

Regional Palliative Care Program Vision, Mission, Philosophy and Goals

Background

The mission, vision, and philosophy of the Regional Palliative Care Program (RPCP) are congruent with those of Capital Health, Caritas Health Group and the Alberta Cancer Board.

The Canadian Palliative Care Association (CPCA) 2001 Proposed Norms of Practice for Hospice Palliative Care, the Regional Palliative Care Program Annual Report April 1, 1999 - March 31, 2000, and the McGill University Council on Palliative Care website guided the revision and further development of the vision, mission, philosophy and goals of the RPCP.

It is anticipated that this document will be useful to multiple audiences including members of the regional palliative care team, other health care professionals who provide palliative care, and to the general public.

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Regional Palliative Care Program
VISION, MISSION, PHILOSOPHY AND GOALS

Our Vision

Regional Palliative Care Program
'Improving the Quality of Living and Dying'

Our Mission

Through an integrated program of compassionate and accessible palliative services, care is provided to patients and families within the Capital Health Region. Our caring tradition embraces all aspects of person. As we engage in the work of our mission, we strive to exceed the ordinary, endeavoring always to provide exemplary care.

CARING being with each individual, providing care that aims to improve the quality of living and dying,

EDUCATION ongoing learning for patients, families and caregivers,

RESEARCH the advancement of care through research,

LEADERSHIP accountability and continuance of program excellence, and

OUTREACH providing clinical consultation, education and tertiary level care.

This is our mission.

Our Philosophy

The Regional Palliative Care program recognizes, respects, and incorporates into their practices the following fundamental values based in part on the values and ethical principles identified by the Canadian Palliative Care Association in the document *2001 Proposed Norms of Practice for Hospice Palliative Care*:

We believe

- *Access is Foundational* - Palliative care services should be available to all who require care.
- *Care is Patient-Focused* - Palliative care strives to meet the physical, psychological, spiritual and social needs of patients and families. It is sensitive to personal, cultural and religious values, beliefs and practices, developmental state, and readiness to deal with the dying process.
- *People Have the Right To Choice* - Each person is an autonomous and unique individual with the right to participate in informed discussion related to care and to choose the best possible options and outcomes based on that information.
- *Dying is Part of Life* - Palliative care affirms life. Euthanasia and physician assisted suicide are not considered options. Palliative care never intentionally hastens death.
- *Quality of Life Guides Decisions* - Care choices should be guided by quality of life as defined by the patient.
- *Team Work Is Essential* - Palliative care is a network of services most effectively delivered by an interdisciplinary team who rely on shared knowledge, expertise and effective interactions.
- *Service is Coordinated* - A palliative care program should promote continuity of care across settings and coordination amongst all involved caregivers and programs/services.
- *Accountability is Demonstrated Through Outcomes*- We are accountable to ourselves, each other, to our individual sites, to the regional program and to the public we serve. Accountability is demonstrated through measurable goals.
- *Confidentiality is Central* - Patient information is treated with the utmost respect. Team members must adhere to this principle.

- *Care Setting Is Important* - Palliative care is provided in a patient and family-focused environment in the most appropriate care setting such as the home, hospice, continuing care centers, acute hospitals or on a tertiary palliative care unit. The needs and preferences of the patient and family, as well as the resources available, are taken into consideration.
 - *Caregiver Well-Being Is Fundamental* - The provision of ongoing support to enhance formal and informal caregivers' well-being is integral to a successful palliative care program.
 - *On-going Education is Essential* - Patient, family, caregiver and public education is important to the maintenance and enhancement of the quality of palliative care.
 - *Research Leads to Advancement in Care* - The development, dissemination and integration of research are critical to palliative care.
 - *Resources Influence Program Quality* - Adequate resources, responsibly managed, are imperative to maintain and advance palliative care programming.
 - *Collaborative Leadership is Advantageous*- The development and maintenance of a quality palliative care program requires the active involvement of all stakeholders in the decision-making processes.
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Our Goals

Broad Program Goal

Access to exemplary palliative care provided in the most appropriate setting.

Specific Program Goals - The goals of the Regional Palliative Care program are to:

1. Ensure a coordinated, continuous plan of care that minimizes duplication of efforts and is maintained across all settings from referral of the patient to support of the bereaved family.
2. Review and follow relevant norms of practice based on CPCA guidelines at each site of care.
3. Provide timely access to palliative care services 24 hours a day, 7 days a week, throughout the region.
4. Ensure consultation team availability in all settings to support primary caregivers.
5. Support community based care by providing proactive palliative care in the home and hospice, thereby decreasing the use of emergency and acute care services.
6. Offer tertiary level palliative services to patients with complex care needs that exceed care levels available in other settings.
7. Support the interdisciplinary nature of palliative care emphasizing that the patient and family are key members of the team.
8. Further the development of the bereavement program to ensure that the needs of bereaved family members and caregivers are addressed.
9. Recognize and support the essential role of volunteers on the palliative care team.
10. Offer effective palliative care education, based on norms of practice, to patients, caregivers, health professionals and the public.

11. Facilitate a program of ethically-based research which advances palliative care practice.

12. Develop accountability and program excellence through a collaborative regional leadership model.

13. Increase support for formal and informal caregivers.

14. Advocate for resources to maintain and further enhance a program of excellence.

15. Review and articulate the palliative care needs of non-malignant populations and of cancer patients with needs that arise as treatment options advance.

