SIX NATIONS SHARED CARE OUTREACH TEAM

CARE PATHWAY DESCRIPTION

In order to receive the services of the Shared Care Outreach Team, all external service providers must receive a referral. These referrals would be received from all access points including hospitals, families, family health teams, cancer clinics and CCACs and Home and Community Care Programs and do not need to be by physician alone. Any care provider who identifies an individual who could benefit from end of life care can discuss this with the individual and initiate the referral. Generally clients are identified as palliative if their prognosis is within one year and if they are having pain and symptom issues. All palliative clients are admitted directly to the provincially funded Community Care Access Center palliative team and so to the acute nursing agency with the contract for the Reserve and the Home and Community Care Program.

The CCAC palliative case manager or the Home and Community Care case manager, whoever receives the referral first sets up an initial joint home visit. A palliative assessment is completed and shared between each Case Manager and consent is signed for each agency. All appropriate palliative services are initiated and required equipment is put in place. Client and family are given the contact information for each service to ensure that they can access assistance on a 24/7 basis. The end of life checklist is put in the home which includes the number for all services including the funeral home.

Either case manager can make the referral to the Shared Care Team by calling the 24/7 intake person at the Hospice and also facilitates a Physician (Family doctor) to Physician (Palliative Outreach Physician) referral based on acuity, with a crisis intervention seen within 24 hr, high risk seen within 3 days, moderate risk seen within 7 days and minimal risk within one month. A referral form is completed requesting the services of the clinical nurse specialist, psychosocial /spiritual advisor and bereavement service.

The palliative physician, clinical nurse specialist and psychosocial bereavement clinician make a joint initial visit, assess the client, and make ongoing visits, to ensure that the client's care is comprehensive, seamlessly integrated, and monitored on a regular basis. The team maintains regular contact with the acute nursing agency for new orders, the case managers if any further equipment or services need to be started and updates the other team members for on call coverage. The team completes electronic charting on the Info Anywhere system maintained at the Hospice/Outreach Team database. The CCAC in-home chart is the common chart and the case manager must ensure that the individual and the family, and all other care providers coming into the home, are educated on the chart and encouraged to use it. A case conference may be called by any member of the clinical team at any time, in order to gather a patient's providers together to discuss any issues arising from their care. The CCAC palliative case manager and the clinical nurse specialist attend regular palliative rounds. If and when the palliative client is admitted to hospital, services will then be put on hold and

the appropriate facility will be contacted to request notification when the client is discharged. Prior to the individual returning home, a CCAC case management assessment will be completed and any new orders will be forwarded to the Shared Care team. Where there is no family physician, the Outreach physician will follow the client through hospital stay.

Expected Death in the Home forms, which are, Plan of Treatment Regarding Cardiopulmonary Resuscitation and Nursing Record Pronouncement of Expected Death at Home are put in place and discussed with the client and family by CCAC Palliative case manager, the acute nursing agency or the palliative physician or clinical nurse specialist. All nurses have been trained in Pronouncement of Expected Death and the palliative physician completes the death certificate if the family physician is not available. Case Managers will notify each member of the clinical team that an in-home death is being planned for so that no calls are made to the emergency response team. Families are encouraged to call the acute nursing provider who notifies the Shared Care team.

In the event of a sudden, tragic, difficult or emotionally draining death or where there is family conflict, a debriefing will be coordinated by the Psychosocial Spiritual Bereavement Clinician and /or Case Manager and everyone who had a part in the client's care will be invited. Notes will be taken during the debriefing to maintain a record of the issues that were discussed, and any possible solutions and/or program modifications that were suggested.

The Psychosocial Spiritual Bereavement Clinician completes one bereavement visit to the family/caregiver (prior to the debriefing), within 2 weeks following the death of the individual. A follow-up phone call one month following the death is made to check up on the family and see how they are doing. If further support is needed, the family/caregiver can be provided with a list of bereavement services offered in the community.