«COMMUNICATION»
…FROM CONVERSATION TO CONNECTEDNESS

Maryse Bouvette, BSc N.,MEd., CON (C), CHPCN (C)
Palliative Care Advanced Practice Nurse
Education and mentorship

I do not have any conflict of interest for doing this presentation

I do not have any commercial conflict of interest.

Maryse Bouvette

OBJECTIVES

At the end of this session, participants will be able to:

- Understand the complexity of communication in the context of today's societal reality.
- Implement communication tools effectively demonstrate using on clinical scenarios
- Recognize the "therapeutic alliance" as communication tool in continuous evolution

COMMUNICATION
WHY ARE SOME ENCOUNTERS DIFFICULT?

Patient/family related factors

Situation related factors

Clinician related factors

PATIENT/FAMILY RELATED…

- Angry, defensive, frightened, resistant, anxious, depressed, personality d/o.

Manipulating

- Play on guilt
- Rage
- Legal action

Grieving

SITUATIONS…

Culture

Language

Complexity ie. particular circumstances…

CLINICIAN RELATED

Frustrated

Stressed

Burned out

Over-worked

Sleep deprived

Over committed

I am not having a good day!

PRINCIPLES OF GOOD COMMUNICATION

…an **acquired** skill

…many ways, many means and many styles…

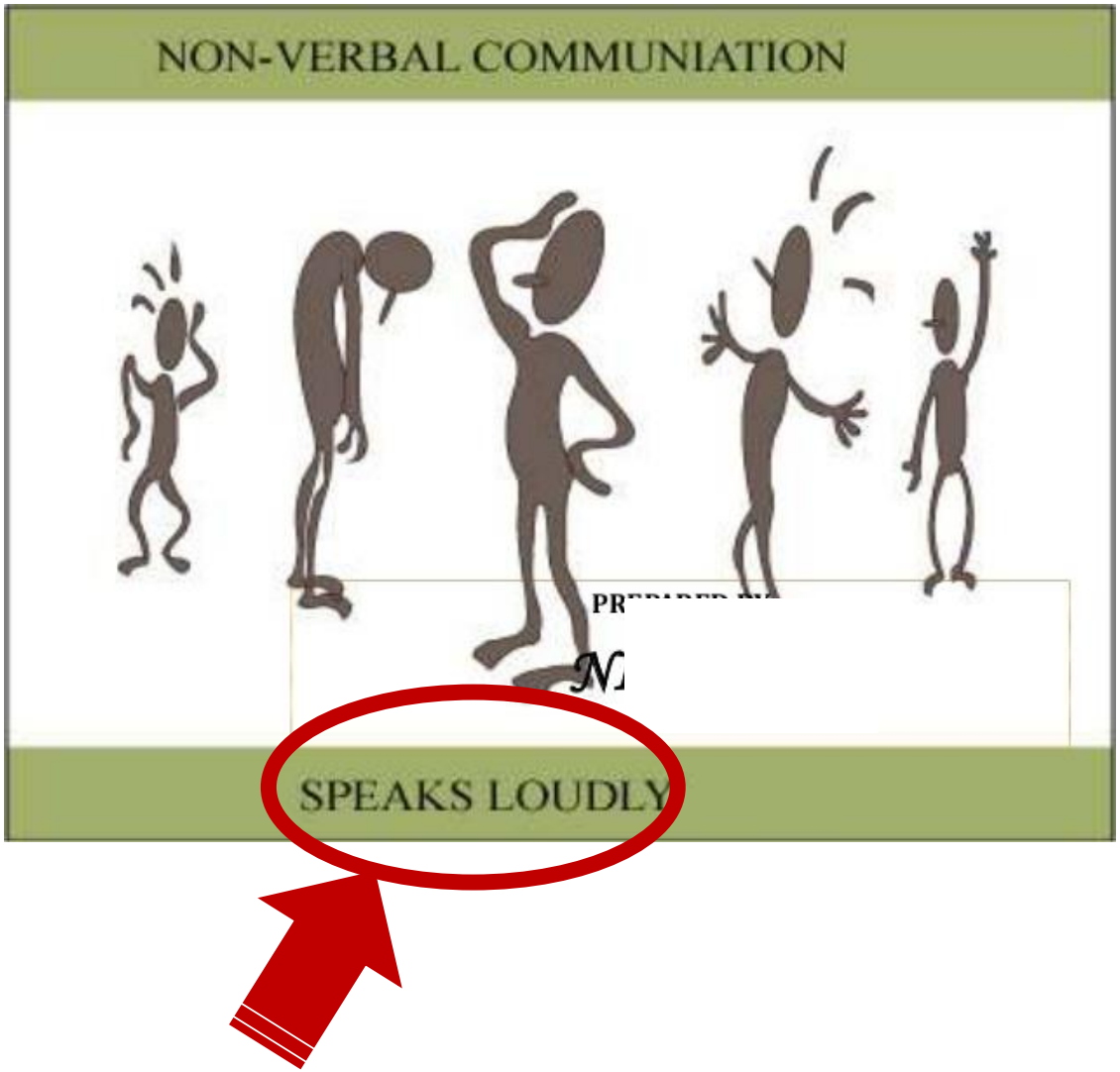
…verbal and non-verbal communication

…**essential is created by the other**

…key messages – **often « non-verbal »** or are shared at the end of the conversation with **silences**

NB: need to be aware of power hierarchy

COMMUNICATION



NON-VERBAL COMMUNICATION

- Subtle, or not so subtle
- Involuntary
- Usually speaks the truth
- 70% of your message
- Context is important
- **Don't assume**

  – clarify just in case

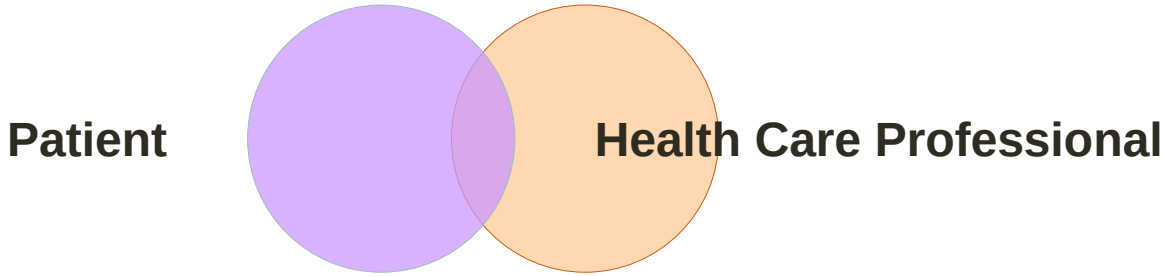
…CARING

RELATIONSHIP CENTERED CARE

Health Care Professional and Patient are both **human beings** and this is the **connector** between them.

Both retain their role as health care provider and patient but are not defined by this relationship

Relationship-centred care (Beach, M.C., Inui, T. 2006)



(Slides from Dr P. Hall)

RELATIONSHIP-CENTRED CARE

(BEACH, INUI 2006)

Patient

Other care providers

Community

Self

Palliative Care: Holistic care: Relationships "connectedness"

Bal Mount & Michael Kearney

Communication!

Perception!

Reactions!

