Palliative Performance Scale & Care Plan Reviews

Resident Name: **Unit/Room #:**

Date	Time	PPS Score %	Resident-Specific Care Plan Reviewed/Updated	Date next review due.	Signature

NURSING GUIDELINES FOR END-OF-LIFE CARE

ADMISSION & REGULAR REVIEWS		
ADMISSION	**Initiate PPS score within ≤ 1 week** **Follow corresponding interventions (page 2)**	**ADMISSION REVIEW** √ Complete all routine admission documentation and diagnostics (eg. Liver function tests, electrolytes, creatinine.) √ Complete PPS score & consider corresponding interventions √ Consider ESAS if resident able to complete. √ Assess pain, physical, psychosocial & spiritual issues (See Domains of Issues). Identify issues, progress toward meeting goals. √ Initiate monitoring tools as applicable √ Consider pressure relief surface as needed √ Identify care & safety needs, develop resident-specific nursing care plan. √ Review goals and expectations of resident/family/SDM. √ Consult interdisciplinary team members as needed. √ Discuss & complete Advance Directives with resident/family/SDM.
REVIEWs	**Complete PPS score** • **quarterly (PPS ≥ 40)** • **weekly x 3 (PPS = 30; if stable change to quarterly)** • **weekly (PPS ≤ 20)** **Follow corresponding interventions (page 2).** **In case of Outbreak: & no improvement in 72 hrs after onset of resident's symptoms, conduct regular review & follow corresponding interventions.**	**REGULAR REVIEWS** √ Complete PPS score & consider corresponding interventions √ Consider ESAS if resident able to complete. √ Assess pain, physical, psychosocial & spiritual issues (See Domains of Issues). Identify issues, progress toward meeting goals. √ Initiate monitoring tools as applicable √ Consider pressure relief surface as needed. √ Identify care & safety needs, update resident-specific nursing care plan. √ Review goals and expectations of resident/family/SDM. √ Consider referral to interdisciplinary team members & community services (eg. hospice support services, pastoral care, volunteers, social worker, CCAC, etc.) √ Review medications (Consult pharmacist/physician prn) √ Assess nutrition, hydration (Consult dietician prn) √ Consider review of advance directives & discuss with resident/family/SDM prn) √ Provide safe comforting environment.

PPS & CORRESPONDING INTERVENTIONS

PPS	CONDITION	SUGGESTED INTERVENTIONS
70% +	*Full Self Care* . See Palliative Performance Scale Tool	√ Complete regular review
60 %	*Reduced ambulation.* Unable to do hobby/house work**. Significant disease. *Occasional assistance required to complete self care*, Normal or reduced intake, Full conscious level or confusion.	√ Complete regular review
50 %	*Mainly sit/lie.* Unable to do any work.** Extensive disease. *Considerable assistance required for self care*. Normal or reduced intake. Full conscious level or confusion.	√ Complete regular review
40 %	*Mainly in bed*. Unable to do most activity. Extensive disease. *Mainly assistance required for self care*. Normal or reduced intake. Full conscious level or drowsy +/- confusion	√ Complete regular review √ Prepare resident/family/SDM for expected/potential changes in health condition as appropriate while maintaining sense of hope. √ Support resident/family/SDM through process of life review, identified issues and final separation.
30 %	*Totally bed bound.* Unable to do any activity. Extensive disease. Total care required. Intake normal or reduced. Full conscious level or drowsy +/- confusion.	√ Complete regular review √ Consider need for interdisciplinary care conference, which includes resident/family/SDM, to review expectations and goals √ Discuss care options & resources available within home. √ Offer brochure on EOL care in home as appropriate. √ Anticipate & prepare for physical changes in last hours of life. √ Initiate medication/treatment review in consultation with physician • Continue only necessary medical interventions • Consider alternative routes of medication administration.
20 %	*Intake minimal to sips. Totally bed bound. Total care required*. Extensive disease. Unable to do any activity. Full conscious level or drowsy +/- confusion.	√ Complete regular review √ Consider need for interdisciplinary care conference which includes resident/family/SDM to review expectations and goals √ Discuss care options & resources available within home. √ Offer brochure on EOL care in home as appropriate. √ Update resident specific nursing care plan re: needs at EOL & last hours. √ Initiate/continue management of physiological changes. √ Reassess medications/treatments in consultation with physician; • Continue only necessary medical interventions; • Consider alternative routes of medication administration. √ Prepare resident/family/SDM for expected changes in condition & signs of approaching death √ Provide anticipatory grief support. √ Review resident/family/SDM bereavement plan. √ Inquire about cultural and spiritual needs (ie. Rites & rituals) resident/ family/SDM would like observed at time of death.
10 %	Moribund. *Mouth care only. Totally bed bound. Total care required.* Drowsy or Coma, +/- confusion. Extensive disease. Unable to do any activity.	√ Complete regular review √ Follow PPS 20 % suggested interventions √ Focus care towards promoting optimal comfort, dignity, and respect. √ Notify family/SMD, inquire if they would like to be present at time of death.
0 %	Death	√ Notify family/SDM, offer support and information re: grief resources, etc. √ Offer spiritual support/pastoral care. √ Contact practitioner for pronouncement according to policy. √ Prepare for release of body incorporating resident's/family's/SDM's cultural and spiritual requests.

