Palliative Care Quality Standard: Guiding Evidence-Based, High-Quality Palliative Care in Ontario

Presented by:
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Presentation Objectives

• Introduce the Palliative Care Quality Standard
  – What is a quality standard?
  – How do we develop quality standards?
  – What is the scope and timeline of the Palliative Care Quality Standard?

• Approach to support quality standard adoption
  – What is our approach for implementation and adoption?

• Help identify your role in the process
  – What opportunities are there for stakeholder engagement?
Working Together

• The Ontario Palliative Care Network (OPCN) is:
  – A partnership of community stakeholders, health service providers and health systems planners
  – Developing a coordinated and standardized approach for delivering hospice palliative care in Ontario
  – Funded by the Ministry of Health and Long-Term Care

• Health Quality Ontario (HQO) is the provincial advisor on the quality of health care

• As a key partner in the OPCN, HQO is supporting the development of a new quality standard focused on palliative care
Develop Evidence Based Guidance
Support Quality Improvement and Adoption
Monitor and Report on the Quality of the System

Health Quality Ontario

Let's make our health system healthier

Strategic Partnerships and Patient Engagement
• **Accessible:** for patients to know what care to expect; and for clinicians to easily know what care they should be providing

• **Concise:** five to 15 quality statements

• **Measurable:** each quality statement is accompanied by one or more process indicators and if appropriate, structural indicators

• **Implementable:** associated quality improvement tools and resources specific to each quality standard, to support adoption
Quality Standard Products

- A clinical guide
- A patient reference guide
- Implementation supports (e.g., recommendations for adoption, a getting started guide)
- An information and data brief
Example: Clinical Guide

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http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/Behavioural-Symptoms-of-Dementia
Individualized Nonpharmacological Interventions

People living with dementia and symptoms of agitation or aggression receive nonpharmacological interventions that are tailored to their specific needs, symptoms, and preferences, as specified in their individualized care plan.

Background

There are a variety of nonpharmacological interventions that can be effective in managing symptoms of agitation or aggression in people living with dementia. Treatment approaches should include a combination of nonpharmacological interventions that are individualized based on the person’s needs, symptoms, preferences, and history. Nonpharmacological interventions may be oriented to the senses (e.g., aromatherapy, multisensory therapy) or cognition (e.g., reminiscence therapy) and should have demonstrated effectiveness in improving behavioral and psychological symptoms of dementia. Recreational activities and exercise may also improve a person’s ability to function and their quality of life.


The Audience Statements

What This Quality Statement Means

For Patients
Non-drug treatments should be tried first.

For Clinicians
Before considering drug therapy, offer people at least three nonpharmacological interventions (described in the Definitions section of this statement) for managing their symptoms. Tailor nonpharmacological therapies to people’s needs, symptoms, preferences, and history, as documented in their individualized care plan.

For Health Services
Ensure that hospitals and long-term care homes have the systems, processes, and resources in place to offer a variety of nonpharmacological interventions (described in the Definitions section of this statement).

Definitions

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Nonpharmacological interventions
Effective nonpharmacological interventions may include the following:
- Aromatherapy
- Multisensory therapy
- Music therapy
- Dance therapy
- Pet-assisted therapy
- Massage therapy
- Reminiscence therapy
- Recreational activities
- Physical activity

This list is not intended to be exhaustive. Other nonpharmacological interventions may also be effective for some individuals.

Quality Indicators

Process Indicators

Percentage of people living with dementia and symptoms of agitation or aggression who are offered nonpharmacological interventions
- Denominator: total number of people living with dementia and symptoms of agitation or aggression
- Numerator: number of people in the denominator who are offered at least three nonpharmacological interventions
- Data source: local data collection

Percentage of people living with dementia and symptoms of agitation or aggression who receive nonpharmacological interventions as specified in their individualized care plan
- Denominator: total number of people living with dementia and symptoms of agitation or aggression who have an individualized care plan
- Numerator: number of people in the denominator who receive nonpharmacological interventions as specified in their individualized care plan
- Data source: local data collection

Structural Indicator

Availability of three or more evidence-based nonpharmacological interventions to manage the symptoms of agitation and aggression in people living with dementia
- Data source: local data collection
Patients, residents, families, and health care professionals partnered together on this guide to define what the best care should look like for people living with dementia and experiencing behavioural symptoms such as agitation or aggression. The information in this guide has been created to help patients, residents, families, and caregivers know what to ask for when receiving treatment in a hospital or long-term care home. It is based on the best available research and is designed to help ensure the highest-quality care possible.

If you or your loved one is living with dementia and experiencing behavioural symptoms...

