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**NSMHPCN – Strategic Plan**

Strategic Plan 2018-2020

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# Vision

Communities, patients, families and healthcare providers working together to improve palliative care for everyone [[1]](#footnote-1)across all sectors.

# Mission

Providing a compassionate, and holistic palliative approach to care as the cornerstone of living and dying well. Engaging, educating and serving communities with advance care planning, palliative care and grief and bereavement support [[2]](#footnote-2).

In the next three years, we are committed to accomplishing the following goals[[3]](#footnote-3) in support of our vision:

* Strengthen and support a well-defined integrated care framework
* Expand and provide support for literacy around death
* Promote and advocate for early advanced care planning
* Communicate and demonstrate our role presence and value in the community
* Improve understanding of the choice of care in our community

# Values

The following values [[4]](#footnote-4) will guide the organization:

**Respect**: We recognize the inherent worth of every person and their choices.

**Collaboration**: We operate as a unified team with our partners and promote agencies and communities working together to provide optimum care and service by demonstrating respectful behavior, open communication, professionalism, and accountability.

**Diversity:** We honor diversity and promote inclusiveness.

**Integrity**: We are honest and transparent.

# Philosophy of Care

**We believe that high-quality palliative care includes:**

* A culture that perceives death and dying as a normal occurrence that requires planning
* The early identification of individuals who will benefit from an early palliative approach to care
* Collaboration in all sectors between formal and informal care providers, and community partners.
* Equitable access to all

**Our role in this is:**

* Collaborating with care partners, community members, volunteers, informal care providers and the medical community, particularly the regional palliative care network to assist the roll out of their plan to improve palliative care in North Simcoe Muskoka
* Providing education (health promotion) about Advance Care Planning and how to support friends and families with life-limiting illnesses and bereaved family members though the linkage with the Hospice Orillia program and other services
* Educating service providers about a palliative approach to care and pain & symptom management
* Supporting individuals with unique or complex needs and those transitioning between locations of care
* Supporting HPC service delivery at a sub-regional level by identifying specific, non-duplicate roles for the Hospice Palliative Care NSM team
* Sharing current, best practice evidence in hospice palliative care to build capacity utilizing current resources and guiding documents. HPC requires strong partnerships in the community. Our role is to participate in the community planning and service delivery model that exists in each sub-region of North Simcoe Muskoka and, when necessary, take a leadership role in coordinating services.

# Obstacles Summary

The following set of obstacles was identified as important factors to take into account when building strategies to guide the future of the organization.

* Unclear expectations create **overlapping roles**
* PHIPA creates barriers to communication, solutions to navigate these obstacles is essential
* Limited human resources combined with increasing community demand results in an increasing workload for both informal and formal care providers
* Limited use of the surprise question (would you be surprised if end of life would occur in the next 12 months) hinders the ability to do timely purposeful ACP
* Current societal values impact our ability to normalize death and provide a palliative approach to care earlier in the illness trajectory

# Strategies for the Organization

Our strategies for the next three years will support natural communities (i.e. work places; faith communities; neighbourhoods), health care providers and families.

**Strategy: Refresh the identity of the organization**

We will work in the community to communicate our role our work will include the following activities:

* Communicate our mission, vision and role
* Evaluate the communication strategy and amend it as required

**Strategy: Clarify and promote the role of the HPC Nurse Consultant:**

We will clarify, and promote the Nurse Consultant role. Our work will include the following activities.

* Re-establish role of Clinical Manager
* Evaluate current state and develop future role statement regarding core services
* Communicate revised role statement of the Nurse consultant in each sub-regional area
* Clarify the target audience of the 24x7 on call service and promote the 24x7 on call service

**Strategy: Community Engagement model development, the Hospice Orillia program**

We will participate and support communities in providing a palliative approach to care. Our work will include the following activities.

* Developing a Terms of Reference for community engagement outlining what this means, key areas of focus, and key principles
* Supporting engagement in the dialogue and use of Advance Care Planning
* Supporting communities to be involved in informal and formal palliative and bereavement care
* Providing education to informal care providers and community groups throughout North Simcoe Muskoka through social and traditional media
* Participating in Indigenous Cultural Safety Training; include teachings in our work with First Nations, Métis and Inuit (FNMI) populations;

**Strategy: Provide education, mentoring and supports**

We will share resources and provide learning opportunities though education, support and mentoring for formal and informal care providers across sectors. Our work will include the following activities:

* Offering community Hospice and Bereavement services in Orillia including Caregiver Support programs, Community Volunteer Hospice Services, Community Education and Peer Led Bereavement Supports
* Facilitating introductory and advanced learning in Palliative Care including but not limited to Fundamentals, LEAP, CAPCE, ACE in concert with the OPCN and RPCN education strategy
* Providing workshops, case base learning and in-services. Topics will be identified by RPCN, community and LTC partners and relevant to the current educational needs
* Increasing the capacity of our health care partners to provide current best practices resources in palliative and bereavement care
* Staying current on emerging practices in palliative and bereavement care through review of current research and case base studies
* Evaluate the effectiveness of current staff learning opportunities including Journal Club and CLIP; Identify, and if appropriate, implement opportunities for improvement.

