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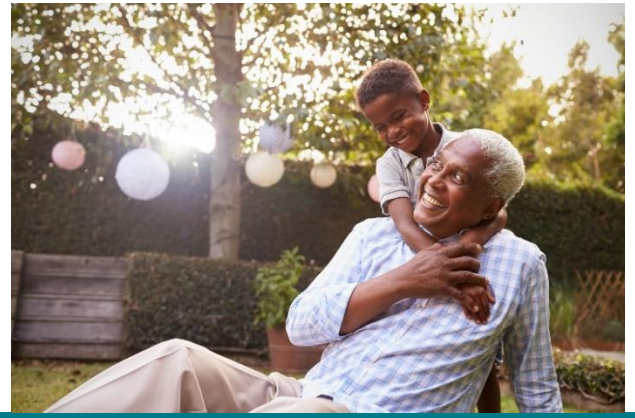
Week 1

Identify & Assess – Early Identification



Learning Objectives

1. What is Palliative Care
2. Early Identification
   - ✓ How to identify
   - ✓ How to assess

Materials

1. Early Identification Tool
2. ESAS/PPS
3. Domains of Issues
4. CAM/Pain Assessments

Palliative Care in LTC

The Mississauga Halton Palliative Care Network (MH PCN) in collaboration with your LTC home as part of a palliative long term care strategy helped develop a pilot project aimed "To ensure all MH LTCH residents receive high quality palliative care and die in their place of choice".

Education/Capacity Building	• Strengthen and expand the palliative care knowledge of the LTCHs' staff, residents, caregivers and families through educational and mentoring opportunities
Communication	• Improve communication between LTCH teams, external stakeholders, residents, caregivers and families including advance care planning and goals of care discussions
Early Identification	• Ensure all LTCH residents requiring palliative care are properly and early identified in a timely manner as per HQO Palliative Quality Standards
Palliative Care Resources	• Ensure LTCH staff have access to palliative care support, knowledge and available resources
Roles & Responsibilities	• Ensure a clear understanding of roles and responsibilities within the spectrum of palliative care – e.g. LTCH staff, leadership and physicians, NPSTAT, PPSMC, LHIN Palliative Home Care, etc.

What is palliative care?

…a *philosophy* of care that aims to relieve suffering and improve the quality of living and dying.

Palliative Approach: Meeting a person's and his/her family's full range of needs – physical, psychosocial and spiritual – at all stages of a chronic progressive illness… an approach to care that can enhance their quality of life throughout the course of their illness or the process of aging.