You can use this list of recommendations to help you and your health care professionals develop a care plan that works for you. You should use this information to become aware of what high-quality care looks like and to ask informed questions about your care. Care plans can be very different for each person, so it is important to work closely with your health care professionals.

Here are some things to consider if you or a loved one is being treated in a hospital or long-term care home.

Understanding and Planning Your Care

- You should receive an examination and full assessment every time you arrive at or leave a hospital or long-term care home. An assessment means that your care team will want to learn more about you to understand how best to help you. It should include questions about your physical health, your medical history, what medications you’re taking, how you spend your time, and how you’re feeling.
- A care plan should be created to meet your individual needs. A care plan is a written statement that describes the care you receive, who provides it, and what medications you are on. It is based on your full assessment.
- No changes should be made to your treatment until you have been given information about their benefits and harms and have agreed to these changes. In very rare circumstances, where someone is at risk of being hurt, you might be treated first and then provided with information as soon as possible.
- You should receive care from a team of health care professionals who have been trained to care for people living with dementia.

Example: Implementation Tools and Supports
Completed Quality Standards

- Quality Standards published to date are available at [http://www.hqontario.ca](http://www.hqontario.ca)

- 13 other topics currently in development
Based on the data from HQO’s 2016 *Palliative Care at the End of Life* report, more than 54,000 people in Ontario were determined to have received palliative care services between April 2014 and the end of March 2015.
Reviewing the Evidence

- A systematic search conducted for clinical practice guidelines

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<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th>Country</th>
<th>Title</th>
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<tbody>
<tr>
<td>1</td>
<td>National Institute for Health and Care Excellence (NICE)</td>
<td>United Kingdom</td>
<td>Caring of Dying Adults in the Last Days of Life</td>
</tr>
<tr>
<td>2</td>
<td>Ontario Health Technology Advisory Committee (OHTAC)</td>
<td>Canada</td>
<td>End-of-Life Health Care in Ontario: OHTAC Recommendations</td>
</tr>
<tr>
<td>3</td>
<td>Institute for Clinical Systems Improvement (ICSI)</td>
<td>United States</td>
<td>Palliative Care for Adults</td>
</tr>
<tr>
<td>4</td>
<td>Registered Nurses’ Association of Ontario (RNAO)</td>
<td>Canada</td>
<td>End of Life Care During the Last Days and Hours</td>
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</table>

- Guidelines were critically appraised using the AGREE II Instrument
Palliative Care Quality Standard: Scope

**In Scope:**
Adults 18 years or older with progressive life-limiting illnesses from which they are not expected to recover

General palliative care content

**Out of Scope:**
Individuals under 18 years of age
Condition-specific content

- All health conditions
- All settings
- All health care providers
25 Members
Palliative Care Quality Standard Working Group

Lived Experience Advisors

Physicians

Allied Health: Social Worker, Occupational Therapist, Pharmacist

Registered Nurses & Nurse Practitioners

Spiritual Care Provider

Ethicist, Barrister & Solicitor

Palliative Care Volunteers

Administrators, Researchers
Palliative Care Quality Standard Development Timeline

Spring to Fall 2017: Development and implementation planning meetings

Fall 2017: Public consultation and stakeholder engagement

Winter 2017-18: Finalizing quality standard products

Winter 2018: HQO board and OPCN Executive Oversight approval

Spring 2018: Quality Standard launch and implementation

www.HQOntario.ca
Prioritized Palliative Care Topic Areas

- Identification & Assessment of Needs
- Advance Care Planning – Substitute Decision Maker
- Discussions & Goals of Care
- Caregiver Support
- Pain & Symptom Management; Psychosocial Aspects of Care
- Individualized, Person-Centered Care Plan
- Education
- Transitions in Care
- Setting of Care and Place of Death

Access to Palliative Care Services / Intro-professional Team-Based Care
Stakeholder Engagement Opportunities

• Public Consultation – Fall 2017:
  ➢ The draft quality standard will be posted on the HQO website for 3 weeks and open for public feedback

• Join our Mailing List:
  ➢ qualitystandards@hqontario.ca
  ➢ We will notify stakeholders once the draft quality standard is available online; we will reach out to you for any stakeholder engagement opportunities (2-3 emails/year)
APPROACH TO SUPPORT QUALITY STANDARD ADOPTION
What Does Successful Adoption Look Like?