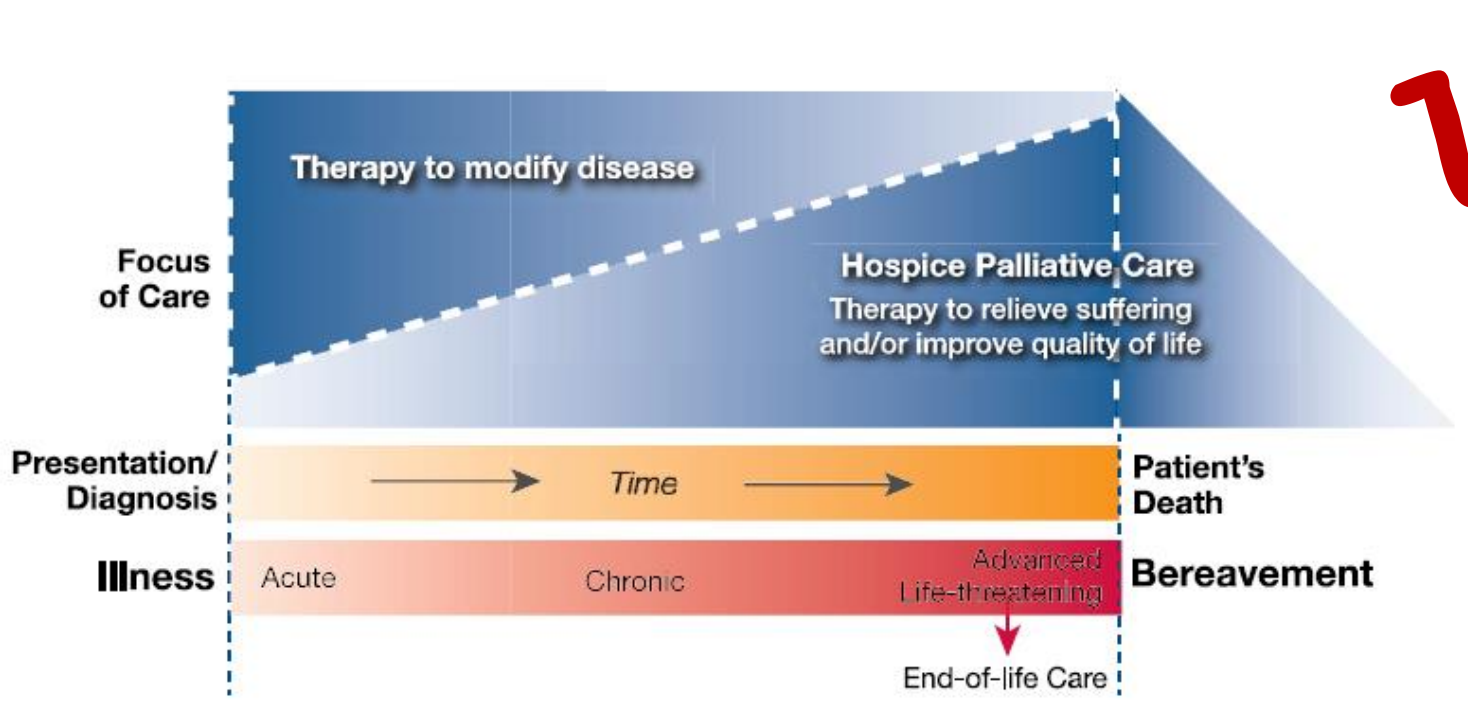
MANY COMMUNICATION TOOLS AVAILABLE

!!!!!.....

