Cancer Care Ontario
Action Cancer Ontario

Palliative Care Collaborative Care Plans
CCPs

End-of-Life Stage

Ontario
Cancer Care Ontario
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Collaborative Care Plan - End-of-Life Stage
Palliative Performance Score 30 - 0
ECOG or Patient ECOG/Patient Reported Functional Status (PRFS) Score 4

Background Information
Collaborative Care Planning is a process used by interdisciplinary teams to improve quality and efficiency of care for specific patient populations. Teams develop collaborative care plans to:

- Guide the care of patients
- Promote the critical review of care processes
- Promote quality patient care
- Promote interdisciplinary collaborative practice
- Promote patient satisfaction

What are the Collaborative Care Plans?
These Collaborative Care Plans (CCPs) build on the work of the Kingston Frontenac Leeds and Addington Palliative Care Integration Project[1] and align with the Canadian Hospice Palliative Care Association's (CHPCA) Model for Hospice Palliative Care[2]. These revised CCPs were developed by a provincial working group[3] that was tasked with developing a tool targeted at the generalist provider that would improve the quality of patient care by increasing consistency across providers and settings.

The CCPs uses the CHPCA Model as a framework. Each "Domain of Issue" from the Model (e.g., Disease Management) is listed on a separate page and is broken down by the Model's Essential and Basic Steps During a Therapeutic Encounter The Palliative Performance Scale[4] (PPSv2)/ECOG/Patient ECOG (Patient Reported Functional Status) can be used to determine which plan is appropriate. A separate Care Plan is provided for each stage; Stable (PPS 100 - 70%/ECOG/PRFS 0-1), Transitional (PPS 60 - 40%/ECOG/PRFS 2-3), and End-of-Life (PPS 30 - 0%/ECOG/PRFS 4).The Edmonton Symptom Assessment System (ESAS)[5] is being used as a common symptom self screening tool for cancer patients in Ontario and therefore is referenced throughout the document.

Definition of Collaborative Care Plans
CCPs are interdisciplinary guides to practice designed to place the patient at the focal point of care, to promote continuity and coordination of care, and to promote communication amongst all disciplines. The CCPs define the activities, interventions and expected patient outcomes that should occur for patients requiring palliative services based on their functional performance as defined by the Palliative Performance Scale[4] (PPSv2)/ECOG/Patient ECOG (Patient Reported Functional Status). The CCPs provide a guide to clinical practice but should never replace sound clinical judgment. Each patient is an individual and treatment should be modified according to the individual patient's needs and the particular circumstances.

Disclaimer
Care has been taken in the preparation of the information contained in this report. Nonetheless, any person seeking to apply or consult the report is expected to use independent clinical judgment in the context of individual clinical circumstances or seek out the supervision of a qualified clinician. Cancer Care Ontario makes no representation or guarantees of any kind whatsoever regarding the report content or use or application and disclaims any responsibility for its application or use in any way.

Acknowledgements
We would like to acknowledge the work of the Palliative Care Integration Project, Palliative Care Medicine, Queen's University who developed the original version of the CCPs. We would also like to acknowledge the provincial CCPs Working Group members who generously donated their time and expertise toward the development of this resource (refer to Table entitled CCPs Working Group for a complete list of the members).

How do levels of Palliative Performance Scale (PPSv2) version 2 *(developed by Victoria Hospice Society)/* ***Patient Reported Functional Status (PRFS) or Patient ECOG/ECOG compare?[1],[2]***

	ECOG Level	Patient Reported Functional Status (PRFS) or Patient ECOG Level	PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
Stable Stage	0	0	100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
	1	1	90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
			80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
Transitional Stage	2	2	70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
			60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
	3	3	50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
			40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
End of Life Stage	4	4	30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
			20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
			10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
	5		0%	Death	-	-	-	-

*Home is defined as the person's usual residence (may include long term care facility)
Used with permission Victoria Hospice, 2006

[1] Ma et al. Interconversion of three measures of performance status: an empirical analysis. Eur J Cancer. 2010 Dec;46(18):3175-83
[2] Baracos et al. *Prognostic Factors in Patients With Advanced Cancer: Use of the Patient-Generated Subjective Global Assessment in Survival Prediction.* Journal of Clinical Oncology, October 1, 2010 vol. 28 no. 28 4376-4383.

