

ASSESSING ANTECEDENT CONDITIONS FOR DEVELOPING PALLIATIVE CARE PROGRAMS IN LONG TERM CARE HOMES

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BACKGROUND

In Canada, approximately 39% of residents die in long-term care (LTC) homes each year. However, most LTC homes lack formalized palliative care (PC) programs that provide holistic palliative care for residents & their family members. LTC funding, legislation & compliance regulations have not acknowledged and supported the role of LTC in caring for dying people. Participatory Action Research is currently underway by a Quality Palliative Care in Long Term Care Alliance to create PC programs in LTC homes & develop a tool kit of interventions to support a cultural change for LTC homes.

OBJECTIVE

A community capacity development model is being used as a theory of change to develop PC programs. The 4 phase model, depicted in the figure below as a growing tree, illustrates a bottom-up & sequential change process. Phase 1, Having Antecedent Conditions, identifies four conditions underpinning organizational change that must be assessed & strengthened to achieve sustainable progress through the subsequent phases of PC program development.

METHOD

The research began by conducting a comprehensive assessment of the antecedent conditions in 4 LTC homes in Ontario, Canada. Data were collected through document reviews of policy & procedures as well as surveys (8), interviews & focus groups with residents, families, community stakeholders & LTC staff of all disciplines. The identified barriers, gaps & enablers provided the basis for developing & evaluating a series of evidence informed interventions to strengthen the antecedent conditions & build organizational capacity. Over the next three years multiple interventions will be implemented & evaluated.

THE 4 PHASE PROCESS OF PALLIATIVE CARE DEVELOPMENT IN LONG-TERM CARE HOMES

PHASE 1 HAVING ANTECEDENT CONDITIONS WITHIN THE LTC HOME

In the model at the roots of the tree, 4 antecedent conditions form the basis for future palliative care development. An assessment of these conditions thus began the change process & included assessing the state of: 1) health care infrastructure in the LTC home; 2) collaborative team approaches to care; 3) vision to improve care of dying people; 4) sense of empowerment amongst staff to influence organizational change.

PROJECT OUTCOMES: The environmental assessment identified the following barriers in the LTC homes: staff lacked knowledge of PC & access to PC education; there was no comprehensive resident PC assessment and no systematic process to identify residents approaching end-of-life; the LTC home lacked policies and procedures relating to PC; communication problems existed amongst staff, residents, and families regarding PC issues.

PHASE 2 EXPERIENCING A CATALYST FOR CHANGE WITHIN THE LTC HOME

In phase 2 of the model, a catalyst for change occurs within the LTC home that disrupts their current approach to caring for dying people. This catalyst can be a person or an event.

PROJECT OUTCOMES: The QPC-LTC Alliance was the catalyst to create change within the 4 participating LTC homes. The change process was supported by a new LTC home act that required PC programs & by personal support workers who were champions within each home.

PHASE 3 CREATING THE PALLIATIVE CARE TEAM WITHIN THE LTC HOME

In creating the team, providers join together in order to collectively improve care of the dying & develop PC programs. The team requires dedicated people of all disciplines & getting the “key” LTC staff & managers involved.

PROJECT OUTCOMES: An interdisciplinary Palliative Care Resource Team was developed using a full day planning retreat & a series of meetings to engage the staff. The focus was on engaging direct care workers.

PHASE 4 GROWING THE PROGRAM WITHIN THE LTC HOME

In this phase, the PC team continues to build, but now is ready to deliver palliative care. Ongoing tasks include: strengthening the team; engaging LTC staff of all disciplines; engaging community PC experts & resources; sustaining new palliative care practices.

