Appendix 4. *Instructions for Use of the Process Map*

Introduction

A process map is a tool used to visually display the steps in a process and the related resources required to follow the steps. It may also depict the people for whom the process is defined, as is the case with the map for advance care planning and palliative care early identification in a variety of settings.

A legend in the top right corner explains what each of the shapes represent including the start/end points in the process - oval, the steps - rectangle, the documents or resources used at each step - rectangle with a wave at bottom, and the decision points - triangles.

Each start/end, step, document, and decision are numbered. It is as straightforward as following the numbers in sequence. Should you have any difficulties following the map, please contact the Central West LHIN (see information in Appendix 5).

The Basis of the Map

The process map is organized according to the Model for Palliative Care and the Early I.D. tool. The first column is labelled stakeholders listing the parties involved in this process and the horizontal "lanes" capture the two stakeholder groups involved i.e. 1. regulated health professionals and 2. all caregivers and regulated health professionals.
In consideration of care for people with complex needs, these two stakeholder groups follow the steps reflected in the second through seventh columns:
2nd – Advance Care Planning
3rd – Early I.D. Surprise Question
4th – Early I.D. General Decline
5th – Early I.D. Specific Decline
6th – Coordinated Care Planning
7th – Bereavement

Regulated Health Professionals

Looking at the map, you can see that only regulated health professionals i.e. physicians, nurse practitioners and nurses assess for Specific Decline per the Early I.D. tool and as shown in the 5th column. Regardless of the setting in which one of these three regulated health professionals work, they may assess for Specific Decline, per their professional scope of practice and their organization's policies and procedures.

Following the Process Map

Begin at the start (the first oval) and follow the directional arrows to the next number. In all instances for formal caregivers, it is important to understand and follow your organization's policies and procedures as it relates to palliative care.

Here is a brief explanation for each numbered activity.

#	Activity	Description	Notes
1.	Start	Introduce Advance Care Planning to patients >50 years of age	Documents include Speak Up! training and tools; >50 years is a suggestion, there is no standard
2.	Step	Ask the surprise question as part of assessment or re-assessment process	This is part of the Early I.D. guide and postcard; additional information available at www.cwpcn.ca/en/toolkit
3.	Decision	Would you be surprised if the patient were to die in the next year?	See above
3a.	Step	Yes, surprised - reassess regularly*	Follow agency policies and procedures for re-assessment
4.	Step	No, not surprised - observe general health and well-being	This is part of the Early I.D. guide and postcard. See Step #2.
5.	Decision	Has there been a decline?	See above
5a.	Step	Reassess regularly*	See Step #3a.
6.	Decision	Yes - do they have specific clinical indicators?	See Step #2. This step is for regulated health professionals only.
7.	Step	Yes - flag general decline and as appropriate specific indicators of decline in patient's record	Document patient status/experiences per agency policies and procedures
8.	Step	Refer to Primary Care Provider and/or Central West LHIN H&CC	If you are familiar with the patient's family physician or nurse practitioner, refer to them; the other option is LHIN H&CC to explore with them if the patient has early palliative care needs; it is in the best interest of the patient to make an inquiry, so don't hesitate; process for referrals is shown in Appendix 5
9.	Decision	Patient confirmed as requiring palliative care?	Primary Care or H&CC will make this decision
10.	Step	Yes - (re)-introduce Advance Care Planning to patient and/or family	Documents include Speak Up! training and tools; it is important to revisit this issue, particularly if the patient/family was not interested when you first introduce it
11.	Decision	Need to make accommodations in your service?	Given the patient's general or specific decline and still within the scope of your usual services, decide whether or not you can/need to make service changes e.g. frequency
12.	Step	Yes - discuss needs with patient and/or family and implement changes	Explore options with patients/families, explain the rationale
13.	Decision	Continued decline that may require a change in service plan?	See Step #12.
14.	Step	No - Reassess regularly*	Re-visit as necessary and per agency policies and procedures
15.	Step	Yes – contact Central West LHIN H&CC	Refer to H&CC per Appendix 5
16.	Step	Per H&CC discussion, participate in the development of or ongoing revisions to a Coordinated Care Plan	Follow agency policies and procedures; if training is required, please visit (LHIN CCP in HPG) for information
17.	Step	Notified of patient's death; ensure Coordinated Care Planning Lead and/or Care Team members are also aware	It's important that all the patient's care providers are aware
18.	Decision	Involved with patients family?	If your usual practice means you're involved with family, you may have a role in supporting them through your patients' dying and death
		No - to Step 20.	It may not be in scope for you, but it likely is for another provider.
19.	Step	Yes – per CCP, offer support to the family	Defer to agency Policies and Procedures for participating in this step
20.	Step	Case(s) debrief amongst Coordinated Care Team	See Step #19
21.	Step	Complete the discharge process and inform family	See Step #19
22.	End	Close patient's file	See Step #19