HOSPICE PALLIATIVE CARE CHPCA MODEL

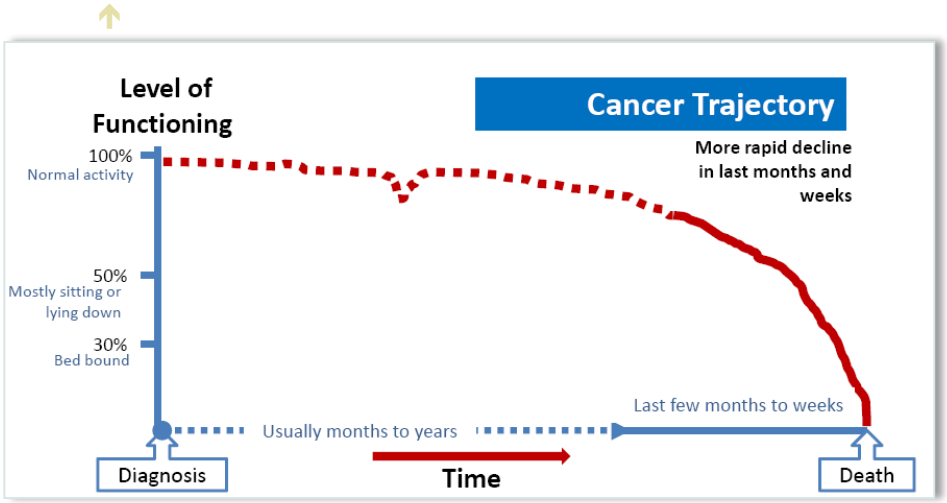
Illness trajectory

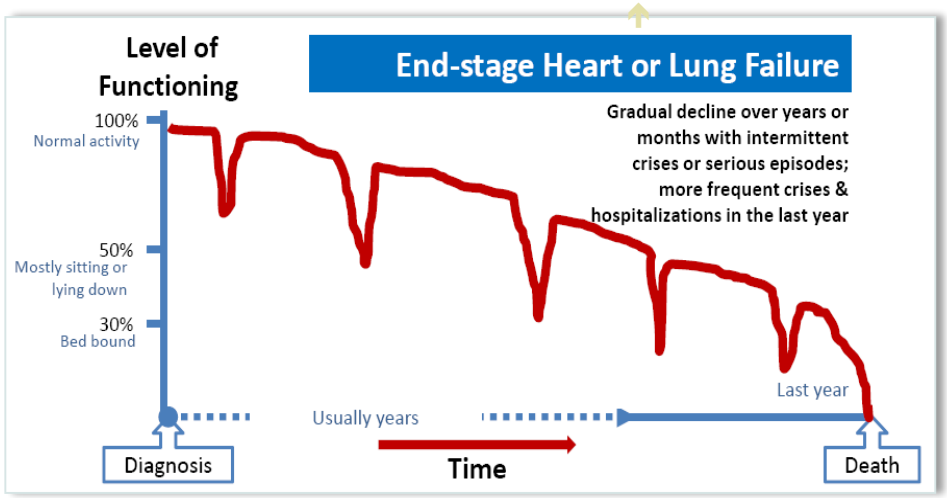
- More predictable in cancer and ALS, Less predictable in AIDS, lung & heart disease

