Palliative Nurse Clinicians: Leaders, Navigators, Advocates, Educators
– *Sharing & Building Wisdom*
Session 5: Anticipatory planning – the good, the bad and the ugly

Date: May 16, 2023

AGENDA ITEM	DISCUSSION	RESOURCES
Objectives, Overview and Session Materials	Presenter: Lorna Ross RN MA CHPCN (C) Palliative Care Coordinator, Palliative & End of Life Program, Island Health <u>Learning Objectives</u> By the end of the session participants will be able to: • *Reflect on what Anticipatory Planning is…or isn't* • *Bring ideas to support the team when there is tension around goals of care* • *Think more deeply about and explore barriers to "planning"*	
Presentation Key Points	• Hope for everyone to think deeply about Anticipatory Planning • Session grew out of what Lorna has learned, what she has experienced, and what she has observed working with other HCPs and with patients over her career • Acknowledges that the resources she has access to working on the South Island (at Saanich Peninsula Hospital) may not be the same for everyone across the province, in their specific location or in the Health Authority • Started the session by asking "what comes to mind when you think about Anticipatory Planning?" • Participants were encouraged to add their thoughts to the chat:	

	○ Thinking of the future ○ Goals of care ○ Advanced directive? ○ Planning when there is still time ○ Client and families goals of care, what is important to this client? Who are decision makers, are people on the same page? Any resources or questions needed ○ Plan for the unexpected ○ Thinking of the worst-case scenario ○ Understanding of current health status ○ Future health planning when well ○ Long weekend preventing crisis ○ I think about how to prepare family and patient for a home death and thinking of all variables to make it successful ○ Advance care planning. Goals/understanding. Route changes ○ Nursing schedules, med access, interdisciplinary teams, emerg visits... ○ Preventing crisis ○ Ambivalence of client, not wanting to engage in GOC and/or not wanting to have the conversation - "if things don't go as planned!" ○ Love that about denial, often nurses say it in judgement & denial does have its place. Ive seen that professionally and personally. • Lorna notes that when we are thinking ahead, this is the good, and many of the comments are about thinking ahead • What happens when not thinking ahead, reacting in the moment, or trying to reach the patient/family where they are in terms of readiness to talk and to plan? This can be the bad or even the ugly	

	• The tension points are where we rub-up against the planning and the reality that will be the focus today • How do our own expectations play into this, what we want or need for ourselves in the process and hope for the patient?	

Discussion	**Break out room: First Discussion Questions:**
	• How do you navigate clients who are receiving palliative care or a palliative approach to their care with active goals of care?
	  • Supporting clinicians who may be distressed by a client's choices/wishes/ hopes
	  • Supporting clients what helpful phrases do you use
	  • Supporting in the tension
	
	Large Group Discussion:
	Groups reported back following 10 minutes time to discuss in small groups the following is a summary of what was shared:
	• Important to keep conversations consistent
	• Check your own bagged
	• To be "Curious not Furious"
	• Get to know the persons, they are not going to change at end of life
	• Accept where they [patient/family] are
	• Ask permission
	• Walk beside
	• Speak in a language that they [patient] are most comfortable with
	• Ask what they know of their illness, what they understand
	• Sitting in the tension
	• Pre and post debrief for clinical team
	• Interdisciplinary support
	• People die as they live
	
	• Lorna notes that having a healthy respect for denial as this is a means of coping for many
	• Also agrees that language can be a stumbling block	

	• Sometimes the Anticipatory Plan can and should include the family • Helps the family get ready for what is to come • Chronically ill patients, can sit in a grey area – should they be managed with a palliative approach, when they handed off to the palliative team? Who is responsible for them the case manager or the palliative coordinator	
Closing	• Communication Tips poster	