It is NOT about end-of-life or dying

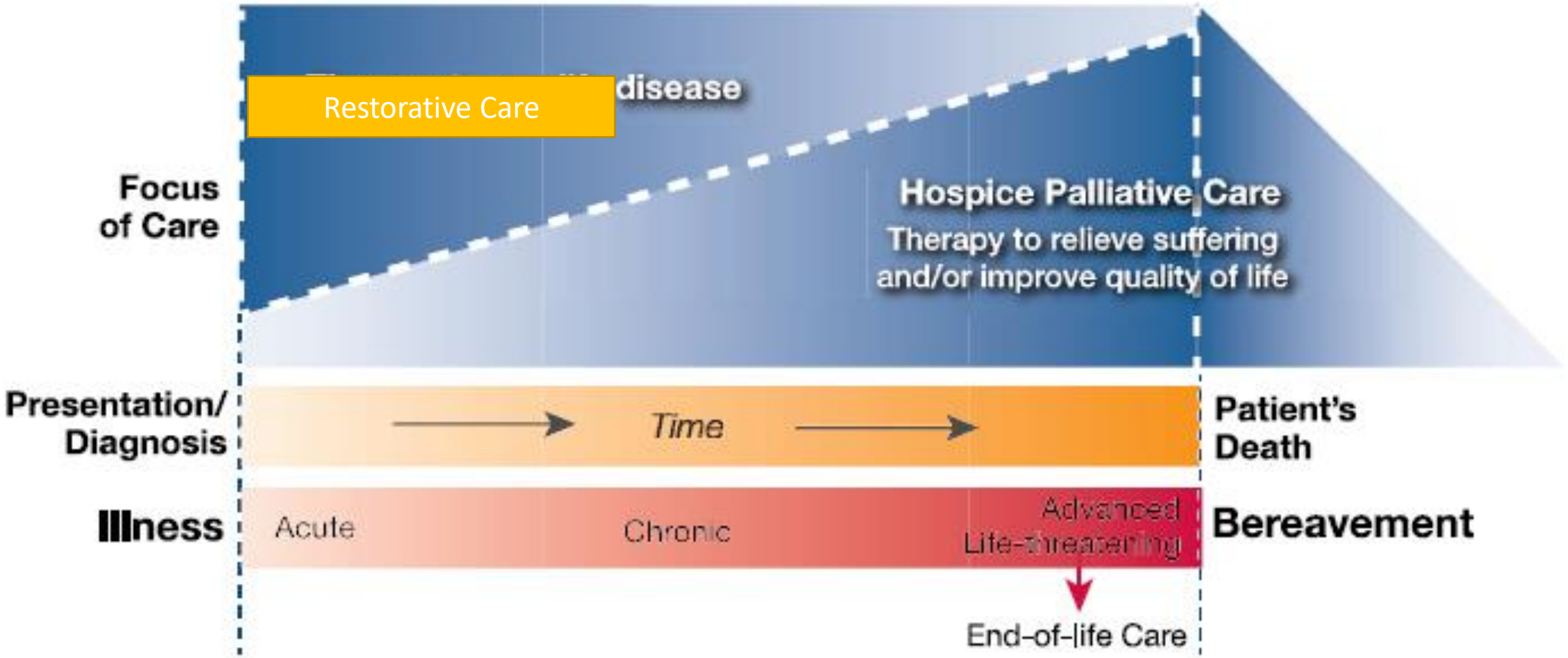
It is NOT a diagnosis – a patient does not become "palliative"

It is simply GOOD CARE

A Palliative Approach to Care

- ✓**ANYTIME**, at any age and stage of a serious illness. Initiation should not be determined by prognosis; it can begin as early as the time of diagnosis and be provided alongside treatment.
- ✓**ANYONE** within the circle of care. Family physicians, primary care NPs, oncologist, internists, nurses, PSWs, chaplains, volunteers, etc…
- ✓**ANYWHERE** – home, clinics, hospital, LTC homes, RH, hospice

Figure #2: The Role of Hospice Palliative Care During Illness



Benefits of Identifying Patients Early

- ✓ Better quality of life
- ✓ *Improved management of symptoms*
- ✓ Less depression and anxiety
- ✓ *Greater satisfaction in care*
- ✓ Facilitates access to appropriate resources and supports
- ✓ *Greater participation in advance care planning, fewer hospitalizations, and lower medical costs.*
- ✓ For some, there is also an indication of longer survival time, as compared to those who received palliative care later

Step One: Identify

The Surprise Question

"Would you be surprised if your patient died in the next year?"

