



# **2017 Canadian Hospice Palliative Care Conference**

## **Expanding Our Horizons: A Palliative Approach to Care**

**September 20 – 23, 2017**

**Ottawa Conference and Event Centre, Ottawa, ON**

*Join us for what promises to be a wonderful learning and networking experience*

The Canadian Hospice Palliative Care Conference is the foremost national conference in Canada focusing on hospice palliative care. This event provides hospice palliative care professionals, volunteers, family and informal caregivers, and other allied health care providers with an opportunity to share their experience and expertise on a national platform.

**Wednesday,  
September 20, 2017**

**11:00 – 18:00**

**Satellite**

**Compassionate Communities: Compassionate Communities – Presented by Pallium**

**09:00 – 17:00**

**Satellite**

**Pediatric Palliative Care: Evidence is growing – coming of age**

Roger's House site visit for  
5:30 – 6:30 (Pre-registration  
required)

9:00 – 10:15 Opening, welcome and plenary

10:15 – 10:45 Break

10:45 – 12:00 Workshop session #1

12:00 – 1:00 Lunch provided

1:00 – 2:00 Workshop session #2

2:00 – 3:00 Workshop session #3

3:00 – 3:30 Break

3:30 – 4:30 Workshop session #4

4:30 – 5:00 Plenary wrap-up and closing

\*Sessions currently in development.

**Thursday,  
September 20, 2017**

**08:30 – 11:30**

**Satellite**

Long Term Care

**Long Term Care: Palliative Care in Long Term Care: Challenges, Planning and Goals**

This presentation will include an interactive session exploring the challenges in providing evidence based palliative care for the elderly, especially the difficulties with frailty and the slower dying process. Both local and regional resources will be shared. Join in the game show as you learn more about advance care planning and differentiate between ACP and Goals of Care.

Learning Objectives:

At the end of this presentation, the participants will:

Identify the impacts of frailty on the dying process

Define the term “goals of care” and understand how goals change as health status changes

Review the components of Advance Care Planning

Differentiate between Advance Care Planning and Goals of Care

Speakers:

Dr. Benoit Robert, MD, MBA, Medical Director, Perley Rideau Veterans' Health Centre

Dr. Declan Rowan, MD , Rural family physician at the Petawawa Centennial Family Health Centre; Co-lead of the Regional Primary Care Cancer Program

Dr. Jill Rice, MD, CCFP(PC), Champlain Regional Palliative Consultation Team (RPCT), Champlain Regional Palliative Care Lead

**08:30 – 11:30**

**Satellite**

**Nursing**

**Nursing: Palliative Care Matters: A Call for Nursing Action**

The Canadian Hospice Palliative Care Nurses Group (CHPCNG) believes that every Canadian should have access to quality palliative care and that all formal and informal caregivers must be supported with the knowledge, expertise and resources they need in order to provide compassionate care that will lessen the burden of suffering and improve the quality of living and dying.

In November 2016, a Consensus Development Conference was held in Ottawa led by The Covenant Health, Palliative Institute in Alberta. The Consensus Development Conference brought together citizens, decision-makers and experts to address issues of public importance specific to Palliative Care. The conference involved a series of experts who delivered scientific evidence on a series of questions to a Lay Panel of 12 people. The Lay Panel delivered a consensus statement and series of recommendations based on the evidence presented, which will be used to develop policy going forward.

Nurses can play an integral part in moving the Palliative Care Matters action plan forward and this collaborative session allows an opportunity for the members to be active in advancing this initiative across Canada.

This satellite session will:

1. Familiarize nurses with the Palliative Care Matters initiative, including:

- A review of the consensus development process;
- Key questions explored by the scientific experts;
- Views of over 1500 Canadians on a palliative care system for Canada;
- Responses and recommendations of the scientific experts;
- Consensus statement and recommendations;
- Recommendations of the Conference Board of Canada;
- Reflect on and analyze the recommendations from a nursing perspective

2. Invite attendees to engage in a facilitated discussion to identify key action items that can be led by nurses in moving the Palliative Care Matters agenda forward

3. Close with a collaborative perspective on bringing Palliative Care Matters to action

**08:30 – 11:30**

**Satellite**

Research

### **Research in a Community Context**

This two hour satellite meeting will look into how to partner with the research community. How does clinical practice, policy and research establish effective research partnerships. How does research feed into good policy and clinical practice.

Speakers:

Carolyn Taylor (policy)

Christopher Klinger (young researcher perspective)

TBA from the senior research community

Moderator:

Kelli Stadjuhar

**08:30 – 11:30**

**Satellite**

CFN Research Forum

**Integrating palliative care into the care of frail older adults: but when? - Presented by CFN**

Integrated palliative care has been most commonly described and used in patients with oncologic diagnoses, in whom, the end-of-life trajectory maybe more predictable. However, patients who are in late life from non-oncologic diagnoses may also have significant symptoms that reduce quality of life and there has been work and interest in the integration of palliative care earlier into the life course of these patients. The challenge to this approach is that the life course may be variable. This session will outline the challenges and possible solutions to the integration of palliative care in those living with frailty.

**08:30 – 11:30**

**Satellite**

Social Work

**The changing landscape of palliative care and its impact on Social Work practice; Building the capacity for advocacy.**

Objectives:

This Satellite will focus on championing the role of social work advocacy in palliative care which includes:

- Informing the population of the various palliative care services
- Training and educating the next generation of social workers

- Ensuring a holistic approach in every setting where palliative care is offered
- Improving access to care for vulnerable populations
- Supporting informed choices
- Strengthening the community response to the needs of the individuals requiring end-of-life care
- Addressing caregivers' needs during the illness trajectory and during bereavement
- Leading research activities and knowledge translation on evidence based practice
- Championing strategies to address clinical and policy issues on the micro, meso and macro levels of the health care system and in the community at large

We will discuss current challenges and emerging issues that impact professionalism, the need for expanding leadership and advocacy to effect change.

Format: presentation and small group discussion. The participants will leave with take-home key strategies to develop an action plan for their community and assist in developing a social work strategy for the CHPCA social work interest group.

Speakers: TBD

**08:30 – 11:30**

**Satellite**

Advance Care Planning

**Advance Care Planning - Engaging With Communities**

Community engagement is an important strategy to both raise awareness about advance care planning and to increase individuals' and families' participation in the process. This satellite session will describe four innovative

examples of community engagement - working with a variety of community stakeholders to reach community members.

**12:00 – 14:30**

***Interest Groups***

Aboriginal Issues

Long-Term Care / Continuing Care (12:00 - 13:15)

Rural and Remote Issues (13:15 - 16:00)

Pediatric Issues

Social Workers / Counsellors

Spiritual Advisors

Volunteer Issues

Nurses

Residential Hospice (For administrators working in a Residential Hospice)

**15:00 – 16:00**

***Opening Ceremonies***

**16:00 – 17:00**

***Opening Plenary***

Theme: Integrated palliative approach to care

**Looking Forward, Looking Back: What History Can Teach Us about the Integration of a Palliative Approach to Care**

Presenter: Kelli Stajduhar

Program description coming soon

**About Kelli Stajduhar**

Kelli Stajduhar, RN, PhD

Professor

School of Nursing and Institute on Aging and Lifelong Health (formerly Centre on Aging) University of Victoria

Research Scientist, Palliative Care Program, Fraser Health

Research Affiliate, BC Centre for Palliative Care

Dr. Kelli Stajduhar has worked in oncology, palliative care, and gerontology for over 30 years as a staff nurse, nurse clinician, clinical nurse specialist, educator, and researcher. She is a Professor, School of Nursing and Institute on Aging and Lifelong Health at the University of Victoria. Her clinical work and research has focused on the health service needs for people who are dying and their family members and on the particular needs of marginalized and vulnerable populations. She is the recipient of numerous awards including Post-Doctoral Fellowships from CIHR, MSFHR, and CHSRF, a New Investigator Award from CIHR and a Scholar Award from the MSFHR, the Anselm Strauss Award from the U.S. Council on Family Relations, the Award of Excellence for Nursing Research from the College of Registered Nurses of BC, the UVic Craigdarroch Award for Excellence in Knowledge Mobilization and the 2016 Award of Research Excellence from the Canadian Association of Schools of Nursing. Dr. Stajduhar publishes and speaks widely on issues pertaining to palliative care, family caregiving, health system design for those with chronic life-limiting illness and on establishing research partnerships and collaborations with health authorities. Along with leading several externally-funded research projects, she is the Scientific Lead of iPANEL (Initiative for a Palliative Approach in Nursing: Evidence and Leadership), a applied nursing health services and policy research initiative comprised of researchers, clinicians and administrators with a focus on investigating the integration of a palliative approach into the care of people with chronic life-limiting illness. Her strong belief in applied health services research, a commitment to engaging clinicians and administrators in research, and her pragmatically

oriented and collaborative approach has allowed Dr. Stajduhar to develop strong research partnerships and collaborations with health authorities across BC, Canada, and internationally, where she is regularly invited to speak and is consulted for her expertise in establishing research excellence and producing research findings that are relevant, applicable, and make a difference in the everyday lives of those with chronic life-limiting illness, their families and the health care providers that provide care.

17:45 – 20:00

*Opening of Posters and Exhibits*

Wine and Cheese

**Friday, September  
22, 2017**

08:30 – 09:45

*Plenary*

**Theme: Clinical Practice**

**The Icing on the Cake – How Volunteers Enhance the Palliative Care Team**

Presenter: Lisa McNeil-Campbell

Every Canadian should have access to quality palliative care from an interprofessional team that includes volunteers. Volunteers are individuals who freely give of their own time and experience and do so much to enhance the care being provided. Their gifts of time, compassion and empathy provide comfort and support to patients and their families who are living with a life-limiting illness.

Volunteers must be supported with the knowledge, expertise and the

resources they need in order to provide compassionate care that will lessen the burden of suffering and improve the quality of living and dying. An identified management structure under which volunteers work is a critical component to the success of a volunteer program. The coordinator of volunteers must be aware of the special nature of involving volunteers and have skill in the selection, supervision, and engagement of volunteers.

Successfully including volunteers provides an opportunity for palliative care teams to involve citizens in the provision of care and enhances the services that they are able to provide.

This session will:

- Review the role of the Hospice Palliative Care (HPC) volunteer and look at the many ways they enhance the Palliative Care Team
- Provide insight into what inspires people to volunteer in Palliative Care
- Examine the key components to becoming a HPC volunteer
- Review work currently underway in Nova Scotia regarding Palliative Care Volunteer competencies and training
- Highlight key lessons gleaned from being a coordinator of palliative care volunteers in Nova Scotia

#### **About Lisa McNeil-Campbell**

Lisa McNeil-Campbell is a Volunteer Resources Consultant for the Nova Scotia Health Authority (NSHA) in Cape Breton, Nova Scotia. Lisa oversees more than 800 volunteers and has also been training and working with Palliative Care volunteers for over 11 years. In 2007 she completed a two-year Leadership Development program as well as a Volunteer Management course through the NSCC Human Services Program. In 2015 Lisa was awarded the Cancer & Palliative Care Support Services Award of Excellence for her work

and dedication. In November, 2016 she successfully completed her Certification in Volunteer Administration.

Since 2015 Lisa has been a member of the NSHA Provincial Palliative Care Capacity Building and Practice Change Task Group which was developed to address the requirements for standardized education and capacity building of health providers and volunteers within Palliative Care. She has also been an advisory board member for the Hospice Palliative Care Society of Cape Breton County for the past 12 years.

Lisa resides in the town of New Waterford with her husband Graham and their two cats, Leo and Archie. They have a 22-year-old daughter, Presley, currently studying Sound Design at Vancouver Film School.

**10:15 – 11:45**

***Challenging Issues Panel***

**Advance Care Planning**

**Advance Care Planning (ACP) in the Environment of Medical Assistance in Dying (MAiD)**

The legalization of medical assistance in dying, (MAiD), has changed the context of healthcare care in Canada. It has also changed the discourse that Canadians are having – about quality of life and death. What is and what will be the impact of medical assistance in dying on ACP and on conversations about future healthcare wishes? What is the impact of ACP on medical aid in dying?

Our plan is to have a physician, a lawyer and an ethicist. The purpose of the panel is not to debate - but to present the audience with challenging thoughts/information - to create a conversation. The format is that each panellist speaks for 10 to 15 minutes, and then there is xx minutes for dialogue with the audience. In the past any Challenging Issues panel we have done on ACP have been very well attended.

Presenters: Lonny Rosen, Eric Waslenko, and Blair Henry

Moderator: Louise Hanvey or Chad Hammond

**10:15 – 11:45**

***Challenging Issues Panel***

**Public Health**

**Public Health Perspectives – Highlights from the IPHPC conference**

The 5th International Public Health and Palliative Care conference is being held just before the Canadian conference from September 17-20, 2017. The conference has 4 plenaries, 8 fireside chats; 20 workshops; over 58 oral presentations and over 40 posters from presenters around the world. This challenging issues panel will bring the highlights of the international conference to you and are presented by the two program co-chairs of the IPHPC conference.

Presenters: Denise Marshall and Kathy Kortés-Miller

Moderator: Kathryn Downer

**10:15 – 11:45**

***Challenging Issues Panel***

**Integration**

**Integration - Moving to the Optimal System**

This challenging issues panel will discuss what we mean by integration? There are different focuses including chronic disease and HPC; cancer care and HPC; and lastly integration as it pertains to our health care system (primary, tertiary and specialist care). We need to look at how we engage with other settings and other providers within the health care systems.

We will look at barriers and challenges in moving care to the community. What about change management strategy as a focus? The presenters will bring three focuses including one from a provincial perspective using case studies, CPAC a national organizations perspective and also from a change management perspective.

		Presenters: Jamie Tycholiz, Doris Barwich and Deb Dudgeon
		Moderator: TBA
<b>10:15 – 11:45</b>	<b><i>Challenging Issues Panel</i></b> <b>Indigenous People</b>	<b>Indigenous communities and hospice palliative care: The current environment</b>  Come hear stories and the narrative from the First Nations community. What does hospice palliative care look like in their own communities? Also, hear how Ontario is moving forward with a First Nations initiative including promoting a guide for external audiences. Could this be a model for other provinces and jurisdictions?  Speakers: Holly Prince, Lori Monture and Maxine Crow  Moderator: Rosella Kinoshameg
<b>11:45 – 13:00</b>	<b><i>Lunch</i></b>	<b>Celebration of Life Ceremony</b>
<b>13:00 – 14:30</b>	<b><i>Workshops and Oral Presentations</i></b>	<b>Please see workshops/oral presentations listing for full presentations details</b>
<b>14:30 – 15:00</b>	<b><i>Break</i></b>	
<b>15:00 – 16:00</b>	<b><i>Workshops and Oral Presentations</i></b>	<b>Please see workshops/oral presentations listing for full presentations details</b>
<b>16:00 – 16:15</b>	<b><i>Transition (No Break)</i></b>	
<b>16:15 – 17:15</b>	<b><i>Workshops and Oral Presentations</i></b>	<b>Please see workshops/oral presentations listing for full presentations details</b>
<b>17:30 – 18:30</b>	<b><i>Reception</i></b>	

18:30 – 22:00

*Evening Soirée*

Casino Themed Evening of Fun

**Saturday,  
September 23, 2017**

08:30 – 09:45

*Plenary*

**Theme:  
Leadership/inspirational**

**Using Humour to Deal with Terminal Illness**

Presenter: Jeremie Saunders

Program description coming soon

**About Jeremie Saunders**

Jeremie is a multi-award winning professional actor and yoga instructor who happens to live with a genetic lung disease called Cystic Fibrosis.

He is also the producer and host of the award-winning comedy podcast Sickboy which he founded with his two best friends Taylor and Brian. Together they explore conversations surrounding what it's like to live with terminal or chronic illness in order to tear down the walls of stigma and find levity in an otherwise dark situation.

In another life, prior to this he hosted the CBC Television show Artzooka and traveled the world, from Kazakhstan to New Mexico and many places in between, with Col. Chris Hadfield as he hosting a documentary about Hadfield's training to become an astronaut.

Jeremie is based out of Halifax, Nova Scotia where he lives with his wife Bryde

and their oversized muffin of a dog Bigby.

Most audiences remark that what they loved the most about Jeremie has been his sincerity, the insight he brings into the patient experience and the way he can (cleanly for audiences) bring great humour to the challenges of living with illness and working in health care.

**10:15 – 11:45**

***Challenging Issues Panel***

**International issues**

**What is the provision of hospice palliative care in Africa**

Description TBA

Presenters: Zipporah Ali and TBA

Moderator: Sharon Baxter

**10:15 – 11:45**

***Challenging Issues Panel***

**Marginalized Populations**

**Social Determinants of Health - What Are the Biggest Challenges to the Social Determinants of Health**

This panel will present the challenges faced by people in a quantitative way by telling their story. The panel will use a Jeopardy type answer and then question process to elaborate on the critical aspects and what barriers might look like.

The session will bring in the issue of not having choices and how society has taken away their decision making. Then we will tackle the issue of seeking care while living with trauma. Then finally we will bring into the conversation how does one advocate – what might be five steps to act on. We will be using a polling system to bring the audience into the dialogue.

Presenters: Naheed Dosani, Simon Colgan and Namavig Ahmed

<p><i>10:15 – 11:45</i></p>	<p><i>Challenging Issues Panel</i></p> <p><b>MAID</b></p>	<p>Moderator: Kelli Stadjahar</p> <p><b>Hospice Palliative Care in the MAiD environment: Practically how do we co-exist in the new environment.</b></p> <p>CHPCA is planning to survey its membership around stressors and challenges in the new environment. Results of this survey will be explored. How do we keep patient-centred care in mind in providing the best care possible?</p> <p>Speakers: David Henderson, Maryse Bouvette and Sarah Levesque</p> <p>Moderator: Sharon Baxter</p>
<p><i>10:15 – 11:45</i></p>	<p><i>Challenging Issues Panel</i></p> <p><b>Pediatrics</b></p>	<p><b>Thinking outside the Box: Innovative ways of providing palliative care to children within their home communities</b></p> <p>This challenging issues panel will explore different models of care across Canada to examine the current ways that pediatric palliative care is being delivered. This session will focus on creative ways to support pediatric patients in communities where access to a children’s hospital or dedicated pediatric palliative care programs isn’t available. Panelists will learn about and discuss how pediatric palliative care can be integrated into adult centered models, and will look at programs and services currently serving their pediatric populations with creative and innovative outreach, hybrid, and/or partnership models.</p> <p>Presenters: TBA</p> <p>Moderator: TBA</p>
<p><i>11:45 – 13:00</i></p>	<p><i>Lunch</i></p>	<p><b>Conference Reflection Remarks</b></p>
<p><i>13:00 – 14:30</i></p>	<p><i>Workshops and Oral</i></p>	<p><b>Please see workshops/oral presentations listing for full presentations details</b></p>

*Presentations*

**14:30 – 15:00**

*Break*

**15:00 – 16:00**

*Workshops and Oral  
Presentations*

**Please see workshops/oral presentations listing for full presentations details**

**16:00 – 16:15**

*Transition (No Break)*

**16:15 – 17:15**

*Workshops and Oral  
Presentations*

**Please see workshops/oral presentations listing for full presentations details**

## Workshops

Title	Presenter(s)	Description
Mindfulness practice: It's not what you think. Really.	Stephen Liben	Mindfulness is a word has become synonymous with thoughtfulness, and while related they are not the same thing. Being mindful is a state of awareness that observes non-judgmentally whatever appears in the conscious mind, including thoughts, sensations and emotions. Mindfulness is not what you think but rather the awareness THAT you are thinking. This experiential workshop will guide participants in different mindfulness based exercises (e.g. brief meditations) and then examine what comes up and how it might be helpful in their own work life (where “work” and “life” are meant to be both separate and one and the same). There will be no powerpoint slides and this is not a lecture based workshop.
Clinician suffering: A paradigm shift for palliative care providers	Maxxine Rattner, Joan Berzoff	The prevention and relief of suffering is the primary aim of palliative care, described as an “obligation” (Cassell, 1982; Sacks & Nelson, 2007) and “duty” (WHO, 2014) for clinicians. This session will introduce a new conceptual and clinical framework that acknowledges that there is intrinsic psychosocial suffering at end of life — loss, feeling burdensome, loneliness, death anxiety and worry for family — which may be resistant to relief, despite clinicians’ best efforts. This new framework pinpoints a profound ethical and clinical tension in palliative care: the paradox of the expectation that we can relieve suffering, and our inability to necessarily do so. It also runs counter to the common adage that palliative care providers can and must “replac[e] suffering with joy” or meaning for dying patients (Witt Sherman, 2015. p. 477). While there may indeed be meaning and joy at end of life, it is possible that there may be no meaning to be found, and the pressure to make meaning may work to increase suffering for patients, families and clinicians. That some suffering endures indicates neither poor quality of care, nor of clinician inadequacy, but rather that dying is intrinsically hard. Currently, little

clinical guidance exists on how clinicians can work with psychosocial suffering that persists at end of life, and this workshop will help to fill this gap.

Innovating the delivery of CSCI for Pain and Symptom Management Using an Elastomeric Infusor

Michelle Dagloria, Allison Crombeen, Puja Shanghavi

Interdisciplinary workshop featuring the expertise of a physician, nurse, and pharmacist discussing the innovative practice in Southwestern Ontario with the use of a non-electronic ambulatory elastomeric infusor for the delivery of CSCI for pain and symptom management in a variety of settings (hospital, community, and residential hospice).

Objectives for the workshop include:

1. An introduction to elastomeric infusors,
2. Review of challenging clinical scenarios and the use of elastomerics,
3. Prescribing practices,
4. Patient benefits with use of elastomeric infusors,
5. Pharmacist's experience mixing and compounding elastomeric infusors
6. Hands on review of device.

The Community Access to Palliative Care via Interprofessional Teams intervention (CAPACITI): A workshop to strengthen collaborative practice

Hsien Seow, Daryl Bainbridge

Interprofessional collaboration in which nurses, physicians, personal support workers, and other healthcare providers work together is critical for providing patient-centred palliative care in the community. Role clarity, open communication, interdependence, mentorship, and other qualities of provider cohesion are indicative of well-functioning, effective, palliative care programs. Although standardized curriculum exists to improve the clinical competency of healthcare professionals in providing palliative care, there is little in the way of training to help these individuals develop their team building skills or explore opportunities to strengthen relationships with other providers in their community.