	COLLABORATIVE CARE PLAN FOR END-OF-LIFE PATIENTS	
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE END-OF-LIFE STAGE: ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	
DISEASE MANAGEMENT • Primary diagnosis, prognosis, evidence • Secondary diagnoses (e.g., dementia, psychiatric diagnosis, substance use, trauma) • Co-morbidities (e.g., delirium, seizures, organ failure) • Adverse events (e.g., side effects, toxicity) • Allergies	**STEP 1 : ASSESSMENT**	**STEP 4: CARE PLANNING**
	Assess: • Person and/or family members' understanding of disease, possible/expected co-morbidities and prognosis • Relevance of current disease management protocols e.g. ongoing investigations, medications, treatments, clinic visits • Monitor functional status scores daily • Reassess investigations, clinic visits, goals of care and the plan of treatment • Confirm if the physician will make home visits	• Develop a plan of treatment related to disease management that takes into account the person's values and goals • Mutually determined goals of care provide a foundation for all care planning
	STEP 2: INFORMATION SHARING	**STEP 5: CARE DELIVERY**
	• Determine need for translation • Confirm confidentiality limits • Address any deficits in understanding of disease, co-morbidities and prognosis	• Identify the most responsible physician • Determine the professional care team member who will lead, coordinate and facilitate the functions and activities of the team • Provide family and informal caregivers with the orientation, ongoing education, training and support required to promote confidence and competence in the provision of care • If relocation of care delivery occurs, facilitate communication of the plan of care to the appropriate health care professional in the new setting through transfer forms, or telephone consultation
	STEP 3: DECISION-MAKING	**STEP 6: CONFIRMATION**
	• Determine who the person wants to include in the decision making process (e.g., substitute decision maker if the person is incapable) • Obtain consent from the capable person or the substitute decision maker if the person is incapable for an end-of-life plan of treatment that includes: • Setting for care • Resuscitation status • Having, withholding and or withdrawing treatments (e.g. lab tests, medications, etc.)	• Determine the person/family/team's understanding of: • the prognosis • expected course of the illness • Determine the person/family/team's satisfaction with the current plan of treatment as it relates to management of the disease and co-morbidities

COLLABORATIVE CARE PLAN FOR END-OF-LIFE PATIENTS		
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE END-OF-LIFE STAGE: ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	

PHYSICAL
• Pain & Other Symptoms (other symptoms include, but are not limited to):
  • Cardio-respiratory: breathlessness, cough, edema, hiccups, apnea, agonal breathing patterns, effusions (pleural, peritoneal)
  • Gastrointestinal: nausea, vomiting, constipation, obstipation, bowel obstruction, diarrhea, bloating, dysphagia, dyspepsia
  • Oral conditions: dry mouth, mucositis
  • Skin conditions: dry skin, nodules, pruritus, rashes
  • General: agitation, anorexia, cachexia, fatigue, weakness, bleeding, drowsiness, fever/chills, incontinence, insomnia, lymphoedema, myoclonus, odor, prolapse, sweats, syncope, vertigo
• Level of consciousness & cognition
• Motor Function (e.g. mobility, swallowing)
• Sensory Function (hearing, vision)
• Physiologic Function
• (e.g. breathing, circulation, sexual)
• Fluids, nutrition
• Wounds
• Habits (e.g. alcohol, smoking)
	STEP 1 : ASSESSMENT
	• Assess the person and/or family's' knowledge and understanding of the ESAS score
	• Utilize person or caregiver completed ESAS daily to identify any physical issues of concern
	• Conduct a comprehensive physical assessment to identify any issues related to any of the body systems Only techniques with the potential to provide beneficial information without undue risk or burden are used
	• Any identified issue will require further in depth assessment
	• Utilize validated assessment tools (e.g., comprehensive pain assessment)
	• Assess for urinary retention/infection, oral intake, skin integrity, mobility and need for assistive devices
	• Reevaluate the need for routine assessments (e.g., vital signs, blood glucose)
	• Assess swallowing ability
		STEP 4: CARE PLANNING
		• Consider consult to Palliative Care Team for complex symptom management issues
		• Initiate other interdisciplinary referrals
		• Customize a plan of treatment that is flexible and aims to:
		  • address the identified symptoms
		  • respect the person's choices
		  • respect the person's culture, values, beliefs, personality and preferences
		  • support the desire for control, independence, intimacy and sense of dignity for as long as possible
		  • proactively address emergent issues (e.g. who to call, what to do, escalating symptoms)
		  • anticipates potential complications
		• Adjust the care plan to individual need (e.g., turn q2h only if tolerated, frequent mouth care, supportive surfaces)