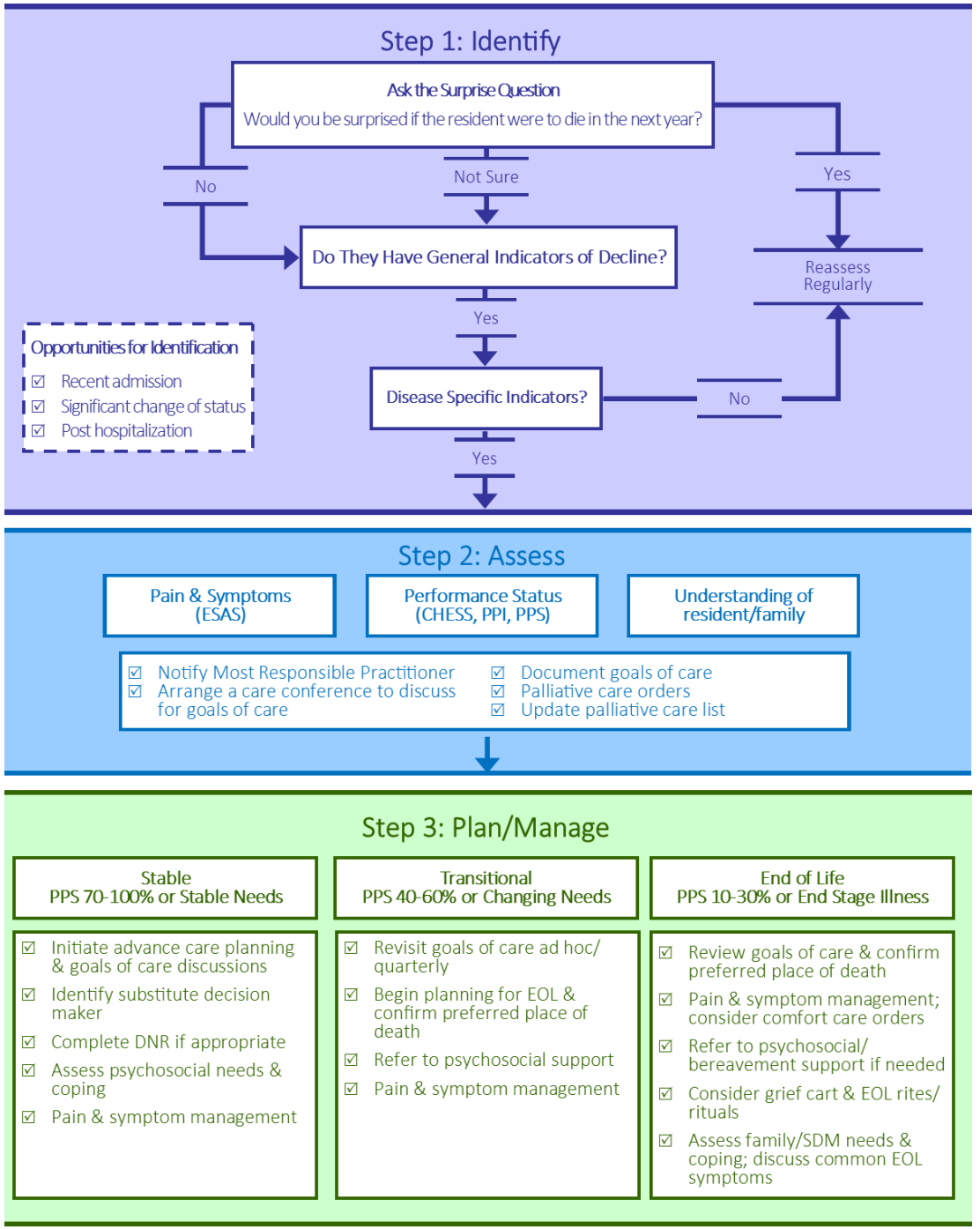
General Indicators of Decline
Disease Specific Indicators

Disease Trajectory

Has the patient and/or family expressed a need or preference for a palliative approach?

A Palliative Approach to Care for LTC

Adapted from the Mississauga Halton Palliative Care Early Identification & Prognostic Guide



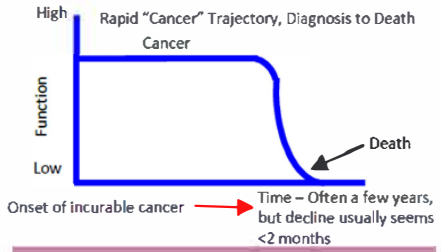
Adapted from the Mississauga Halton Palliative Care Network Early Identification & Prognostic Guide

Disease Specific Indicators

Adapted from the Mississauga Halton Palliative Care Network Early Identification & Prognostic Guide

Cancer

- ☐ Metastatic cancer
- ☐ More exact predictors for cancer patients are available, e.g. PPS, ECOG, PPI, PaP
- ☐ The single most important predictive factor in cancer is performance status and functional ability—if patients are spending more than 50% of their time in bed/lying down, prognosis is estimated to be about 3 months or less



General Neurological Diseases

- ☐ Progressive deterioration in physical and/or cognitive function despite optimal therapy
- ☐ Symptoms which are complex and too difficult to control
- ☐ Swallowing problems (dysphagia) leading to recurrent aspiration pneumonia, sepsis, breathlessness or respiratory failure
- ☐ Speech problems: increasing difficulty in communications and progressive dysphasia

Parkinson's

- ☐ Drug treatment less effective or increasingly complex regime of drug treatments
- ☐ Reduced independence, needs ADL help
- ☐ The condition is less well controlled with increasing "off" periods
- ☐ Dyskinesia, mobility problems and falls
- ☐ Psychiatric signs (depression, anxiety, hallucinations, psychosis)
- ☐ Similar pattern to frailty (see frailty)

