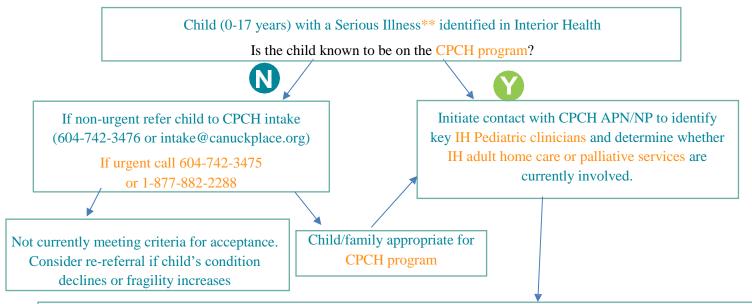


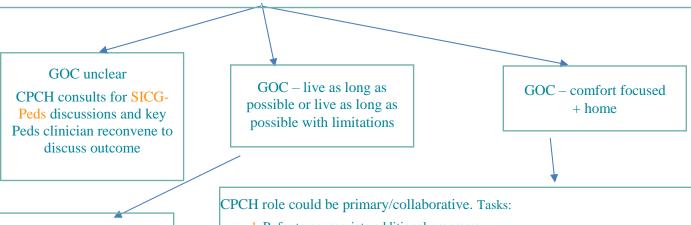
## | Collaborative Pediatric Palliative Care Pathway Interior Health





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).



CPCH role = Consultative care
Establish communication
pathway/pattern

Assess community team learning needs/team supports needed by CPCH or others

- 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

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5. Determine health authority learning/education needs for PPC support (CPCH to support via ECHO sessions, etc.)