Capital Health Palliative Care Service Revamping Community Based Palliative Care Teams

In January 2014, the Capital Health Palliative Care Service will launch a new model for its community-based palliative care service aimed at improving patient and provider continuity and enhancing access to community-based services. Two teams will operate out of Halifax and Dartmouth respectively, and will see patients in both the ambulatory clinic setting and in their homes. In addition to existing clinic space at the Nova Scotia Cancer Centre, Hants Community Hospital, and Cobequid Community Health Centre, new community-based clinics are expected to open in Dartmouth and Halifax.

What is the role of the community palliative care team?

Our main role is to assist you in the care of your terminally ill patients. We can help by:

- Recommending appropriate treatment based on illness prognosis and patient/family goals of care
- Providing advice about management of pain and symptom issues
- Providing patient and caregiver education and reassurance about living with a terminal illness
- Assisting with arrangements to facilitate ongoing care and planned death at home
- Facilitating admission to hospital for evaluation and treatment of symptoms or provision of end-of-life care.

Who are the people on the community palliative care team?

Each team is staffed by experienced palliative care nurses who work with family doctors, VON and district continuing care coordinators to optimize care of patients with terminal illness. The nurses are supported by a palliative care consultant physician who provides advice on complex cases and assists family physicians in caring for patients.

How can I continue to work with the community palliative care team?

We value ongoing active involvement by family physicians and encourage your participation in a shared care model. You can expect that we will continue to provide advice and practical assistance while you continue to manage your patient in the community. We encourage nursing staff to involve you directly regarding the ongoing management of your patient. In the event that we make changes to your patient's management plan due to circumstances that require urgent intervention, we will keep you informed so that you can continue to be involved. If you have concerns or questions about the management of your patient, or require advice, call our main office at 473-4341

Referral Criteria:

Patient has a diagnosis of a terminal illness with limited life expectancy

The primary care physician, consultant or patient requires:

- Advice on management of pain and symptom issues
- Assistance and support with decision-making and defining goals of care
- Assistance with planning for end-of-life care

The patient has been informed and is in agreement with the referral

Follow-up:

After an initial assessment or follow-up visit, you will receive a written summary with treatment and follow-up recommendations. We often elect to continue to follow some patients because of:

- Complex or uncontrolled physical or psychosocial symptoms requiring potential frequent modification of treatment plan or ongoing specialist advice.

- Unstable illness trajectory in the setting of an estimated short time prognosis

These patients are usually booked for a follow-up clinic/home visit or telephone contact within 4 weeks.

If a follow-up appointment has not been booked, you are encouraged to contact our service by phone if there is change in status or further advice is required.

*There is no requirement to send a new referral if the patient has been seen within the previous 6 months

Contact Information:

- Fax referrals to **902-473-3103**
- All referrals are triaged, urgent cases are booked within 48 hours, with most others seen within 14 days.
- Your patient will be contacted directly with an appointment.
- To contact the team, call our main office at **902-473-4341**
- After hours advice: **473-2222** for the on-call palliative care consultant physician