Dr. Hsien Seow and his team have developed a workshop intervention to assist community healthcare providers strengthen their own interprofessional palliative care capacity. Design of the workshop exercises was informed through a synthesis of existing literature and tools on team building and input from a broad cross section of palliative care providers and experts. The workshop will be fully interactive, with attendees participating in the session activities in reflection of their own practice community and fellow providers who work there. The goal of the workshop is to provide participants with ideas of how to engage other providers, including primary care physicians, in their daily work and strengthen professional relationships.

Advance Care Planning: It's All About the Conversation  
Nadine Valk

Thanks to a partnership arrangement, the HPC Program in the fall of 2016 hosted a very exciting initiative: "It's All About the Conversations," a 3 part series on Advance Care Planning. Part One is a general overview to ACP and Health Care Consent in Ontario. Part Two is a workshop to help people connect their wishes, values and beliefs to choices they (or their Substitute Decision Maker) might make about their care. Part Three includes ideas for having the difficult discussions. The series was repeated in 3 communities and once in French. Resources including a Facilitator Manual and participant Reflection Booklet were developed. The workshop will provide an overview of the ACP series, summarize lessons learned and provide an opportunity to experience some of the tools used.

The Reflection Room: Two Years Later  
Paul Holyoke, Karen Oikonen

The Reflection Room study posed the question: How might we use human-centred design and qualitative research to go from being a death-avoiding society to a death-discussing society? We hypothesized that providing places for storytelling — and places for reading the stories of others — might trigger more thinking and break through the social complexity that can be a barrier to discussing dying and death. At the 2015 CHPCA conference, Saint Elizabeth

researchers installed a Reflection Room, the prototype for all the other Reflection Rooms installed since that time.

Two years later, we are bringing the study results back to the CHPCA conference. We will discuss the reaction to TheReflectionRoom.ca and the more than 25 installations of the Reflection Room across Canada. We will report on the themes that have emerged over the 2 years, including: the importance of being more careful and attentive to space and time for reflection; the specific features of the Reflection Room that seem to be most effective in encouraging and facilitating reflections and dying and death; and, the nature of the stories that people have been willing to share on the physical and virtual Reflection Walls. We will also discuss the learnings that Reflection Room hosts across Canada have shared with us, and the early results on the longer term impact of the Reflection Room on people's willingness to think about dying and death and engage in advance care planning. We will also present our next steps for the Reflection Room project.

An Online End of Life  
Experience to Encourage  
Advance Care Planning

Karen Oikonen, Kate Sellen,  
Paul Holyoke

In a co-design exercise with family members, healthcare providers, volunteers and administrators associated with Hospice Georgian Triangle, we used an extended scenario with specific personas to examine and record the feelings, concerns and desires that can arise as people experience dying and death. The participants, though all well experienced with dying and death, felt that the experience of going through the scenario and using personas to do so was deeply moving and highly effective in re-engaging themselves in thinking about dying and death. In particular, the participants felt that providing an opportunity for others to experience the scenario could be very helpful in familiarizing them to the choices and decisions they may face while experiencing their own dying or death, or someone else's. While this exercise may be helpful to encourage Advanced Care Planning, it is time and resource

intensive and may not reach people distanced from family or in rural and remote communities.

We have responded by translating the in person exercise to an online experience for people, that enables them to move through some reality-based end of life scenarios, with choices and decisions to make, and includes an opportunity to explore the consequences of those choices and decisions.

In this workshop, we will share the challenges and opportunities that the online experience project presented. Participants will engage in the prototype online experience, followed by a facilitated discussion about the experience and its potential to encourage earlier discussions by people about their expectations about dying and death.

Using a social determinants of health approach in the provision of palliative care

ise Huynh, Blair Henry,  
Naheed Dosani

In a separate publication, the authors noted that with an ever increasing number of individuals living with chronic and terminal illnesses, that palliative care is poised for unprecedented expansion. However, it was also recognized that underserved populations experience a disproportionate decrease in access to all health resources in spite of poorer health outcomes and some would argue, higher need. Enhanced education and understanding of the impact that social determinant of health can have on access needs to be addressed. This workshop aims to identify the impact SDOH have on palliative care services itself and to introduce an assessment tool, designed specifically with palliative care in mind, to assist clinicians in proactively assessing barriers and biases and providing patients with resources for self-advocacy and support.

Easing the transition from  
curative care to palliative care

Manon Coulombe

Objectives of this workshop will include:

- 1) Identify how SDOH's impact the delivery of palliative care service in underserved populations
- 2) Review the barriers and potential bias inherent in the existing design of palliative care services
- 3) Build capacity among clinicians to identify and address key SDOH issues in palliative care delivery through the review of a newly developed tool

The transition from curative care to palliative care is a very important step in the disease process. Health care professionals are often uncomfortable discussing the fact that end of life has become inevitable. To ease this transition, it is important to acknowledge this eventuality and to be able to discuss it with the patient and his family.

In an attempt to offer guidance and comfort to patients and families confronted to the cessation of active treatments (advanced stage of cancer), concrete steps to ease the discussion will be presented.

To ease this process, sources of discomfort of the health care professional will be explored.

To be able to discuss the transition, health care professionals must be aware of their own values and beliefs because they have a major impact on the approach used with patients and families.

Emergency Medical  
Services/Palliative and End of  
Life Care Asses, Treat and  
Refer Program

Cheryl Cameron

Emergency Medical Services (EMS) and community clinicians are taking care to palliative and end of life care (PEOLC) patients who would otherwise be required to be taken to hospital. Many patients receiving palliative and end of life care prefer to be at home, but complex care issues have historically left EMS practitioners and community clinicians with few options but to transport them to hospital during unexpected symptom crisis. Launched in April of 2015, the program is helping to improve patient and family centered care by focusing on high quality interdisciplinary teamwork between community clinicians and paramedics. This innovative program supports community clinicians (in the homecare and supportive living environments), paramedics and an online physician to collaboratively manage symptom crisis to keep patients at home, when appropriate, improving patient and family experiences and reducing the impact on emergency departments.

Grief Matters.

Rachelle Mcguire

Why does it matter that we do grief well?

And what are the repercussions when we don't?

What does it take to metabolize grief well?

What is it that we do culturally to inhibit and impede these very things?

Do other cultures do it differently? What might we learn from them?

As professionals, we hold common agreements about grief. We believe that grief is normal, that it is a deeply personal and unique experience and that it is not time-limited.

If this is so why do so many of our bereavement support programs offer support that is in-congruent with these beliefs?

These are just some of the questions and ideas we will explore in this engaging workshop & conversation. I hope you will join me.

Revisiting the role of social workers involved in palliative care within the context of Bill 2 in Québec and C-14 in Canada

Patrick Durivage, Zelda Freitas

This workshop is intended to give social workers involved in palliative care in all settings (home, community, hospital, residential care facility, hospice) an opportunity to reflect on the impact of the new end-of-life care laws in their clinical practice with individuals, their caregivers, families and within the interdisciplinary team. After a brief presentation of the Bill 2 and C-14, participants will discuss their professional roles in relation to advance care planning, palliative care, palliative care sedation and medical aid in dying. In this plenary, participants will learn insights on how to prepare individuals, their caregivers and families in the new landscape of dying in Canada.

Co-designing Hospice Palliative

Karen Oikonen, Paul Holyoke,

The Ontario Ministry of Health and Long-Term Care provincial strategy aspires

Care: Deep engagement with family members, hospice staff, healthcare providers and community members

Kelly Borg, Susan Paterino

to put 'Patients First' however there is not a strong history of developing services for patients and families WITH patients and families.

The Saint Elizabeth Research Centre partnered with each of Hospice Georgian Triangle and Hospice Vaughan to use co-design methodology to guide the process of developing services and facilities from problem framing to developing ideas to translating to reality.

Co-design goes well beyond the “informing” and “consulting” forms of patient and family engagement. It involves a wide variety of stakeholders — bereaved family members, hospice staff, nurses, doctors, PSWs, navigators, spiritual care providers, architects, and community members – while holding firm to the idea of person and family members being at the centre. The co-design is highly process-driven, potentially leading to outcomes that the stakeholders may not have even considered prior to the process. As such, it requires a commitment to deep listening and attentiveness, but ultimately, leads to a wider commitment to a vision and results that will more closely meet the needs and expectations of the patients and families – and the other stakeholders.

In this workshop, we will provide the principles and general approach of co-design, and provide some perspectives on the co-design experience from two hospice organizations. Then, we will enter into a dialogue with workshop participants about co-design and how it works, and how it might benefit future work participants will be undertaking in their own hospice palliative

Program leadership and development in Pediatric Palliative Care

Dave Lysecki, Kimberley Widger, Adam Rapoport, Hal Siden

care work.

Between 2002 and 2012, the number of patients seen increased by tertiary pediatric palliative care (PPC) services across Canada increased from 317 to 1401; the number of programs from 8 to 13, and the number of clinician FTEs from 14 to 40. Despite this growth, an estimated 81% of patients who may benefit from this service continue to go unserved. In the rapidly developing field of PPC, there is no room for idle passengers: all involved individuals require a proficiency in program leadership and development.

Active programs vary dramatically in their composition, resources, patient volumes, and care models; within this diversity lies a wealth of experience and expertise in PPC program development. This workshop will bring together individuals from health care systems in various stages of program development for a review of the current climate, a discussion of topics of interest in program development, and an exchange of challenges, successes, failures, and ideas for innovation.

Prior to the workshop, members of the Canadian Network of Palliative Care for Children will be polled for topics of interest in PPC program development, which will be used to create frameworks of discussion. Facilitators include a PPC health services researcher and the medical directors of three PPC programs in various stages of program development: the historic Canuck Place program (Vancouver), the rapidly expanded PACT/Emily's House program (Toronto), and the newly established QoLA Care program (Hamilton).

Creating a Creative Writing

Kyra Harris

In this workshop, Dr. Kyra Harris will lead participants through a series of writing exercises designed to help palliative and hospice care professionals

## Based Self-Reflective Practice

learn to use creative writing for both independent and group self-reflection. By leading participants through collaborative writing exercises on themes relating to death and dying, she will demonstrate how arts-based techniques can be used to explore emotional experiences as a team. Through independent exercises, she will help participants develop comfort in their own writing abilities, and take the first steps towards using poetry and journaling for self-care. Participants will have the opportunity to share their work with the group, discuss group themes, and troubleshoot any challenges and discomforts with the writing process. No previous writing experience necessary.

Palliative Care: not all about dying

Pippa Hawley

I will discuss how language related to palliative care can sabotage efforts to engage patients early in the course of illness. I will present a new way of communicating with patients, their families, our colleagues and the public which will facilitate appropriately timed engagement with palliative care services, reduce the risk of resource-intensive crises and increase the capacity of palliative care services.

Serious Illness Care More, Earlier, Better Conversations

Elizabeth Beddard-Huber,  
Gillian Fyles

It is well known that more, better and earlier conversations with seriously ill patients can lead to improved health and psychosocial outcomes. However, conversations often occur too late, and focus on choices about procedures rather than aligning care to what matters to patients. Clinicians often feel underprepared and/or lack confidence to conduct high-quality conversations. The BC Centre for Palliative Care is working with patients, families, caregivers, clinicians, health administrators, researchers and community organizations to implement a provincial initiative to improve serious illness conversations. Our aim is for goal concordant care for individuals throughout British Columbia.

In this workshop we will introduce the Serious Illness Conversation Guide,

patient and family tools as well as recommended system change strategies, all developed and tested by Ariadne Labs-Harvard Medical School. The tools are designed to help patients prepare for the conversation, help clinicians guide the conversation and then help patients talk to their families. The workshop will focus on skills development using the guide through role play and structured feedback from experienced facilitators. The system change strategies that will be discussed include identifying a trigger for the conversation, developing a reminder system, dedicating clinician time for the conversation, facilitating documentation in the patient's medical record, and integrating patients and family resources in the process of care.

We will also share lessons learned from pilot sites in British Columbia that are implementing the serious illness conversation program into their standard of care.

Establishing the Nova Scotia  
Palliative Care Competency  
Framework

Janet Carver, Meg McCallum

In 2014 Nova Scotia released a provincial palliative care (PC) strategy and implementation working groups were established. The Capacity Building and Practice Change Working Group (CBPCWG) is comprised of health professionals, a public advisor, educators and a Volunteer Resources Consultant. The CBPCWG is responsible for determining an approach to provide standardized PC education, identifying PC learning needs, and establishing PC practice support tools. The first step in achieving this mandate was to establish PC competencies for:

- health professionals caring for patients with life limiting illness and their families
- health professionals and volunteers specializing in PC.

## Methods

In the fall of 2015, a literature search for PC competencies and a scan of PC education programs were conducted.

The Irish PC Competence Framework (IPCCF) serves as the foundation of the Nova Scotia Palliative Care Competency Framework (NSPCCF). PC competencies established by Canadian associations were incorporated, additional competencies were added and any competencies not specific to PC were removed.

To highlight Interprofessional practice, the NSPCCF illustrates shared and discipline-specific competencies.

The IPCCF does not include Para-medicine, Volunteer or Volunteer Coordinator competencies. The objectives for the program to prepare Paramedics to provide PC and the Canadian Paramedic Competency Profile framed the Para-medicine competencies. A number of resources underpin the Volunteer Coordinators' and PC Volunteers' competencies.

Stakeholders were asked to review and validate the NSPCCF. Additional stakeholders were asked to map the competencies to educational programs. Recommendations were incorporated and re-circulated. Numerous rounds of

review refined the NSPCCF.

The CBPCWG then sought the support of Health Professional Colleges and Associations, NSHA and IWK.

### Results

Two documents were created. An internal document includes mapping to educational programs, the public document does not.

### Conclusions

The CBPCWG was successful in establishing shared and discipline specific PC competencies and selecting PC educational programs. The NSPCCF will also support the refinement of PC quality indicators.

Other provinces and national organizations have expressed considerable interest in the NSPCCF.

Developing a volunteer  
navigator program to support  
early palliative care: Would it

Barbara Pesut

In this workshop participants will have the opportunity to explore an innovative program called NCARE (navigating, connecting, accessing, resourcing, engaging) in which hospice volunteers provide supportive services

work for you?

in the home for clients who are early in the palliative trajectory. In this model, hospice volunteers receive training in navigation and then conduct regular visits with clients in the home. Supportive interventions include assisting clients with making connections, identifying and accessing relevant resources, engaging with meaningful activities, and assisting with decision-making. NCARE was successfully piloted in 2015/2016 and is now being implemented in communities across Canada. Findings from these studies will be shared with participants including experiences learned through implementation and the impact on volunteers and clients. Participants will have the opportunity to work with the NCARE implementation tool-kit to better understand the potential of the program for their hospice society and community.

Participants in this workshop will meet the following objectives:

- Understand the NCARE program.
- Explore how NCARE fits with a public health and a compassionate communities approach to palliative care.
- Describe the types of services that volunteers can provide for an early palliative population in the community.
- Understand the potential impact of the NCARE program on volunteers, clients, and community.
- Weigh the potential of implementing the NCARE program within their hospice society and community.

Using an evidence-based online toolkit to promote

John Rosenberg, Wendy Gain

The workshop has been developed from a large project designed to improve end-of-life care for older persons through promoting linkages between

linkages between palliative care and aged care: the Decision Assist project

palliative care services and aged care providers. The project aimed to improve the quality of end-of-life care given to older persons, reduce the preventable transfer of older persons into acute care, and improve the knowledge, skills and confidence of aged care staff.

We identified seven evidence-based linkage strategies that promote inter-organizational linkage between palliative care services and aged care providers. The strategies are:

- multidisciplinary team structures
- communication pathways
- formalized agreements
- designated linkage workers
- role clarification
- knowledge exchange and upskilling
- continuous quality improvement

We introduce and demonstrate the use of the new online Linkages toolkit to enable workshop participants to consider strategies to develop, implement and evaluate linkage strategies in their own workplaces. The Linkages Toolkit is comprised of a guide with specific tools and resources to enable implementation of each of the seven strategies. The toolkit includes templates for formalizing service-level agreements, the clarification of partners' roles, communication mechanisms to promote information exchange, shared assessment tools and care plans, position descriptions for linkage nurses, and strategies for multidisciplinary care. It also guides organizations through the process of developing effective and sustainable

partnerships.

The development of an Activity Plan is a key action for the practical application of the Linkage strategies and will be included in the workshop.

Kids Grieve2: A New Resource  
for Supporting Grieving  
Children

Andrea Warnick, Susan Cadell,  
Camara Van Breemen,  
Candace Ray

The death of a significant person represents one of the most powerful disruptions in all aspects of a child’s emotional existence. Yet there is little guidance available to most adults who are supporting children through the dying and death of a family member or friend. Adults often struggle to determine how involved the child should be with the person who is dying, what language to use, and how much information to share. It is not uncommon for a dying adult to choose against a home death in an effort to “protect the children.”

While many families welcome guidance in this area from their healthcare providers, few HCPs receive formal training on the topic despite the substantial body of literature available. This results in reluctance across the disciplines to offer families advice on how to support children dealing with dying and death.

In this workshop we will introduce “Kids Grieve2”, a new online resource designed to equip professionals, parents and other caregivers with evidence-based grief support strategies for children 2 – 12. This interactive workshop will give participants the opportunity to explore their own concerns and barriers in terms of supporting grieving children, and to experience the resource. Developed by Canadian Virtual Hospice and a team of children’s

grief experts from across Canada, Kids Grieve2 will go a long way towards bridging the wide gap that currently exists between the literature and practice when it comes to supporting children who are experiencing the dying or death of someone close to them.

The role of palliative care nursing when preparing for home death

Maxine Lybert

The burden of anticipating one's own death can be a heavy load to bear. Multiple losses of control in day to day living are a challenge to face. How can we be attentive to the individual needs of client and family at such a traumatic time? Can we smooth the transition from life to death? The primary mandate of our community health team is to provide optimal cancer care and palliative care at home. Ideally our nurses meet client and family just after diagnosis of a life threatening illness, at a time when loss and grief is prevalent. Fear and anxiety about their future and how the illness will progress can be overwhelming for all concerned.

At this time, our initial objective is to establish trust ensuring open communication with client and their family. Assessing the needs of the dying individual to determine how we can help is essential. Encouraging the client to consider ways of accompaniment through their daily living is key to meeting them where they are in their journey. The workshop will highlight the importance of involving client and family every step of the way to help smooth transition from life to death. The presenter will share examples of empowerment through education, preparation, and a calm presence at any time of day or night.

Improving Access to a Palliative Approach to Care in the Community: Learnings from the Early Identification

Dr. Samantha Winemaker,  
Susan King, Mila Ray-Daniels

Planning quality palliative care service delivery models in community settings is challenging. This workshop will offer participants the opportunity to learn from a region who has tested a model to improve access and optimize service delivery for all patients and families who could benefit from a palliative

## Project

approach to care. The Hamilton Niagara Haldimand Brant (HNHB) Regional Palliative Care Network implemented a project to develop a reliable process of early identification of patients with palliative care needs and to develop a coordinated process for assembling the interdisciplinary team of generalists supported by specialists.

Project focused on:

- engaging family physician practices in early identification, assessment and care planning for patients who could benefit from a palliative approach. This included skills building regarding the use of an early identification prognostic indicator guide and provision of a palliative care approach.
- co-designing a new relationship for community care coordinators with family physician practices that supports the provision of an early palliative approach based on patient and family needs
- shifting the role of specialist palliative care providers from being the principal providers of palliative care to earlier engagement with family physician practices and offering consultation, collaborative practice and mentorship.

Learning Objectives:

How to implement earlier identification of patients and engage primary care practices in provision of a palliative approach

Advancing quality palliative care through iEPEC-O: Bringing Larry Librach's Vision to Fruition

Mary Jane Esplen, Paul Daeninck, Judy Simpson, Susan Blacker

How to build an effective and sustainable collaborative model of community-based palliative care

Offer participants an opportunity to reframe perceived barriers in system change as opportunities for improvement for palliative care.

Demand for high quality palliative care is increasing in community and institutional settings. To meet the demand, healthcare providers require educational support to recognize when palliative care services are appropriate, and have the confidence in delivering high quality palliative care to Canadians.

The Education in Palliative and End of Life Care (EPEC) curriculum is internationally recognized and originally developed by a team at Northwestern University in partnership with the National Cancer Institute in USA. It was updated and adapted for the Canadian landscape, to "EPEC-O Canada", by an interprofessional Canadian team. To increase accessibility and uptake across Canada, this workshop-based curriculum was enhanced to support interprofessional team-based care and transitioned to an online learning platform.

Interprofessional EPEC-Oncology or iEPEC-O, is an online self-directed course. It augments the learning experience by including the core competencies in palliative symptom management, as well as emphasizing comprehensive team-based care, and integration of a culturally sensitive person-centred

approach. In the workshop, presenters will demonstrate online modules highlighting comprehensive symptom assessment and management. Interactive activities will emphasize the culturally sensitive approach to communication and working with patients and families. Case illustrations will spotlight psychosocial aspects of end of life care. Quantitative and qualitative data will be presented from experiences among early adopters of the program, including physicians, nurses and social workers.

Participants will gain knowledge on the online learning process, appreciate learner-controlled experience and pace, as well as obtain clinical tools and decision supports that can be immediately applied to day-to-day practice.

Partnering to Transform  
Hospice Palliative Care in  
Ontario

Michael Sherar, Melody Boyd,  
Gregg Brown

This panel discussion will highlight how the establishment of the OPCN, a partnership of community stakeholders, health service providers and health-system planners, is building a coordinated, standardized approach for delivering hospice palliative care services in the province. With strong sustainable partnerships, knowledge and the release of various palliative care related reports, there is now greater understanding of the hospice palliative care landscape, where gaps exist and what patients and families desire.

The panelists will highlight OPCN's work to date both provincially and through the 14 Regional Palliative Care Networks. The panelists will share current pockets of excellence in the field, new approaches and partnerships being implemented to achieve greater integration and better health outcomes for patients and families. This interactive session will also seek to solicit your feedback and advice to inform OPCN's future work.

Thrive Anyway: fostering  
personal and family resilience  
in the midst of life threatening  
illness

Eileen Dahl

Be part of the conversation to change hospice palliative care in Ontario!

When a healthcare professional with experience in palliative and end of life care is the patient, knowledge and experience is both a blessing and a curse.