Multiple Sclerosis

- ☐ Significant complex symptoms and medical complications
- ☐ Dysphagia + poor nutritional status
- ☐ Communication difficulties e.g. dysarthria + fatigue
- ☐ Cognitive impairment notably the onset of dementia

Motor Neuron

- ☐ Marked rapid decline in physical status
- ☐ First episode of aspiration pneumonia
- ☐ Increased cognitive difficulties
- ☐ Weight loss
- ☐ Significant complex symptoms and medical complications
- ☐ Low vital capacity (below 70% of predicted using standard spirometry
- ☐ Dyskinesia, mobility problems and falls
- ☐ Communication difficulties

Dementia

- ☐ Unable to walk without assistance and
- ☐ Urinary and fecal incontinence, and
- ☐ No consistent meaningful verbal communication and
- ☐ Unable to do self-care without assistance
- ☐ Reduced ability to perform activities of daily living

Plus any of the following:

- ☐ Weight loss, urinary tract infection, severe pressure sores (stage 3 or 4), recurrent fever, reduced oral intake, aspiration pneumonia

Frailty

- ☐ Multiple co-morbidities with significant impairment in day to day living

Plus the following:

- ☐ Deteriorating functional performance status
- ☐ Combination of at least 3 of the following symptoms: weakness, slow walking speed, significant weight loss, exhaustion, low physical activity, depression

Renal Disease

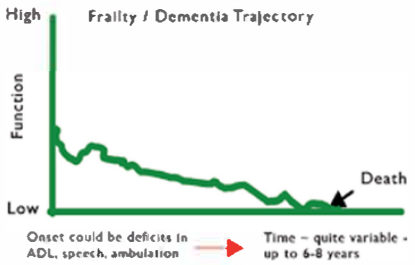
- ☐ Stage 4 or 5 Chronic Kidney Disease (CKD) whose condition is deteriorating
- ☐ Patients choosing the 'no dialysis' option or discontinuing dialysis (by choice or due to increasing frailty, co-morbidities)
- ☐ Patients with difficult physical symptoms or psychological symptoms despite optimal tolerated renal replacement therapy
- ☐ Symptomatic Renal Failure – nausea and vomiting, anorexia, pruritus, reduced functional status, intractable fluid overload

Lung Disease (COPD)

- ☐ Disease assessed to be very severe (e.g. FEV1<30% predicted)
- ☐ Recurrent hospital admissions (≥3 in last 12 months due to COPD)
- ☐ Fulfills long term oxygen therapy criteria
- ☐ MRC grade 4 to 5 – dyspnea after 100m on the level or confined to house
- ☐ Signs and symptoms of right heart failure
- ☐ More than 6 weeks of systemic steroids for COPD in preceding 6 months

Stroke

- ☐ Persistent vegetative or minimal conscious state or dense paralysis
- ☐ Medical complications
- ☐ Lack of improvement within 3 months of onset
- ☐ Cognitive impairment/post-stroke dementia

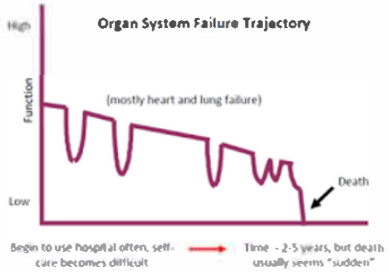


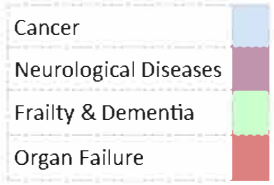
Heart Disease

- ☐ CHF NYHA Stage 3 or 4 – shortness of breath at rest on minimal exertion
- ☐ Repeated hospital admissions with heart failure symptoms
- ☐ Difficult physical or psychological symptoms despite optimal tolerated therapy