	STEP 2: INFORMATION SHARING • Determine the person and/or family's desire for information at each visit • Share information related to issues identified in a timely manner and in a language and manner understandable and acceptable to the person and/or family • Openly discuss any requests related to management of physical symptoms (e.g., nutrition, hydration, dyspnea) • Provide information regarding physiological changes with progression of disease (e.g., appetite, hydration, fatigue)	**STEP 5: CARE DELIVERY** • Facilitate caregivers' awareness of the resources and supplies necessary to deliver physical care based on current and anticipated needs (e.g., symptom response kit, contact information list) • Facilitate caregivers' understanding, knowledge and skill necessary to execute the plan of treatment (e.g., medication administration)
	STEP 3: DECISION-MAKING • Assess the person's decision making capacity whenever a decision related to treatment is being made • Encourage person and/or family to consider their options and current goals and prioritize the importance of each of the identified issues • Obtain informed consent for treatments based on options offered • Use an ethical framework to guide decision making around end-of-life care (e.g., palliative sedation, artificial hydration)	**STEP 6: CONFIRMATION** • Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of physical issues • Anticipate the need for alternative routes of medication administration (e.g., PO to SC) • Anticipate the need for crisis management (e.g., symptom response kit, dark towels available for hemorrhage)

<table>
<tr><th></th><th colspan="2">COLLABORATIVE CARE PLAN FOR END-OF-LIFE PATIENTS</th></tr>
<tr><th>DOMAINS OF ISSUES</th><th colspan="2">THE PROCESS OF PROVIDING CARE IN THE END-OF-LIFE STAGE:
ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER</th></tr>
<tr><td rowspan="6">PSYCHOLOGICAL

• Personality strengths, behaviour, motivation

• Depression, anxiety

• Emotions (e.g., anger, distress, hopelessness, loneliness)

• Fears (e.g., abandonment, burden, death)

• Control, dignity, independence

• Conflict, guilt, stress, coping responses

• Self-image, self-esteem</td><td>STEP 1 : ASSESSMENT</td><td>STEP 4: CARE PLANNING</td></tr>
<tr><td>• Review ESAS scores for anxiety, depression and well being daily to identify any psychological issues of concern
• Listen for subtle cues in conversation that reflect anxiety, depression and fear (e.g., I am tired of this …")
• Observe for behavioural cues (e.g., withdrawn, facial expression)
• If required a comprehensive assessment should be done by a health care professional
• Utilize validated assessment tools (e.g., comprehensive depression assessment tools)
• Identify:
  • strengths & vulnerabilities
  • emotional and behavioural responses
  • methods of coping
  • realistic and unrealistic expectations
  • previous losses
  • level of tolerance for inconsistency and changes in the plan of treatment
  • conflicted relationships
• Explore person and/or family's fears, as appropriate</td><td>• Customize a plan of care that is flexible and aims to:
  • address the identified psychological issues (fears, anger, anxiety, depression, etc.)
  • respect the person's choices
  • respect the person's culture, values, beliefs, personality and preferences
  • support the desire for control, independence, intimacy and sense of dignity for as long as possible
• With the permission of the person and/or family, refer to other team members/community resources as appropriate
• Consider referral to Social Work/Mental Health/Spiritual/ Pastoral Care Consultant, Hospice and other volunteers</td></tr>
<tr><td>STEP 2: INFORMATION SHARING</td><td>STEP 5: CARE DELIVERY</td></tr>
<tr><td>• Respect the confidentiality limits as defined by the person
• Share information in a timely manner and in a setting where privacy can be ensured
• Be prepared for open discussion of topics such as euthanasia, assisted suicide, withdrawal of treatment, etc
  • Provide clear and consistent responses
  • Identify need for team meetings
• Foster realistic hopes as illness progresses</td><td>• Promote a setting of care that is safe, comforting and provides ample opportunity for privacy and intimacy
• Be sensitive to changes that may cause anxiety for the person and/or family</td></tr>
<tr><td>STEP 3: DECISION-MAKING</td><td>STEP 6: CONFIRMATION</td></tr>
<tr><td>• Offer therapeutic interventions aimed at relieving suffering and enhancing quality of life and that are not associated with undue risk or burden (e.g., music therapy, massage, guided imagery)
• Voluntary consent is required for any treatment options offered</td><td>• Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of psychological issues</td></tr>
</table>