This workshop utilizes the consolidated learnings of the presenter as a family member / bereaved individual, a spiritual care practitioner, and as an individual navigating cancer. As she struggled to cope with a metastatic diagnosis, she found hope and direction in resilience theory. A parent of a young child, she turned to Michael Ungar's "Nine Things All Children Need to be Resilient" as a roadmap for intentionality and possibility. The uncertainty of illness, an expectation of lifelong treatment and a shortened lifespan, heightened the need to raise a resilient child. Over time, she adapted "Nine Things..." and embraced a resilience approach for herself and the whole family. Since doing so, she has experienced improved health, quality of life, and the ability to thrive in the midst of uncertainty.

This workshop will examine resilience theories and explore practical and concrete applications and discussion opportunities for individual clients or clients with families, with the hope that resilience perspectives will be introduced early in the therapeutic relationship to improve quality of life and coping from illness through bereavement.

Participants will engage with the concepts through personal narrative, reflection and small group sharing and will be encouraged to reflect on their

Implementation of a Provincial Palliative Care Strategy: Three Years of Change in Nova Scotia Cheryl Tschupruk

own clinical cases through the lens of resilience.

In 2014, Nova Scotia released its provincial palliative care strategy, a framework to guide palliative care planning in the province. The strategy outlined four pillars: Integrated Service Delivery, Accountability, Family and Caregivers and Capacity Building and Practice Change. Each pillar included key recommendations- 37 in total. This workshop will take participants along one province's implementation journey, describing the process of putting a policy framework into practice. Key activities will be described, including: working groups that were formed, how work plans were developed and monitored, how hospice planning was addressed, how a provincial accountability structure was created, quality indicators that were developed, coordinated capacity building, and palliative care projects and partnerships. The workshop will frame implementation in the context of familiar quality improvement and change management concepts, while also highlighting the reality of implementing a provincial strategy in the midst of health system restructuring. In 2015, Nova Scotia transitioned from 9 District Health Authorities to two, the Nova Scotia Health Authority and the IWK, which led to prioritized health services planning in seven key areas (palliative care was not one of them). The coordinator responsible for the strategy's implementation will reflect on the first three years of implementation and the balance between developing an action plan and being able to confidently and comfortably adjust the plan in order to leverage key opportunities along the way.

Let's Live a Little: Developing a Compassionate Community with Young Adults Karen Cook

Young adults with life limiting conditions face extraordinary challenges to live ordinary lives. Like all young adults, they have dreams of going to college, being employed, living independently, having meaningful opportunities, and living independently. However, the uncertainty of their disease trajectory, and living with progressive and painful conditions, may interrupt or stop their dreams. Compassionate communities for young adults are about living life full

speed ahead, creating social connection, reducing the barriers and challenges to achieve their goals, AND supporting declining health and end of life. Compassionate communities for young adults will forge partnerships with colleges and universities, sports, arts and spiritual communities, social media, housing and funding initiatives, disability employment advocacy programs, community service groups, and the health sector to ameliorate barriers, and support their journey. This approach will empower young adults and their families, match their unpredictable disease trajectories, support community development, and promote cross-sectoral collaborations.

With limited resources and programs supporting young adults with life limiting conditions, and research demonstrating the key priorities for these young adults, Let's Live a Little (L3), was launched. L3 is an organically developing group of young adults and their supporters working towards developing a compassionate community. In this workshop, we will describe our foundational research and our successes and challenges to: engage young adults, create and build a community without a "place", overcome the many barriers getting young adults with complex and progressive physical disabilities together, use language that is inviting, support parents and family, and implement innovative evaluation methods.

The Quebec Palliative Sedation    Rose Deangelis  
Guidelines

Imbedded in the development of Law 2 (Quebec's medical aid to die law) was also the provision for new standardization of clinical practice guidelines for palliative sedation. Physicians across the province were brought together to share their expertise and best practices in order to develop clear, research-based guidelines for the use of palliative sedation therapy in patients having a prognosis of less than 2 weeks. In this workshop, the participants will become familiar with the guidelines and have a chance to discuss its implications in their places of work. Indications for and medications commonly used in

palliative sedation therapy will be reviewed. The guideline also provides standardized assessment tools for nurses to use when a patient is receiving palliative sedation. The presenter will review all relevant information that now must be legally documented in the patient's medical record, which includes charting discussions that occurred within the team and with the patient/family. Participants will be invited to share their clinical experiences and the challenges that they have when providing sedation palliative therapy. Palliative sedation itself can sometimes be viewed as a controversial treatment. Methods to decrease the possibility of causing emotional distress amongst members of the interdisciplinary team will be examined. The challenges of offering palliative sedation, including suggestions as to what to discuss with the patient-family beforehand and after therapy begins, will be discussed.

Improving End-of-Life in First Nations Communities

Holly Prince, Maxine Crow, Lori Monture

Four First Nations communities in Ontario and Manitoba partnered with a research team based at Lakehead University (2010-2015) with the goal of improving the end-of-life home care in First Nations communities. The research was a comparative case study design, funded by the Canadian Institutes of Health Research, and focused on implementing and evaluating a community capacity development approach to developing local palliative care programs and teams. Outcomes demonstrated that First Nations communities can develop unique, culturally appropriate, community-based palliative care programs through creating new partnerships with regional health services, and coordinating existing community health and social support programs. Additional outcomes were a workbook of research informed strategies and tools for use by other communities, and new knowledge about the barriers and facilitators to the community capacity development process. A new model for The Process of Palliative Care Program Development in First Nations communities was validated.

This workshop will provide an overview of the research methodology, outcomes and lessons learned. First, it will present the five-phase community capacity development model that guided the research, adapted from the Kelley model for this research by the participants. This First Nations model includes local community development, regional partnerships, education and community empowerment. Presenters will then discuss the supports and barriers to program development through the five-phases from each community. Similarities and differences in progress, process and outcomes among the two communities will be compared. Lastly, presenters will present outcomes of the research, which are grounded in data collected over five years.

Medication deprescription and increasing comfort medication use in patients with advanced medical illness

Rachel Whitty, Sandra Porter,  
Kiran Battu, James Downar

Many people take medications to manage chronic illness or prevent complications. As patients develop serious and terminal illness, these medications are often continued even when they offer little or no benefit. In this workshop, we will review some of the important guidelines for medication deprescription in patients with advanced illness (e.g. Beers, STOPP, Choosing Wisely). In particular, we will use interactive case presentations to explore the deprescription of medications used for primary and secondary prevention (e.g. statins), modified targets for blood pressure and glycemic control, anticoagulants, vitamins/minerals and natural health products.

We will also present our own experience with a MEDication RAationalization (MERA) pilot project at our institution, including qualitative and quantitative findings that highlight barriers to deprescription. We will break into small groups to discuss how to overcome these barriers and discuss deprescription

A Gentle Touch: Integrating  
Therapeutic Touch® into  
Hospice Palliative Care

Nancy Hall

in different settings. We will conclude by presenting future approaches to automating the process of medication deprescription.

Therapeutic Touch® is a holistic, evidence-based therapy that incorporates the intentional and compassionate use of universal energy to promote balance and well-being.

Therapeutic Touch has been shown to be effective in populations often thought to be fragile, such as the elderly, people with cancer and dementia . Therapeutic Touch has been used extensively in the palliative care setting for decades. The philosophy and goals of Hospice Palliative Care and Therapeutic Touch are similar and complementary.

Therapeutic Touch can be offered to anyone who is open to improving their health and sense of well-being. It can be taught to anyone with compassion and an intention to help others.

Through experiential exercises, a demonstration of Therapeutic Touch and the use of case studies to highlight some of the many benefits; participants will see how Therapeutic Touch can be responsive to the unique needs of an individual with a life threatening illness as well as their families anytime from diagnosis, throughout treatment, remission, end of life or bereavement and anywhere, whether in the community, in hospital, LTC or hospice.

There will be reference to the significant benefits to ourselves as individuals

and to our organizations of integrating Therapeutic Touch into our expanding basket of services.

Creating a Palliative  
Community of Care in  
Supportive Living

Marion Baines Coomber

As elderly residents in supportive living facilities decline towards end-of-life status, statistics demonstrate that a majority of failing seniors are admitted to hospital to palliate, ultimately passing away removed from the compassionate care that would be provided by friends, familiar sights, sounds and care staff. As caregivers, can we not support our residents to die peacefully and comfortably in familiar surroundings, supported by an excellent, in-house, palliative medical and direct care team if care needs are not medically complex? This workshop introduces a Palliative Community of Care developed by the Brenda Strafford Foundation in the Calgary Region, Alberta. It includes effective clinical teaching tools to engage the medical team, build a collaborative team with stakeholders, support direct care staff and achieve excellence in compassionate and caring service delivery from all members of the team. Training also includes a resident and family-centered education tool and guidelines for policy and clinical practice decision-making. This workshop is appropriate for either rural or urban-based facilities.

Building Compassionate  
Communities: Rural/Urban  
perspective

Bonnie Tompkins, Pam  
Blackwood, Karen Candy, Dr.  
Denise Marshall

Across Canada, many in this field are increasing interest in the role the community can play to prepare for the imminent demands on palliative care/end of life. In this workshop, participants will be introduced to the Compassionate City Charter as a community based initiative that a hospice can play a key role in, why a Public Health approach is important and the rural and urban landscape differences. Participants will also assess who the key community stakeholders are including Board of Directors, Politicians, and community partners. Participants will learn about important success factors and lessons learned from two communities who have been working to build compassion around death, dying, loss and bereavement for over two year.

MyGrief.ca: Reflections from  
key stakeholders on a new  
web-based tool for  
bereavement

Shelly Cory, Sylvie Lalande

Research confirms that a significant number of family members suffer not only in anticipation of a death but also into bereavement. The accompanying physical, social, and emotional distress is often referred to as grief. Grievers frequently encounter major obstacles when seeking formal support, including lack of access to specialized grief support due to temporal, financial or geographic constraints.

To address these gaps in service, the Canadian Virtual Hospice, in collaboration with

pan-Canadian partners developed MyGrief.ca, the world's first evidence-based, online psycho-educational tool to support those who do not or cannot access existing in-person loss and grief supports and as a supplementary resource for those who do. The tool also serves as a rich educative tool for health providers. The content was developed with families and international leaders in the field of bereavement, with attentiveness to issues of cultural diversity. Funding was provided by the Canadian Partnership Against Cancer.

MyGrief.ca includes nine self-directed modules that cover a diversity of topics across the bereavement trajectory. Embedded within each module is a great variety of video testimonials detailing grief narratives that represent diverse age, cultural, gender, and sexual orientation groups.

Attendees will be given an in-depth tour of MyGrief.ca, followed by an interactive conversation on the tool with a bereft family member, health

provider, and educator on their unique perspectives and the overall impact of using MyGrief.ca.

Exploring the Cultural,  
Spiritual and Religious  
Perspectives of Palliative Care

Hodan Nalayeh, Shelly Cory

To address a gap in cultural-specific information Canadian Virtual Hospice launched LivingMyCulture.ca – an evidence-informed collection of videos of immigrants, refugees, and Indigenous people sharing their stories about the intersection of culture, spirituality, and religion with their experiences of advanced illness, palliative care, and grief. The video repository includes over 650 video clips, available in 11 different languages. These narratives empower and support patients and their families with a tool that assists them in accessing, advocating, and receiving culturally safe and inclusive care as they navigate the Canadian healthcare system. LivingMyCulture.ca also serves as a rich educational tool for health providers wishing to enhance their knowledge and skills in providing culturally safe and inclusive care in order to improve care outcomes. LivingMyCulture.ca was developed in collaboration with a national team of researchers, educators, health providers, patients and families.

This presentation will introduce LivingMyCulture.ca, provide strategies for incorporating the tool into practice to support patient and family care and share summative evaluation results. A Somali-Canadian journalist and community leader will share her unique Muslim and Somali perspective about the way illness, dying and grief is approached and the impact of LivingMyCulture.ca in the community. She will engage participants in a discussion to contribute to a better understanding of culturally safe and inclusive end-of-life care. Overviews of other culture groups' video resources will also be shared, reflecting Canada's rich cultural tapestry.

Integrated Comprehensive

Cheryl Moore, Bernedette

The Integrated Comprehensive Care (ICC) program is an innovative patient

Care

Mcneil

centered model of care that directly integrates hospital and community care services for patients.

The program is developed to make points of transition in care seamless and less confusing for patients and their families. This model, designed by the St. Joseph's Health System, enables health care providers to communicate with each other more effectively resulting in better outcomes for patients.

The Stedman Community Hospice is a proud partner of the St. Joseph's Health System. At the core of our philosophy of care, Stedman Community Hospice recognizes that end of life is a normal process of living and our goal is to ensure that the final stages of one's life is a positive experience for the patients and their families.

Unique to our hospice are programs that not only serve and support our patients and their families while at the 10-bed residential hospice, but also those patients who wish to remain in their homes. This care extends from the time of a diagnosis of a life-limiting illness until the patient's death and continues into bereavement care for the family

Life Through My Eyes –The  
Implementation of a Patient  
Engagement Tool

Kathy Mazza

Patient- and family-centered care (PFCC) in healthcare is described as provision of care that is consistent with the beliefs, desires and needs of patients. This is achieved when health care providers collaborate with patients and family members. PFCC has many benefits and has been part of a movement to achieve better health-outcomes, increase patient satisfaction, and create partnerships among healthcare professionals, patients, and their

families. Studies increasingly show that when health care organizations, patients, and families work in partnership, the quality and safety of health care increase, costs decrease, and most importantly provider and patient satisfaction results improve.

CBI Health Group takes pride in its Registered Nurses Association of Ontario (RNAO) Best Practice Spotlight Organization (BPSO) designation and as a BPSO, CBI recognizes the importance of the PFCC best practice guideline. As part of the guideline implementation and tool development an interdisciplinary committee was formed that included our patient advisors. Our patient-advisors play a key role in the success of this committee and CBI's ongoing efforts to foster a collaborative approach to patient care.

We share our journey with you through the development, implementation, and evaluation of a nation wide, interdisciplinary patient engagement tool. The Life Through my Eyes (LTME) tool was developed to assist the health care provider to get to know the person; who they are and what is important to them.

Canadian home healthcare organizations are increasingly focusing on improving client experience, patient- and family- centered care (PFCC), and patient engagement. CBI's LTME document supports the work being done to engage clients – and their families – in designing, delivering and evaluating quality improvement in our service delivery.

Providing the right care, in the Maria Judd, Anya Humphrey, DESCRIPTION:

right place, at the right time –a Dr. Jose Pereira  
pan-Canadians call for  
palliative care innovations

- Learn about the top innovations in palliative and end-of-life care identified through CFHI's 2017 Open Call for Innovations <http://www.cfhi-fcass.ca/WhatWeDo/palliative-care>
- Explore and share how these innovations resonate with you and/or your organization.
- Learn more about how CFHI is working shoulder to shoulder with leaders to help transform palliative care in Canada and upcoming opportunities to help make change happen in palliative care.

## ***20 Minutes Oral Presentations***

### **Title**

### **Presenter(s)**

### **Description**

Who are the Rural Nurses  
Providing Hospice, Palliative  
and/or End of Life Care in  
Canada? Results from a  
National Survey

Kelly Penz

The availability and sustainability of palliative health care professionals is considered a global concern, especially within rural and remote practice settings. Nurses across all domains of practice are expected to advocate for high-quality palliative and end of life care that is made accessible to all Canadians. However, within many rural and remote geographical areas, formal palliative care services are non-existent, leaving generalist nurses with no specialty training in palliative and hospice nursing to take on this complex responsibility. Examining results from a CIHR funded National survey of rural and remote nurses (N=3822) in Canada, the presentation explores a subset (n=295) of nurses (Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, and Registered Psychiatric Nurses) who provide hospice, palliative and/or end of life care as part of their practice. Areas that will be examined include their roles, responsibilities, and characteristics, as well as, the geographical settings and domains of practice that they work within. In addition, key factors linked to their occupational health and well-being (e.g.,

work engagement, community cohesion), and areas of concern (e.g., perceived stress, burnout) will be explored that may have an influence on the sustainability of these nurses in rural and remote palliative nursing practice. This is the first national profile of rural and remote nurses who provide hospice and palliative care. The results of this analysis will inform practice and policy development for effective health human resource planning in hospice, palliative and/or end of life care across rural and remote parts of the country.

Medical Cannabis in Palliative and Hospice Care Philippe Lucas

Canada was one of the first nations in the world to establish a federal medical cannabis program, but the medical use of cannabis in palliative care is still subject to stigma and misunderstanding.

This presentation will provide a brief history of medical cannabis in Canada, followed by an overview of cannabis-related research relevant to palliative and hospice care. This will include a review of cannabis as a treatment for chronic pain, with a focus on cannabis as a potential alternative or adjunct to prescription opioids, and its positive impact on quality of life.

The Impact of the Palliative and End-of-Life Care Alberta Provincial Framework 2014 Michelle Peterson Fraser

In 2014 a Palliative and End-of-Life Care (PEOLC) Alberta Provincial Framework document was developed and endorsed by PEOLC experts and multiple stakeholders. The framework recommended 36 initiatives to be developed over several years to address the PEOLC program and service gaps in Alberta.

Some of these provincial initiatives include:

- EMS PEOLC Assess, Treat and Refer, the PEOLC website, and

bereavement and grief recommendations help to address gaps in service to rural and rural remote geographies in Alberta.

- Volunteer Resource and Facilitator manuals to improve current programs and help communities with volunteer issues. The manuals can be used to start a volunteer program and to help develop practical skills and skills building for volunteers.
- 24/7 On-Call Palliative Physician coverage implemented to support primary care physicians with adult and pediatric PEOLC issues.
- A Resource Guide for Community Based PEOLC to help build capacity and to support compassionate care in communities.

In 2014/15 Alberta Health Services implemented a province wide policy and procedure for Advance Care Planning and Goals of Care Designation (ACP/GCD). A website was developed for patients, families and health care providers to access information, education and resources about ACP/GCD. A one year review and evaluation was completed and a revised policy and procedure has been approved and implemented.

This presentation will highlight the framework, initiatives completed and in progress, and the impact on Albertans living with a life limiting illness. Participants will learn what provincial PEOLC initiatives were implemented in Alberta and how they have contributed to patient centred care.

Facts, Feelings and  
Fears: Supporting Families  
through Dementia's End-of-  
Life

Mary Schulz

As of 2016, 564,000 Canadians are living with Alzheimer's disease and other dementias (Alzheimer Society of Canada, 2016). Many diseases can cause dementia, the most common being Alzheimer's disease. Alzheimer's disease (AD) is a fatal disease that eventually affects all aspects of a person's life: how they think, feel, and act. People with dementia can therefore benefit from a palliative approach, long before death is near. However, palliative care has

typically not been available to people whose prognosis is uncertain and where the dying process is protracted (Small, 2007). Many misconceptions persist regarding palliative care and active versus comfort care among lay people as well as health care providers.

While it is human nature to avoid talking about sad and difficult topics such as end-of-life, people impacted by dementia are hungry for practical, reliable information about what to expect at this stage.

The topic of end-of-life is on people's minds. Three-quarters of Canadians (74%) report having thought about end-of-life. (Canadian Hospice Palliative Care Association, 2013)

Health care providers have an important role to play in preparing people with dementia and families for end-of-life. Resources are available to assist health care professionals in supporting a person centred approach to palliative end-of-life dementia care as well as strategies that can lead to a more comfortable end-of-life experience for the person with dementia.

Remote Rural Communities  
Have a Big Heart for Hospice  
Palliative Care

Karen Wagner, Lisa Hubers

The demands of rural living two or more hours from a tertiary care center presented unique challenges for developing quality accessible hospice (HPC) care in the isolated communities of the Madawaska Valley, Ontario, that was financially sustainable in this economically depressed area.

The heart of HPC service is a team of 85 volunteers who visit patients and

families in their homes, the local hospital, long term care facility, retirement residence, and community living group homes or hospice. An individual care plan is developed for each patient and family based on physical, emotional, spiritual, and practical needs. Volunteers then offer their time, assistance, and a variety of skills ranging from a friendly visit to sitting at the bedside to taking a family member fishing.

Hospice is a two bedroom apartment within the local hospital which provides a home like setting for families. It is a separate entity from the hospital, but hospice shares operational services such as housekeeping, maintenance, snow clearing, information technology, but not nursing care. The family is responsible for the care of their loved ones just as they would be at home. Local community agencies provide nursing and supportive care as they would to any palliative patient wishing to remain at home. Volunteers are present at hospice to enhance the services provided, but not to replace health care practitioners.

This workshop will address the practical operating issues of this unique service, the training and ongoing support for the volunteer team, community integration with a focus on education and teaching about end-of-life issues and advanced care planning, to not only the public, but also members of the health care team, and the comprehensive bereavement follow-up for family for one year.

We developed this model of care and are now mentoring other communities. We are also being served by the first community healthcare foundation that

fundraises for the hospital, the long term care home and the hospice and we all work together to put patients first.

We invite you to join us as we share our exciting 6 year journey of developing and delivering cost-effective (annual operating of 130K), personalized, and comprehensive hospice /palliative care in an isolated rural community.

An exploration of regional variations across a set of potential quality indicators for seriously-ill home care clients in Ontario

Dawn Guthrie

This study examined a subset of potential quality indicators for seriously-ill (SI) home care clients stratified by region.

Secondary analysis of Resident Assessment Instrument for Home Care data for Ontario completed between 2009 and 2013 was used to examine the rates of 13 quality indicators (QIs) thought to be relevant to the needs of older (65+) SI clients. The rates of these QIs were generated for each of Ontario's 14 Local Health Integration Networks (LHINs) to compare these regions. Serious-illness was defined as a prognosis of less than six months to live or the presence of severe health instability.

Within the sample (n=13,862), 62.4% were female, and 49.4% were aged 85+. The QIs with the highest overall rates were shortness of breath (70.2%), daily pain (49.4%), fall frequency (49.3%), caregiver distress (41.7%), and hospital admission (40.6%). The QIs with the largest range (i.e., difference between lowest and highest rates) across LHINs were shortness of breath (range= 24.9%), fall frequency (17.5%), caregiver distress (16.7%), social isolation (15.3%), and negative mood (15.3%).

Lorsque le temps est compté : Isabelle Van Pevenage,  
temporalités et identités chez Laurence Hamel-Roy  
les conjoints âgés en soins  
palliatifs à domicile

Hospice palliative care services in Ontario are undergoing a process of restructuring and this research can assist in understanding where potential quality issues may exist, which can ideally contribute to quality improvement initiatives within this sector.

Le rapport au temps des conjoint(e)s de personnes âgées en fin de vie à domicile est encore peu documenté. Or, nous savons que cette période peut être particulièrement éprouvante pour ces proches, l'annonce d'un pronostic réservé, et donc d'une fin de vie à venir constituant un tournant, tant pour la personne malade que pour son ou sa conjoint(e). Le temps (qu'il reste à vivre) et le lieu (« chez soi ») sont investis de nouvelles significations alors même que de nombreuses transitions et ruptures viennent rythmer le quotidien.

