Appendix

Business Process – is a collection of activities designed to produce a specific output for a particular customer or market. It implies a strong emphasis on how the work is done within an organization in contrast to a product's focus on what. A process is thus a specific ordering of work activities across time and place, with a beginning, an end, and clearly defined inputs and outputs: a structure for action. [1]

Care Co-ordinator – Most commonly the term refers to a Continuing Care practitioner (i.e. employed by DOH CC), who is either Hospital-based or Community-based (provides services in the home). Community-based co-ordinators can also be referred to as Home Care or CC Co-ordinators. Palliative Care Co-ordinators can either refer to a CC community-based co-ordinator (usually VON) or a Palliative Care Nurse Consultant/Co-ordinator who is not part of CC but employed by GASHA (i.e. a GASHA PC nurse).

Caregiver – is 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. They are sometimes called "providers".
Informal caregivers are not members of an organization. They have no formal training and are not accountable to standards of conduct or practice. They may be family members or friends. [2]

Careteam – is a team of caregivers who work together to develop and implement a plan of care.[3] Team membership reflects local and district services.

Case Management - Coordination of the care plan by a member of the palliative care consult team.[4]

[1] Taken from Sparx Systems UML Tutorials – The Business Process Model , pg 2
[2] Taken from 'A Model to Guide Hospice Palliative Care' pg 92 CHPCA 2002
[3] Taken from 'A Model to Guide Hospice Palliative Care' pg 93 CHPCA 2002
[4] GASHA/CC Integrated Palliative Care Services Manual, pg 34, September 12, 2006 version

Case Manager – Most commonly the term refers to a Palliative Care Nurse Consultant or PC Co-ordinator (i.e. a GASHA PC nurse), who co-ordinates the patient's plan of care. Sometimes the Case Manager can be a Continuing Care Co-ordinator.

Continuing Care (1) - is a community-based organization funded by the NS Department of Health (DOH) to provide in-home care services to people who need ongoing care outside of hospital, either on a short-term or longer-term basis. Even though Continuing Care (CC) works with hospitals and in the community, it is a separate organization from the hospital organization, and is funded through separate revenue streams. Within GASHA, there is a CC office in Antigonish, in Guysborough and one in the Strait area. Unlike hospital and physician services, continuing care services are not insured under the Canada Health Act. Therefore, the provinces have developed unique systems, terminology and service options. In general Continuing Care services include the following:

• Assessment and case management
• Long-term care facilities, including chronic care facilities
• Home care nursing
• Homemaker and personal care services
• Community rehabilitation services such as physiotherapy and occupational therapy
• Palliative care
• Respite care

Other commonly provided continuing care services include:

• Meal programs
• Adult day support
• Group homes
• Equipment and supplies
• Quick response teams [5]

[5] http://www.gov.ns.ca/health/ccs_strategy/SFP_Provincial_Steering_Committee_Report.pdf

Continuing Care (2) - also refers to the services provisioned by CC practitioners. These practitioners include VON, CC nurses, CC co-ordinators, LPNs, homecare workers, and HITH. The NS DOH Continuing Care programs include among others: Long-term care (Nursing homes, Residential Care Facilities, and Community Based Options), and Home Care under which Palliative Care is a sub-program. Home Care services include home support (such as personal care, respite, and light housekeeping), nursing care (such as dressing changes, catheter care, and intravenous therapy) and home oxygen. If a patient is designated to receive Palliative Care under this program, they are allowed an increase in the number of hours of Home Care services (about 50 hours per month for 3 months) if they are deemed to have less than 3 months to live.[6]

Essential Services – The critical services required to implement the plan of care. [7]

FMEA – is a team-based systematic and proactive approach for identifying the ways that a process or design can fail, why it might fail, the effects of the failure, and how it can be made safer.

HITH (Hospital in the Home) – is a programme that provides *acute* nursing care services to patients in their homes. In GASHA it was originally funded through the hospital up until 3-4 years ago. It has been devolved to Continuing Care and is now funded through them.

Indicator – A statistical compilation of multiple similar or related performance measures/metrics. It is used to link related organizational issues, to evaluate interrelated leading or lagging indicators, or to effectively reduce the overall number of metrics or measures to a manageable level. [8]

[6] http://www.gov.ns.ca/health/ccs/

[7] Taken from 'A Model to Guide Hospice Palliative Care' pg 92 CHPCA 2002

[8] Taken from 'A Model to Guide Hospice Palliative Care' pg 93 CHPCA 2002

Intake – is the process of receiving referrals and assessing patients for acceptance into the Palliative Care programme and/or into the Continuing Care programme. Patient baseline data and information may be collected at this point.

MDS-HC – stands for Minimum Data Set for Home Care. It is a provincial information system for Continuing Care.

Measure – is to find out the extent, size, quantity, capacity, etc. [9]

Norm of Practice – is a statement of usual or average practice for hospice palliative caregivers and organizations. Norms are less rigid than standards. [10]

Palliative Care (1) – is care that aims to relieve suffering and improve the quality of living and dying. Aka Hospice Palliative Care. [11]

Palliative Care (2) – is a programme based at St. Martha's Regional Hospital, which funded by the Acute Care stream of the DOH**,** as is the hospital, through GASHA. The PC team and the Cancer & Supportive Care team are the same entity in GASHA. The Cancer side deals with curative measures but the Supportive care side is the same as PC. The PC programme is implemented by the PC team which is made up of the PNN, 2 PC doctors and the PC assistant.

