A GUIDELINE FOR INITIATING PALLIATIVE CARE

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OBJECTIVES OF S-PCG PART 2

To meet the patient's physical, mental, social, and spiritual needs with the aim of the patient living with the greatest well-being as possible. To ensure that the patient and their relatives are given the opportunity to prioritize what they consider important and meaningful since the patient has limited time left.

PURPOSE OF NCP

Assure the quality of care

Provide support in converting theoretical knowledge of palliative care into clinical practice

Increase security and quality of life for both the patient and their relatives by identifying, addressing, following up, and documenting needs in a structured manner

Increase a sense of security for staff by calling attention to important aspects of care

Increase the opportunity for shared planning and involvement

Create shared understanding of needs and possibilities

A GUIDELINE FOR INITIATING PALLIATIVE CARE

The guideline offers person-centred support to identify, assess, and address the patient's palliative needs, wishes, and priorities.

Through use of S-PCG PART 2, healthcare efforts can be quality assured for patients approaching the end of life. The content addresses the issues and areas that are important to decide on, regardless of whether the time left in life is one week or one year.

The decision support can be used within both the medical services system and municipal care and welfare organisations, regardless of the patient's age and diagnosis.

PALLIATIVT UTVECKLINGSCENTRUM
REGION SKÅNE | LUNDS UNIVERSITET
THE INSTITUTE FOR PALLIATIVE CARE

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Date: _____ Personal identity number: _____

Patient's name: _____

Organisation|Care unit: _____

Main diagnosis|secondary diagnoses _____

2.1 SYMPTOMS AND STATUS

CHOICE OF ASSESSMENT TOOLS :

☐ ABBEY PAIN SCALE ☐ ESAS ☐ FLACC ☐ IPOS ☐ VAS/NRS ☐ OTHER _____

	date _____	date _____	date _____
Pain	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Fatigue/lack of energy	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Nausea	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Depression	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Anxiety	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Confusion	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Sleepiness|drowsiness	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Loss of appetite	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Impaired well-being	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Shortness of breath	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
_____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
_____	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
The patient is cognitively adequate	☐ yes ☐ no ☐ varying ☐ cannot be assessed	☐ yes ☐ no ☐ varying ☐ cannot be assessed	☐ yes ☐ no ☐ varying ☐ cannot be assessed
The patient is able to communicate	☐ yes ☐ no ☐ varying ☐ yes, via interpreter	☐ yes ☐ no ☐ varying ☐ yes, via interpreter	☐ yes ☐ no ☐ varying ☐ yes, via interpreter
	_____ sign	_____ sign	_____ sign

The impact of the symptoms on daily life _____

_____ _____ sign

Patient ID: _____

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2.2 FUNCTION IN DAILY LIFE

LEVEL OF FUNCTION*	date _____	date _____	date _____
Fully active in daily life	☐ 0	☐ 0	☐ 0
Reduced physical ability, but ambulatory	☐ 1	☐ 1	☐ 1
Confined to bed or chair < 50% of the day	☐ 2	☐ 2	☐ 2
Confined to bed or chair > 50% of the day	☐ 3	☐ 3	☐ 3
Totally confined to bed	☐ 4	☐ 4	☐ 4

*Based on WHO Performance Status|ECOG

PATIENT NEEDS HELP WITH	date _____	date _____	date _____
Personal hygiene	☐	☐	☐
Dressing and undressing	☐	☐	☐
Toilet visits	☐	☐	☐
Moving about	☐	☐	☐
Eating and drinking	☐	☐	☐
Household activities	☐	☐	☐
Transportation	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
HANDLES ADL INDEPENDENTLY	☐	☐	☐
	_____ sign	_____ sign	_____ sign

Current assistive devices _____

Comments _____

_____

_____ sign

Patient ID:

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2.3 UNDERSTANDING

The patient expresses understanding that they have limited time left ☐ yes ☐ no ☐ cannot be assessed

The family/person of importance to the patient express understanding that the patient has limited time left ☐ yes ☐ no ☐ cannot be assessed

Comments _____

_____

_____

_____
sign

2.4 MEDICAL DECISIONS physician ●

Anticipatory medication for symptom relieve prescribed	☐ yes	☐ no
Decision made regarding discontinuation of non-relevant medicines	☐ yes	☐ no
Review of ongoing medical interventions has been made*	☐ yes	☐ no
Decision made regarding treatment interventions and life-sustaining treatments**	☐ yes	☐ no

Decision _____

_____

*E.g. regarding investigations, treatment **E.g. regarding treatment limitations, resuscitation status, intensive care, dialysis

Comments _____

_____

_____

_____
sign physician ●

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2.5 WISHES AND PRIORITIES

QUESTIONS THAT MAY APPLY

- How, when and to whom should information be given?
- Who is/are particularly important to you?
- What should we know about you to be able to provide you quality care?
- What is important to you right now?
- Is there anything you are concerned about?
- Do you have any wishes/preferences?
- Is there anything you would like to do?
- Do you have any special cultural wishes we should know about?
- Do you have a faith or spiritual needs that we should know about?
- Where would you like to live and be cared for?
- Other issues of importance, such as pets.

date _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

sign

date _____

_____

_____

_____

sign

date _____

_____

_____

_____

sign

The patient has expressed wishes in writing (e.g. advanced care plan, living will or advance directives for medical decisions) ☐ yes ☐ no

The patient's wishes about who should make decisions when he/she are no longer able or willing

_____

_____

_____

sign

Not for distribution

Patient ID:

2.6 PATIENT INVOLVEMENT

The patient is capable of being involved in decisions about care and treatment ☐ yes ☐ no ☐ cannot be assessed

The patient wants to be involved in decisions about care and treatment ☐ yes ☐ no ☐ cannot be assessed

Comments _____

_____

_____
sign

2.7 FAMILY / PERSONS OF IMPORTANCE TO THE PATIENT

Contact information for the family/persons of importance

Name, relation, tel.(primary contact) _____

Name, relation, tel. (secondary contact) _____

Is there a need for interpreter for the family/persons of importance ☐ yes ☐ no

Indicate who and what language _____

_____

Have any of the family/persons of importance been anxious or worried about the patient? ☐ yes ☐ no

_____

_____

Does any family member/person of importance need support ☐ yes ☐ no

Indicate reason* and what kind of support** _____

_____

* E.g. due to anxiety, lack of social network, existential|spiritual|religious needs, overload
** E.g. counselling, contact with a social welfare officer, spiritual leader, alleviating interventions.

Wishes and preferences of the family/person of importance to be involved in the care

_____

_____

_____
sign

Patient ID:

Not for distribution

2.8 CHILDREN OF IMPORTANCE TO THE PATIENT (0 –18 YEARS OLD)

Are there any children in the family/children of importance to the patient ☐ yes ☐ no

Number of children _____

Year of birth | | |

2.10 END-OF-LIFE CONVERSATION physician •

Conversation with patient needed regarding the focus and content of care ☐ yes ☐ no ☐ cannot be assessed

Family member/persons of importance to the patient is in need of a conversation regarding the the focus and content of care ☐ yes ☐ no ☐ cannot be assessed

End-of-life conversation was conducted date _____ date _____ date _____ ☐ not applicable

Present during conversation ☐ patient

☐ family/persons of importance to the patient (with the patient's (presumed) consent).

_____

☐ other

_____

☐ doctor _____ ☐ nurse _____ ☐ assistant nurse _____

Content of conversation

date _____

_____

_____

_____ sign physician •

date _____

_____

_____

☐ See electronic record entry. Date _____

_____ sign physician •

date _____

_____

_____

☐ See electronic record entry. Date _____

_____ sign physician •

Patient's preferences regarding treatment interventions and life-sustaining treatments*

date _____

_____

_____

_____

_____

*E.g. regarding examinations, treatments, treatment limitations, life-sustaining treatment, intensive care, care interventions etc.

_____ sign physician •

Patient ID:

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2.11 COORDINATION OF CARE

General practitioner NAME | TEL _____

Contact nurse NAME | TEL _____

The patient needs contact with/referral to

☐ occupational therapist ☐ dietician ☐ physiotherapist ☐ religious/spiritual leader ☐ social worker

☐ psychologist ☐ interpreter ☐ other medical specialty _____ ☐ other _____

☐ not applicable

Need to establish an individual plan for coordinated care	☐ already exists	☐ yes	☐ no
Contact with a care organiser	☐ already exists	☐ yes	☐ no
Contact with the palliative care consulting team referral sent _____	☐ already exists	☐ yes	☐ no
Contact with specialised palliative care referral sent _____	☐ already admitted	☐ yes	☐ no

Comments _____

_____

_____

_____
sign

2.12 CARE INTERVENTIONS

The patient's care needs are met at the moment ☐ yes ☐ no date _____ _____
sign

The patient is in need of care interventions:

☐ According to S-PCG Part 2 Care interventions for palliative

☐ care According to S-PCG part 2[D] The patient may be entering the last days/

☐ weeks of life According to the unit's plan for care interventions

date _____ _____
sign

date _____ _____
sign

date _____ _____
sign

Patient ID:

Not for distribution

2.13 UPDATE / RE-ASSESSMENT

New assessment planned at next

☐ outpatient care |home visit ☐ inpatient care ☐ other _____

date _____ date _____ date _____

_____ |
sign

2.14 CONSENT

The patient gives consent that other care providers involved get access to this document ☐ yes ☐ no ☐ presumed consent

Copy of this document sent to _____

_____ |
sign

2.15 SIGNATURES AND PRINTED NAMES

Name printed _____ Position _____ _____ |
sign

Name printed _____ Position _____ _____ |
sign

Name printed _____ Position _____ _____ |
sign

Name printed _____ Position _____ _____ |
sign

Not for distribution

Patient ID:

CONVERSATION* WITH CHILDREN IN THE FAMILY (CHILDREN OF IMPORTANCE)

Conversation carried out date _____ ☐ not applicable

☐ with child/children ☐ with child/children and guardian ☐ with child/children and other relative _____

Healthcare professionals present

☐ social worker ☐ doctor ☐ nurse ☐ other _____

Content of conversation _____

_____

* e.g. about the diagnose, prognosis and the care

_____

sign

HEALTHCARE CONTACT-PERSON APPOINTED

Name, profession _____

Contact details _____

Contact details given to the child|children ☐ not applicable ☐ yes

_____

sign

CHILD|CHILDREN IN NEED OF SUPPORT*

Indicate what type _____

_____

NEED TO ARRANGE CONTACT WITH THE CHILDS|CHILDRENS

☐ student health ☐ social worker ☐ psychologist ☐ school|preschool ☐ not applicable

☐ social services ☐ grief support group ☐ medical centre ☐ other _____

Comments _____

_____

* can be e.g. social, practical or counselling

_____

sign

Patient ID:

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