Pour mieux comprendre ces transitions et ruptures, nous avons organisé six focus group avec différents types d'intervenants qui œuvrent auprès de personnes âgées en soins palliatifs à domicile. Nous avons interrogés ces intervenants sur les éventuelles transitions et ruptures identitaires vécues, selon eux, par les conjoints de personnes âgées en soins palliatifs à domicile, leurs significations et leur importance.

Le temps passé, le temps présent ainsi que le futur sont évoqués par les intervenants. Le passé, à travers l'histoire personnelle et conjugale semble au cœur de la relation d'aide. Le temps présent doit être constamment reconsidéré, au gré des transitions du soin et de la maladie. Enfin, le futur, limité par la mort à venir du conjoint est difficile à appréhender, et ceci tant

No need for snow  
tires! Adaptation of palliative  
care education for rural  
settings

Kathleen Yue

pour les proches que pour les intervenants.

In rural BC, health care providers support people with life-limiting illness in a variety of settings across great geographical distance. For Northern and Interior Health Regional Health Authorities (RHAs), the challenges of weather, isolation and workload have for many years limited accessibility to continuing education in palliative care. Then in 2016, these challenges were transformed into an opportunity for collaborative innovation.

Seeing the need for both a basic and an intermediate level of education, these two RHAs began to seek ways to support their clinicians with the fundamentals course developed by Pallium Canada, “Learning Essential Approaches for Palliative Care (LEAP)” and Victoria Hospice’s intermediate level “Palliative Care: Medical Intensive”.

First, they partnered with Victoria Hospice to modify delivery of the 5-day course, which usually requires air travel outside of the RHAs. Education was provided within the regions in segments, some via webinar and co-facilitated by local RHA educators, all of which contributed to clinician engagement.

Next, the RHAs sought to increase capacity within their existing practice support teams for facilitating basic palliative care education. BC LEAP facilitators have historically been trained in the lower mainland or on Vancouver Island and are required to be certified by a Pallium lead facilitator. The BC Center for Palliative Care worked with Pallium Canada to adapt this model, enabling local coaches to certify and support new facilitators in a

“train the trainer” format. As a result, there are now local coaches and LEAP facilitators in each BC Health Authority to deliver the LEAP course.

Due to Victoria Hospice’s and Pallium Canada’s flexibility, the RHAs “yes we can” approach, and BC Center for Palliative Care’s (BC-CPC) catalyzing, over a hundred clinicians participated in education that was previously inaccessible. Moving forward, the partners will be conducting evaluation, planning for sustainability and spread, and creating a community of practice for facilitators and coaches.

Assessing the Content Validity of a Proposed Conceptual Model of a Palliative Approach Joshua Shadd, Molly Touzel

Background:

A palliative approach to care should be available for all patients facing serious illness, from all care providers, in any setting, at any point in their illness trajectory. Achieving this will require a description of the palliative care approach that is measurable, applicable across care settings, and explicitly linked to core concepts of palliative care. Existing characterizations tend to be primarily philosophical or purely behavioural.

To address this gap, the authors propose a conceptual model describing three core domains of a palliative approach: whole person care, mortality acknowledgement, and quality of life focus. This presentation describes the literature review undertaken to test the content validity of this proposed conceptual model.

#### Method:

A search of the academic and grey literature identified definitions of “palliative care” or “palliative approach”. Two authors independently conducted a directed content analysis to assess congruence with the proposed conceptual model.

#### Results:

Nineteen definitions were identified. The three domains were represented in the vast majority of definitions: whole person care (17/19), mortality acknowledgement (15/19) and quality of life focus (17/19). Published definitions also included other concepts, but only one of these (family as part of the unit of care) appeared in more than a few definitions.

#### Discussion:

The content validity of the proposed conceptual model is supported by the high degree of consensus among published definitions regarding the core domains. A conceptual model able to link definitions to behaviours can help achieve the goal of universal access to a palliative approach.

Developing a Palliative  
Approach to Care for Young  
Adults

wired for living and aspire to developmental goals of attending post-secondary education, having a meaningful vocation and work, and living independently. However, their developmental goals may collide with their changing health or end of life, and adult services do not wrap around their developmental, social, education and financial needs.

YAs with life-limiting conditions will benefit from a palliative approach to care, that matches their chronic disease trajectories of a series of declining plateaus over a period of months to years, punctuated by unpredictable periodic crises. A palliative approach to care for YAs will develop collaborative partnerships across community and professional agencies to ensure that timely and seamless resources are available. These resources will support their quest to maximize their quality of life and opportunities in an abbreviated time frame. Currently, there are few health and social service programs that recognize their unique needs.

We will describe the successes, challenges and results of our research, Bridging the Gap: Developing a Palliative Approach to Care for Young Adults. We used a three phase online patient engagement strategy to hear the voice of young adults with life limiting conditions, their families, and health and community professionals. This research culminated in a prioritized plan to enhance well-being, improve access to services and funding, build relationships and develop a supportive community. Opportunities and barriers to research engagement with these YAs, their parents and adult and pediatric providers will also be presented.

Communication issues and  
suffering of older men with

Valerie Bourgeois-Guerin,

As the risk of developing cancer increases with old age, numerous older men live with an incurable cancer (and Gammack Cepeda, 2006; Garrison and al.,

incurable cancer

Antonin Marquis

2011). Yet, little research is conducted on the experience of these men for whom the psychological suffering resulting from the disease often overlaps with the experience of aging. Therefore, what do we know about the psychological suffering of older men with incurable cancer?

We base our answer to this question on the results from a qualitative research in which 5 focus groups were held with 27 health care providers working with men with incurable cancer aged 65 and over. The participants were asked about the psychological sufferings of these men and how they alleviate them. Using NVivo Software, a thematic analysis was used to analyse the data (Paillé and Mucchielli, 2012; 2016).

The results reveal three major issues of communication that are linked to the suffering of older men with incurable cancer: 1) the complex dynamics of silence and verbal expression; 2) the manifold manifestations and functions of denial and its impact on communication; 3) the variety of points of views emerging from the good death paradigm, the values shared by the health care providers, and the experience of the elderly men with incurable cancer. These innovative results serve to better understand how suffering as experienced by older men with incurable cancer relates to various communication issues. They can also inform the development of courses of actions to relieve this population.

L3: Let's Live a Little!  
Compassionate Community  
Development with Young  
Adults

Karen Cook

Young adults with life limiting conditions face extraordinary challenges to live ordinary lives. Like all young adults, they have dreams of going to college, being employed, living independently, having meaningful opportunities, and living independently. However, the uncertainty of their disease trajectory, and living with progressive and painful conditions, may interrupt or stop their

dreams. Compassionate Communities for young adults are about LIVING life full speed ahead, creating social connection, and reducing the barriers and challenges to achieve their goals. Compassionate communities for young adults will forge partnerships with colleges and universities, sports, arts and spiritual communities, social media, housing and funding initiatives, disability employment advocacy programs, community service groups, and the health sector to ameliorate barriers, and support their journey. This approach will empower young adults and their families, match their unpredictable disease trajectories, support community development, and promote cross-sectoral collaborations.

With limited resources and programs supporting young adults with life limiting conditions, and research demonstrating the key priorities for these young adults, L3: Let's Live a Little, was born. L3 is an organically developing group of young adults and their supporters working towards developing a compassionate community. In this workshop, we will describe our successes and challenges to: engage young adults, create and build a community without a "place", overcome the many barriers to getting young adults with complex and progressive physical disabilities together, use language that is inviting and representative, support parents and family, intelligently use social media, and evaluate our progress.

Student comfort and satisfaction following participation in an adapted version of the Social Work Competencies on Palliative Education (SCOPE) Training

Zelda Freitas

Purpose: This presentation reports on the development, implementation, and evaluation of the student adapted Social Work Competencies on Palliative Education (SCOPE) program offered to 25 McGill social work students to improve their comfort participating in the delivery of palliative and end of life care to older adults.

## Modules

Background: Social workers are increasingly called on to offer psychosocial support to older adults facing end of life and their families. Yet most graduating social workers have received little training in the provision of end of life care and consequently express discomfort working with clients facing issues related to death and dying.

In response to this training gap the Canadian Hospice and Palliative Care Association (CHPCA) partnered with social work educators and practitioners on the Social Work Competencies on Palliative Education (SCOPE) project which included the development of five teaching modules that can be used to enhance education and training for social workers caring for individuals at end of life. Our team recently adapted the modules for training undergraduate and graduate social work students.

Methods: Following curriculum adaptation this 2 day intensive workshop was delivered to social work students. All students were asked to complete pre-post measures reporting on their comfort and knowledge about end of life care. Students were also asked to provide direct feedback on program modules.

Results: Student interest in the training affirmed an overwhelming need for training in end of life issues amongst social work students. Changes in comfort, knowledge and overall feedback will be reported.

Staff Involvement in End-of-life Decision Making for

Nisha Sutherland

Decision making can have a significant impact on the quality of life for persons with advanced dementia in long-term care (LTC). Decisions for late-stage

Persons with Advanced  
Dementia in Long-term care:  
Barriers and Facilitators.

complications can lead to aggressive treatment and unnecessary suffering, potentially denying people with dementia palliative care, an approach focused on comfort rather than cure. Decision making has been focused largely on the risks and benefits of treatment; however, evidence suggests that personal knowledge of the person with dementia can prevent transfers from LTC to hospitals that may compound delirium, cause discomfort and result in death at hospital. Staff members spend the most time in direct care with residents and family members; yet, staff knowledge of the preferences and values of the person with dementia often is undervalued in the hierarchal culture of LTC. The purpose of this study was to examine the barriers and facilitators to staff involvement in end-of-life decision making for people living with advanced dementia.

An interpretive descriptive methodology was used to gain understanding of subjective experiences and shared realities of disciplinary practices related to decision making. Semi-structured interviews were conducted with personal support workers (n=9), registered practical nurses (n=8) and registered nurses (n=4) from two long-term care facilities. Using thematic analysis, findings suggest LTC protocols promote a dichotomy between curative and palliative care, shaping staff involvement in decision making. Alongside biomedical knowledge, staff personal knowledge of the person with dementia must be acknowledged to enhance palliative dementia care in LTC.

Exploring Resident Physicians'     Andrea Johnson  
Experiences Practicing in  
Pediatric Palliative Care: A  
Phenomenological Method of  
Inquiry

This oral presentation will present findings of a recent research study involving medical residents. This study explores the diverse experiences of pediatric medical residents completing a training rotation in a pediatric palliative care setting. This oral presentation will describe the background of this study (this included a pilot study that generated findings un-seen in the literature: included themes of: unrecognized grief, mutual and overlapping

professional and personal responses to patients' deaths, the perception of re-humanizing of the child patient, and validation of self as a 'whole' physicians) its qualitative research methodology, findings, and implications for practice. A clear rationale for this study will also be discussed and supported by what is currently known about the experiences of medical residents training in pediatric palliative care and why the findings of this study are significant.

Substance Use and Addictive Disorders in the Palliative Care Patient  
Maureen Allen

Addiction is a chronic, relapsing illnesses that has a high morbidity and mortality if left untreated. It is a complex chronic illness that is subject to prejudice, misinterpretation and cultural biases. A patient with an addiction history will always be at higher risk of relapse when opioids are used to treat pain. Effective management requires a broad, multi-disciplined approach rooted in an ideology that focuses on reducing harms associated with their substance use while supporting individuals back to a life of purpose and connection. Our failure to recognize and stabilize addiction in the patient living with a life threatening condition such as cancer often leads to further pain, suffering and disconnection and prevents them from working on the more complex emotional and psychosocial challenges that are before them as they come to terms with their impending death.

Using case-based illustrations this presentation will discuss the challenges of recognizing substance use and addictive disorders in the palliative care patient and explore that myths and barriers to effective pain management. It will also discuss how to engage patients in meaningful conversation using "addiction talking points".

A reflection and a critique on the concept of anticipatory grief  
Emilie Allard

The goal of palliative care is to offer active and holistic care, as well as psychological and spiritual support, to terminally ill persons and their families. Palliative care's mission is, amongst others, to support the family during the

entire period surrounding the death itself. This includes both the course of the illness leading up to, as well as the grieving period that follows, the death of the loved one. The scientific and clinical community typically refers to anticipated grief when discussing an individual's experience before the death of a loved one. Even if this concept seems to be generally accepted, it appears that there isn't a unique definition and conceptualisation. The goal of this presentation is to present the results of a critical literature review on the concept of anticipatory grief and the reflections that emerge from these results. The review was done using four databases, CINAHL, Medline, PsycINFO and Cairn, with the key words: "anticipated grief", "pre-death grief" and "preparatory grief". The results present the key authors of the concept of anticipatory grief and how their different philosophical and theoretical perspectives are related to the development of the concept. We advocate that the concept of anticipatory grief, as it exists today, is linked to a linear view of grief and a non-holistic way to see a unique individual experience. This presentation will help raise questions and reflections about how, as health professionals, we treat the period before the death of a loved one in palliative care.

Being Instead of Doing-have  
we medicalized the End of Life  
too much? Brian Berger, Anne-Marie  
Dean

With the multitude of medicines and medical interventions available ,the speakers ponder whether the value of compassionate care at the bedside at the end of life has been forgotten. They through story telling examples remind us of the therapeutic benefit of bedside care and what a real difference that makes. Incorporating listening and being present to general medical care ,they discuss how beneficial it can be for the patient and caregivers alike. The audience is invited to share their stories as to what has impacted them.

Medical Cannabis in Hospice  
and Palliative Care; Patient-  
Centered Research &; Philippe Lucas

Tilray is a federally authorized Licenced Producer within the Access to Cannabis for Medical Purposes Regulations (ACMPR), and an international leader in medical cannabis research. In order to learn more about patient

## Practices

experiences with medical cannabis and the ACMPR, Tilray has conducted a number of clinical and observational studies examining the impact of medical cannabis on various conditions and symptoms, patient patterns of use, and the substitution of cannabis for prescription opioids and other substances.

Philippe Lucas has over 20 years of experience as a medical cannabis provider, researcher and patient advocate. This presentation will share his experiences with the palliative use of medical cannabis, and present the results of a number of Tilray studies, including research indicating that medical cannabis is primarily used to treat chronic pain and mental health issues such as stress, anxiety and depression, and that patients report a high self-reported use of cannabis as a substitute for prescription drugs, particularly pharmaceutical opioids and benzodiazapines.

These studies suggest that cannabis is a safe and effective adjunct or substitute treatment to prescription opioids and other drugs commonly used in palliative and hospice care, and that it can lead to significant improvements in the quality of life of patients.

Shift your thinking: Knowledge translation for a palliative approach in nursing practice Carolyn Tayler, Kelli Stajduhar

Are you concerned about getting research evidence into practice? The Initiative for a Palliative Approach in Nursing: Evidence and Leadership (iPANEL) is a province-wide nursing research-practice partnership in British Columbia that has been collaborating on research and knowledge translation since 2011. All of our projects are based on the core value that incorporating practice wisdom throughout the research process is the best way to ensure that results are meaningful and useful to practitioners, whether they are front-line providers, leaders or administrators. In this presentation, we will walk you through how we transformed our extensive research findings into

user-friendly formats to facilitate understanding and uptake. Practitioner team members were central to the development of our KT products, bringing their expertise about the best tools and language to use when trying to initiate change in health care delivery. We began with the development of guiding principles and processes, including clearly stating team member roles, core evidence, key messages, target audiences, specific KT products, timeframe and distribution plan. KT products, such as infographics and an animated video, were developed through a series of drafting and refinement stages, in collaboration with a professional designer. Distribution of final products occurred via multiple methods, including social media (websites, Twitter, Facebook, YouTube), professional networks, and targeted emails.

The Nurse Practitioner Role is  
Ideally Suited for Palliative  
Care Practice: A Qualitative  
Descriptive Study

Carmel Collins

Persons with progressive chronic diseases, such as cancer, heart disease, and chronic respiratory disease, among others, need palliative care for best quality of life as the conditions become life-threatening and deteriorate toward death. Chronic diseases are most common among older persons; therefore, with an ageing population nurse practitioners (NPs) in various areas of practice likely will encounter an increasing number of patients needing palliative care. This study was conducted to understand the role that NPs, who are not palliative specialists, play in providing palliative care. A qualitative descriptive design was used and 19 NPs were interviewed. The findings revealed a central and 5 other themes, indicating that the nurse practitioner role is ideally suited for palliative care practice. Their broad scope and autonomy, presence, and unique practice situations facilitate palliative practice. Impediments to such practice are having limited specialty palliative care knowledge and lacking emotional comfort with providing palliative care. This presentation will describe the research, the findings, and the implications for NP education, NP practice, and future research.

Soigner les morts pour guerir

Herve Kabamba Kananga,

Le deuil est une phase importante dans la prise en charge palliative dans le contexte de la R D Congo l'équipe de PalliaFamilli propose durant cette

les vivants

Simplice Mukaya Kananga

période un accompagnement spécifique de la famille et de la communauté pour leur permettre de mieux faire le chemin du deuil.

nous partagerons au cours de notre exposé les différentes étapes que nous entreprenons dans la préparations du deuil “de l’annonce du diagnostique jusqu’à l’enterrement .

Integrating Spirituality as a Key  
Component of Care

Jeanne Weis

Care of advanced cancer patients and other patients with life limiting illnesses frequently focuses on the physical aspects of disease. Seldom are these individuals invited to share their spiritual and psychosocial needs, or discuss how their lives have changed as a result of their circumstance. And yet, seriously ill patients have indicated that the possibility of continued spiritual suffering adds to the distress associated with their illness. Spirituality, broadly defined as that which gives meaning and purpose to life, often is a central issue for patients at the end of life or those dealing with cancer and chronic illness. Growing evidence has demonstrated that spirituality, whether expressed through religious or secular means, is an important component of quality of life (allowing individuals to effectively face the circumstances of life, and cope with feelings of loss, hopelessness, despair, guilt, shame, anger, or abandonment), and affects patients’ healthcare decision making and healthcare outcomes. Despite a strong evidence base, clinicians are often reluctant to make spiritual care a core component of patient care. Few health care professionals are prepared to talk to patients about spiritual needs, believing that such discussions require a substantial time commitment and because they do not know how to meet such needs. This workshop will bring forth discussion related to research that integrated an spirituality assessment instrument into care; the strengths, opportunities and challenges.

The Do's and Don'ts of

Irene Ying, Dori Seccareccia

Advance care planning (ACP) is a process of discussing, reflecting on, and

## Advance Care Planning

planning for future medical care in the event an individual becomes unable to communicate and consent to treatment. It is an iterative process that involves identifying a substitute decision-maker and discussing a patient's wishes, values, and beliefs in relation to future health care needs. The positive outcomes of ACP have been consistently demonstrated, including improved patient and family satisfaction with end-of-life care, less aggressive treatments near the end of life, decreased hospital and ICU admissions, and reduced costs to the health care system. There are several perceived barriers to engaging in ACP including a lack of skill and comfort in initiating this process; perceived lack of time and fear of removing hope. During this workshop, using various reflective exercises, we will review common misconceptions and pitfalls with respect to ACP conversations. We will also present a simple step-wise process to ACP that involves: 1) identifying the patient's substitute decision-maker (SDM), 2) ensuring the provided SDM aligns with the legal hierarchy; 3) discussing and documenting the patient's wishes, values, and beliefs, and 4) ensuring the patient has discussed their wishes with their SDM and loved ones. By carrying out these steps over multiple visits, normalizing the conversation, and building ACP in systematically, many of the barriers to engaging in ACP can be easily overcome.

Engaging Public Advisors in the  
Development of a Palliative  
Care Resource

Meg McCallum

## Background and Project Objectives

The release of the Nova Scotia (NS) palliative care (PC) strategy in 2014 and the subsequent formation of the Nova Scotia Health Authority presented an opportunity to standardize PC patient and family (herein referred to as patient) education resources.

## Methods

In 2014, an environmental scan revealed that various PC patient education resources were in use in NS. CCNS created a new resource from existing resources and input from PC Consult Teams (PCCT) and Hospice Associations (HA). PCCT and HA were also asked to review the draft and complete a survey. The reviewers were generally positive about the resource and provided feedback about how to strengthen it. However, some expressed concern that it contained too much detail about symptoms near death; they felt patients would find this section distressing.

CCNS typically uses an electronic survey to engage patients in the development of resources. However, given the sensitive nature of the PC resource we believed it was inappropriate to use this methodology. Instead, we recruited family members to participate in a focus group.

In 2015, 6 family members participated in a focus group, an additional person sent in feedback. One participant said “There were parts of this book that were very emotional, which means it was saying the right things.” Unlike the providers who had reviewed the resource, family members wanted more information and felt strongly that a single resource be developed. As one participant noted “After all, eventually we are all the patient.”

The focus group provided incredibly powerful feedback which was incorporated into the resource, including family member quotes. The

resource was re-circulated to the family members, PCCT and HA. All reviewers were supportive of the changes and one family member commented “Thank you, you really listened to us and responded to our needs, I can see our contributions in the booklet”.

## Conclusions

Patients and families want to be involved with projects that providers believe may be too complex or too distressing. Our “Preparing for Death and Dying” resource was vastly enriched by engaging family members, the final version bears little resemblance to the first draft.

BC Compassionate  
Communities Movement-  
Where we are now.

Eman Hassan

Like elsewhere in Canada, the British Columbia population is ageing and the number of people with serious conditions continues to rise. Although medicalized dying in hospital continue to be the norm, the health system lacks the capacity and resources required to address the social and emotional dimensions associated with serious illness, dying and loss. These dimensions are central to the well-being of patients and families. Research indicates that communities have the resources that can help patients and families feel supported and cared for close to home.

Based on international best practices, the BC Centre for Palliative Care has launched a provincial grassroots movement to foster the spread of Compassionate Communities across BC by engaging citizens and community groups to be part of a network of compassionate champions and ambassadors.

In Spring of 2016, the movement was sparked by a Seed Grant Program to mobilize proactive community support networks, under the leadership of local hospice societies, whose mission is to promote awareness around end of life issues and leverage opportunities to support seriously ill patients and their families. In the Fall of 2016, the BC CPC has widened its circle of focus to involve population health and community organizations and groups from all sectors and at all levels.