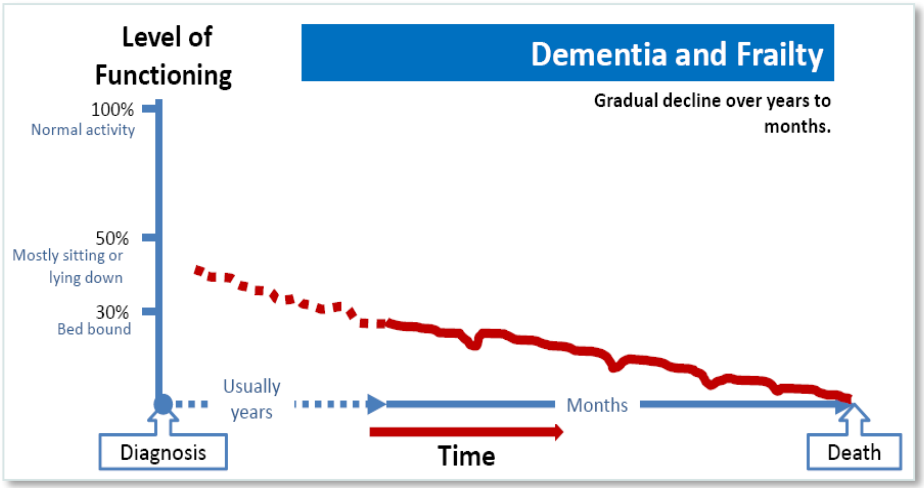


Canadian Hospice Palliative Care Association, 2002, 2013

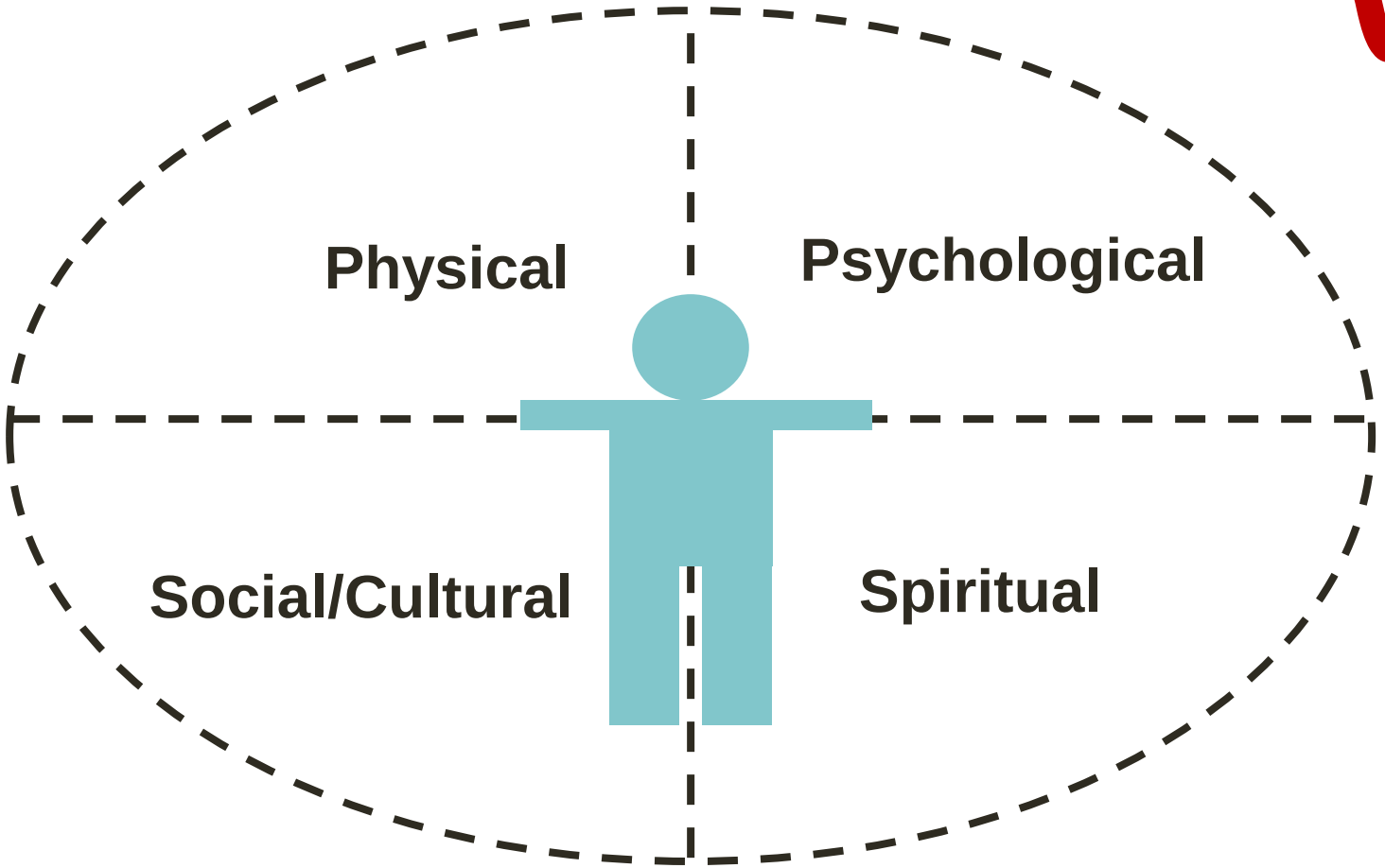
PALLIATIVE AND END OF LIFE TRAJECTORIES





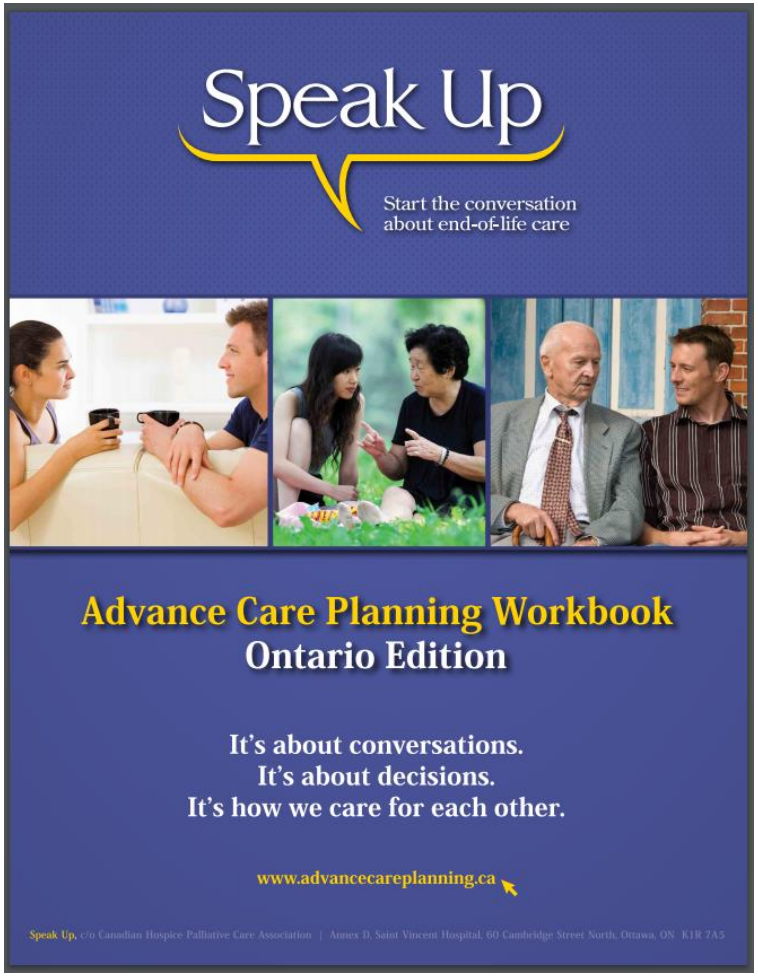


Aspects/Domains of Holistic Care



Adapted from: "Domains of Issues Associated with Illness and Bereavement" in A Model to Guide Hospice Palliative Care: *Based on National Principles and Norms of Practice. CHPCA, March 2002, page 15.*

ADVANCE CARE PLANNING



http://www.forms.ssb.gov.on.ca

Ontario Ministry of Health and Long-Term Care

Office of the Fire Marshal

Serial Number _____

Do Not Resuscitate Confirmation Form

To Direct the Practice of Paramedics and Firefighters after February 1, 2008

Confidential when completed

When this form is signed by a physician (M.D.), registered nurse (R.N.), registered nurse in the extended class (R.N. (EC)) or registered practical nurse (R.P.N.), a paramedic or firefighter **will not** initiate basic or advanced cardiopulmonary resuscitation (CPR) (see point #1) and **will** provide necessary comfort measures (see point #2) to the patient named below:

Patient's name – *please print clearly*	
Surname	Given Name

1. **"Do Not Resuscitate"** means that the paramedic (according to scope of practice) or firefighter (according to skill level) **will not** initiate basic or advanced cardiopulmonary resuscitation (CPR) such as:
   - Chest compression;
   - Defibrillation;
   - Artificial ventilation;
   - Insertion of an oropharyngeal or nasopharyngeal airway;