Patient and Caregivers
- Know that the quality standard exists
- Know where to access it
- Use the quality standard
- Know what to anticipate
- Feel empowered by it

Providers
- Know that the quality standard exists
- Share and use the quality standard with their patients
- Embed quality standards into their practice

Health System Partners
- Actively share and promote quality standards
- Incorporate the quality standard into professional education
- Request new topics
- Use quality standards:
  - for monitoring & reporting
  - to guide QI initiatives
  - for funding decisions
Quality Standard Adoption

• Two major activities for each standard:

1. Develop quality standard adoption recommendations
2. Resources to support adoption & improvement

Recommendations For Adoption:
• Recommendations will be unique for a given standard
• Informed by the Quality Standards Working Group, evidence informed strategies and broad consultations with key stakeholders, including regional and local context
• Reflects a system-level approach
• Forms the basis of formal ‘recommendations’ for each standard
Quality Standard Adoption:

1. Develop the Adoption Recommendations
   - Readiness assessment including regional context
   - Use of levers (contracts, QIP)
   - Identified needs for clinical tools
   - Proposed Quality Improvement strategies
   - Partners (specific to each of above)
   - Resources / costs
   - Expectations on timing (what can start immediately or is longer term)
   - Monitoring and evaluation plan
   - Policy or regulatory implications

2. Resources to support adoption and Improvement
   - Getting started guide
   - Clinical pathways
   - Decision aids
   - Order sets, methods to embed in systems of care
   - Audit & feedback
   - Education / training

*appropriate partners and existing programs where they exist
Regional Contextualization
What we heard about gaps and facilitators to adoption

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<thead>
<tr>
<th>Topics</th>
<th>Facilitators</th>
<th>Gaps</th>
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</table>
| **1. Identification for palliative care** | • Gold Standard framework  
• SPICT tool a 5-point scale for early identification | • Lack of palliative care physicians in some areas, making referral for people with non-cancer diagnosis challenging |
| **2. Illness understanding, advance care planning, and goals of care** | • Public health involvement to help reduce stigma around death and dying  
• Help frontline clinicians understand when to initiate ACP | |
| **3. Assessment of needs** | • Improve access to allied health professionals (e.g. SW, PT, OT) and spiritual care | • Limited access to equipment provided at home  
• Variation in response time from physicians vary across the province |
What we heard about gaps and facilitators to adoption

<table>
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<tr>
<th>Topics</th>
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<tbody>
<tr>
<td>4. Individualized, person-centred care plan</td>
<td>• Enable health care professionals to work to their full scope of practice</td>
<td>• Variations in coverage of services within and across LHIN(s)</td>
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<tr>
<td>5. Management of pain and symptoms</td>
<td>• Enable health care professionals to work to their full scope of practice</td>
<td>• Health human resources issues</td>
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<td></td>
<td>• Access to hospice staff and volunteers that provide home visits</td>
<td>• Nursing staff ratio in community and LTC settings is low</td>
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<td></td>
<td>• Integrated palliative care community team: patient navigator, care</td>
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<tr>
<td></td>
<td>coordination, supportive care counselor, bereavement support, social work</td>
<td></td>
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<td></td>
<td>• Compassionate City Charter and Volunteer Navigator Program</td>
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<tr>
<td>6. Psychosocial aspects of care</td>
<td>• Access to hospice staff and volunteers that provide home visits</td>
<td>• Rural communities have limited resources and access to psychosocial support programs</td>
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<td></td>
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<td>• Compassionate City Charter and Volunteer Navigator Program</td>
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<td>7. Education for health care professionals</td>
<td>• Continue to support education on palliative nursing</td>
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<td>and volunteers</td>
<td>• Competency training for PSWs</td>
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<td></td>
<td>• Leverage PPSMC programs and services</td>
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<tr>
<td>8. Health information and education for patients, families and caregivers</td>
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<tr>
<td>9. Setting of care and place of death</td>
<td>• VOICES survey</td>
<td>• People with a prognosis of 3 to 6 months can’t return home, neither eligible for hospice residential home</td>
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<tr>
<td>10. Models of care</td>
<td>• Focus on building capacity for primary-level palliative care</td>
<td>• Limited funding to support the development of health information systems or technology solutions in hospices</td>
</tr>
<tr>
<td>11. Transitions in care</td>
<td>• Leverage local volunteer programs</td>
<td>• Drug coverage is different between hospital-based to community-based setting</td>
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Discussion Questions

1. What initiatives are you involved in that could support the implementation of the Palliative Care Quality Standard?

2. Based on the prioritized topic areas, what are some barriers and gaps for individuals to receive palliative care in Ontario?

3. Who are the natural partners and champions that could support adoption of the Palliative Care Quality Standard?
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Your Role in the Process

• Some ideas for how you can get involved:
  - Provide feedback during public consultation
  - Identify opportunities to embed the quality standard within your practice
  - Share tools, templates, and innovative practices
  - Promote the quality standard within your networks
QUESTIONS?

Please contact us:

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