COLLABORATIVE CARE PLAN FOR END OF LIFE PATIENTS		
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE END-OF-LIFE STAGE: ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	
SOCIAL • Cultural values, beliefs, practices • Relationships, roles with family, friends, community • Isolation, abandonment, reconciliation • Safety, comforting environment • Privacy, intimacy • Routines, rituals, recreation, vocation • Financial resources, expenses • Legal (e.g., powers of attorney for business, for business, advanced directives, last will/ testament, beneficiaries) • Family caregiver protection • Guardianship, custody Issues	**STEP 1 : ASSESSMENT** • Assess changes in roles and the impact within family unit (e.g., caregiver strain and fatigue, lack of privacy/intimacy). • If children living with person assess their level of comfort with person's presence in home • Identify issues of isolation, abandonment, conflicted relationships, mental health, socio economic status • Identify the need for assistance with financial, legal affairs and issues related to future incapacity • Identify the person and/or family's current and potential support systems • Consider an in-depth assessment by a Social Worker	**STEP 4: CARE PLANNING** • Scheduling of visitors may be restricted at this time to close family and friends • Encourage activities that will strengthen family bonds (reminiscence, life review) • Consider referral to Social Work, Legal/Financial Consultant, Hospice and other volunteer programs, First Nations and other cultural groups
	STEP 2: INFORMATION SHARING • Inform the person and/or family of the resources available in the community to address social issues • Facilitate family members' awareness of compassionate care benefits • Share information about advance care planning	**STEP 5: CARE DELIVERY** • Maintain a calm peaceful and comfortable environment in all settings for persons and family • Maintain meaningful interaction with the person without the expectation of a response • Be respectful of person's culture, values, beliefs, personality and preferences
	STEP 3: DECISION-MAKING • With person and/or family's permission, encourage family and close friends to organize shifts for respite • Facilitate identification of goals and social priorities (e.g., financial, relationship, legal)	**STEP 6: CONFIRMATION** • Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of social issues

COLLABORATIVE CARE PLAN FOR END-OF-LIFE PATIENTS		
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE END-OF-LIFE STAGE ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	
SPIRITUAL • Meaning, value • Existential, transcendental • Values, beliefs, practices, affiliations • Spiritual advisors, rites, rituals • Symbols, Icons	**STEP 1 : ASSESSMENT**	**STEP 4: CARE PLANNING**

	• Review ESAS scores for anxiety, depression and well being daily to identify any spiritual issues
	• Utilize comprehensive spiritual assessment tools
	• Explore with person and/or family:
	  • their meaning of life, death and illness
	  • their relationships
	  • the concept of anticipatory grieving
	  • their hopes and fears
	  • beliefs and practices that have sustained them in the past
	• Consider an in-depth assessment by a Spiritual Advisor
		• Customize a plan of treatment that is flexible and aims to:
		  • Respect the persons' and family's culture, values, beliefs, personality and preferences
		  • incorporate the icons, symbols, rites and rituals that have particular meaning to the person
		  • make the environment conducive to reflection, compassion, tenderness, transcendence, love, the sacred
		  • acknowledge hope
		  • reframe goals into short term tasks that can be accomplished
		• Consider referral to Pastoral/Spiritual Advisor or other appropriate team member

	STEP 2: INFORMATION SHARING	**STEP 5: CARE DELIVERY**
	• Facilitate timely and uninterrupted interactions • Allow the person to express fears and suffering without hesitation or shame • Discuss goals	• Team members employ the appropriate communication skills that are key to sensitive discussions • Avoid quick fix responses and religious clichés • Meaning comes from within the person and is best discovered by the person telling his or her story and the caregiver listening
	STEP 3: DECISION-MAKING	**STEP 6: CONFIRMATION**
	• Offer options to both person and family members in support of spiritual healing (e.g. journaling of thoughts and feelings, meditation, music) • Determine what rituals and devotional practices would have meaning in the circumstances and obtain consent to incorporate them into the plan of treatment	• Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of spiritual issues

	COLLABORATIVE CARE PLAN FOR END-OF-LIFE PATIENTS	
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE END-OF-LIFE STAGE ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	

PRACTICAL
 	
• Activities of daily living (e.g., personal care, household activities)
 	