Definition of Terms

For clarity the following definitions have been endorsed. Most definitions are adapted from those presented in the *Canadian Palliative Care Association (CPCA) 2001 Proposed Norms of Practice for Hospice Palliative Care*.

Palliative Care – Palliative care aims to relieve symptoms and improve the quality of living and dying for a person and/or family living with a life threatening illness.

Palliative care strives to help individuals and their families:

- address physical, psychological, social, spiritual and practical issues and associated expectations, needs, hopes and fears,
- prepare for, and manage, life closure and the dying process, and
- cope with loss and grief during the illness and bereavement.

Palliative care may:

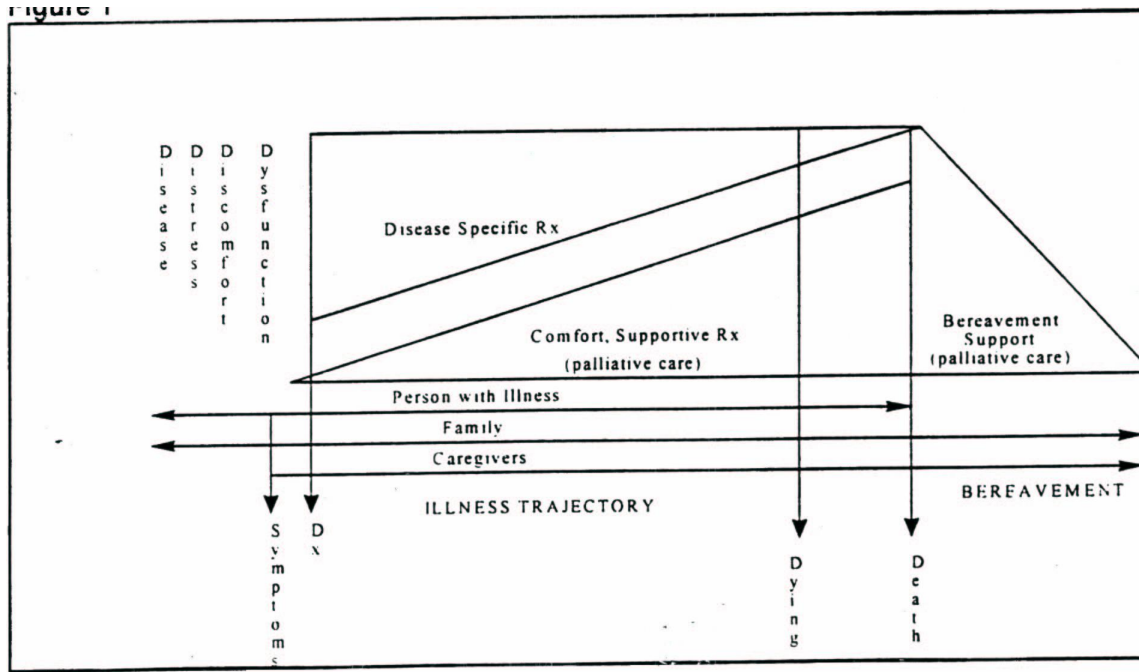
- complement and enhance treatment of the disease at anytime during the disease trajectory, or
- become the total focus of care. (see figure 1)

Palliative care may be provided to individuals:

- with any diagnosis,
- regardless of age, and
- when they have unmet needs and are prepared to accept care.

Services in palliative care are arranged in a coordinated network, delivered by an interdisciplinary team, and provided in an atmosphere of respect for human dignity.

Figure 1 - Continuum of Palliative Care (modified from the CPCA, 2001 Proposed Norms of Practice for Hospice Palliative Care)



Other Definitions

Autonomy - "the state of being self-governed" (CPCA, 2001, p. 11). Thinking and acting independently without outside influence and direction.

Bereavement - "the state of having suffered the death of someone significant" (CPCA, 2001, p. 4).

Caregiver - "anyone who provides care."

Formal caregivers are members of an organization and accountable to defined norms of conduct and practice. They may be professionals, support workers, or volunteers.

Informal caregivers are not members of an organization. They [usually] do not have formal training, and are not accountable to norms of conduct or practice. They may be family members or friends" (CPCA, 2001, p. 4).

Dignity - To treat individuals with respect, esteem and regard

Family - Whomever the person says is his or her family. The family may include relatives, partners, friends and pets.

Grief - Reactions (physical, emotional, behavioral, spiritual) experienced in anticipation of, during and after a loss.

Interdisciplinary team - "A team of caregivers who work together to develop and implement a plan of care" (CPCA, 2001, p. 6). The composition of the team may vary depending on the needs, however, the patient and family remain central team members.

Needs - Issues that patients and caregivers mutually agree require attention in the plan of care.

Patient - The person living with the illness. The term patient is used throughout this document. It is meant to include other nomenclature such as client or resident that may be used within various elements of the broader program.

Symptoms - Manifestations of physical, psychological and/or spiritual distress.

Well-being - The answer to the question, "How are you today?" Well-being considers the physical, psychological and spiritual aspects of self from the patient's perspective.

Quality of Life - "Well-being as defined by each individual. It relates both to experiences that are meaningful and valuable to the individual, and his/her capacity to have such experiences" (CPCA, 2001, p. 8).
