Canuck Place CHILDREN'S HOSPICE | Collaborative Pediatric Palliative Care Pathway Interior Health

Interior Health

Child (0-17 years) with a Serious Illness** identified in Interior Health

Is the child known to be on the CPCH program?

N

If non-urgent refer child to CPCH intake (604) 742-3476 or intake@canuckplace.org)

If urgent call: (604) 742-3475 or 1-877-882-2288

Not currently meeting criteria for acceptance. Consider re-referral if child's condition declines or fragility increases

Child/family appropriate for CPCH program

Y

Initiate contact with CPCH APN/NP to identify key IH Pediatric clinicians and determine whether IH adult home care or palliative services are currently involved.

CPCH to initiate reciprocal contact between key Pediatric clinicians identified and family to discuss palliative needs and to assess the following:

- Assess Health zone status of child and current concerns/ symptoms/needs
- Family resources
- Known child/family Goals of care (GOC)
- Available services (both CPCH and community)
- Need for inter-agency and/or further program referral (i.e. IH Palliative CNS, home care, etc.)
- Assess need for interdisciplinary multi-team meeting (+/- NSS, Nursing Agency, PPC lead, home care, pediatrician**) and whether further discussions with child/family needed prior to meeting (if GOC is unclear, see below).

GOC unclear:

CPCH consults for SICG- Peds discussions and key Peds clinician reconvene to discuss outcome

GOC: Live as long as possible or live as long as possible with limitations

GOC: comfort focused + home

- CPCH role = Consultative Care Establish a Communication Pathway / Pattern
- Assess community team learning needs/team supports needed by CPCH or others

CPCH role could be primary/collaborative.

Tasks:

1. Refer to appropriate additional programs
2. Join IH Whole Community Palliative Rounds in closest community to Child's/Family's home when appropriate (complete Palliative SBAR)
3. Creation of Collaborative Care Plan (symptoms + holistic care) and advanced directives
4. Establish reciprocal ongoing communication pathway (zoom, rounds, phone, email) and pattern (daily, weekly, monthly) for changes in care plan and ongoing care and updates between child and care provider
5. Determine health authority learning/education needs for PPC support (CPCH to support via ECHO sessions, etc.)