged from hospital
- Has had a recent specialist consultation
- Is experiencing a decline in functional ability
- Is living with an advanced chronic or serious illness
- Is 65 years of age or older
- Is entering or residing in long-term care
- May be at risk of losing capacity to make healthcare decisions
- Does not have a family member or friend available to act as a substitute decision-maker (SDM), and may require one to be appointed through the Office of the Public Guardian and Trustee (PG&T)

Advance Care Planning is a continuous process—it should be revisited whenever there are changes in a patient's health status.

RESOURCES

Hospice Palliative Care Ontario

- **A Clinician's Guide to Substitute Decision Making:** https://www.pcdm.ca/acp/clinicians-guide-for-substitute-decision-making
- **Level of Care Forms**: https://www.pcdm.ca/acp/clinician-primer/level-of-care-forms

Sarnia-Lambton Ontario Health Team

- **A Guide to Living with a Serious Illness - A Toolkit for Patients and Care Partners:** https://agefriendlysarnialambton.ca/68/End-of-Life_Planning/

Diagnosis of a Serious Illness

After discussing a serious illness, take time to check in and explore the patient's needs and available supports.

Questions to Ask:

- Would you like time to reflect or speak with your family? Should we schedule a follow-up?
- How are you feeling about today's visit and the information shared?
- What support do you need moving forward?
- How are things at home—any challenges with daily tasks or stressors?
- Are any services already in place?
- If something happened at home, who would you call first?

Consider additional community and self-management supports that may benefit your patient. Ask if they would like a referral to services such as:

- CHF or COPD clinics
- Ontario Health atHome
- Hospice's "Living Life Well" program
- Community support services (e.g., Meals on Wheels, transportation to appointments)
- Social work or counseling supports

AGE-FRIENDLY SARNIA-LAMBTON **For a directory of local programs and services, visit: agefriendlysarnialambton.ca**

RESOURCES

Hospice Palliative Care Ontario (HPCO)

- **Goals of Care Discussions**: https://www.pcdm.ca/goc
- **Goals of Care Discussion Documentation Template**:
- https://www.pcdm.ca/HPCO/Assets/Documents/PDFs/Goals%20of%20Care%20Conversation%20Template-1.pdf
- **Goals of Care E-Learning Module**: http://goalsofcaremodule.com/

Ontario Palliative Care Network

- **Quality Standard Placemat for Palliative Care:** https://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-palliative-care-placemat-en.pdf

Disease Progression and Palliative Care Team Referrals

Identifying patients with advancing illness early allows for timely referrals to palliative care, ensuring better symptom management and proactive care planning.

When to Consider a Referral to a Specialist Palliative Care Team:

- When symptoms such as pain, breathlessness, or fatigue are difficult to manage
- When patients are unable to tolerate adjustments to heart medications or further optimization is no longer feasible (e.g., in cases of CHF or other cardiac conditions)

Questions to ask:

- Do you need any more information about how to manage your pain or symptoms?
- Do you keep a journal of what's happening and bring to your appointments? – provider can suggest this.
- Do you have any questions about your medications?
- Do you have any fears, concerns about your illness, or treatments? (if yes, consider adding social work, counselling supports)

RESOURCES

Supportive and Palliative Care Indicators Tool SPICT™: is used to help identify people with deteriorating health due to life shortening conditions including frailty in older age. This means more people can benefit from a palliative care review and future care planning (advance care planning). https://www.spict.org.uk

Gold Standard Framework (GSF): is a practical and evidence-based end of life care service improvement program https://www.goldstandardsframework.org.uk/

Edmonton Symptom Management Scale (ESAS): addresses nine common symptoms including pain, nausea and anxiety. The tool is designed to assist in the assessment of: pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well being, and shortness of breath. https://www.albertahealthservices.ca/frm-07903.pdf

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Pallium Canada LEAP CORE

LEAP Core is a foundational palliative care course by Pallium Canada designed for healthcare professionals who support patients with life-limiting illnesses. It teaches essential skills like symptom management, communication, and advance care planning through an interprofessional, evidence-based approach.

