Collaborative Pediatric Palliative Care Pathway
Interior Health

Canuck Place CHILDREN'S HOSPICE

Interior Health

Child (0-17 years) with a serious illness** identified in Interior Health (IH)

Is the child known to be on the Canuck Place Children's Hospice (CPCH) program?

No

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.

Yes

Initiate contact with CPCH Advanced Practice Nurse (APN) / Nurse Practitioner (NP) to identify key IH pediatric clinicians and determine whether IH adult home care or palliative services are currently involved.

Child and their family appropriate for CPCH program

CPCH to initiate reciprocal contact between key pediatric clinicians and the family to discuss palliative needs and 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 and 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 at the community closest to child's/family's home. When appropriate complete palliative SBAR.
3. Creation of a 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.)