As a social change organization, we will share our experience with the BC Compassionate Communities movement and the progress of the Compassionate Cities initiatives that are underway in BC and the Centre is supporting.

Le respect des volontés des patients en fin de vie : exposé d'une recherche collaborative

Nicole Croyere, Beatrice Birmelé

L'objectif du travail est de questionner le respect du droit du patient en fin de vie à décider pour lui-même, comme cela est prévu dans la loi française. Il s'agit de voir avec des professionnels qui prennent en charge des patients atteints de polyopathologies, de maladies graves ou incurables comment ils recueillent les volontés, les respectent et les problèmes que cela leur pose.

Les choix méthodologiques comprennent une recherche qualitative avec une approche collaborative. Ce modèle de recherche repose sur un travail « avec » et non pas « sur » les praticiens, en faisant des liens entre la théorie et la pratique. Il s'agit d'une étude de dossiers pour repérer ce qui est tracé, puis de rencontres avec des équipes soignantes pour un recueil de narrations de situations vécues. La démarche est réalisée dans six unités choisies parce qu'elles accueillent des patients en fin de vie et qu'elles sont imprégnées

d'une culture de la délibération pluridisciplinaire.

Les résultats montrent des points de recoupement :

- La notion de volonté est ambivalente et fluctuante, sujette à interprétation par les professionnels.
- Le contexte est important : l'information donnée et reçue, le soulagement des symptômes gênants, les interactions complexes particulièrement avec les proches, modifiant les demandes des personnes.
- Le tissage émotionnel est dense, générant des tensions, en particulier dans un contexte d'irréversibilité des décisions.
- Tracer des informations fluctuantes est difficile et ainsi peu d'éléments sont tracés dans les dossiers.

Bridging the Gap: Developing a Palliative Approach to Care for Young Adults Karen Cook

A growing population of young adults (YAs) with life-limiting conditions require a developmentally appropriate approach to care. Like all YAs, they are wired for living and aspire to attending post-secondary education, having meaningful vocation or work, and living independently. However, their developmental goals may collide with their changing health or end of life, and adult services do not wrap around their developmental, social, education and financial needs.

YAs with life-limiting conditions will benefit from a palliative approach to care, that matches their chronic disease trajectories of a series of declining plateaus over a period of months to years, punctuated by unpredictable

periodic crises. A palliative approach to care for YAs will develop collaborative partnerships across community and professional agencies to ensure that timely and seamless resources are available. These resources will support their quest to maximize their quality of life and opportunities in an abbreviated time frame. Currently, there are few health and social service programs that recognize their unique needs.

We will describe the successes, challenges and results of our research, Bridging the Gap: Developing a Palliative Approach to Care for Young Adults. We used a three-phase online patient engagement strategy to hear the voice of young adults with life limiting conditions, their families, and health and community professionals. This research culminated in a prioritized plan to enhance well-being, improve access to services and funding, build relationships and develop a supportive community. Opportunities and barriers to research engagement with YAs, their parents, and adult and pediatric providers will also be presented.

Palliative Care Matters  
Initiative: Including the Public  
in the Future of Palliative Care

Carleen Brenneis

The Palliative Care Matters Initiative builds on 20 years of recommendations about palliative care. The Initiative included a public survey about palliative care, a consensus development conference culminating in a consensus statement, and a Conference Board of Canada report. Fourteen national stakeholders partnered to engage the public and listen to the voice of Canadians on how they perceive palliative care. Twenty recommendations on how Canada's health system needs to change, agreed upon by a lay panel, were reviewed by the Conference Board of Canada to provide direction on the change needed. This presentation will:

- Discuss advocacy opportunities and learnings from the Initiative

based upon the Conference Board of Canada report

- Increase participant knowledge on public participation in palliative care
- Highlight aspects of the IPSOS palliative care survey, and expert panel submissions as they relate to the Conference Board Report.

The results of the Survey, Expert and Conference Board reports summarize the current status in key areas of palliative care in Canada. The presentation provides the attendee an opportunity to update and reflect on their individual and collective role in promoting palliative care in Canada.

Expérience de l'aide médicale  
à mourir au Québec

Claude Rivard

Témoignage sur l'application de la Loi sur les soins de fin de vie au Québec, notamment sur l'application du protocole de l'aide médicale à mourir (AMM) aux patients qui le demandent. Est-ce que l'euthanasie est maintenant un soin?

Medical Assistance in Dying  
and Hospice - A Conflict of  
Values or an Opportunity

Andrew Mai

Medical Assistance in Dying (MAID) is now a reality in Canada. We at Hospice Care Ottawa struggled with how to address this issue from a policy perspective and also with how to respect the rights and beliefs of patients, volunteers, doctors and staff. Rather than take a hard line for or against MAID, we sought to find a middle road. We feel that hospice is in a perfect position for leadership in providing palliative and end-of-life care to patients whose suffering has led them to request MAID. The importance of not abandoning these patients cannot be overstated.

This workshop will target the more advanced learners among residential hospice staff and policy makers.

Making use of case studies and a study of relevant literature, we will explore the issues arising in caring for patients at residential hospice who have requested MAID. Participants will be expected to share their own experiences and opinions around MAID in a small group setting.

At the end of this workshop, participants will be able to approach the issue of MAID with a more nuanced understanding of the potential benefits of caring for patients who may be requesting MAID. It is hoped that this understanding will lead to development of policy, education and practice in residential hospice that will allow for whole person care of these patients.

Building An Effective  
Psychosocial Support Program  
at End of Life: For individuals  
facing serious life limiting  
illness and their families.

Liina Mcneil

This session is intended to assist interdisciplinary teams to gain skills in developing, implementing and maintaining effective psychosocial support programs at end of life for individuals living with a life limiting illness and their loved ones. Knowing how to develop and maintain effective psychosocial programs is important in medical practice, evidence based clinical practice and in building community. This workshop will begin the process of preparing communities to accept the important leadership role in bringing forth an industry standard in psychosocial care of individuals living with a life limiting illness and their loved ones. Participants will gain both knowledge and skills in relation to design, implementation and maintenance of a psychosocial program at end of life. Participants will also gain familiarity with some of the resources available to building sustainable, evidence based programs.

Optimizing Palliative Care in  
Nunavik's Communities

Dumont Serge

Background: In Nunavik communities, most of Inuit patients in the advanced or terminal phase of their illness wish to remain in or return to their communities, which represents a major challenge for care providers and also, the interpreters. Few of them have specific training in palliative care and are able to manage complex cases. Therefore, transfer to a southern hospital

becomes the better choice. In such cases, Inuit patients are confronted with the stress of being alone, isolated from their families, in southern healthcare culture with major language barrier. Rationale: Maintaining minimal expertise in palliative care on Nunavik territory appears to be essential so as to keep as many end-of-life Inuit patients in their communities as possible. Hypothesis: Offering recurrent training in palliative care and access to palliative care consultancy services, when needed, could help the health care team to maintain minimal expertise in palliative, and thereby being able to offer palliative care services to Inuit patients in their community. Objective: The project aims to assess the implementation of a 24/7 on-call consultation service offered by professionals specialized in palliative care and of delivering a culturally sensitive palliative care training to Nunavik healthcare professionals and interpreters. Anticipated findings: Clinical team will feel more comfortable to determine with the patient, the appropriate level of care, keep Inuit end-of-life patients in their communities and therefore, be able to honor their wish to die among their loved ones. Aim of the presentation: To highlight the main features this ongoing project, as well as the implementation milestones, and finally the lessons learnt.

Efficacy of Advance Care Planning (ACP) interactive web sites and workbooks to improve patient engagement in primary care: The results of tool evaluations

Michelle Howard, Peter Allatt

Background Rationale: Engagement in advance care planning (ACP) can improve end-of-life experiences for patients and families. Longstanding patient-provider relationships make primary care ideal for initiating ACP. Self-completed ACP tools can help healthcare providers start the conversation with patients and their families.

Study objectives: To evaluate the efficacy of seven ACP tools, including paper workbooks, interactive websites (Speak Up, Conversations Matter, PREPARE) and a graphic values questionnaire (Graphic Values History Tool), to improve

ACP engagement in primary care patients across Canada.

Methods: This multicenter, prospective study used a 55-item version of a validated ACP engagement survey (ACP-55) (with 5-point scales reflecting process-related behaviour change domains and a sum of actions) pre- and post-intervention to evaluate changes in ACP engagement. Eligible patients, 50 and older, English-speaking and cognitively able, completed an ACP-55 survey before and after completing an ACP tool.

Results: Participants (n=384) were 66.3±3.2 years of age; 64.6% women; 70.6% married/common-law; 92.7% White/Caucasian; 94% English-speaking.

The total process score and most subscale scores, including knowledge, contemplation, self-efficacy, and readiness, increased significantly between baseline and six-week follow-up for all of the ACP tools. Total scores for the action measures increased significantly between baseline and follow-up for some, but not all, of the ACP tools.

Conclusions: Our findings demonstrate that, overall, patient-facing ACP workbooks and websites improve patient knowledge, contemplation, self-efficacy and readiness to engage in ACP. Further refinement of some ACP tools may render them more effective at encouraging patients to choose a substitute decision-maker, and consider values and future medical decisions.

Community Organisation and  
Volunteer's experiences  
hosting and facilitating  
Advance Care Planning  
workshops

Rachel Carter, Lawrence Mróz

Advance care planning (ACP) is a process where adults think and talk about their wishes for current and future healthcare. Most ACP studies have focused on experts within the healthcare system however, many key elements of ACP could be facilitated by non-experts.

Community organisations, including hospice societies, have developed ACP initiatives, including public workshops led by trained volunteer (non-expert) facilitators. These semi-structured interactive workshops promote conversation and provide information on beginning ACP. However, the experiences of the organisations hosting these workshops, and volunteers facilitating the workshops has not been explored. Therefore, the BC Centre for Palliative Care has partnered with 8 hospice societies and other community organisations that are hosting interactive ACP workshops in their communities to learn about their experiences.

To explore organisational experiences of planning and organising workshops, semi-structured interviews were conducted with involved representatives from the organisations. We invited them to share their experiences, including the challenges they faced, what supports they found most or less useful, what went well, and their efforts to improve public engagement.

To explore volunteer's experiences of facilitating the workshops, and their suitability as facilitators of, we invited them to take part in focus groups. We invited them to share their experiences facilitating the ACP sessions, including aspects they found challenging, what worked well and areas that need to be

improved.

We will present and discuss findings from this qualitative, exploratory, study, which can improve our understanding of the experiences of community organisations and volunteers in hosting and facilitating ACP workshops.

Increasing Public ACP  
Engagement Through  
Volunteer-Facilitated Advance  
Care Planning Workshops

Rachel Carter

Advance care planning (ACP) is a process by which people think about and communicate their wishes for healthcare, in advance of a time when they cannot make or communicate decisions. ACP helps better align care with patient goals and preferences, and their quality of life (and dying) is improved. However, awareness of and engagement in ACP remains low despite these benefits.

Many key elements of ACP could be facilitated by non-experts or peers, such as increasing awareness, provision of information about the process and encouraging readiness. Community organisations, such as hospice societies, have developed initiatives that utilise trained volunteer (non-expert) facilitators to promote ACP. However, such initiatives have had limited evaluation. Therefore, the BC Centre for Palliative Care has engaged with hospice societies and other community organisations across the province to evaluate volunteer facilitated group ACP workshops for the public.

We trained 35 volunteers from 8 community organisations to facilitate interactive ACP workshops. With the support of their organisations, the volunteers then facilitated around 25 workshops for the public in their communities.

Developing a provincial approach to volunteer facilitated Advance Care Planning workshops

Rachel Carter

To evaluate the workshops, we conducted post-workshop and 4-6 week follow-up questionnaires to assess the effect of the workshop on participant's ACP knowledge, readiness and engagement. The post-workshop questionnaire asked participants about their ACP knowledge, previous engagement in ACP and readiness to engage in ACP behaviours. The follow-up questionnaire asked participants about their engagement in ACP activities since the workshop. We will present our data evaluating the efficacy of these community-based volunteer-facilitated ACP workshops.

Advance care planning (ACP) is a process by which people think about and communicate their wishes for healthcare, in advance of a time when they cannot make or communicate decisions. ACP public education has commonly been restricted to health care providers, however many key elements of this process can be shared by non-experts (peers).

Hospice societies and other community organisations have developed initiatives that utilise volunteer (non-expert) facilitators to promote ACP in their communities. These initiatives increase awareness, provide information about the process of ACP, and encourage readiness to engage in ACP.

The BC Centre for Palliative Care (BC CPC) engaged with two community organisations that have been providing public ACP workshops to develop a training curriculum to support the spread of these workshops throughout the province. The first workshop trained 47 volunteers from 17 organisations to facilitate these workshops. Based on feedback and evaluation from this first round, the curriculum was refined and another training workshop was

delivered to train an additional

24 volunteers from 9 organisations. A third round of training is planned for the spring of 2017.

We will share information about the ACP workshop curriculum and the curriculum development process including the evaluation data obtained at the training days.

The Potential of Cannabinergic  
Medicine for Symptoms  
Associated With Dysregulation  
of the Central Nervous System  
at End-of-Life

Sylvia Bagge

CNS-dysregulation associated with the process of “actively-dying” is an ongoing challenge facing clinicians that deliver end-of-life care. This particular symptom-trajectory is sometimes referred to in hospice teaching literature as the “difficult road”, versus the “usual road.” The “difficult road” often presents as delirium, and is associated with symptoms such as tremors, disorientation, hallucinations, myoclonic jerks, hiccups, and seizures. These symptoms are associated with CNS-excitement and are extremely difficult to reverse.

Experienced hospice clinicians are familiar with the “difficult road”, and the failure-potential of benzodiazepines and barbiturates to effectively bring a dying individual’s comfort status back within acceptable limits.

Cannabinergic medicine excels in the treatment of conditions involving painful uncontrolled movements associated with CNS-excitement, such as spasticity and muscle tightness in Multiple Sclerosis, movement dysfunction in

Huntington's disease, uncontrolled movements as a drug side effect in Parkinson's disease, tics in Tourette Syndrome, and seizures in Epilepsy.

Cannabinergic medicine brings the body's own endocannabinoid signaling system on-line, restoring homeostatic regulation within the cells of the CNS to the extent possible for the condition.

With a track record of neuro-regulative and neuro-protective effects, no lethal dose, no effect upon respiratory status, a range of possibilities for administration, including formats for sublingual and rectal routes, as well as non-psychoactive options, cannabinergic medicine may be a treatment solution worthy of consideration for study as an adjunct to current medications in use for those suffering on the "difficult road" at end-of-life.

Approche anthropologique de la biographie en centre de soins palliatifs Sophie Bobbé

Saisir les mécanismes à l'œuvre dans le travail de biographie pratiqué en centre de soins palliatifs sera au cœur de cette communication. Depuis quelques années dans des établissements hospitaliers français, il est proposé au patient de réaliser avec lui sa biographie pour lui-même et/ou pour la transmettre à ses proches (ceux désignés). Le récit peut prendre la forme d'un livre qui sera remis à ceux que le patient aura désigné.

A partir de notre expérience de biographe et d'anthropologue, nous examinerons dans un premier temps la nature même de cette activité (l'élaboration d'un récit introspectif rétrospectif), la place du biographe en tant que tiers auquel le récit est adressé. Dans un deuxième temps, nous porterons toute notre attention sur les modalités de recueil du récit, les

transformations de celui-ci, l'importance des variantes successives et enfin l'enjeu du passage de l'oral à l'écrit des propos recueillis. Dans un troisième temps, la place de cette activité au sein du service, son incidence pour le patient, pour son entourage (éventuels destinataires de la biographie) et enfin pour l'équipe soignante sont des éléments qui seront ici abordés.

Cultural inclusiveness in the palliative and end of life (EOL) care services for the ageing population of rural New South Wales, Australia

Savana (Sabine) Agustine

The cultural makeup of Australia is increasingly diversifying in regional towns. This study explores the cross or multicultural knowledge and experiences of staff in Residential Aged care facilities (RACFs) as well as of community members from culturally and linguistically diverse (CALD) backgrounds with regard to palliative/ end-of-life (EOL) care services in rural region of New South Wales (NSW), Australia. By following a phenomenological approach to qualitative data, group interviews (n=6) with care staff in RACFs and CALD community members from three towns of NSW (Armidale, Moree and Tamworth) were undertaken. The qualitative thematic analysis showed limitations in social and material resources to accommodate CALD group elderly residents and their families at the end stage of life. Furthermore, there was little awareness among staff in RACFs of the diversifying socio-cultural climate and the need to plan a policy and practice response to the changing demographics. This study argues for the development of culturally sensitive facilities and services and training programs, particularly in rural towns.

Advancing quality palliative care for patients with chronic kidney disease in British Columbia

Helen Chiu, Gaylene Hargrove

Chronic kidney disease (CKD) is characterized by high symptom burden and poor life expectancy at advanced stage. An integrated approach to timely advance care planning (ACP) and palliative care spanning the CKD care continuum is needed.

Acknowledging the needs and importance of delivering quality palliative care for renal patients, an expert panel was formed to develop an evidence-based

framework that articulates four pillars of palliative care: patient identification, ACP, symptom assessment & management, and care of the dying patient and bereavement. Champions from the 5 regional renal programs led to the local implementation of the Framework. Education and support tools were developed provincially to facilitate uptake and capacity building among frontline care providers. Environmental scan was conducted to verify progress and needs. Furthermore, a minimal set of quality indicators were developed with patients and health care professionals to assess both processes and outcomes essential for each of the core areas of palliative care to guide strategic planning and continuous quality improvement.

Environmental scan shows that its implementation varies across the renal programs with each having formalized strategies to facilitate ongoing growth in palliative care. Specifically, prominent improvements were shown in symptom care & management and advance care planning. Key challenges identified include enabling the organizational culture, sustaining quality palliative care and continual improvement.

A series of provincial strategies over the past 7 years enabled the cultural change in nephrology practice for an integrated palliative care approach to CKD care. Routine reporting of quality indicators supports population-based monitoring of progress and continual improvement in palliative care for those living with kidney disease.

Processus de deuil du "proche-tiers" - La relation de soins : un espace transitionnel ouvert  
Isabelle Godard Auray

La question de la fin de vie et du processus de deuil qui s'ensuit pour le proche du défunt reste toujours d'actualité tant elle comporte d'énigmes. Comment pouvons-nous penser que le travail du deuil puisse être facilité ? La présente recherche a pour objectif d'étudier, en appui sur les travaux et les

théories de D. W. Winnicott, comment le soin peut être transitionnel dans la relation et dans l'espace intersubjectif créé par la triade composée du soignant, du patient et du «proche-tiers».

A partir d'un échantillon de 30 patients, les entretiens semi-directifs de 21 soignants et de 8 proches ont été analysés. Cette analyse nous permet de montrer de quelle manière le soin est transitionnel dans l'accompagnement. Elle nous montre également quels bénéfices peut avoir l'accompagnement en fin de vie, d'une part pour le patient dans l'ici et maintenant de sa fin de vie, d'autre part, pour le soignant dans l'ici et maintenant de l'accompagnement proposé mais aussi dans «l'après-coup» pour les autres accompagnements qu'il pourra proposer.

Enfin, un troisième bénéfice certain est pour le «proche-tiers» dans l'ici et maintenant de l'accompagnement de son proche malade mais également par la suite dans la conduite du deuil.

Mots clés : accompagnement, fin de vie, deuil, espace transitionnel, soins palliatifs, Winnicott

The Good Wishes Project: An end-of-life intervention for individuals living in homelessness

Alissa Tedesco, Naheed Dosani

Persons who live in homelessness face high morbidity and mortality, and often have end-of-life concerns that are distinct from the general population. Despite their complex needs, homeless persons have poor access to quality palliative care. In order to address this, interventions need to be comprehensive, flexible and creative. The Three Wishes Study, developed for dying patients in an intensive care unit, shows promise in being adapted to

this population. Inspired by Three Wishes, the Good Wishes Project facilitates granting wishes to patients who are living in homelessness nearing end-of-life. The project is a partnership between the Inner City Health Associates' PEACH (Palliative Education and Care for the Homeless) program and the Good Neighbours Club funded by the Sovereign Order of St. John. Good Wishes aims to personalize the end-of-life experience for homeless individuals and enhance their provider's ability to deliver dignity-centered care. The main objective of this study is to determine the challenges, successes and differences in adapting the Three Wishes Study to this population. This will be investigated with a mixed methods approach. Semi-structured interviews will be conducted with a variety of health and social service professionals in shared care with the PEACH program in Toronto, ON. Interviews will be recorded, transcribed verbatim and analyzed thematically. Providers will also be surveyed, and data analyzed using descriptive statistics. We anticipate that the Good Wishes Project will be a novel intervention in addressing the gap in palliative care for homeless individuals, whose lives have largely been burdened with hardship and marginalization.

A Provincial Palliative Care  
Education Strategy: The  
Coordinated Implementation  
of Pallium Canada's LEAP  
curriculum in Nova Scotia

Cheryl Tschupruk

Nova Scotia's palliative care strategy, released in 2014, highlighted the need for a palliative care education and capacity building plan. In 2016, Pallium Canada's LEAP curriculum was identified as a foundational part of this plan and a Project Lead was hired to coordinate its implementation. There are nine palliative care programs in Nova Scotia, each with a unique approach to education and capacity building, and differently resourced. The Project Lead has been responsible for working with the palliative care teams to develop plans that are feasible and sustainable at a local level, but that are also coordinated within their zone and the province as a whole. The presentation will discuss the process of developing and implementing these action plans. An environmental scan was completed, including the number of certified LEAP facilitators in the province and where they were located. The project

lead worked with local teams to create a plan that would: 1) Double the number of certified facilitators in the province by 2018, 2) Increase the number of LEAP coaches and collaborators and 3) Most importantly, increase capacity building activities in certain parts of the province. Provincially-funded facilitator training took place in early 2017 and strategic LEAP Core offerings were planned across the province for 2017. Indicators of success include the number of LEAP courses and attendees, the number and location of facilitators in the province, pre-and post-course scores, and course evaluations. Evaluation will also take into account the teams' perceptions on the impact of these capacity-building interventions.

Early integration of palliative care in Ontario: INTEGRATE quality improvement project

Dr. Declan Rowan

The INTEGRATE Project aims to identify and manage patients who would benefit from a palliative approach to care early in the illness trajectory and across healthcare settings. Palliative care integrated models were pilot tested in 4 regions in Ontario (4 cancer centres (CCs) and 4 primary care (PC) practices). All sites completed Pallium Canada's LEAP module, which provides primary level palliative care education. The need for a palliative care approach for a given patient is identified using the Surprise Question "Would you be surprised if this person died in the next 6-12 months?", initiating symptom assessment, Advance Care Planning and Goals of Care discussions, and referrals as needed. Data collection began following implementation and sites routinely submitted data to serve as quality indicators of this project.