Liver Disease

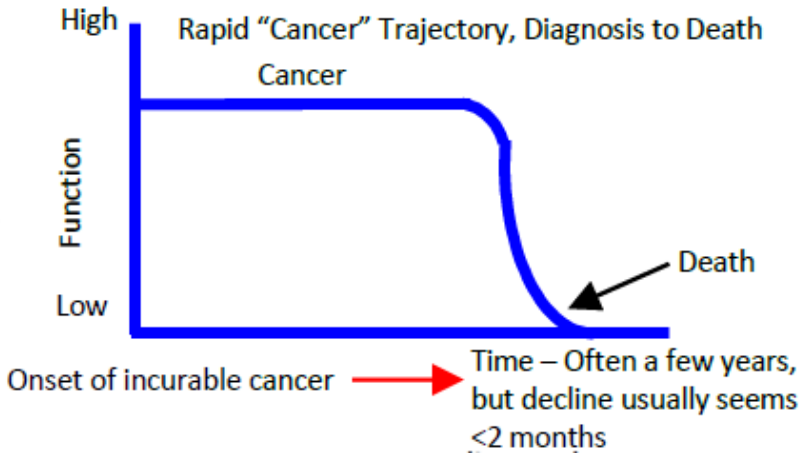
- ☐ Advanced cirrhosis with one or more complications in past year: diuretic resistant ascites, hepatic encephalopathy, hepatorenal syndrome, recurrent variceal bleeds
- ☐ Liver transplant contraindicated
- ☐ Child-Pugh Class C

