Collaborative Palliative Care Planning Team – Boundary Trails and Surrounding Communities

Terms of Reference

Approved:
Regional Director – Home Care & Palliative Care
Review/Revise Date: June 1 2020

Purpose:

Collaborative Palliative Care Planning is a weekly inter-professional forum which can support an individual/caregiver(s) presenting with difficult physical/psychosocial/spiritual symptoms. The CPCP makes recommendations on a consultative/collaborative basis using a palliative approach.

Benefit: CPCP will improve communication and shared decision making between providers, as well as continuity and quality of care for individuals.

Facilitator: (by position)

The Palliative Care Coordinator will be responsible for intake and facilitation of the discussion at rounds. If the Palliative Care Coordinator is not available, the Palliative Care Coordinator or the Regional Manager, Home Care Nursing & Palliative Care will assign a Palliative Care Nurse to assume the duties for the interim.

Membership:

Membership shall be comprised of:

Regional Palliative Care Coordinator

Palliative Care Physician Specialist

Palliative Care Nurse(s)

Social Worker, Community Services

Palliative Care Social Worker

Home Care Case Coordinator(s)

Home Care Nursing Supervisor

Senior's Mental Health Worker

Client Services Manager, Rehabilitation Service

Ad hoc members may be included as appropriate

Meetings:

Meetings shall be held as follows:

- Weekly Thursday morning 9:00 a.m. – 10:30 a.m.
  Teleconference: Dial in: 1-888-289-4573
  Access Code: 1353940
- The individual who requested the consultation will join the conference call only at the time provided by facilitator to present their consultation request. Once the consultation is complete, it is expected the individual will disconnect from the call.

  Catchment area: Southern Health-Santé Sud region
- The Facilitator will review the requests for consults and will allot a predetermined amount of time for each case dependant on the complexity. The rounds will be 1 hour and 30 minutes.

Minutes:

The Palliative Care Coordinator will have copies of the consult requests with applicable notes and follow up recommendations, which will be stored on Accuro. The Palliative Care Coordinator will provide a copy of the follow up recommendations made by CPCP to the professional who made the request for consult as well as the patient's physician or nurse practitioner if appropriate.

Following the release of the recommendations, the role of the CPCP team ends. It is expected that a new consult will be requested should new or existing issues arise.

Terms of Reference:

The Terms of Reference will be reviewed by the CPCP Team annually in November.

Responsible To:

Regional Director – Home Care & Palliative Care