   - Endotracheal intubation;
   - Transcutaneous pacing;
   - Advanced resuscitation drugs such as, but not limited to, vasopressors, antiarrhythmic agents and opioid antagonists.
2. For the purposes of providing comfort (palliative) care, the paramedic (according to scope of practice) or firefighter (according to skill level) **will** provide interventions or therapies considered necessary to provide comfort or alleviate pain. These include but are not limited to the provision of oropharyngeal suctioning, oxygen, nitroglycerin, salbutamol, glucagon, epinephrine for anaphylaxis, morphine (or other opioid analgesic), ASA or benzodiazepines.

The signature below confirms with respect to the above-named patient, that the following condition (check one ☑) has been met and documented in the patient's health record.

☐ A current plan of treatment exists that reflects the patient's expressed wish when capable, or consent of the substitute decision-maker when the patient is incapable, that CPR not be included in the patient's plan of treatment.

☐ The physician's current opinion is that CPR will almost certainly not benefit the patient and is not part of the plan of treatment, and the physician has discussed this with the capable patient, or the substitute decision-maker when the patient is incapable.

Check one ☑ of the following:

☐ M.D. ☐ R.N. ☐ R.N. (EC) ☐ R.P.N.

Print name in full	
Surname	Given Name
Signature	Date (yyyy/mm/dd)

- Each form has a unique serial number.
- Use of photocopies is permitted only after this form has been fully completed.