Note:
**Unable to do Hobby/house work/work in the long term care home can be translated to:
The resident is not able to participate in recreational activities such as bingos, card games, exercise programs and outings.

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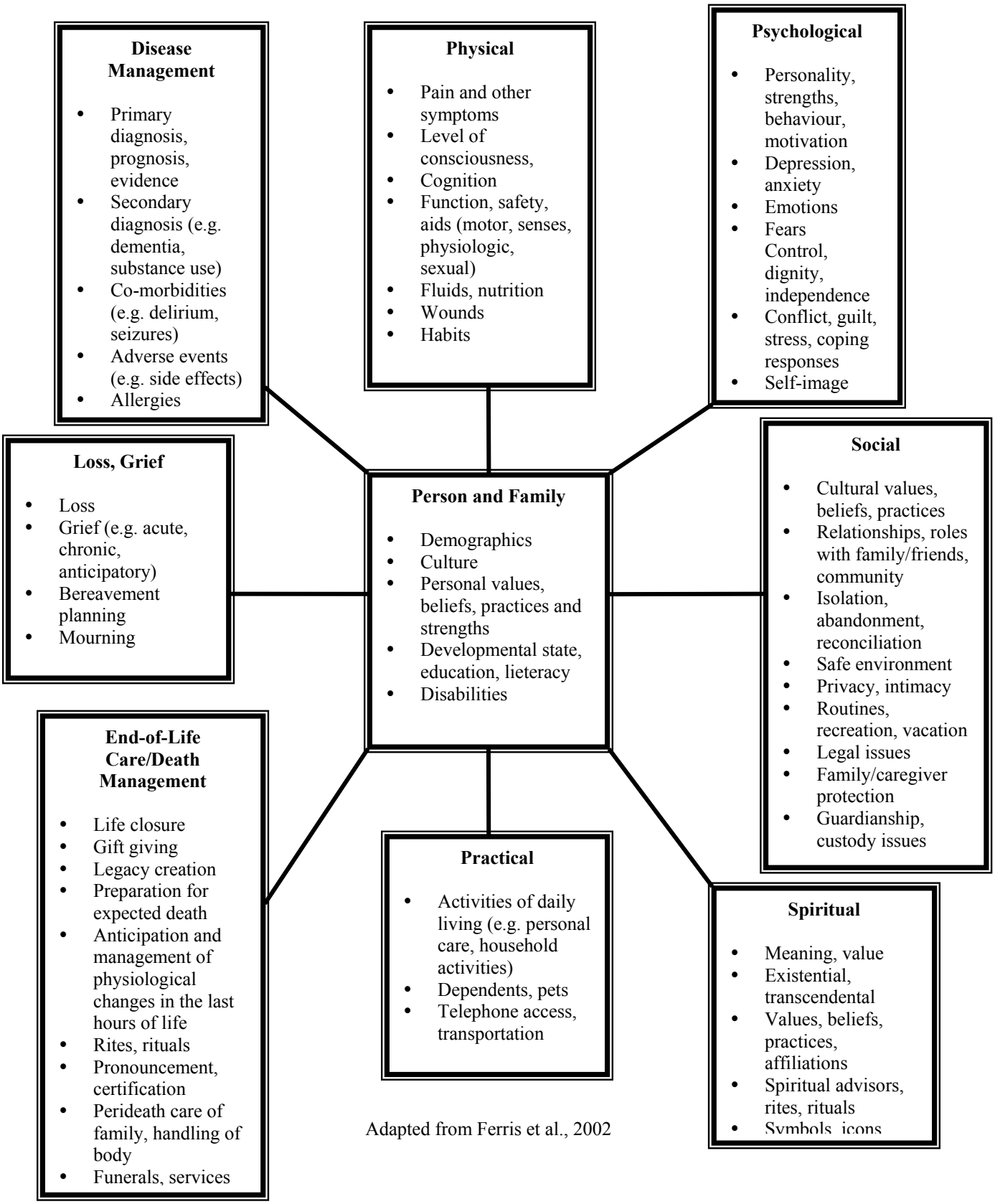
Resident Name: **Unit/Room #:**

Date	Time	PPS Score %	Resident-Specific Care Plan Reviewed/Updated	Date next review due.	Signature

Domains of Issues Associated with Illness & Bereavement



Adapted from Ferris et al., 2002

NURSING GUIDELINES FOR EOL CARE IN LONG TERM CARE HOMES

Instructions:

1. Begin Nursing Guidelines for End-of-Life care within one week of admission for all residents.

2. Complete the 'Admission Review' and follow prompts.

3. Score the resident's Palliative Performance scale (PPS) as indicated by referring to the Victoria Hospice PPS guideline and/or the description of the resident's condition beside each PPS level on page 2 of this guideline.