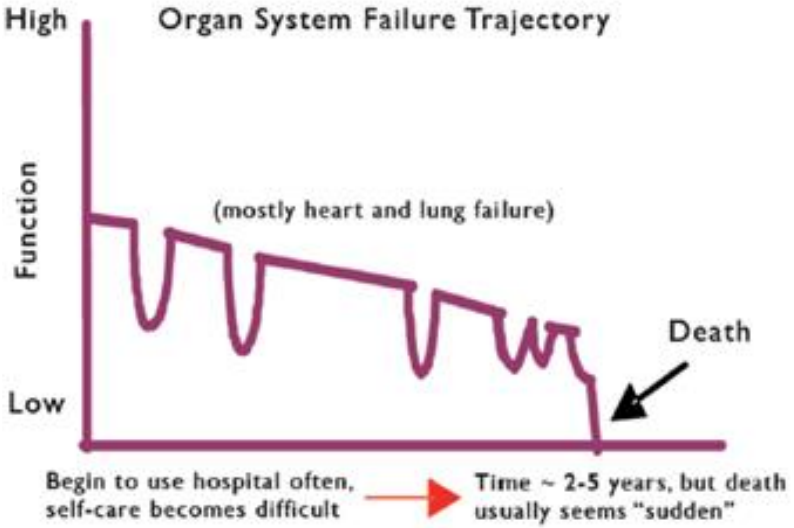


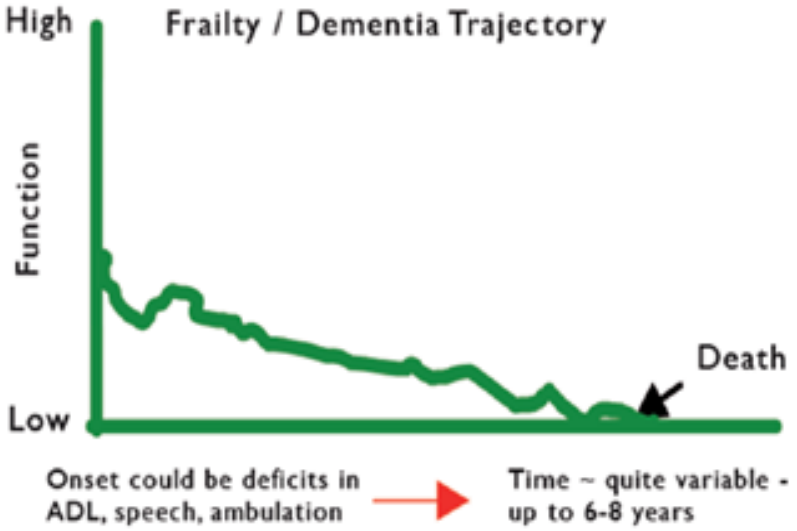


Mississauga Halton Palliative Care Network

Illness Trajectories







Step Two: Assess

Assess Symptoms

Edmonton Symptom Assess System

Assess Understanding

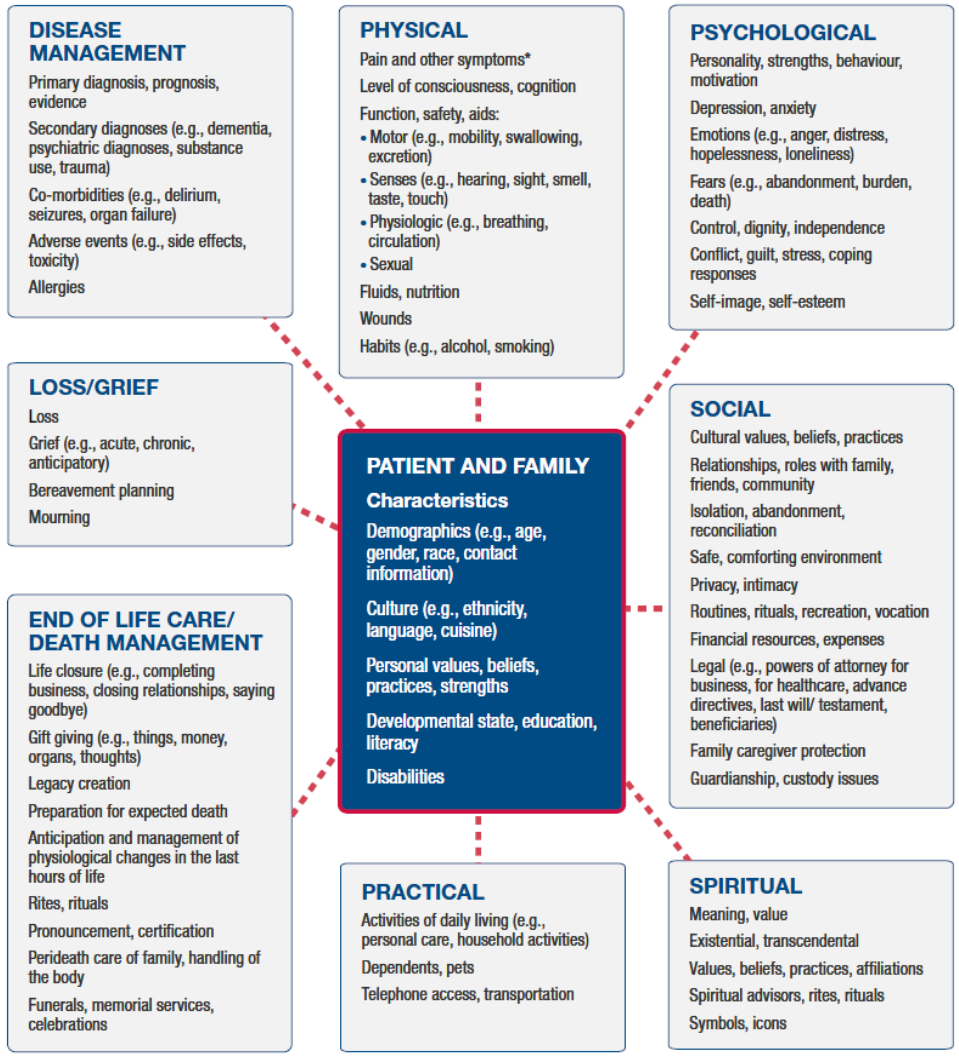
- ✓ Does the patients/family understand the nature of the illness, prognosis & potential limits to reversibility?
- ✓ Have they thought about their preferences, values and goals of care?
- ✓ Do they know who their substitute decision maker is and have they spoken to them about their wishes?

Assess Performance Status

Palliative Performance Scale (PPS)

Domains of Issues Associated with Illness & Bereavement

Figure #1: Domains of Issues Associated with Illness and Bereavement



* Other common symptoms include, but are not limited to:

Cardio-respiratory: breathlessness, cough, edema, hiccups, apnea, agonal breathing patterns