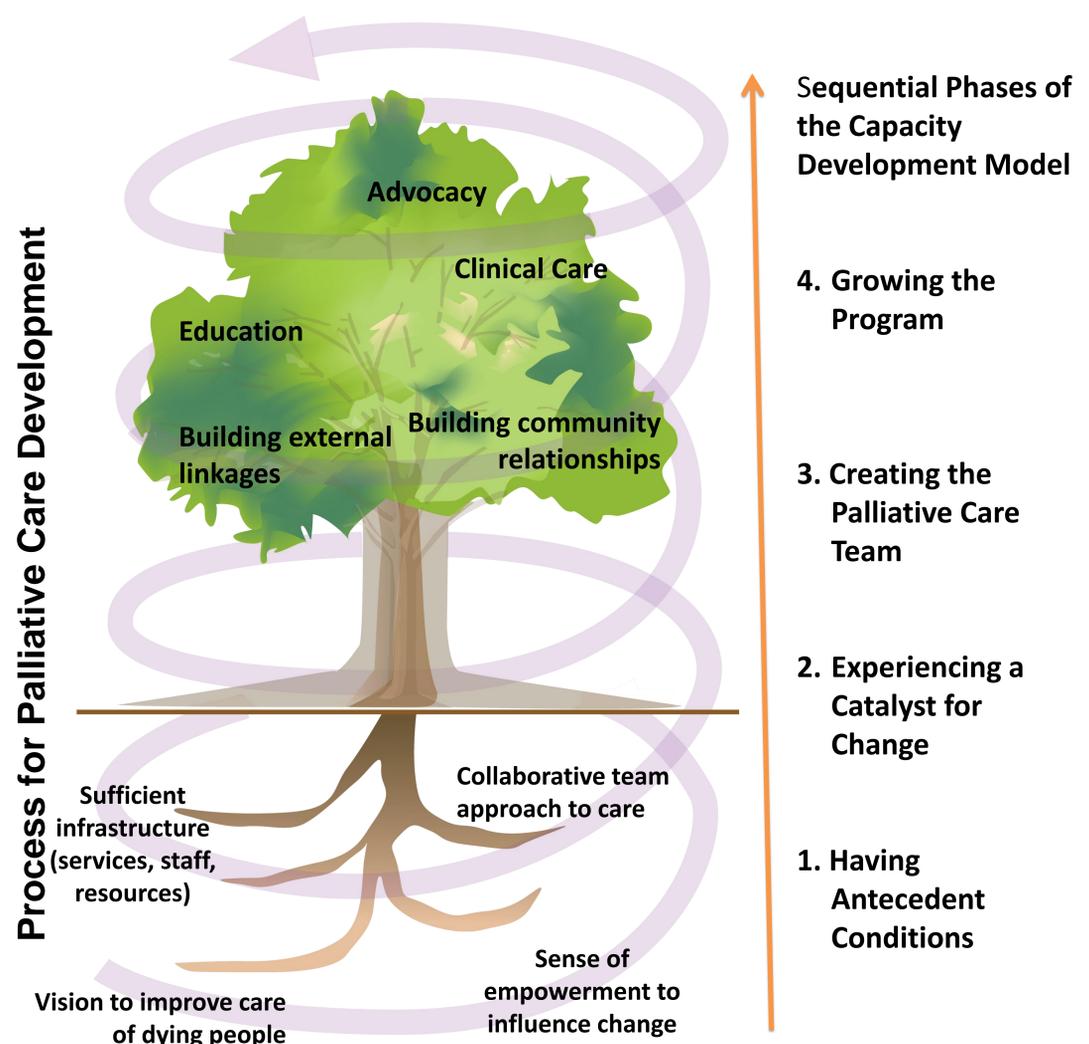
PROJECT OUTCOMES: The 4 LTC homes are now creating their own palliative care programs, policies & procedures while engaging staff, residents and families. Some examples of interventions supporting PC development are:

Enhancing Clinical Care – Created opportunities for staff to improve clinical skills through working in a Simulation Lab, through visiting to a speciality Hospice Palliative Care Unit & by participating in “Comfort Care Rounds” where residents’ care plans were reviewed with a PC consultant.

Enhancing Education - A 6-module (12 hr.) PC education course was offered for direct care workers; a Snoezelen therapy toolkit was created & staff, family and volunteers were engaged to use the resource; “book chats” focusing on understanding dementia were initiated with front line staff.

Advocating for PC –Based on the research, a brief was presented to the Canadian Federal Parliamentary Committee on Palliative & Compassionate Care to advocate for resources & policy to enable providing PC in LTC.

Building External Linkages – Hospice volunteers & divinity students were engaged to work in the TC homes to support staff with providing social & spiritual care.



CONCLUSION

LTC homes should assess their antecedent conditions for change to identify their enablers, gaps, & barriers before developing & implementing their own PC programs. The model provides a theory of change to guide the assessment. A wide of range of data collection methods are needed to assess antecedent conditions. Taking a whole system approach to change within LTC requires engaging families & residents, managers, staff of all disciplines & especially direct care staff. Creating evidence informed interventions will strengthen the antecedent conditions & support growing the PC program. The success and sustainability of new PC programs in LTC requires internal cultural transformation. For more information on the research instruments used and detailed results please visit our website:

www.palliativealliance.ca

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