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CONTINUITY OF CARE FOR PALLIATIVE SERVICES PROJECT (CCPS)

Principal Investigator

Frances Legault RN PhD

Co-Principal Investigator

Kevin Brazil PhD

Co-Investigators and Decision Maker Partners

Sheila Bauer RN MHA
Pippa Hall MD CCFP MEd FCFP

Liliane Locke RN MPA
Lynda Weaver MHA Med

Research Associate

Susan Kasprzak MA

Research Assistant & Quality Assurance Case Manager

Barbara Cameron RN BScN

The Continuity of Care for Palliative Services is a two year study that commenced in January 2005, and is co-sponsored by the Ontario Ministry of Health and Long Term Care (MOH LTC). It builds on the results of the project, "The Community Palliative Care Demonstration Project", a collaborative initiative by The Ottawa Palliative Consortium (now Palliative Network) and led by the SCO Health Service and the Ottawa Community Care Access Centre. It was aimed at providing a practical approach to optimize continuity of care for people at the end of life and their family caregivers.

The goal of this study is to implement and evaluate multiple interventions (service planning, physician referral and support, and communication) to optimize continuity of care in a community-based palliative care program. Components of the Project include:

1. **A "Chart-in-the-Home"**: a single convenient and accessible chart in the patients' homes in which all health service providers and caregivers are asked to document.
2. **CCAC service enhancements**: These will include a telephone call to the client from the Case Manager and a Nursing visit within 24 hours of admission to CCAC Palliative Program. A Quality Assurance Case Manager will monitor and promote consistency and continuity of care. The Oncology Unit of the Ottawa Hospital provides a discharge envelope to study participants and faxes a discharge summary to their family physicians.
3. **Family physician access to palliative care expertise**: promoting 24/7 access to Palliative Care Pain and Symptom Management Team (PSMT at 562-6397), as well as workshops and education sessions.

The results of this project will provide a practical approach to optimize continuity of care. This approach could be applicable to care settings throughout Ontario as it builds on the existing health care system and does not imply additional funding. The proposed reorganization of services will strengthen collaborative relationships among health care providers through effective service planning and coordination, increasing family physician referral and support, and improving communication.

Dr. Frances Legault, Principal Investigator

University of Ottawa School of Nursing, 562-5800, ext. 8532. Email: Frances.Legault@uottawa.ca