Ontario Health atHome

Palliative Care Services

Information for patients and families

Ontario Health atHome connects, supports, and cares for patients who have a life-limiting illness. Our skilled team helps patients and families understand their options and provides support for their choices.

Ontario Health atHome has numerous supports and services available to help meet patient and family care needs. Patients have access to a diverse, inter-professional team with a wealth of knowledge and expertise to support them throughout their care journey.

The Palliative Care Consultation Team

Home is often the most comforting and supportive place to be when you, a family member, or a friend are facing a life-limiting illness or end-of-life decisions. Our team of professionals form an integral part of your circle of care as you enter this next phase of life. We work closely with your existing supports and professional services, and bring in additional services as needed.

To be eligible for palliative care services, patient must:

- Self-refer or referred to the program by a family member or a physician and receive a clinical assessment by an Ontario Health atHome care coordinator.
- Have a life-limiting illness
- Have a present or potential need for complex symptom management and be someone who would benefit from palliative care services.

Our Team

As part of your circle of care, the Ontario Health atHome Palliative Care Consultation team supports you by:

- Providing information about advanced care planning.
- Providing information about other community resources.
- Providing patient- and family-centred care, including expert pain and symptom management.
- Offering medication counselling.
- Partnering with your primary care provider or physician.
- Educating and supporting you and your family about how to manage end-of-life care in the home.
- Improving your family caregivers' knowledge, skills, and confidence.
- Helping you prevent avoidable emergency department visits and/or hospital admissions.

Our inter-professional Palliative Care Consultation Team consists of:

- Care coordinators
- Social workers
- Respiratory and occupational therapists
- Primary care professionals
- Other allied health professionals

Contact Information

If you have any questions regarding this service, please contact: **310-2222** • **ontariohealthathome.ca**

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eShift

Ontario Health atHome understands how hard it can be to care for a loved one at end-of-life. There are numerous community supports available to assist caregivers and their loved ones during this transition.

Our innovative eShift program has been designed to support caregivers who are caring for patients in the home with 24/7 needs when those patients are at end-of-life.

The eShift model places specially-trained personal support workers (PSWs) in the home to provide overnight care for patients, with the support of a registered nurse working from a remote office location. Using a smartphone, the nurse is able to review clinical observations and assessments completed by the PSW at the bedside and provide direction for care.

eShift enables one nurse to provide overnight care to several palliative patients at one time. This allows patients to be at home in their preferred care setting and allows the caregiver to be emotionally present, get needed rest, and share responsibility for caring for their loved one at end-of-life.

Who is eShift for?

eShift benefits any caregiver who is providing 24/7 care, who may be showing signs of stress or burnout, and who requires a strong support system.

Who can refer to eShift?

Any member of the care team can ask for a referral, including care coordinators, physicians, hospital staff, visiting nurses, and other allied health professionals. Patients and caregivers are also welcome to make referrals to the eShift program when they anticipate the need. To make a referral, simply connect with your care coordinator at 310-2222.

Accessing hospice services

Ontario Health atHome helps patients transition to their preferred care setting. We work with them to develop an individualized care plan and explore options and eligibility for access to community services.