**Strategy: Early identification of a palliative approach to care:**

We will support the highest quality of life for individuals and families along the palliative care trajectory. Our work will include:

* Educating primary care providers about the importance of early identification and best practice in a palliative approach to care
* Increasing public awareness about the importance of early involvement of palliative care
* Participating as a member of the Provincial ACP champion’s group and implementing provincial initiatives at a local level.

# Resources to Support the Plan

Implementation of the Strategic Plan will undergo further work to refine the deadlines and deliverables for each of the strategies.

# References

ICA Associates Inc. (2008). *Working Assumptions for Groups.* Toronto: ICA Associates Inc.

Ministry of Health and Long Term Care. (2015). *Patients First: A Roadmap to Strengthen Home and Community Care.* Toronto: Ontario Government.

Standfield, R. B. (1997). *The Art of Focused Conversation - 100 Ways to Access Group Wisdom in the Workplace.* Toronto: The Canadian Institute of Cultural Affairs.

Stanfield, R. B. (2002). *The Workshop Book - from Individual Creativity to Group Action.* Toronto: The Canadian Institute of Cultural Affairs.

Staples, B. (2013). *Transformational Strategy - Facilitation of ToP Participatory Planning.* Bloomington, IN: iUniverse.

# Appendix 1 – Practical Vision Chart

What could be accomplished [[5]](#footnote-5) in three years to make the vision a reality?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Choice for Care** | **Integrated Care** | **Death Literacy - Dying to Know** | **Identify the Network role in the full spectrum of care** | **Early Care Initiatives** | **Mission Clarity** |
| * Understand the supports that are available in each sub-region; the client experience with the current system and identify ways in which HPC can expand the number of supports available through direct service; participation in system planning activities and advocacy. | * Work with communities to ensure that care is integrated between providers and between service systems. | * Promote death literacy and Advance Care Planning among all populations * Promote a palliative approach to care | * Clarify role of the Nurse Consultants | * Promote and educate about the importance of Advance Care Planning; Early approach to Palliative Care | * Clarify the mission vision and values |

# Appendix 2 – Proposed Action Plan for 2018/19

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Fiscal 2017/18** | **April – June** | **July – Sept** | **Oct – Dec** | **Jan – March** | **End Result** |
| Refresh the identity of the organization in the community | Begin work on 2018-19 work plan |  |  | Complete and approve 2019/20 work plan | Communications will have occurred throughout the year with community partners and Network staff |
| Clarify and promote the role of the HPC Nurse Consultant: | Hire Clinical Manager  Evaluate current state  Communicate refreshed role of Nurse Consultant  Internally, agree upon the target audience for 24x7 service | Circulate refreshed job specification to internal staff  Share core responsibilities of the role of the HPC Nurse Consultant to partners in each sub-region | Develop and implement a framework for gathering information about consumer and stakeholder experience to continually improve the services and information we provide  Develop a mechanism to obtain feedback on services | Review consumer and stakeholder feedback to identify common themes and suggested actions. | Services will remain current with stakeholder expectations |
| Community Engagement Model Development | Create a working group (staff and community members) to develop the community engagement model  Participate in Indigenous Cultural Safety training and discuss how this informs our work with First Nations Populations and other specific communities | Identify key principles of community engagement including (but not limited to):   * Being invited by the community; * Listening to the community about their needs and preferences * Joint implementation and evaluation * Participate in or spearhead ACP day (April 16, 2018) planning processes in each sub-region | Prepare a Terms of Reference for working group | Work with partners to identify supports required to support unique community needs | Terms of Reference for Community Engagement will be available and used upon invitation from a community.  Each sub-region will have a plan for implementation of ACP activities in 2018/19  100 % of staff will have Indigenous Cultural Safety Training |
| Providing Education and Support | Introduce a Caregiver Group in Orillia (Hospice Orillia)  Create a schedule of regional educational opportunities that extends to March 31, 2019. | Evaluate Caregiver group and refine plans (Hospice Orillia)  Plan and promote educational opportunities until June 30, 2019  Identify learning priorities for Health Care professionals and develop educational presentations | Plan and promote educational opportunities until September 30, 2019 | Identify training opportunities for family providers  Plan and promote educational opportunities until Dec 31, 2019  Develop an education plan and budget for 2019/2020 | Caregiver group is pilot tested and a plan exists for future groups  Service providers consistently have access to course offerings for the annual calendar of educational events  An education plan and budget has been prepared for 2019/2020 |
| Early Identification of a Palliative Approach to Care | Research opportunities to include ACP component and information about the benefit of Early Identification of a Palliative Approach to Care in other educational forums  Participate in Provincial Advance Care Planning (ACP) Champions working group implement provincial practices locally | Ensure that ACP and Early Identification are on the Nursing and Hospice team agendas each month including current information related to ACP Champions working Group and identification of opportunities for local implementation. | | | A list of venues where ACP and Early Identification of a Palliative Approach to Care were offered  A list of provincially identified best practices in ACP will be available with information about which have been adopted and the outcomes. (RPCN role) |

1. Approved by the Board of Directors – March 6, 2017 [↑](#footnote-ref-1)
2. Approved by the Board of Directors – March 6, 2017 [↑](#footnote-ref-2)
3. Practical Vision Chart – Appendix 1 – Developed by Staff as part of the planning process. [↑](#footnote-ref-3)
4. Approved by the Board of Directors – March 6, 2017 [↑](#footnote-ref-4)
5. [↑](#footnote-ref-5)