• Dependents, pets
 	
• Telephone access, transportation
	STEP 1 : ASSESSMENT
	• Assess practical needs:
	  • Functional assessments (e.g., activities of daily living)
	  • Children's needs
	  • Caregiver's needs
		STEP 4: CARE PLANNING
		• Develop a plan of treatment that incorporates interventions to maintain independent functioning for as long as possible (e.g., transfer techniques)
		• Facilitate timely access to equipment (e.g., hospital bed, walker, commode, continence supplies, raised toilet seat)
		• Anticipate equipment, support needs and follow-up with change in setting of care (e.g., hospital to home)
		• Facilitate appropriate referrals (e.g., physiotherapy, occupational therapy)

	STEP 2: INFORMATION SHARING • Facilitate family members' awareness of available local community resources	**STEP 5: CARE DELIVERY** • Minimize changes in care plan • If relocation of care delivery occurs, facilitate communication of the most current plan of care to the appropriate health care professional in the new setting through transfer of forms, or telephone consultation
	STEP 3: DECISION-MAKING • Determine what services/resources the person/family are prepared to accept	**STEP 6: CONFIRMATION** • Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of practical issues

	COLLABORATIVE CARE PLAN FOR END-OF-LIFE PATIENTS	
DOMAINS OF ISSUES	**THE PROCESS OF PROVIDING CARE IN THE END-OF-LIFE STAGE: ESSENTIAL & BASIC STEPS DURING A THERAPEUTIC ENCOUNTER**	

END OF LIFE CARE/ DEATH MANAGEMENT
 	
• Life closure (e.g., completing business, closing relationships, saying goodbye)
 	
• Gift giving (e.g., things, money, organs, thoughts)
 	
• Legacy creation
 	
• Preparation for expected death
 	
• Anticipation & management of physiological changes in the last hours of life
 	
• Rites, rituals
 	
• Pronouncement, certification
 	
• Perideath care of family, handling of the body
 	
• Funerals, memorial services, celebrations
	STEP 1 : ASSESSMENT
	• Assess person and family's understanding of and preparedness for death (i.e., assess needs of child of dying family member)
	• Assess level of burden and stress being experienced by the caregivers
	• Assess and review resuscitation status
	• Explore what the person and family know and what they don't knot (e.g., prognosis, dying process)
		STEP 4: CARE PLANNING
		• Facilitate the implementation of a plan of treatment that addresses the physical, psychological, cultural and spiritual needs of the person, family and informal caregivers
		• Develop a plan of treatment that addresses symptoms such as upper airway secretions, restlessness, delirium
		• Develop a plan with the family regarding access to 24/7 telephone support
		• Confirm the completion of the Do Not Resuscitate Confirmation Form (DNRC) in Ontario (for persons at home, in LTC and retirement home settings)
		• Discuss the (in)appropriateness of calling 911
		• Develop a plan for expected death which includes:
		  • the desired setting of care
		  • how and to whom the death will be communicated
		  • any post mortem rites or rituals that family desire (e.g. time alone with the body, bathing and dressing, prayers led by a minister or priest)
		  • plan for pronouncing and certifying the death
		  • funeral, celebration of life service, memorial
		  • care of the body after death including who will notify the funeral home for transport of the body

	STEP 2: INFORMATION SHARING
	• Introduce information to family and other informal caregivers related to the physiological changes that are expected to occur in the last hours of life
	• Introduce information about the benefits and burdens of interventions that have the perception of prolonging life such as artificial nutrition and artificial hydration, administration of antibiotics, blood transfusions, etc.
	• Explore and discuss questions
	• Encourage the person and family to consider arrangements regarding:
	  • support desired at time of death
	  • rites or rituals (care of body after death)
	  • funeral, celebration of life service, memorial
	• Introduce information about the process of pronouncing and certifying death
		STEP 5: CARE DELIVERY
		• Promote a calm, peaceful and comfortable environment for the person and family regardless of the setting
		• Encourage and support life review, when appropriate
		• At the time of death:
		  • Implement the pre-determined plan for expected death
		  • Arrange time with the family for a follow-up call or visit, if appropriate
		  • Provide bereavement resources (e.g. booklet)

	STEP 3: DECISION-MAKING • Review desired setting for ongoing care delivery and determine family/caregiver ability/willingness to participate in care at end-of-life • Identify goals and expectations of care	**STEP 6: CONFIRMATION** • Determine the family/team's satisfaction with the plan of treatment as it relates to the management of end-of-life care/death issues

<table>
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<tr><td rowspan="6">LOSS, GRIEF

