Date:  
Attendees:  
Regrets / unable to attend:

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| Note to facilitator: Since it will likely not be possible to review every item at every meeting, agenda items are listed in priority order, and you can make choices about which items to highlight on any given day. The second section is marked in grey because as these items are completed/or in progress, there are fewer of them to review with the team, and once they are all completed, it is no longer necessary to review them. | |
| **Discussion Item** | **Action Items** |
| 1. Reminder of our goal: *“As a reminder, the purpose of our work together is to strengthen a palliative approach in long-term care. As we do this, # \_\_\_\_\_ residents and families are helping us to evaluate the changes that we are making. One of our goals is to make sure we are paying special attention to communicating with and supporting these residents through their changes in health, and of course, we also include other residents and families in need of this support.”* |  |
| 1. Initiation Activities (to be completed upon creation of a PCT)    1. Complete PPS training    2. Implement PPS process (ongoing, quarterly)    3. Complete first PPS for all residents in home    4. Invite staff to the palliative approach champion team    5. Make staff aware who is on the palliative approach champion team    6. Participate in a training workshop (if available)    7. Encourage staff to participate in educational self-study modules |  |
| 1. Palliative performance scale (PPS)    1. New PPS% scores completed on admission    2. Updated quarterly PPS% |  |
| 1. Palliative Care Conferences (PCC)    1. Reminder: *“The main way to improve resident and family experience is through excellent communication and attention to holistic needs. Because this is so important, we are aiming to adapt upcoming care conferences or plan additional conferences as needed to have more focused conversation about changes in health and planning for end-of-life care.”*    2. Cancellations of conferences planned at last meeting:    3. Residents to prioritize for conferences with a palliative approach (e.g., upcoming family care conference, near end of life, recent change in health status, low PPS, complex problems, requested by resident/family):    4. Progress with using illness trajectory pamphlets in the meetings:    5. Progress with PCCs – what’s working well and not so well: |  |
| 1. Resources for Residents & Family Members (e.g., Illness Trajectory Pamphlets, Comfort Care Booklet, Question Prompt List)    1. Reminder: “*Residents and families often say they need more specific information about chronic illnesses. To support this, the SPA-LTC team has offered us illness trajectory pamphlets for conditions often seen in LTC, as well as a comfort care booklet to support family caregivers of people with dementia and other neurodegenerative diseases.”*    2. Which resources are currently available to residents and family caregivers?    3. How are they being distributed (e.g., regular email or newsletter feature, hardcopy in booklet or pamphlet rack, distributed by healthcare team in the context of conversations)?    4. Check in on action items from last meeting |  |
| 1. Comfort Care Rounds (CCRs)    1. Reminder: “*The goal is to coordinate a focused activity to support quality improvement in palliative approach to care at least every 2 months*.”    2. Has PPS been covered in a CCR so all staff are aware?    3. Check in on action items from last meeting    4. Upcoming CCRs (what would we like to teach our team? What does our team need most from us right now?)    5. Anticipated focus for upcoming CCRs (e.g., debriefing, case conferencing, or special education)    6. Progress with CCRs – what’s working well and not so well |  |
| 1. Ongoing staff education 2. Strategies encourage staff to participate in educational self-study modules |  |
| 1. Bereavement Care    1. Reminder: “*Everyone needs support when somebody dies. Our goal is to make sure that there is a respectful way of remembering residents who have died. We also want to make sure that everyone is aware that grief reactions vary, and what supports are available to them. We also strive to support residents and families with their ongoing bereavement needs.”*    2. Who has died since our last meeting? Did anyone in that 2nd group die without a conference using a palliative approach to care?    3. Is there a brief ritual to mark the death of each resident? What’s working well and not so well?    4. Are supportive pamphlets available to families when a resident is dying? How are they being integrated into practice? What’s working well and not so well?    5. What other needs are you seeing in our community? |  |
| 1. Capacity-building initiatives (e.g., supplemental education, encouraging/formalizing staff consultation with champion team members about a palliative approach care, building relationships with experts/consultants, building relationships with other organizations, identifying more supports for residents and families, process changes, policy changes, other ideas): |  |
| 1. Next Palliative Champion Team Meeting Date: Time: Place: |  |