4. Follow the corresponding 'Suggested Interventions' on page 2.

5. Consider using the ESAS with residents who are able to participate in its completion. The tool will help to screen for and identify issues that need attention. Have the resident complete the ESAS if possible. If the resident is unable to complete the ESAS independently, a caregiver (family member, close friend, substitute decision maker, or health care provider) may assist the resident. If the resident cannot or refuses to participate in the ESAS assessment, the ESAS may be completed by the caregiver alone. Note that the subjective symptoms, tiredness, depression, anxiety, and wellbeing, cannot be rated when symptoms are assessed by the caregiver alone. Document on the ESAS form who has completed the assessment.

   When scores are ≥ 4, the issue should be added to the careplan, addressed, and monitored more frequently.

5. To determine the frequency in which the regular reviews are to be performed, refer to the "Reviews' section on page 1.

6. Complete the regular review at weekly or quarterly intervals as determined by the resident's PPS. Follow the prompts. After determining the resident's new PPS score, refer to the corresponding "Suggested Interventions."

7. In the event of a **communicable disease outbreak**: If resident does not improve after 72 hours post onset of illness, complete regular review. If PPS $\leq 20\%$, complete regular reviews weekly and follow the corresponding interventions. If PPS = 30%, complete regular review weekly x 3 and following corresponding interventions. If PPS stable and no deterioration, conduct regular reviews quarterly. If PPS score reaches 40%, complete PPS quarterly.

8. **Documentation:**
   - Documentation on this form is to be done by registered staff.
   - Place resident's name on front of this form.
   - Place date, time, and resident's palliative performance scale (PPS) score where indicated on table.
   - Place a check mark in box when resident specific care plan has been review and updated.
   - Insert due date of next review as indicated by Nursing Guidelines for EOL care.
   - Sign in appropriate column.

9. **Associated resources** include:
   - End-of-Life Care Plan
   - Resident/Family/SDM educational brochure.
   - Palliative Performance Scale (PPSv2) adapted from Victoria Hospice Society.
   - Edmonton Symptom Assessment Scale
   - Pain tools.

References:

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2. Capital Health, Caritas Health Group Regional Palliative Care Program. *The Edmonton Symptom Assessment Scale*. Accessed 2005 from Internet source: http://www.palliative.org/PC/ClinicalInfo/AssessmentTools/esas.pdf

3. Doegnes, M.E., Moorhouse, M. F., & Gessler-Murr, A.C. (2002). *Nursing Care Plans: Guidelines for Individualizing Patient Care. Ed. 6.*. F. A. Davis Company: Philadelphia.

4. Elgin County Palliative Care Committee (2005). *Nursing Interventions for Care Planning and Symptom Management in Long Term Care*. St. Thomas, Ontario.

5. Ferris et al. (2002). *A Consensus-based model to guide hospice palliative care*. Canadian Hospice Palliative Care Association.

6. Grey-Bruce Palliative Care Committee. *End-of-Life Care Plan Checklist.* Accessed 2005 from Internet Source: http://www.palliativecareswo.ca/restricted/Grey-Bruce/EofLcaremap.pdf

7. Oxford County Palliative Care Committee. *Oxford County Palliative Performance Scale Suggested Intervention Markers.* Accessed 2005 from Internet source:. http://www.palliativecareswo.ca/restricted/Grey-Bruce/EofLcaremap.pdf

8. Regional Pain and Symptom Management Consultants, Southwest Region Ontario (2005) *The Fundamentals of Hospice Palliative Care: A resource guide for healthcare providers*. Shop for Learning Publishing Services: Canada.

9. Victoria Hospice Society. The Palliative Performance Scale version 2 (PPSv2) tool is a copyright to Victoria Hospice Society and replaces the first PPS published in 1996 [J Pall Care 9 (4): 26 – 32]. Available in electronic format by email request to judy.martell@caphealth.org.

10. Windsor Essex County Palliative Care Committee (2002). *The Windsor/Essex County Palliative Care Management Tools*. Windsor, ON.

11. Windsor-Essex Community Care Access Centre (2004). *Community Palliative Care Guide—Nursing.* Windsor, Ontario.

Artistry by Isabelle West, RN, Sun Parlor Home for Senior Citizens.

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