Palliative Care (3) - also refers to the provision of services by PC practitioners.

Palliative Care (4) - is also one of the services provided by the Continuing Care program of the NS DOH. If a person is designated as requiring Palliative Care, they are entitled to an increase in the amount of home support services that they can access. This will help palliative care patients remain in their own homes in the last three months of their lives.

[9] Taken from 'A Model to Guide Hospice Palliative Care' pg 93 CHPCA 2002
[10] Taken from 'A Model to Guide Hospice Palliative Care' pg 6 CHPCA 2002
[11] Taken from 'A Model to Guide Hospice Palliative Care' pg 93 CHPCA 2002

Palliative care patients can now access about 200 hours of home-care services per month, for a total of 600 hours in the last three months of life. That is an increase of about 50 hours per month, or 150 hours over three months (taken from NS DOH CC). This funding increase is part of the province's Continuing Care Strategy.

Palliative Care Nurse – is a nurse employed by GASHA who provides Palliative Care services. A PC nurse can also be known as Palliative Care Consult Nurse, Palliative Care Nurse Consultant, or Palliative Care Co-ordinator.

Palliative Care Physicians – are physicians who have palliative care training and expertise. In GASHA they are Mike MacKenzie (a family medicine doctor) and Maureen Allen (an ER doctor).

Palliative Care Rounds – are meetings to review any therapies, their outcomes, issues and concerns of each PC patient/family that have taken place over the course of the week. Medications, procedures and pain-level assessments are some of the items that are reviewed. PC rounds are conducted at St. Martha's Regional Hospital on a weekly basis. The Strait Richmond Hospital palliative care team joins in by teleconference – since March 2008. [12] At SMRH, they are attended by 2 PC nurse consultants Heather and Annie, a representative from the VON (Denise), the CC Co-ordinator (Cathy Doucette) and one or more of the PC doctors. Other people can be in attendance as required such as a Pastoral Care person, the oncologist Dr. Jensen, the psychiatrist Carolyn or the PC Assistant Tracey.

Palliative Nursing Network (PNN) – is managed by the PC Manager (aka the PC Nurse Manager) located at SMRH, who oversees all the PC nurses in the PNN. Currently Charlene Porter is in this position. Also at St. Martha's Hospital there are two PC nurses known as PC Nurse Consultants, currently Heather Brander and Annie Gillis. In the satellite hospitals the PC nurses are known as PC Co-ordinators/Consultants. There is one PC nurse for each satellite hospital. PC Co-ordinator/Consultant for Strait Richmond

[12] Taken from NS HPC Association Annual report 2007-08, DHA 7 – GASHA report for 2007-08

Hospital, located in Evenson, is Nancy Cameron; for Eastern Memorial Hospital, located in Canso, it is Bonnie Richards; for Guysborough Memorial Hospital, located in Guysborough, it is Karen Hoben; for St. Mary's Memorial Hospital in Sherbrooke, it is Patricia MacKay. These people make up the PNN.

Plan of Care – The overall approach to the assessment, management, and outcome measurement to address the expectations and needs prioritized as important by the patient and family. [13]

Referral (1) – is the process of identifying a patient to the Palliative Care programme within GASHA, with the possibility of entering the programme and using the services of the programme.

Referral (2) – is the process of referring a patient for specialist medical services.

Required Organizational Practice – as defined by Accreditation Canada is an essential practice that organizations must have in place to enhance patient/client safety and minimize risk.

Standard – is an established measurable condition or state used as a basis for comparison for quality and quantity. [14]

Therapeutic Encounter – is considered the basic unit of healthcare. When a person with a health concern seeks a medical practitioner's help, this is called a therapeutic encounter.

Therapeutic Relationship – is a relationship between skilled caregivers and the patient/family that aims to change the patient's and family's experience of illness and bereavement.[15] A therapeutic relationship is built up through a series of therapeutic

[13] Taken from 'A Model to Guide Hospice Palliative Care' pg 94 CHPCA 2002
[14] Taken from 'A Model to Guide Hospice Palliative Care' pg 96 CHPCA 2002
[15] Taken from 'A Model to Guide Hospice Palliative Care' pg 96 CHPCA 2002

encounters throughout the three phases of the relationship – Intake, On-going Care, and Closure.

VON (Victorian Order of Nurses) – was started as a volunteer organization funded by donations, before Medicare came into effect. Now funded by (under contract to) Continuing Care. The VON provides everyday, *non-acute* nursing care.

Workflow - is defined as a 'Sequence of tasks. A workflow describes the order of a set of tasks performed by various agents to complete a given procedure within an organization. Repetitive workflows are often automated, particularly in organizations that handle high volumes of forms or documents according to fixed procedures. The co-ordination and management of workflow is an important part of business process management (BPM)'. [16]

[16] http://www.looselycoupled.com/glossary/workflow

Glossary of Acronyms

CC – Continuing Care

CCHSA – Canadian Council on Health Services Accreditation

CHPCA – Canadian Hospice Palliative Care Association

CPOC – Continuing Plan of Care

DOH – Department of Health

GASHA – Guysborough Antigonish Strait Health Authority

HPC – Hospice Palliative Care

HITH – Hospital In The Home

IPOC – Initial Plan of Care

LPN – Licensed Practical Nurse

PCN – Palliative Care Nurse

PNN – Palliative Nursing Network

QRP –

ROP – Required Organizational Practice

SMRH – St. Martha's Regional Hospital

VON – Victorian Order of Nurses