Implementation of the Surprise Question took place between November 2014 – August 2016 and 294 patients have been identified through PC practices and 933 patients through regional CCs. PC practices have reported a variety of life-limiting diagnoses for their patients including cancer, heart disease, and renal disease, among others. Participating CCs targeted specific cancer sites: lung, gastrointestinal, glioblastoma and head and neck. Further analyses will

include completion rates of Advance Care Planning discussions, palliative care referrals and healthcare utilization and final results will be synthesized by project completion in January 2017.

This project has the potential for significant impact on health system design for patients and families who will benefit from earlier identification of palliative care needs in the PC and oncology settings.

Paramedics Providing  
Palliative Care at Home  
Program in Nova Scotia and  
Prince Edward Island

Marianne Arab

Background: The program aimed to enhance the care provided by paramedics for patients receiving palliative care, improve access to palliative care supports at home regardless of location or time of day (24/7 in NS, after-hours in PEI), enhance the palliative and end-of-life experience for patients and their families/caregivers by “bridging” palliative care supports until the usual care team can take over, avoid/reduce emergency department visits for palliative patients and improve paramedic comfort, confidence and satisfaction in the provision of care to palliative patients and their families/caregivers

Method: The new ‘Paramedics Providing Palliative Care at Home Program’ in Nova Scotia and PEI enhances paramedic care for palliative care patients. The program includes an innovative palliative clinical practice guideline, education, and database which provides the opportunity for comfort or selective care instead of a resuscitation-focused encounter. Paramedics can now provide relief of common symptoms (e.g., nausea, breathlessness, pain, agitation, etc.) without transport to the hospital.

Results: Over 1000 palliative care patients have been registered in the enhanced database to date. Qualitative results show the 24/7 support of paramedics enables access to palliative crisis support in an accessible, timely and effective manner and increases patient/family confidence in choosing to remain home.

Conclusion: This program demonstrates that palliative support can be effectively integrated into paramedic practice and result in acute palliative crises being managed at home.

Outcome measures for a palliative approach

Richard Sawatzky, Pat Porterfield

Background: It is imperative to integrate a palliative approach earlier on and across all contexts of care for people who have life limiting chronic conditions. However, successful integration will only be achieved if relevant outcomes are routinely evaluated. As part of the Initiative for a Palliative Approach in Nursing: Evidence and Leadership ([www.ipanel.ca](http://www.ipanel.ca)), we have conducted research with the purpose of identifying outcomes measures that are reflective of a palliative approach.

Methods: The results presented are based on a synthesis of information from several research activities, including: (a) A literature review on “Conceptual foundations of a palliative approach” and (b) qualitative analysis of data from a workshop and interviews with nursing care providers, administrators and leaders focused on “Embedding a palliative approach in nursing care delivery”.

Results: Measures of health and quality of life from the perspectives of

healthcare recipients and family caregivers are emphasized as being congruent with the goals of a palliative approach. Other person-centered measures are those reflective of people's experiences with the health care system, including measures of compassionate care, dignity and access to health care. However, standardized patient- and family-reported outcome and experience measures have not been widely used.

Discussion: Outcomes of a palliative approach must be evaluated from a person-centered point of view. For successful and sustained integration of a palliative approach, it is imperative to routinely monitor and evaluate outcomes that are reflective of what really matters to people as they progress along their trajectories of life-limiting illness.

Comment faire un suivi de deuil auprès des familles endeuillées d'un enfant suite à un décès subi et inattendu

Antonietta Petti, Marion Onno, Aurore Coté

En 1986, M.Eric Rill et Mme Andrée Laganière, parents de Jeremy décédé subitement et de façon inattendue, ont créé le centre afin que des professionnels de la santé puissent venir en aide aux parents qui vivent un tel choc.

Les décès subits et inattendus sont une des causes de décès majeures dans la première année de vie chez l'enfant. Plusieurs de ces décès sont expliqués après une investigation approfondie (cause infectieuse, cardiaque, métabolique/génétique). Plusieurs autres décès demeurent totalement inexpliqués malgré les efforts mis en œuvre pour en déterminer la cause. Le deuil vécu par les familles dont l'enfant est décédé

subitement et en apparence de façon inexpliquée est un deuil particulier, plus

complexe vu les circonstances (implications des policiers, autopsie, attente,....  
incertitude, sentiment de culpabilité,...)

Nous présenterons notre expérience de suivi de deuil fait en collaboration avec le Centre Jeremy Rill, centre de référence provincial pour les décès subits chez les enfants de moins de deux ans. Le centre Jeremy Rill est le seul centre qui fait ce suivi auprès des familles au Québec.

Integrating a Palliative  
Approach in the Primary Care  
setting

Cheryl Tschupruk

In 2014, Nova Scotia released its provincial palliative care strategy, a framework to guide palliative care planning in the province. The strategy is closely aligned with the national palliative care framework, the Way Forward and emphasizes the importance of a palliative approach to care this is integrated across programs and settings, and rooted in the primary care setting. Primary care providers are often the first and most consistent points of contact in the health system. Their role in palliative care is essential as we move toward collaborative team-based care in Nova Scotia. However, as palliative care evolved into a specialty, lack of role clarity for primary care providers has resulted in some providers having limited involvement in palliative care; therefore, competency and confidence in PHC has decreased. Specialty services are designed to offer expertise to complement comprehensive and continuous care provided in the health home and is not intended to sustain comprehensive care or address individuals' needs over time.

Although the expectation is that the majority of palliative care can and will be provided in a primary care setting, a framework to support providers in this role and how they work with other system and community partners did not exist in Nova Scotia. Through the Canadian Foundation for Healthcare

Improvement's EXTRA Program, our goal was to develop an operational framework to support integration of the palliative approach in the primary care setting, in collaboration with a primary care team who then demonstrated how it could be effectively implemented.

End-of-life experiences from the perspective of hospice palliative care volunteers

Stephen Claxton-Oldfield, Jane Claxton-Oldfield

The objectives of this oral presentation include: 1) helping volunteers learn more about end-of-life experiences (e.g., the different types of end-of-life experiences that may occur shortly before, at the time of, or shortly after a patient's death, the frequency of such occurrences); 2) the importance of normalizing and validating patients' and family members' end-of-life experiences; and 3) discussing the need for training to help volunteers deal with end-of-life experiences.

Creation of a competency based text and companion learning activities for nurses and educators

Katherine Murray, Jeanne Weis

The CLPNA 2015 and the Canadian Association of Schools of Nursing (CASN) 2011 hospice palliative end-of-life-care (HPEOLC) competencies clearly identify the central role for nurses in providing care to dying people and their families. It is essential for every nurse to feel confident and to provide competent care for the dying, particularly in light of the aging demographics and the reality that people with chronic life-limiting illness will be cared for and die in all health settings, including those outside of specialized palliative care units. However, research indicates that nursing care providers do not perceive themselves to be competent and confident in providing quality palliative care for people with life-limiting illnesses and their family members.

In this session (2 out of 3) the presenters will highlight a new text, Essentials in Hospice and Palliative Care: A Practical Resource for Every Nurse and companion teaching/learning resources that were developed to address the needs of "every nurse". This text is designed to support the development of skills and attitudes identified by the CLPNA (2015) competencies (as above)

and the CASN PEOLC entry to practice competencies (2011).

The presenters will reflect on the creative and collaborative process involved in developing an engaging and practical resource. The process of sharing the resources with both educational institutions and workplace educators will be introduced.

Development of Hospice  
Palliative End-of-Life  
competencies for Practical  
Nurses in Alberta; Session 1,  
Development of Hospice  
Palliative Care Competencies  
for Practical Nurses in Alberta

Jeanne Weis, Kath Murray

A profession has strength when their contribution is clearly articulated. For the Licensed Practical Nurse profession in Alberta, this articulation is seen in competencies and education that outline the knowledge, skill, behaviors, judgments and attitudes that are expected of the profession.

In 2015, The College of Licensed Practical Nurses of Alberta (CLPNA) completed an exhaustive revision to the Competency Profile for Licensed Practical Nurses, which was released in June 2015. This process resulted in a broad and thorough consultation of nursing and clinical care experts that fielded rich data and feedback related to the LPN education, roles, specialties and advancements in practice. One of these areas of enhancement was the area of hospice palliative care nursing. Recognizing the need for further collaboration, The College involved experts in the field of hospice and end of life care that also included an exploration of national hospice palliative care nursing competencies. This collaborative process ensured that best practice was threaded through the competencies that captured the current landscape of hospice palliative care nursing.

After the release of the Competency Profile for LPN's in Alberta was released

A Scoping Review to Examine  
Symptoms in Children with  
Rare, Progressive, Life-  
Threatening Disorders

Harold (Hal) Siden

in June 2015, an opportunity was introduced to the College to provide an educational resource to the Practical Nursing educational institutions that encompasses each of the Hospice Palliative Competencies that are required for practice. Session #1 will explore the hospice palliative care nursing competency development process and provide a brief overview of the resulting competencies in Alberta.

Objectives: Q3 conditions are progressive, incurable metabolic, neurological, or chromosomal childhood conditions. With no existing curative treatments, children with these conditions face an unknown lifespan and endure uncomfortable and unstable symptoms.

With regard to symptoms, there is a critical need to provide evidence on which clinicians can base care and to identify direction for future research programs. Our objective was to evaluate the level of the research evidence to identify what is known and unknown about the assessment and management of symptoms in Q3 conditions.

Methods: Our initial pilot study identified 10 symptoms as disruptive to a child's health: behaviour problems; bowel incontinence; breathing difficulties; constipation; feeding difficulties; sleep disturbance; temperature regulation; tone and motor problems; urinary incontinence; and vomiting. Pain and seizures were excluded because of the wealth of existing information. Our search strategy combined these symptoms with 180 Q3 conditions that were identified through our pilot study and three literature sources. We searched MEDLINE, Embase, and CINAHL and conducted an extensive search of the grey literature to locate unpublished studies.

New insights into the complex relationship between Palliative Care and Medical Assistance in Dying

Joshua Shadd, Kathleen Willison

Results: We will demonstrate the successful strategy using the PRISMA chart. We will show the scope of knowledge, categorized in levels of evidence, and identify gaps, such as in understanding mechanisms, assessments, and treatment of symptoms in Q3 conditions.

Conclusions: Current knowledge regarding symptoms is needed in this complex population and high-value research opportunities need to be identified. We will provide information for clinical use and guidance for conducting effective searches related to multiple diseases and conditions.

The World Health Organization asserts that Palliative Care “intends to neither hasten nor postpone death.” Many Palliative Care physicians adhere to this as their philosophy of practice. The 2015 Supreme Court ruling (Carter v. Canada) and Bill C-14 legalized medical assistance in dying (M.A.I.D.) allowing physicians to hasten death for patients who have “a grievous and irremediable medical condition”.

We conducted semi-structured, qualitative interviews with 43 of 48 physicians recognized as Palliative Care experts in our region to understand the anticipated effect of the new M.A.I.D. legislation on these physicians and their practice. The interviews were carried out in April and May of 2016, prior to the legislation coming into effect. Interviews were digitally recorded, transcribed and anonymized. Transcripts were analyzed using conventional content analysis.

Our presentation will focus on the varied, complex, and nuanced perspectives of palliative care physicians: 1) how these palliative care physicians understood the legislation 2) their concerns and questions regarding M.A.I.D. 3) their perceived implications for individual medical practice, for the discipline of palliative care, and for society as a whole; 4) the anticipated impact on their ability to care for patients at the end of life and 5) their support needs.

This is a new landscape (medically, legally, and culturally) for Canada, its physicians, and its citizens. There is little research on the impact of M.A.I.D. on physicians, their relationships, and the care they provide to a vulnerable population who are suffering.

Home-based palliative care for older clients and their family caregivers: The role of personal support workers Christine Mcpherson

The shift towards care in the community and preference for people with life-limiting illness to remain at home has seen the demand for home-based hospice palliative care intensify. Many of these clients are older (65 years and over) and have complex health care needs. Although home-based hospice palliative care is provided and overseen by health care professionals, personal support workers (PSW) (also known as, home support workers, unregulated care providers, and nursing aides) contribute a significant proportion to these services. There is little research that has explored the role of PSWs in this context. The aims of the study were to describe the PSW role in home-based hospice palliative care and to identify barriers and facilitators to their role. A mixed methods design was used with data from a review of client charts (n= 86) to identify PSWs' activities and qualitative interviews with PSWs and stakeholders (i.e. health care professionals, home care organizations, and PSW educators) to explore the PSW role in more depth. Findings from analyses of the data revealed the scope of the PSWs' responsibilities and the value placed on PSWs as part of the health care team. Further, challenges and

rewards in caring for older clients at the end of life identified. Knowledge generated from this study is of value to various stakeholders (i.e. decision-makers, health care organizations, and educators) across Canada committed to providing home-based palliative care to older Canadians.

Implementation of a Train-the-Trainer Curriculum to Enhance Palliative Care for Children with Cancer  
Kimberley Widger, Adam Rapoport

Background: Pediatric health professionals (HP) receive little training in pediatric palliative care (PPC). To address this gap, we implemented the Education in Palliative and End-of-Life Care for Pediatrics (EPEC®-Peds) curriculum using a 'Train-the-Trainer' model. The impact of our rollout was assessed in 4 areas: 1) knowledge of HP; 2) knowledge dissemination outcomes; 3) practice change outcomes; and 4) quality of PPC.

Methods: Teams of 3 to 6 HP based at 15 of the 16 pediatric oncology programs in Canada became EPEC®-Peds Trainers who delivered the training to End-Users (HPs involved in providing care to children with cancer) and implemented quality improvement (QI) projects over 4 – 18 months. To assess care quality, data were collected before and after the rollout through: a) parent / child surveys about symptoms, quality of life, and care provided; b) health record reviews of deceased patients; and c) bereaved parent surveys about end-of-life care.

Results: We certified 72 Trainers and reached 3385 End-Users from every province and territory. The majority (78.5%) of End-Users agreed or strongly agreed that their knowledge about PPC improved. Ten of 15 sites achieved practice change goals through QI projects focused on symptom screening, bereavement support, and sibling support. There were no significant differences in the quality of care before and after the rollout though data

indicated areas where care could be enhanced.

Conclusions: Goals were achieved for knowledge dissemination, enhanced knowledge, and practice change. The lack of change in care quality may be related to the relatively short time between intervention and follow-up.

New Evidence on End-of-life Hospital Utilization for Myth Busting and Improved Action Planning

Donna M Wilson

This brief 15 minute presentation (oral) will review the findings of a study designed to highlight myths about place of death, home care services use, and end-of-life care in hospital. It will highlight current, needed information and will encourage action to assist terminally ill and dying people and their families.

Evaluation of a palliative care capacity building project for rural Mauritania

Alhousseynou Sall

Palliative care capacity in rural communities across Mauritania was reinforced in 2016 and 2017, through the training of community health workers and visits to several of these communities. Over 70 community health workers, selected from across Mauritania were trained in the foundations of palliative care. The three 5-day trainings were interactive, employing a variety of teaching approaches, these included lectures, small group learning and role play. Eight communities were visited, incorporating mentoring of participants, jointly visiting palliative patients, and running community conversation workshops, during which the principles of PC were discussed.

The project was evaluated through the use of participant evaluations, confidence rating scales, pre- and post-training knowledge tests, semi-structured interviews, and focus groups. Over 20 semi-structured interviews were carried out with participants, and nine focus groups with either participants, bereaved relatives or local community leaders. These were audio-recorded and transcribed into French. Thematic analysis was carried

out on these transcripts by an international team experienced in social science and anthropology research.

The training was well received by participants, with many hearing about palliative care and holistic care for the first time. It is vital to involve the local community in the implementation of palliative care in the community. A Mauritanian interpretation of palliative care should be established for further incorporation into the health care system.

Ethics of finitude: nursing and the palliative approach Elise Skinner

Access to palliative care is a growing public health issue and current palliative care leadership calls for a “palliative approach” whereby everyone who is facing problems associated with aging should benefit from a palliative approach to care regardless of their care setting. As part of a larger research project on the palliative approach to nursing care in a psychiatric care setting, the presented research explores the phenomenon by which nurses engage with mortality as both an antecedent to adopting a palliative approach and as a phenomenon that captures nurses’ continued engagement with patients within a palliative approach to care. This research intersects a central challenge facing palliative care provision: ensuring access to appropriate and dignified care to some of the most marginalized populations in our community. The findings are found to reflect the call to articulate an “ethics of finitude” based on human social, temporal and mortal facticities. The presentation describes the research phenomenon of interest, conceptual elements, analysis of qualitative interviews with forensic and psychiatric nurses and discussion pertaining to findings and the articulation of an ethics of finitude. This research serves to articulate elements of an ethical framework from which to further conceptualize the palliative approach and hence support the legitimacy of this claim as a current orientation to palliative

Integration of a palliative approach to care in core curriculum for Practical Nurses in Ontario

Stephanie Buchanan,  
Katherine Murray

care provision.

In today's rapidly changing health care system, technological advances, increased budgetary restrictions and a growing aging population has led to patient populations with multiple chronic diseases and life-limiting conditions, leading to longer trajectories to death; this requires a shift in the focus of care from episodic acute care to continuous long term chronic disease and symptom management.

The academic preparation of nurses, Practical Nurses in particular, involves adequately preparing practical nurses to care for complex patients in challenging contexts. In light of these issues, there is an increased demand for high quality palliative and end of life education within academic programs. If incorporated into current curriculum a palliative approach to care will prepare future nurses to be able to cope with the care needs of this population.

A palliative approach to care involves introducing palliative care principles (i.e., dignity, hope, comfort, quality of life, relief of suffering) with people facing chronic, life-limiting conditions at all stages, not just at the end of life (CHPCA 2014). Unfortunately, nursing students are receiving very limited palliative care education and are largely unaware of this approach to care due to competing curriculum content needs; this often results in student anxiety regarding death and a widening gap between theory and practice in the health system.

In this presentation, we will describe the process of integration of the

palliative approach to care into the PN clinical setting in an Ontario Community College. An interactive case study will be presented to illustrate the integration of palliative and end of life competencies and the Essentials in hospice and palliative care: A practical resource for every nurse, into the classroom and clinical curriculum.

Palliative Care in Ontario  
Regional Cancer  
Centres: Time to Consult

Ahmed Jakda

Cancer Care Ontario introduced the time to consult indicator for outpatient palliative care clinics in order to measure access to care about two years ago. Recognizing the important of early palliative care is necessary to ensure quality care for patients facing an advanced illness. The regional cancer centre score card is reviewed on a quarterly basis in order to monitor a number of indicators, including access to palliative care. Since its' introduction, there have been varying results in improvement within centres, although the objective of the metric was to improve access to care. This oral presentation will review the results and trends since measurement began, and review blinded regional data with analysis around the data.

When Patients with Dysphagia  
Eat for Quality of Life: Factors  
That Affect the Comfort of  
Health Care Professionals

Peter Allatt, Joyce Lai,  
Benjamin Walmsley, Phoebe  
Smith-Chen

Many palliative care patients experience dysphagia. Despite swallowing difficulties, some request oral intake. "Quality of life feeds" (QoLF) give a patient with dysphagia small amounts of food/drink for pleasure, taste sensation, oral sensation (mastication), companionship, or a sense of normalcy but are not intended for nutritional needs or caloric intake. Patients with dysphagia who receive QoLF are at increased risk of aspiration and/or choking, causing moral distress for health care providers (HCP).

To identify the factors that affect HCP comfort with QoLF for patients with dysphagia, determine if there were differences between HCPs and to identify the criteria used to determine if a patient should receive QoLF, a mixed-methods pilot study was conducted in a continuing care/complex

rehabilitation hospital with a large palliative care unit. The format involved semi-structured focus groups or 1:1 interviews followed by a survey with five case vignettes.

Participants (n=23) were health care providers including physicians, nurses, SLPs, dieticians and therapeutic recreation therapists. Participants ranged in degree and frequency of involvement in QoLF and were divided into 4 groups. HCP comfort level was associated with frequency and degree of involvement with QoLF. Prominent themes were risk, perceived incongruences with goals of care, conflict between HCP and patient's family, and patient decision-making capacity. The concordance between QoLF and palliative care status was significant.

This presentation is designed to share and discuss the results of the study, engage the audience in a reflection exercise and further explore an area with a paucity of research.

Everyday Clinical Practices  
That Contribute to a Palliative  
Approach in Primary Practice

Samantha Winemaker,  
Michelle Howard

Primary care providers provide most of the ongoing care for patients with life limiting illness. This is increasingly described as a "palliative approach". However, evaluation of palliative care is often done in the context of cancer care and palliative specialist involvement. It is often cited in the literature that primary care providers do not provide palliative care due to lack of training and skills, and overall perceived complexity of end of life care. However, provision of comprehensive family medicine involves seamless care across the lifespan and transitions to "palliative approach" are often not recognized or labeled as 'palliative care', but instead are backgrounded as they are interwoven with the relational and continuous care of primary care model. We set out to uncover the strategies, skills, resources and

relationships currently employed and to define primary palliative approach from the perspective of family medicine. We conducted in-depth, semi-structured interviews with key informant primary care providers. Interview questions pertained to 1) the identification of patients with progressive life-limiting illnesses, 2) the specific strategies used to provide care for these patients, 3) the barriers to providing care and facilitators to providing care. By delineating how primary care providers identify patients, what kinds of strategies and care practices family medicine is already capable of providing, the barriers and facilitators, we can better work to integrate these practices into emerging conceptions of a primary palliative approach to care.

Nursing contribution to end-of-life care decisions and medical assistance in dying

Josette Roussel

Nurses have always supported patients and families during end-of-life care planning and discussions and are vocal advocates for improved access to palliative care across Canada. The significant changes on end-of-life decisions with the passing Bill C-14, An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying or MAID) allow eligible persons to receive MAID under specific circumstances.

The Canadian Nurses Association (CNA) recognizes the ethical and professional dilemmas for nurses and nurse practitioners with MAID. In response, CNA led the development of a National Nursing Framework for Medical Assistance in Dying. The main purpose of the framework is to raise awareness with nurses and nurse practitioners of the change in the law, describe their role in MAID and support nurses and nurse practitioners in their practice as they work with persons considering and receiving MAID, their families and the teams. This framework also guides nurses and nurse practitioners when reflecting on ethical issues that may occur and provides case studies to apply the values and responsibilities to consider.

