

Understanding the Organizational Change Process

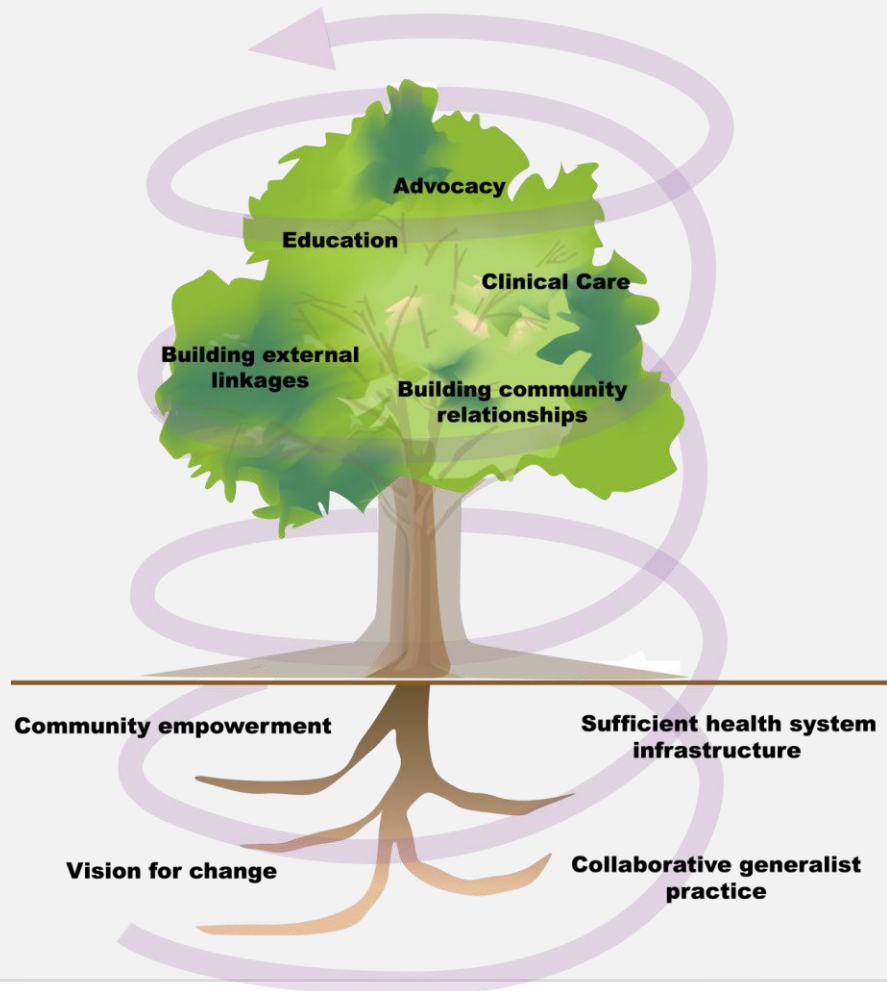


palliativealliance.ca

This presentation will:

- Outline the process of formalizing of palliative care programs in long term care homes using a community capacity development model
- Compare four LTC home study sites participating in the Alliance project
- Share perspectives of long term care staff, management, and organizational partners involved in the change process

Community Capacity Development Model



Process of Palliative Care Development

Sequential phases of the capacity development model:

1. Antecedent community conditions
2. Community Catalyst
3. Creating the PC team
4. Growing the PC program

Phase 1: Having Antecedent Conditions within the LTC Home

Antecedent Conditions:

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 the organizational change

Project Outcomes:

- Environmental assessment to identify strengths and gaps

Phase 2: Experiencing a Catalyst for Change with the LTC Home

- A catalyst for change occurs within the LTC home that disrupts their current approach to caring for dying people
- Can be a person or an event

Project Outcomes:

- PSW champions – catalysts
- The Alliance-facilitators
- New LTC act requiring PC education-incentive

Phase 3: Creating the Palliative Care Team

- In creating the team, LTC staff 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:

- Interdisciplinary teams formed within LTC
- Retreat and regular PC team meetings