Edmonton Symptom Assessment Scale (ESAS)

Date of Completion: _____Time: _____ Patient's Name: _____

Please circle the number that best describes your symptoms *right now*:

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible pain
Not tired	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible tiredness
Not nauseated	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible nausea
Not depressed	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible depression
Not anxious	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible anxiety
Not drowsy	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible drowsiness
Very good appetite	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible appetite
Very good feeling of well being	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible feeling of well being
No shortness of breath	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible shortness of breath
Very good sleep (*over last 24 hours*)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible sleep
Other problem _____	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

ESAS completed by*:	**If not completed, why:**
1. ☐ Patient	4. ☐ Cognitive impairment/delirium
2. ☐ Patient assisted by family/friend	5. ☐ Patient refuses
3. ☐ Patient assisted by health professional	6. ☐ Patient unable to speak/point to numbers
	7. ☐ Other:

***ESAS can only be completed by the patient, either alone or with assistance**

Edmonton Symptom Assessment Scale (ESAS)

Date of Completion: _____ **Time:** _____ **Patient's Name:** _____

PPS- 70%

Please circle the number that best describes your symptoms *right now*:

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible pain
Not tired	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible tiredness
Not nauseated	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible nausea
Not depressed	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible depression
Not anxious	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible anxiety
Not drowsy	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible drowsiness
Very good appetite	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible appetite
Very good feeling of well being	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible feeling of well being
No shortness of breath	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible shortness of breath
Very good sleep (*over last 24 hours*)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst possible sleep
Other problem	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

_____

ESAS completed by*:	**If not completed, why:**
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	7. ☐ Other:

***ESAS can only be completed by the patient, either alone or with assistance**

A Circle Of Care
Victoria Hospice
SOCIETY

Palliative Performance Scale (PPSv2)

version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS (see also definition of terms)

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.

2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others

AN "ETHICAL GRID" TO ASSIST IN DECISION MAKING

Medical Considerations Facts of the medical history Prognosis Treatment options, risks vs. benefits Are treatments being considered consistent with goals of care?	**Patient (and Family) Factors and Preferences** Patient/family understanding of illness Patient capacity to make decisions Patient goals
Quality of Life Issues What does quality of life mean for the patient (and family)? What gives meaning and brings dignity to their life?	**Contextual Considerations** Whose interests are affected? What are societal norms and expectations? What are the thoughts of the caregivers?

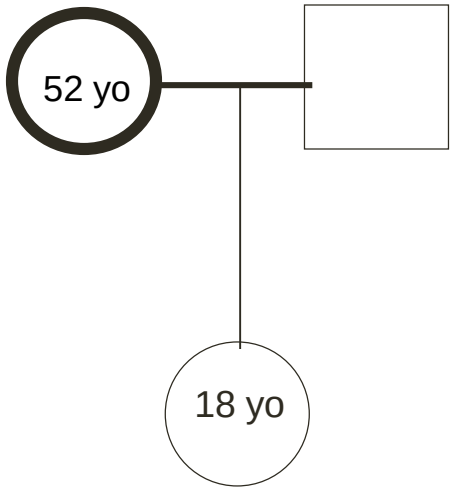
Adapted from D. Kuhl & P Wilensky. Journal of Palliative Medicine. 1999; 2: 75-86. (Pallium)

Silence

MRS TRUST

Frailty…

MRS TRUST



- Suffering from very advanced ALS
- Refused all medical management/ interventions except for a feeding tube and oxygen

MRS TRUST

Her story?

Transformation…

. . . A VERY HUMAN EXPERIENCE

MRS TRUST

HELPING, FIXING AND SERVING REPRESENTS 3 DIFFERENT WAYS OF SEEING LIFE.

1. WHEN YOU **HELP** YOU SEE LIFE AS **WEAK**.

2. WHEN YOU **FIX**, YOU SEE LIFE AS **BROKEN**.

3. WHEN YOU **SERVE**, YOU SEE LIFE AS **WHOLE.**

FIXING AND HELPING MAY BE THE WORK OF THE EGO, AND SERVICE THE WORK OF THE SOUL.

RACHEL NAOMI REMEN
KITCHEN TABLE WISDOM: STORIES THAT HEAL

Slide from Eugene Dufour