In this presentation, participants will learn more about MAID, the ethical responsibilities for nurses in MAID and the specific pathway for MAID in Canada. Nurses and nurse practitioners in Canada have a unique perspective and bring an important contribution to the health-care team in the provision of end-of-life care that includes MAID.

“The Challenges of educating nursing students about Medical Aid in Dying”

Jackie Santiago, Judith Wiens

The changing landscape of End of Life Care in Canada now includes Medical Aid in Dying. Adopting the Canadian Hospice Palliative Care integrative framework, The Way Forward, nursing students in the final year of the Red River College BN program in Winnipeg learn about a palliative approach to chronic illness care that includes end of life care. Educating nursing students about Medical Aid in Dying provides an opportunity to discuss the global context, the current clinical practice in Canada and Manitoba, clarify terminology, and outline ethical nursing responsibilities and practical implications. The complexity of these discussions invite personal values assessment and personal reflection surrounding end of life preferences. The challenges include discerning nursing behaviors consistent with ethical and legal expectations when guidelines are in the developmental stages, when the practitioner is guided to review multiple information resources, when the nursing role varies inter-provincially. The novelty of Medical Aid in Dying attracts attention enticing educators to add this discussion to their courses while limiting important pre-requisite discussions such as Advance Care Planning, ethical principles of decision-making, advocating for comprehensive palliative care. Developing an educational framework for Medical Aid in Dying provides a valuable tool to prepare student nurses to process important issues surrounding end of life care and to identify nursing behaviors consistent with ethical, compassionate care. Discussing Medical Aid in Dying within the broader context of palliative care allows the learner to gain

Enhancing Hospice Palliative  
Care: A comfort care guide to  
support patients and family  
caregivers in end-of-life care

Melissa Hill

perspective of the current issues and approaches to care at end of life.

“The goal of palliative care is to provide comfort and dignity for the person living with the illness as well as the best quality of life for both this person and his or her family.

— Canadian Hospice Palliative Care Association

CBI health group recognizes that family caregivers are essential to our interdisciplinary approach to end of life care. Family caregivers must provide emotional, physical, psychological, spiritual and social support and often do this with little or no experience or information to guide them. Quality end-of-life care can only be achieved when both the dying person, and the family caregiver is provided with the assistance, tools, and support that they require and deserve.

Through the collaborative work of our Palliative Task Force and Person and Family-Centered Care Committee, our comfort care guide brings together information, knowledge and experience for family caregivers caring for loved ones at home and community settings. The guide provides information specific to common symptoms or changes at end of life and how the family caregiver can provide comfort measures to support their loved one. Since experiences with the dying will forever impact a person, this tool aims to provide knowledge and insight to make this encounter meaningful and as comfortable as possible.

Strengthening a Palliative Approach in Long-Term Care (SPA-LTC): A New Program to Improve Quality of Living and Dying for Residents and their Family Members

Olivia Virag

Join us to learn about our successes and challenges related to the care guide development, implementation, and evaluation and how it has impacted palliative practices and caregivers across Canada.

Residents living and dying in long-term care (LTC) homes represent one of society's most frail and marginalized populations of older adults. The average length of stay within LTC has decreased significantly in recent years making LTC a major location of death for frail older adults nationally and internationally. The purpose of this oral presentation is to provide an overview of the components of a palliative intervention, called Strengthening a Palliative Approach in Long Term Care (SPA-LTC). First, an overview of the state of knowledge about palliative care in LTC care will be provided including documented challenges to providing optimal palliative care at all stages of the LTC trajectory. Second, key areas targeted by the SPA-LTC program will be introduced including direct care components: (a) tools to support advance care planning; (b) mechanisms to trigger transitioning to end-of-life (c) family care conferences to support communication with residents and families for end-of-life planning; and capacity building components (a) interdisciplinary champion teams to support implementation; (b) data audit and feedback reflections to raise awareness and staff engagement and (c) comfort care rounds to enhance comfort and support team building. Findings and impact of this program on staff, families and residents will be discussed.

This program has the potential to improve the quality of life of older adults living and dying in LTC and provide better support to their families. It is currently being implemented and evaluated in 4 LTC homes in southern Ontario.

## Posters

### Title

Five great ideas to extend hospice services farther into the community: the results of a co-design exercise at Hospice Georgian Triangle

### Presenter(s)

Paul Holyoke, Karen Oikonen, Kelly Borg

### Description

Hospice Georgian Triangle had a vision to extend its services into the community, through digital and other means, so that more rural patients and families might benefit from what the Hospice could offer when they choose a home death.

Hospice Georgian Triangle and the Saint Elizabeth Research Centre partnered to use co-design methodology to guide the process of moving from the vision to concrete ideas and then to action. The 5 projects that emerged from the co-design process included: (1) developing a name for services to be offered to community members with life-limiting disease diagnoses before they are ready to access “palliative” or “hospice” services; (2) defining that set of services; (3) developing a more expansive Self-Care Kit to include resources and plans to respond to concerns including but beyond pain management; (4) developing a communications tool to enable patients and family caregivers and healthcare workers to share information about the journey toward death; and, (5) developing an online ‘end-of-life experience’ to help people understand the kinds of choices and decisions they may encounter as they journey toward death.

In this workshop, we will describe how the co-design process worked and who was involved, and how we narrowed a very large list of potential ideas to an essential five. We will provide details of the 5 projects and how co-design processes have continued to evolve the ideas and bring them to reality. In an interactive segment of the workshop, we will encourage and facilitate

Innovative care to honour people's wishes about where they want to die

Vicki Lejambe

discussion about the five projects.

To provide real change so that people can make the choice to die at home – what many want, but few actually get — organizations have to challenge the status quo and apply innovative models. This presentation will highlight the initiative that one home and community care organization took, partnering with acute care organizations in South Central Ontario and jointly making significant adjustments to ‘business as usual’ to make major differences in the lives of palliative care clients and their families. We will review the changes and activities that we needed to make, and the kinds of successes we have had for people.

A collaborative journey towards provincial symptom management guidelines

Kathleen Yue

The BC Center for Palliative Care (BC-CPC) was asked by several health authorities to coordinate a revision to their current Palliative Symptom Management Guidelines. Each health authority acknowledged a lack of sufficient resources to independently update their regional guidelines and desired to participate in a provincial process instead. This project fit within the Center’s strategic plan to support the creation of new hospice spaces by:

- Promoting excellence in end of life care and innovation / best practices in end of life care
- Implementing provincial end of life clinical guidelines, protocols and standards

(BC Center for Palliative Care Strategic Plan 2015)

Educators, operational leaders and clinicians in every BC health authority are collaborating to design a core set of provincial best practice guidelines. The

intent is for these guidelines to be endorsed for use by clinicians throughout BC, in every care setting, with every patient population.

This presentation will share lessons learned about facilitation of a provincial collaboration process: gaining organizational endorsement, formation of a representative steering committee, coordination of a clinician review process, involvement of patient and family representatives, and cultural sensitivity. As well, the guidelines which are completed at the time of the conference will be introduced.

A community of practice in action: moving through conflict, consensus and collaboration to synergy

Kathleen Yue

In 2015, BC-CPC met with members of the BC Learning Center for Palliative Care, key educators and organizations throughout BC in a consultation process. One of the key recommendations was formation of a Community of Practice: a self-governed partnership between organizations working together on a provincial strategy to build capacity for palliative care provision in a variety of care settings. This Community is Pall Ed BC.

The purpose of Pall Ed BC is to support health care professionals to deliver evidence-informed care to British Columbians living with serious, life-limiting illness by developing strategies and resources to support education and practice change. This community has brought together researchers, operational leaders, educators and clinicians to design, implement and evaluate a provincial education strategy.

Developing a province – wide plan required coming together of health care providers who had been dedicated to palliative care throughout their careers

with researchers, clinicians and operational leaders, many of whom were newer to the palliative philosophy. While there have been some challenges, the group has seen the benefit of learning from different perspectives and is committed to working in true synergy.

This poster will describe the process of establishing a community of practice and outline initiatives currently underway: development of a competency framework, creation of standardized symptom management guidelines, supporting palliative care in First Nations Communities, and integration of a palliative approach in residential care facilities.

Collaborative and participatory approaches to building community capacity for palliative and end of life care

Martin Labrie, Harold Pliszka, Emma Buzath

People living in rural and smaller urban areas near Calgary experience difficulty accessing palliative care services which are concentrated in metropolitan areas. The Cumming School of Medicine, Alberta Health Services and community hospice palliative care societies in two rural communities have been working to develop a partnership that incorporates local health system resources and community initiatives in supporting individuals and families living with progressive, life – limiting illnesses. This presentation will provide an understanding of how academic institutions and health services can collaborate with community members to enhance capacity for end of life care, and enrich communities in the process.

Early Palliative Care In Advanced Heart Failure

Daphna Grossman

Background:

Heart Failure (HF) is a chronic life-limiting illness that is associated with increased symptom burden, compromised quality of life and increased care needs. Palliative Care (PC) focuses on addressing and relieving symptoms as well as promoting goals of care discussions. Unfortunately, few advanced HF

patients are referred to PC.

Purpose:

To develop a collaboration between Cardiology and PC to address the PC needs of patients with advanced HF seen at the North York General Hospital (NYGH).

Methods:

In July 2014, PC team was embedded into the NYGH Heart Function Clinic. Patients with advanced HF, who screened positive using trigger criteria, were referred to PC who then met with the patient and family either with the cardiology team or immediately after the appointment.

Results:

During the study period, the number of HF patients seen by PC increased three-fold and the number of inpatient HF patients referred to PC increased by 130%. Documentation of Do Not Resuscitate, increased from 41% to 91%. Undocumented code status decreased from 34% to 2%. Results post 1-year study period has shown that the involvement of PC in HF patients has been

sustained.

Conclusion:

The involvement of PC in HF patients has enhanced goals of care discussions and documentation. PC involvement is valued by the Cardiology team, as reflected by their continued use of the trigger criteria and the sustained referrals to PC. There has also been positive feedback from patients and families, which has encouraged the expansion of PC to other advanced chronic diseases.

The Impacts of Cognitive  
Change Associated with ALS

Tamara Wells

Research into ALS is showing that there is a strong incidence of cognitive dysfunction associated with the disease beyond bvFTD. These cognitive changes impact decision making and can influence the experience of caregiving by family or others as the changes present. This presentation aims to review possible anticipated cognitive changes associated with ALS, review the importance of addressing this early in the disease course in order to support decision making, and present strategies for managing some of the changes that may present. Case examples will be used to illustrate key points.

End Stage Renal Failure-an  
urgent need for palliative care

Brian Berger

End stage renal failure therapy especially dialysis is growing at an exponential rate. Many times end of life issues may not be addressed early enough with the concern it may destroy a 'life focus' hope. In addition many of the patients may not be getting their pain and symptom needs addressed for fear of causing other medical issues. Finally patients and their families may be inadequately prepared for very end of life care. Dr Berger working in a Hospital with a large dialysis program discusses these challenges and suggests

Using Design Tools to Get  
Patients Talking

Joseph Donia

numerous advice re therapies

Design tools have been applied in business settings for some time, and are increasingly being adopted by the healthcare sector. These tools gather insights through conversations with 'actors' – those impacted by a product, service, or process. The design tool set is vast, but there is one tool in particular that can both demystify palliative care and get people talking – the journey map.

A journey map is a collaborative visualization technique that encourages stakeholders to imagine how an individual will think, feel, and act at key points. Journey maps consist of two axes. The X-axis lists time-related stages or touchpoints, while the Y-axis lists experiential components (thoughts, feelings, actions, and actors for example). Together, they allow collaborators to imagine how time and experience intersect at touchpoints, places where emotional or physical challenges may exist. By visualizing how different care settings, treatment options, and illness stages influence thoughts, feelings, and actions over time, journey maps can elucidate more informed care decisions, and facilitate innovations in care experiences.

The workshop will begin with an introduction to key service design principles. Participants will then be broken into groups, assigned an actor type (e.g. patient early stage illness, or caregiver in rural or remote community), and be asked to complete a journey map together. Groups will present their maps along with key insights to each other, and together, will cluster insights by theme to understand the value of journey maps in facilitating innovation across care settings.

The Impact of Health System  
Changes on the Delivery of  
Palliative Care at Home

Kelli Stajduhar

Patients' ability to die at home is heavily dependent on the efforts of family caregivers (FCGs). Even where patients receive home care services, the likelihood of dying at home is reduced if FCGs are unable to provide care. Our team is currently conducting an intervention aimed at identifying FCG needs for support. The intervention, however, has been challenging to implement in the context of constant changes in the home care environment. We undertook a qualitative study to document the impact of health system changes on the delivery of palliative care at home. We conducted focus groups and in-depth interviews with 29 home care nurses and 9 key informants. Data were thematically analyzed to gain insight and better understanding of how these changes were impacting nursing care specifically and home care nurses abilities to care for patients and FCGs.

Findings suggest that system issues such as increasing medical and psychosocial complexity of patients and FCGs, increasing volume of home care patients, and late admission to home care and palliative care are influencing the ability to provide quality care. Organizational changes and a drive to reduce service to patients in home care, underpinned by the need for system efficiency, were also identified. Findings also suggest home care nursing practice is changing to meet these system demands in ways that are not always aligned with the core principles and philosophies of palliative care.

The Maple Key to Wellbeing  
Project

Mary Hocking

The poster describes how a multi-pronged Health Promoting Palliative Care project grew out of a car-park salvage operation.

Joni Mitchell sang "They paved paradise and put up a parking lot"-

and Nature seems to have replied by encouraging hundreds of Japanese Maples to germinate out of our Hospital parking lot.

A “ground swell” of seedlings emerged this year- inspiring a rescue operation- that required volunteers with boots and shovels.

The project this year quickly grew to involve

Patients, families, staff, volunteers, as well as a local gardening business.

A local school is ear-marked to aid in next year’s seedling rescue operation.

The trees have been shared and replanted in a growing radius around Melbourne and we are tracking and collecting the stories that they have inspired.

Stories that may help others with the journey that they have before them.

Much more than just a “salvage operation”-the project has provided for some

patients – a sense of purpose, occupation and meaning.

For others, it has become a means of leaving a legacy in nature and via the written word.

For some families and friends – it has provided an avenue of honouring a life.

Still, for others in the community – it has been a gesture of solidarity with that positive life force that seems to be trying to “Re-seed Paradise-out of the Parking lot”.

Patient and Family Centred  
Care and the child with  
complex needs/medical  
fragility

Lisa Patterson-Morissette

How do we ensure families can cope? How do we ensure the child is properly cared for? Is raising a child with complex needs/medical fragility similar to palliative care but chronic? What can we take from palliative care to provide to this family to ensure quality of life for all, how can we improve?

Respite is a huge issue for families. Where does the child go, quality of care? Is it different in rural areas? What if accessibility is an issue? Mixing of adults and children-is it an issue-with proper supports in place? How do we ensure proper care, funding? Are volunteers available that are available to Hospice Care? Can we provide more spiritual care? Are there holistic training methods that are of interest for self care to this family?

This family is introduced to constant care, appointments, research, from the

get go while trying to love their child and function as a family. They are thrown into this quickly, for no end in sight, not that they want an end as they want to love their child that is part of their family. How can we be more compassionate in sending this new family home? What supports can we put in place before doing so? This family at some point might be looking at palliative care after years of struggling and suffering how do we keep this family strong so they can maintain that bullet proof life? Support from other families is key, understanding they themselves need a break in the beginning, having compassionate care given to their child while doing so. Connections need to be simpler for medical needs, forms need to be less, begging for continuous services need to be less. Access to respite care with properly trained and paid caregivers is essential to this family as well as the quantity of Respite care provided. Every Province should have the proper facility with proper staff in place as well as staff coming to the home. This allows families to be families not just caregivers, it allows parents to work, parents to connect with their other children and each other so they can keep themselves bullet proof!

Three Learning Objectives:

1. Awareness for the need for Hospice Care for the pediatric patient
2. Other supports already in the community that can be utilized
3. How do we send the family and patient home to ensure success in their care

L'idée de la mort en tant que naissance est ancienne, mais les recherches et découvertes de Bernard Montaud sur la naissance grâce au revécu du traumatisme périnatal en psychanalyse corporelle ont poussé l'auteur à rechercher le lien possible entre le processus de la naissance et celui de la «mourance ».

## Méthode

Hypothèse : la « mourance » se déroulerait selon le schéma des 7 étapes de la naissance. La psychothérapie de 75 de patients atteints de maladie incurable jusqu'à la mort et l'analyse des dossiers ont permis à l'auteur d'établir le parallèle pour les étapes 1 à 4. Pour identifier les 3 phases de l'agonie, l'auteur a utilisé ses observations et les recherches sur les visions au seuil de la mort et leurs états de conscience modifiée (Nearing Death Awareness NDA).

## NAISSANCE      MOURANCE

- |    |  |  |
|----|--|--|
| 1. | « Décision » de naître, premiers spasmes | 1) Diagnostic de maladie incurable     |
| 2. | Contractions non expulsives              | 2) Contractions en fin de vie : pertes |

et infirmités

3. Points de blocage du ventre    3) Points de blocage de l'attachement
4. Sortie du ventre    4) Sortie de l'identité du moi, détachement (début d'états modifiés de conscience )
5. L'imperfection humaine    5) Bilan de vie, voir sa propre imperfection
6. L'amour conditionnel des parents    6) Amour inconditionnel ou auto-jugement
7. Fermeture des grands organes des sens    7) Mort, ouverture des organes des sens

Perspectives

Ce parallèle souligne l'évolution de l'être et permet de formuler les défis pour le mourant, ses proches et les soignants, de comprendre les contenus des

états non verbaux de l'agonie et d'identifier les enjeux psychologiques et spirituels liés à chaque étape. En conférant sens, cette vision dédramatise la mourance et diminue la peur de la mort et de la souffrance. Elle dégage aussi les tâches d'accompagnement pour les proches et les soignants à chaque étape. Si le mourant vit sa mourance "tête en avant" c'est une grâce. S'il est "en siège" l'auteur donne des directions d'actes sur comment l'aider. Cette approche nous concerne tous.

A Survey of Knowledge and Attitudes of Nurses About Pain Management in End Stage Liver Disease in a Geriatric Palliative Care Unit.

Giulia-Anna Perri

Background:

Palliative care is often initiated late for patients with end stage liver disease (ESLD) with pain being a common morbidity that is under-treated throughout the disease trajectory. When admitted to a palliative care unit (PCU), nurses play a pivotal role and must be highly informed to ensure effective pain management. The aim of this study is to determine the baseline level of knowledge and attitudes of PCU nurses regarding pain management in patients with ESLD.

Methods:

A descriptive, cross-sectional self-administered survey design was used for this study. The sample comprised 35 PCU nurses working at a continuing chronic care facility in Toronto, Ontario, Canada. Data on the knowledge and attitudes of the nurses regarding pain management in patients with ESLD, was obtained using a modified version of the "Nurses Knowledge and Attitudes Survey Regarding Pain" (NKASRP) tool.

## Results:

Thirty-one PCU nurses were included for the analysis, giving a response rate of 89%. The mean total percentage score for the nurses on the modified version of the NKASRP was 72%. Only 26% of the nurse participants obtained a passing score of 80% or greater. There were no significant differences in mean total scores by age, gender, years of nursing experience or education level.

## Conclusions:

The findings of this study provide important information about the inadequate knowledge and attitude in nurses regarding pain management for patients with ESLD. It is suggested that targeted educational programs and quality improvement initiatives in pain management for patients with ESLD could improve knowledge and attitudes for PCU nurses.

la famille au maintien de soins  
palliatifs à domicile cas de la R  
D Congo

Anselme Mubeneshayi  
Kananga, Herve Kabamba  
Kananga

Personne n'ignorent l'importance de la famille considérée dans plusieurs cas comme aidant proche entre l'équipe soignante et le malade, C'est pourquoi il est prudent de relativiser cette question tout en prenant en compte d'autres facteurs tels que : le contexte dans lequel va se développer la relation Soignants/malade , la situation économique du patient et surtout du lieu où il est suivi, étant donné que la famille n'exerce pas la même influence selon que le malade est suivie en institution ou à domicile.

Quelle difference entre soins spirituels et accompagnement spirituel réalité en RD Congo

Simplice Mukaya Kananga,  
Herve Kabamaba Kananga

Les besoins spirituels sont souvent accrus face à la maladie. Les patients et leur famille obtiennent force et espoir grâce à leurs croyances religieuses spirituelles.

En R.D.Congo, en institution, plusieurs intervenants au nombre de quel les référents spirituels agissent pour la prise en charge des personnes malades admises à l'hôpital et à domicile. Ce dernier font le pont entre les intervenants interne et externe et assurent les liens avec la famille. A ce stade il est difficile de la part des soignants d'évaluer l'étendue du rôle que ces derniers jouent dans la prise en charge. Une grande partie de ce rôle pourtant très essentiels reste caché.

LA CONTINUITÉ DES SOINS  
PALLIATIFS DE L'HOPITAL AU  
DOMICILE : UNE RÉALITÉ  
COMPLEXE

Anselme Mubeneshayi  
Kananga, Simplicite Mukaya  
Kananga

Il y a aujourd'hui une demande plus importante des familles pour un retour au domicile.

De fait, un lien étroit et constant entre l'hôpital et le domicile doit être maintenu. Le souci principal de l'équipe des soins palliatifs et des équipes traitantes hospitalières est de confier un patient à un nouveau groupe de professionnels tout en s'assurant que le plan de traitement initié sera respecté.

Les équipes à l'externe, qu'elles soient d'ordre médicales, psychosociales ou scolaires, doivent être soutenues, préparées et formées pour appréhender ces situations lourdes et complexes. Dans ce contexte, l'équipe de soins palliatifs « Palliafamili » a mis à son expertise à profit et leurs outils d'évaluation et de gestion de symptômes dans le contexte locale de la R D

## Congo

L'équipe médicale de PalliaFamilli a également un rôle essentiel dans le maintien du contact dit « triangulaire » : Hôpital-famille-externe pour ne pas créer un sentiment d'abandon de la part des familles

Use of Methadone as an  
Adjuvant Medication to Low-  
Dose Opioids for Neuropathic  
Pain in the Frail Elderly

Tammy Bach, Daphna  
Grossman, Anne Kirstein

### Introduction

Palliative care physicians are increasingly involved in managing elderly patients with complex neuropathic pain. In the frail elderly, opioids and pain adjuvants can result in unwanted effects such as sedation, confusion and falls. Most pain adjuvants are taken orally, which is a challenge for patients with advanced dementia or neurodegenerative diseases. Furthermore, dosing of most pain adjuvants is limited by renal function. Methadone is an opioid analgesic with evidence supporting its use for neuropathic pain, however it is used rarely in the frail elderly. Our presentation will discuss the role of methadone in treating neuropathic pain, review its advantages and disadvantages compared to other pain adjuvants, and introduce an approach to its use.