• Loss

• Grief (e.g., acute, chronic, anticipatory)

• Bereavement planning

• Mourning</td><td>STEP 1 : ASSESSMENT</td><td>STEP 4: CARE PLANNING</td></tr>
<tr><td>• Determine person and family understanding of and preparedness for death
• Identify previous losses
• Identify person and family members' previous and current coping (e.g., alcohol use and substance use)
• Assess for evidence of suicidal ideation
• Identify person and family members who are at risk for complicated grief (e.g., multiple unresolved losses, death of a child)
• Utilize comprehensive assessment tools</td><td>• Incorporate cultural and spiritual rites and rituals that have meaning for the family into the plan of treatment (e.g., gift giving, legacy creation, memory boxes, hand casts)
• Consider referral for person and family to address anticipatory grief
• Encourage the bereaved to make an appointment with an appropriate health care provider within weeks of the death
• Encourage the bereaved to make an appointment with the family physician within weeks of the death
• Refer to appropriate Health Care Providers for advanced interventions (e.g., suicidal ideation)
• Consider referral of bereaved family member to appropriate local resources
• Consider referral to, Spiritual Advisor, Pastoral Care, Grief Counselor, Hospice and other Volunteer programs</td></tr>
<tr><td>STEP 2: INFORMATION SHARING</td><td>STEP 5: CARE DELIVERY</td></tr>
<tr><td>• Encourage the person and/or family to express feelings and emotions
• Share information about the grieving process and anticipatory grief
• Provide examples of rituals that can facilitate healthy grieving
• Provide age appropriate information about grief responses.</td><td>• Provide age specific resources for those who are grieving</td></tr>
<tr><td>STEP 3: DECISION-MAKING</td><td>STEP 6: CONFIRMATION</td></tr>
<tr><td>• The person and/or family to determine the support desired unless there is evidence of suicidal ideation.</td><td>• Determine the person/family/team's satisfaction with the plan of treatment as it relates to the management of loss and grief issues</td></tr>
</table>

References

1. Kingston Frontenac, Addington and Leeds Palliative Care Integration Project, Collaborative Care Plans, Palliative Care Medicine Queen's University March 2006
2. Ferris FD, Balfour HM, Bowen K, Farley J, Hardwick M, Lamontagne C, Lundy M, Syme A, West P. A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice. Ottawa, ON: Canadian Hospice and Palliative Care Association, 2002 http://www.chpca.net/
3. Refer to Table below for list of Working Group Members
4. Victoria Hospice, 2003 Palliative Performance Scale (PPSv2)
5. Alberta Health Services (previously Capital Health) Regional Palliative Care Program. Edmonton Symptom Assessment System (ESAS)

Regional Educational Programs

CAPCE - **C**omprehensive **A**dvanced **H**ospice **P**alliative **C**are **E**ducation **P**rogram for **N**urses **-** The program focuses on developing a Hospice Palliative Care Resource Nurse within the health care provider organization in which they work – long-term care homes, hospices, hospitals, Community Care Access Centres` and community nursing agencies.

LEAP- **L**earning **E**ssential **A**pproaches to **P**alliative and **E**nd-of-Life Care - The 2.5 day LEAP course offers an opportunity for active learning about current best-practice in caring for patients with life-threatening and life-limiting illness, with a special focus on family practice and community settings.

CCPs Working Group Members

Stephanie Buchanan Clinical Practice Leader Bayshore Home Health	Kathy Coulson Advanced Practice Nurse, Palliative Care Kingston General Hospital
Debbie Devitt Palliative Pain and Symptom Management Consultant Central East Durham Region	Carole Gill Palliative Pain and Symptom Management Consultant Southwestern Ontario Windsor and Essex County
Susan King Provincial Improvement Coordinator, Ontario Cancer Symptom Management Collaborative Cancer Care Ontario	Linda Marie Pacheco Client Services Nursing Supervisor Comcare Health Services
Marie Palmer Palliative Care Consultant	Sharon Preston Palliative Pain and Symptom Management Consultant Southeastern Ontario
Margaret Poling, Palliative Pain and Symptom Management Consultant Northwestern Ontario Thunder Bay	Judy White Palliative Pain and Symptom Management Consultant Southwestern Ontario Huron/Perth County
Raquel Shaw Moxam Program Manager, Nursing, Psychosocial Oncology and Palliative Care, Cancer Care Ontario	