Phase 4: Growing the Program within the LTC homes

- The PC team continues to build and begins to deliver palliative care
- Ongoing tasks include: strengthening the team; engaging LTC staff of all disciplines; engaging community PC experts as consultants & resources; sustaining new palliative care practices

Project Outcomes:

- Clinical Care
- Education
- Advocacy
- External Linkages

Strategies for Developing Formalized Palliative Care Programs

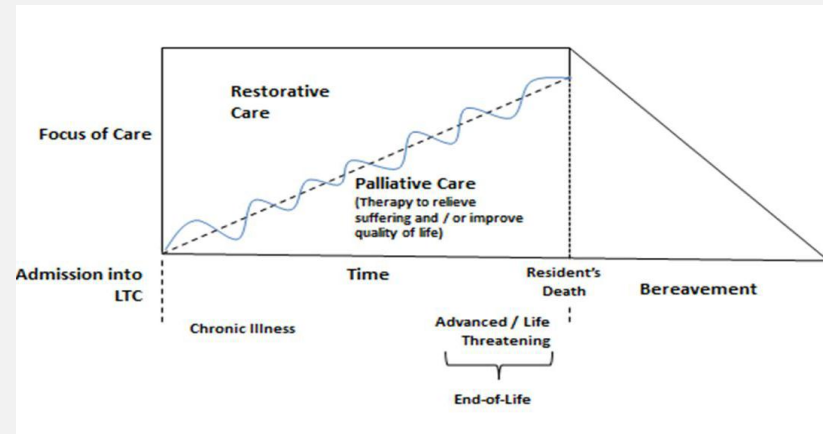
- 2 homes developed palliative care resources teams
- 2 homes incorporated palliative care development into Comfort Care Rounds (Pain and Symptom Management Rounds)
- Monthly Meetings

Most Significant Changes

1. Enhanced staff understanding of palliative and end-of-life care
2. Increased interest and opportunities for palliative care education
3. Strengthened internal and external communication
4. Enhanced resident-centered care during end of life
5. Empowered Personal Support Workers
6. Increased interprofessional teamwork and collaboration
7. Developed formalized palliative care programs

1. Enhanced staff understanding of palliative and end-of-life care

- Strengthened understanding of palliative and end-of-life care
- Heightened awareness of the differences between PC and EOL care
- Increased acceptance that PC is a process and that it is done everyday
- Increased awareness that PC is a significant role for the LTC home



2. Increased interest and opportunities for palliative care education

- Increased awareness of opportunities to receive PC education
- Increased motivation of staff to receive PC education



“Staff are eager to find out more about palliative care including education and support. Staff are seeking out resources identified through Comfort Rounds and discussion at Monday morning meetings.” (Community Partner)

3. Strengthened Internal and external communications

- Strengthened communication with families, residents and staff
- Supported communication with other LTC homes
- Supported communication with other community partners



“The development of the Palliative care teams at both homes has given me the opportunity to meet and converse with staff that I did not have a chance to get to know.” (Manager)

4. Enhanced resident centered care during end-of-life

- Increased number of palliative care case conferences
- Increased staff comfort speaking with residents
- Improved understanding of how to meet resident PC needs

The most significant change that I have noticed in the homes is, the staff's comfort level around providing EOL care, especially PSWs. Staff were typically shy or unsure of how to converse with residents and/or their caregivers at EOL. I have noticed the staff are able to converse more openly now and support all involved (including their team mates).”

5. Empowered Personal Support Workers

- PSWs have more of a presence at LTC meetings
- New appreciation of PSW providing PC and EOL care
- PSWs are feeling more engaged
- PSWs are able to make decisions
- PSWs have had tremendous professional growth



6. Increased interprofessional teamwork and collaboration

- Heightened sense of interdisciplinary team
- Creation of the PC resource teams
- Members of the team support one another
- Registered staff feel comfortable leading meetings



7. Developed formalized palliative care programs

- Program description and implementation of interventions and quality improvement process
- Internal organizational structures and leaders
 - Comfort care rounds
 - Palliative care resource team
 - PSW leads
 - CAPCE nurse
- Enhanced community partnerships

Further Information

Visit our website

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