Understanding the Need for Palliative Care

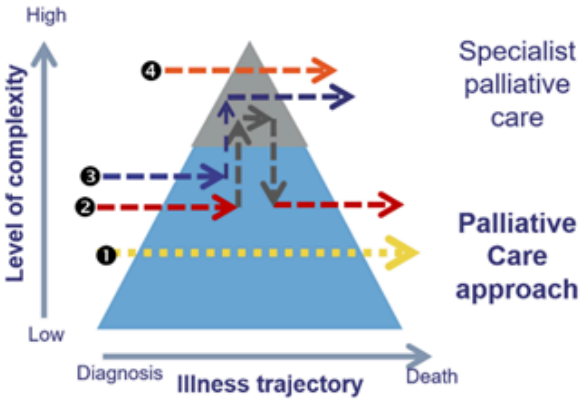
While approximately 1% of the general population dies each year, certain healthcare settings—such as long-term care, heart failure clinics, oncology, and renal programs—see significantly higher mortality rates. This highlights the importance of identifying patients who could benefit from a palliative care approach earlier in their illness trajectory.

Source: Pallium Canada, LEAP Core (June 2021)

Matching Care to Patient Needs

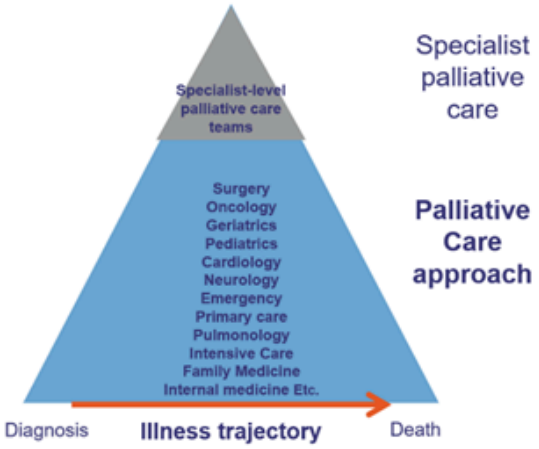
As illness progresses, the level of care should align with the complexity of the patient's needs. Most patients benefit from a general palliative care approach, while those with more complex needs may require specialist palliative care.

Source: Pallium Canada, LEAP Core (June 2021)



Palliative Care: It Is Everyone's Business

Palliative care involves a team-based approach, engaging various healthcare professionals across the illness trajectory—from diagnosis to end of life—to ensure holistic, person-centered care.



End of Life Planning

Supporting patients through end-of-life planning involves compassionate conversations, practical tools, and connections to local services that align with their values and wishes.

Key Planning Considerations

- Revisit and involve the Substitute Decision Maker (SDM); ensure organ donation wishes are understood.
- Discuss funeral planning options – https://www.agefriendlysarnialambton.ca/51/Funeral_and_Planning_Assistance/
- Finalize Advance Care Plans, including:
  - Home pronouncement planning
  - Level of Care forms
- Use the Palliative Performance Scale (PPS) to explain functional decline.
  - https://victoriahospice.org/wp-content/uploads/2019/12/PPSv2-English-Sample.pdf

Questions to Consider with Your Patient

- Have you thought about your end-of-life plan?
- Is it your wish to remain at home? Would your family be able to support that?
- Do you and your family understand the level of care that may be needed at home?
- Have you visited or considered the local hospice?
- Would you like to meet again after discussing with your family?

Medical Assistance in Dying (MAiD)

For provider information, visit: https://www.ontario.ca/page/medical-assistance-dying-and-end-life-decisions

LOCAL RESOURCES

St. Joseph's Hospice Sarnia Lambton
stjosephshospice.ca

AGE-FRIENDLY SARNIA-LAMBTON
agefriendlysarnialambton.ca

Ontario Health atHome
ontariohealthathome.ca/