### Methods

A current literature review addressing the use of adjuvant methadone in managing complex non-malignant neuropathic pain in the frail elderly is

presented with examples of real-life cases to support its use.

## Results

Current literature on the use of adjuvant methadone is sparse, however the results are promising for its safety and efficacy. Methadone has no neurotoxic metabolites, is excreted by the bowels, and can be administered via various routes. Our case reports demonstrate the use of methadone from 0.5 to 5mg daily, much lower doses compared to what is reported in literature, alongside conventional opioids in order to provide relief from neuropathic pain.

## Conclusion

The use of adjuvant methadone is safe and effective in managing complex neuropathic pain in the frail elderly who cannot tolerate increasing doses of conventional opioids and pain adjuvants.

What are the attitudes and perceptions on death and dying in hospital, of adult patients and families who have received palliative care?

Diana Bowalgaha Ralalage

Many people prefer to die at home, and family members are often keen to uphold this wish for their dying loved one. However, some have no alternative, but to stay in hospital during this precious time. Health professionals have one chance only to make a positive difference to a patient's dying journey. This systematic review of qualitative primary research articles focused on the perspectives of patients and families who received palliative care services, with the aim of understanding their attitudes and

perceptions on death and dying in hospital.

A comprehensive search for articles between 2004 to 2014, in 17 databases, was conducted. The Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI QARI) critical appraisal checklist was used to assess methodological quality, and the JBI data extraction form was used to extract data. Data was synthesised by utilising the concept of thematic analysis, and the findings were reported in a narrative format.

Conversations around death and dying need to take place between patients, families and health professionals. This will facilitate patients to voice their opinions and choices when considering their own death, and lift the burden of decision-making from family members. It is imperative that nurses look after not only the dying patient, but also their family, as family members will go on to live with these memories of their loved one. Dying is a uniquely special time, and it should be treated as such.

Poursuite de la ventilation non  
invasive en fin de vie

Nathalie Dieudonné Rahm,  
Jérôme Mercier

Les patients atteints de sclérose latérale amyotrophique, demandeurs de poursuivre la ventilation non invasive, jusqu'en fin de vie, ne sont pas rares. La gestion de la ventilation non invasive en fin de vie pose des problèmes émotionnels, pratiques et éthiques. Dans les situations où un patient choisit de bénéficier de la ventilation non invasive jusqu'à son décès, la poursuite de la ventilation non invasive en mode spontané dès la survenue d'une carbonarcose ou d'une décompensation respiratoire aiguë irréversible, et ce jusqu'au décès, est une alternative faisable et éthiquement acceptable à la discontinuation simple de la ventilation. Dans les cas où un spécialiste de la ventilation non invasive n'est pas disponible en permanence, il est possible de préenregistrer un deuxième jeu de réglages du ventilateur pour permettre un

<p>Inpatient Palliative Trigger Tool: A Pilot Study</p>	<p>Donald Mcdonah, Kristin Fox, Colleen Flaherty</p>	<p>changement rapide et simple de mode ventilatoire.</p> <p>Patients admitted to the medical surgical oncology unit often have complex medical processes. Palliative care needs of hospitalized patients often go unmet. These medically complex patients often have unrelieved symptoms, unclear goals of care, poor understanding of their disease state and a lack of understanding about advanced care planning. This pilot study had three primary aims:</p> <ol style="list-style-type: none"> <li>1. Identify whether a palliative care trigger tool as part of the nursing admission assessment would help in the identification of patients with palliative needs.</li> <li>2. Determine the specific palliative needs of the patient including symptom management and goals of care.</li> <li>3. Completion of advanced directives.</li> </ol>
<p>Implementation Barriers to Medical Assistance in Dying: A Scoping Review</p>	<p>Jamie Fujioka</p>	<p>When Canadian Parliament passed Bill C-14, physicians and nurse practitioners were granted the legal ability to provide medical assistance in dying (MAID) for competent adults with “grievous and irremediable” life-terminating illness. However, the timely delivery of MAID is challenged by complex ethical, legal and pragmatic barriers, thus, delaying services to those seeking permission to die. While new federal legislation often lacks initial clarity and consistency, the controversy and moral debate surrounding medically assisted death has deterred professionals from the practice. In addition, the medical profession, including hospice staff, physicians, nurse practitioners and pharmacists, have yet to mobilize practical guidelines and a streamlined response to patients requesting MAID. Drawing on evidence from regions where physician-assisted death has been legalized, a scoping review was conducted to synthesize literature on key implementation barriers to</p>

inform practical solutions. An exhaustive database search using keyword strings yielded 3000+ articles. Abstracts were manually curated with 352 studies fulfilling inclusion criteria. Studies of practitioner perspectives on medically-assisted death highlighted four main challenges (N=38): establishing objective and stringent criteria for qualifying cases (N=11), balancing legal safeguards to protect practitioners while simultaneously maintaining access to all who qualify (N=8), ensuring that personal characteristics of medical professionals (i.e. religious beliefs) do not interfere with ethical and objective decision-making (N=12), and training practitioners to be adequately equipped to communicate MAID services (N=7). Findings from this scoping review inform policy, practice and research, and highlight that vulnerable populations, such those with mental health issues, require additional safeguards.

Medical Assistance in Dying (MAID): A Person Centred Approach for Patients and Health Care Providers

Melody Boyd

The WHO Definition of Palliative Care (1990) states that palliative care affirms life and regards dying as part of the normal process of living and neither hastens or prolongs dying. Medical Assistance in Dying (MAID) refers to a doctor or nurse practitioner helping a person, at their request, to end their life. Studies of health care providers' attitudes and willingness to be involved in MAID show that palliative care providers are least likely to be in favour. There is evidence that palliative care interventions can mitigate the desire to die and people who at one time would have requested MAID during the course of their terminal illness, change their minds along the way. Moral distress is a significant issue in palliative care and MAID only adds to this moral complexity. If moral distress is not managed effectively, the crescendo effect model posits that a residue lingers creating a negative outcome for the individual impacted. To avoid moral distress among health-care providers, it is important to ensure they are supported, emotionally, psychologically and ethically such that the risk of the moral residue crescendo effect is mitigated. Resilience is the ability to withstand or recover from difficult situations and

Towards an Understanding of  
How Aboriginal Status Impacts  
Palliative and End-of-Life Care  
for Older Adults (55+) in  
Canada: A Scoping Review

Alison Dillman

includes our capacity to make the best of things, and to cope with stress. An overview of the MAID process will be presented with strategies to mitigate moral distress and the residue crescendo effect. A Regional model for accessing MAID and the results of a MAID Moral Distress Consult Service will be presented.

Not only does the Aboriginal population face a disproportionate burden of disease and disability situated within a harmful context of inequity throughout the life course, Aboriginal seniors (55 years and over) in Canada do not have adequate access to palliative or end-of-life care. This is an important and complex issue experienced by a vulnerable and marginalized population that deserves attention, and highlights that the healthcare needs and challenges of the Aboriginal senior population have been largely neglected. Access to meaningful and respectful palliative care to reflect the diverse needs of marginalized populations situated within broader national and international contexts is needed. A scoping review was conducted to synthesize existing knowledge on the effect of Aboriginal status on palliative care for older adults (55+) in Canada. Keywords were identified and exhaustive searches of multiple databases performed, including AgeLINE, Ovid MEDLine, PsycINFO, EMBASE and Applied Social Sciences Index & Abstracts (ASSIA). Eight studies were selected for review from the database search. Two additional studies were discovered by screening reference lists of selected studies. Eight major themes were identified across the reviewed studies, including: (1) access to healthcare; (2) tradition, culture and spirituality; (3) family and community; (4) communication; (5) respect; (6) end-of-life decisions; (7) social determinants of health; and (8) unique individual needs. The reviewed studies highlight the need for future research, policy and practice to ensure consistent standards of care at end-of-life, and more comprehensive approaches for the provision of services to address underlying drivers of social, political and economic inequity.

The Flipped Learning Program  
of Bereavement Assessment

Yu-Hsuan Wang

This study aims to provide a bereavement assessment training program to enhance the quality of palliative care. Grief is an important issue in palliative care domain. There is an ongoing development of systematic bereavement service in Taiwan. At hospice ward of Changhua Christian Hospital, we use Bereavement Risk Assessment Tool Revised (BRAT-R) to enhance our bereavement program through evidence-based bereavement assessment, predict complications for bereaved persons, improve communication among team members, provide interview guideline, and provide following bereavement care service. The BRAT-R is comprised of 40 items, which could function as guidelines for interviews. However, according to previous studies, the inter-rater reliability ranges between 0.05 and 0.97, which means that a program must be established to improve the reliability among team members. Therefore, we develop a series of flipped learning programs in which team members could preview materials through the Internet and discuss in class.

Pre- and post-program evaluation for inter-rater reliability were conducted, and course evaluation questionnaires were also collected. Results shows that: (1) the mean inter-rater reliability before the training is 0.43; the mean inter-rater reliability after training is 0.71. (2) Course evaluation questionnaires show that it is more efficient to learn BRAT-R items in flipped learning program than through face-to-face teaching. The finding proves that this training program can help team members learn more efficiently, reach consensus about bereavement assessment, and provide reliable bereavement assessment.

Palliative care education –  
applying strategic planning  
and instructional design model

Margo D'Archangelo

Victoria Hospice (VH) has a long history of providing educational opportunities for clinicians, volunteers, families and the community. These activities attract attendees not only locally but also from across BC, Canada and beyond. In

to program development

2015, VH began a strategic process guided by an instructional design model (ADDIE – Analyze, Design, Develop, Implement, Evaluate). The goal was to review its education activities aligning content and structure with professional competencies and adult education theories. The process included internal and external discussions and culminated with the establishment of three key principles to steer the review: (1) ensuring broad awareness and understanding of the palliative approach to care, in order to improve access to resources for those facing end-of-life issues, paying special attention to rural and remote populations; (2) increasing capacity to deliver end-of-life care for volunteers and professionals through knowledge and skill development that reflect learner’s level of expertise; and (3) basing education activities in adult education theory that reflects the needs and expectations of today’s learners. Whole learning activities should have up-to-date materials, be culturally literate, be learner-focused, and include meaningful evaluation and follow-up. Through this strategic thinking process the current courses have been revised and a new education program is currently being developed with launch expected by mid-2017.

Care Provider Grief: The Impact on Staff & Volunteers

Maeve Blake, Sandra Watson

This workshop will commence by defining and detailing the unique features of care-provider grief, which is an often over-looked phenomenon in the health-care setting. It will reflect the many ways in which staff and volunteers at a community hospice are impacted on both a personal and professional level by the deaths of the patients they work with. The concept and the long-term effects of multiples losses will be considered. Through audience participation and discussion, opportunities for the development and enhancement of resilience will be identified.

Factors associated with Palliative Care referral at end of life in a community hospital - a retrospective case-control

Evan Schneider, Emily Harrison

Despite the known benefits of palliative care involvement for patients nearing end of life, several barriers impede patient access to inpatient palliative care referral. Our study aims to identify factors that are associated with palliative care referral for patients at end of life. A retrospective chart review is

study

currently being conducted of all patients who died in St. Joseph's Health Centre (Toronto, Ontario) during 2015. Using a case-control study design, patients who were referred to the palliative care consultation service prior to death will be compared to those who did not receive a formal palliative care consultation. Variables to be incorporated in the analysis will include demographic information, palliative diagnosis, code status, end of life symptom management, and hospital factors (including most responsible service and location in hospital). Preliminary descriptive statistics revealed that there were 632 inpatient deaths in 2015. Of these patients, 60 (9.5%) were seen by the Palliative Care service. Of the patients seen by Palliative Care, 35 (53.3%) had a documented cancer diagnosis, 14 (23.3%) had a non-cancer diagnosis, and diagnosis was not specified for 11 (18.3%). The majority of patients were seen by Palliative Care within one week of admission (56.7%). Completion of this study will provide new insight regarding the broader patient population who may benefit from, but are currently not receiving, formal palliative care consultation.

Spiritual care at Victoria  
Hospice: knowledge exchange  
and quality improvement  
supporting practice change

Helena Daudt

Spiritual care has been an integral part of palliative care since its inception. However, people with advanced illnesses frequently report that their medical care team does not attend to their spiritual needs. To address this paradox Victoria Hospice became a pilot site for the Sacred Art of Living and Dying Program in 2014-2015. The program aims to provide tools to recognize and respond to spiritual pain, stimulating culture change. More than 40 staff and volunteers participated. In order to evaluate the expected culture change, staff and volunteers were engaged into a Quality Improvement project using a mixed methods approach. Surveys, interviews and focus group inquired into the impact of the program on culture and practice of spiritual care. Qualitative data analysis using Braun and Clarke (2006) Thematic Analysis is underway. Chart and administrative data reviews are also being conducted. We are using the Knowledge Exchange-Decision Support framework

(Kazanjian et al 2011) to guide the evaluation process. This model, based on an iterative approach, involves researchers, clinicians and any relevant stakeholders. The focus on process aims to be inclusive of different types of knowledge, such as experiential, tacit as well as scientific research. Interim data analysis suggests that the program had a profound impact on individuals and is slowly shifting practice patterns at our Hospice including language, use of specific tools and behaviors (e.g. being present and deep listening). The results of this project will be presented to Hospice leadership and guide next steps related to spiritual care education and practice.

Palliative Care Quality  
Standard: Guiding evidence-  
based, high-quality palliative  
care in Ontario

Lisa Ye, Tara Walton

Background: One of the mandates of the Ontario Palliative Care Network (OPCN) and Health Quality Ontario (HQO) is to develop provincial clinical standards.

Objective: To develop a Palliative Care Quality Standard – a concise-set of evidence-based, measurable statements with associated quality indicators and supports for implementation – based on the best available evidence, focused on people with progressive life-limiting illness, their caregivers, and their healthcare professionals.

Methods: Guided by a multi-disciplinary working group, the development process included: background research and scoping, open call working group recruitment, stakeholder identification, analysis of Ontario data, selection and critical appraisal of guidelines, prioritization of outcomes and topic areas, development of quality statements and indicators, development of an implementation plan, and public consultation.

The working group includes clinicians, individuals with lived experience and representation across sectors in Ontario to ensure health linkages for an integrated approach to palliative care. Key outcomes and topic areas for quality statements were identified through an environmental scan, a review of guideline recommendations, and of open call responses. Topic areas are prioritized as key areas for quality improvement. The outcomes and topic areas are ranked by the working group via survey.

Results: The prioritization survey results support the development of quality statements and indicators. The working group selects 3-5 key outcomes and 5-10 priority areas to guide the development of quality statements in the quality standard.

Conclusions: The quality standard provides an evidence-based resource outlining what high-quality care should look like to help teams and providers prioritize improvement efforts and measure success.

Living well until the end: data analysis and lived experience of the variation in treatment received by patients at the end of life

Naira Yeritsyan

“It’s really about giving me energy... joy in my days to do what I need to do,” said Pat, whose views on palliative care, life and death were captured in a video before she died at her home in 2014.

Pat, other patients, and their caregivers shared how difficult it can be for people to navigate the health system to receive palliative care, where and when they want it. Our research looked at the variation in the care and

services patients received during the last month of life.

We examined data on the more than 54,000 people in Ontario who died in 2014/15 and had a record of receiving palliative care services in their last year of life. We looked at the characteristics of the care they received and some of their outcomes. We also included results of a survey of caregivers for patients who died in selected residential hospices.

We showed that palliative care started in the last month of life for half of palliative care patients in Ontario. Nearly two-thirds (62.7%) had unplanned visits to the emergency department in their last month of life, about one-quarter (25.8%) spent half of their last month of life or longer in hospital, and the majority (64.9%) of all palliative care patients died in hospital. Less than half (43.3%) of palliative care patients received palliative home care services and about one-third (34.4%) received one or more home visits from a doctor.

Bereavement - It's Effect on Work, Careers, and the Workplace Donna M Wilson

This will focus on the issue that no information exists on leaves from work for bereavement, or the impact of bereavement grief on work, careers, and the workplace. Evidence on this will then be provided.

Primary Thromboprophylaxis in Noncancer Patients Admitted to a Geriatric Palliative Care Unit Giulia-Anna Perri

Objectives

Patients with end-stage, noncancer disease are increasing in prevalence on Palliative Care Units. The aim of this study was to compare venous thromboembolism (VTE) prophylaxis in elderly patients with noncancer diagnoses to those with advanced cancer on a dedicated Palliative Care Unit.

## Methods

This was a retrospective chart review for all patients admitted to and discharged from the Baycrest Health Sciences PCU in 2015. We measured the association between demographic data and palliative performance scale, admission source and length of stay in patients with cancer and noncancer diagnoses.

## Results

316 patients were included in the final analysis, 56 (17.7%) with a noncancer diagnosis. VTE Prophylaxis was administered in 31.8% of the cancer patients and 26.8% of the noncancer patients ( $p=0.285$ ). Patients admitted from hospital were more likely to receive VTE prophylaxis (39.8% vs 13.7%;  $p<0.05$ ). Mean admission PPS score was 31.43 for noncancer and 36.04 for cancer patients ( $p<0.05$ ). Length of stay was shorter for patients with a PPS $\geq$ 30 (18.64 vs 33.62 days;  $p<0.05$ ). The rate of VTE prophylaxis in bedbound patients was similar to that in ambulatory patients (29.8% vs 32.2%;  $p=0.363$ ).

## Conclusion

Approximately one-third of all patients admitted to the Baycrest PCU regardless of cancer or noncancer diagnosis were given VTE prophylaxis. Patients with noncancer diagnoses were significantly younger, and had a lower PPS and shorter LOS compared to cancer patients. Further research would help to better guide VTE prophylaxis decisions and minimize suffering for patients at the end of life.

Advance Directives and their  
Impact on Cost of Care

Rayelle Richard

The sustainability of our current healthcare system has been a growing issue for some years, as ages rise and healthcare costs follow. It has long been established that patients may require an especially large amount of financial resources as they near the end of life. An advance directive (AD), in the form of documentation specifying an individual's will and wishes should he or she become too ill to communicate them effectively, may allow for such a sense of agency at end of life. Patients prioritize a sense of control and an avoidance of unnecessary prolonging of life as key features of end of life care. Furthermore, evidence suggests that ADs enhance satisfaction with the care received. ADs may even help cut costs by promoting effective healthcare and avoiding unnecessary interventions. A systematic review was conducted to evaluate the effect of advance directive initiatives on cost of care. Although 651 studies were originally canvassed, only six met all inclusion criteria. This systematic review summarized the available studies of the past 15 regarding the correlation of AD efforts with cost savings ; an analysis of each selected study's methodological quality was also led in order to contextualize the results. The conclusion of the review indicated that advance directives paired with educational initiatives or palliative care are correlated with a reduction in costs.

Navigating the Meaning,  
Significance and Context:  
Mothers and Daughters in

Pamela Grassau

This study focuses on the cathexis, the flow of energy that moves between mothers and daughters as they navigate the meaning, significance and context of their connection as a mother is at the end of her life. Drawing on feminist epistemology and relational cultural theory this study examines how

## End-of-Life and Bereavement

mothers and daughters experience care, dignity, and support at this time in their lives.

This study draws on multiple end-of life conversations with 20 mothers and adult daughters as a mother is receiving palliative or hospice based end of life care. Guided by a narrative methodology and joint/dyadic interviews, mothers and daughters shared relational stories from the past, present and thoughts about the future. Follow-up bereavement interviews with daughters, offered daughters the opportunity to share their learning, insights and perspectives six to eight months after the loss of their mothers.

Applying a narrative thematic and dialogic/performance analytic approach, end of life relational stories were examined to further our understanding of the specific elements that flow between mothers and daughters, and how and why experiences of end of life are experienced and performed in particular ways. Findings across the two analytic approaches reflect interwoven processes between mothers and daughters which are individual, relational and intersubjective.

This study strongly encourages clinical and research practices to expand to dyadic interviews and interventions in end of life, with an emphasis on what we can learn if we carefully listen to what, how and why people say things in particular ways.

You will know when you know: Sheryl Shermak  
Everyday life with metastatic

In the contemporary landscape of rapid changes in biotechnologies, a number of life-limiting illnesses once characterized primarily by trajectories of decline

breast cancer as a chronic health condition

now have the potential to become chronic conditions. Metastatic breast cancer (MBC) is one of the documented and growing chronic life-limiting illness populations. There are many questions around what are realities of daily life for individuals living with MBC long-term and what are their healthcare needs? Contributing to emerging healthcare conversations on chronic life-limiting illness and ambiguous forms of dying, the purpose of this doctoral research project was to provide insight into living within the suspended terrain of chronic MBC, while considering the context of non-urban community. This qualitative study found that destabilization of the body permeates life with chronic MBC in both unexpected and irregular ways. Illness is characterized by a) novel experiences with time and b) living in transitions. Time is experienced as a mix of confining routines and sudden changes, and in day-to-day moments illness may or may not be a discernible presence. Liminal transitions also characterize life with chronic MBC; where women find themselves needing to make critical choices without adequate information, and navigating horizons of hope that wax and wane. Findings suggest that everyday life with chronic MBC is an embodied terrain of contradictions and uncertainties, where women build maintenance routines around fragmented healthcare services. Participants will leave this presentation with a greater understanding of challenges faced by individuals living with chronic forms of MBC.

Quick and simple expansion of bereavement education offerings with film-based discussion. Kathy Sparnins

Dealing with grief is difficult in our death-phobic society. This program illustrates how hospice providers can utilize a new documentary film to expand their bereavement support offerings and reach the under-served population that does not currently utilize bereavement support services. The 42-minute film, "Voices of Grief, Honoring the Sacred Journey" and supporting discussion materials are being made available to all US and Canadian hospice organizations at no cost. It helps support clients in a time of loss, engages family members in open discussion about grief, encourage

individuals' explorations of their personal grief journeys, and builds community and compassion during one of the most stressful times in an individual's life. The film features interviews with today's foremost thought leaders in the fields of grief, bereavement, and spirituality interwoven with everyday people's personal accounts of loss and transformation.