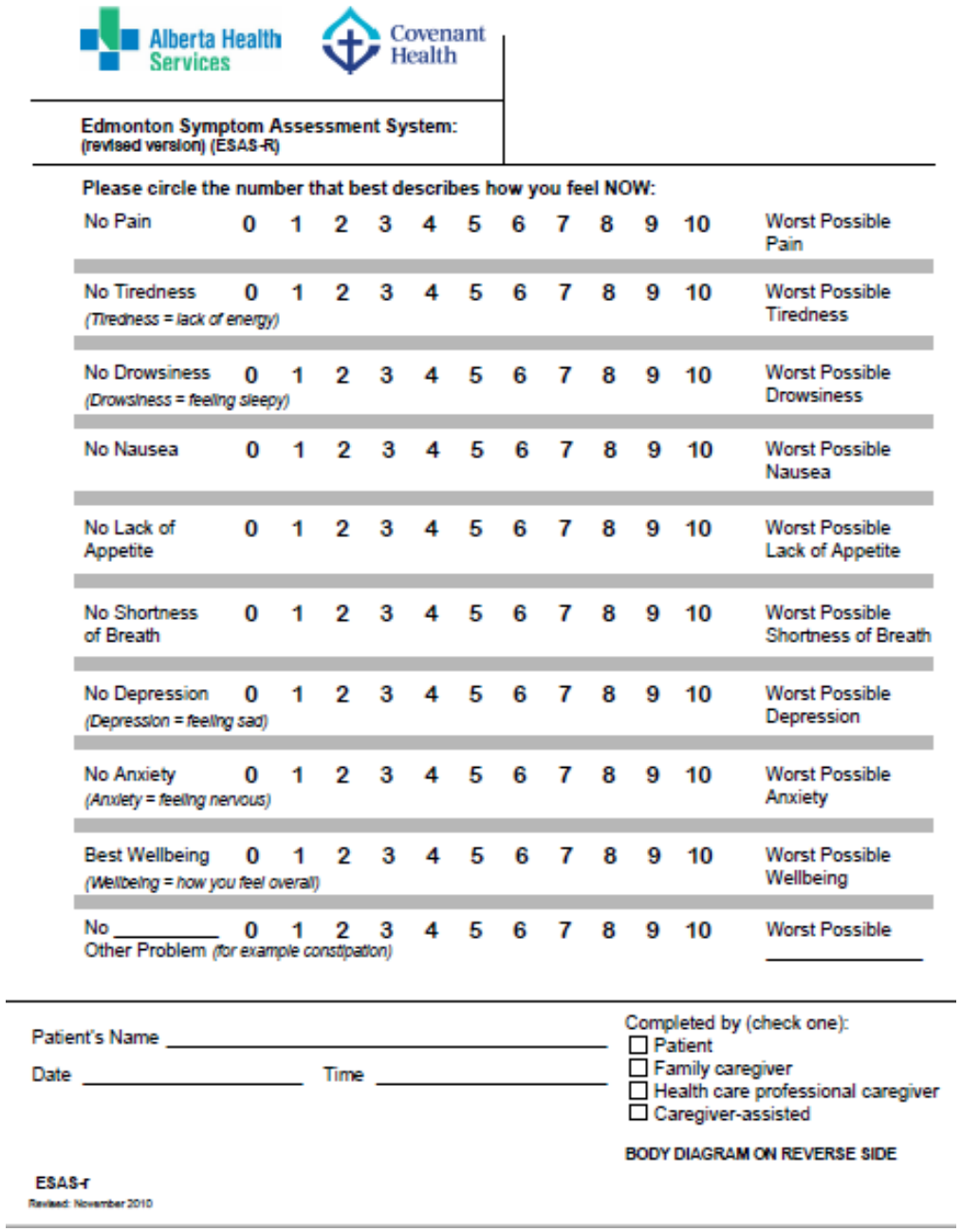
Gastrointestinal: nausea, vomiting, constipation, obstipation, bowel obstruction, diarrhea, bloating, dysphagia, dyspepsia

Oral conditions: dry mouth, mucositis

Skin conditions: dry skin, nodules, pruritus, rashes

General: agitation, anorexia, cachexia, fatigue, weakness, bleeding, drowsiness, effusions (pleural, peritoneal), fever/chills, incontinence, insomnia, lymphoedema, myoclonus, odor, prolapse, sweats, syncope, vertigo

Edmonton Symptom Assessment Scale (ESAS)



Alberta Health Services | Covenant Health

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name _____

Date _____ Time _____

Completed by (check one):
- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS-r
Revised: November 2010

Palliative Performance Scale

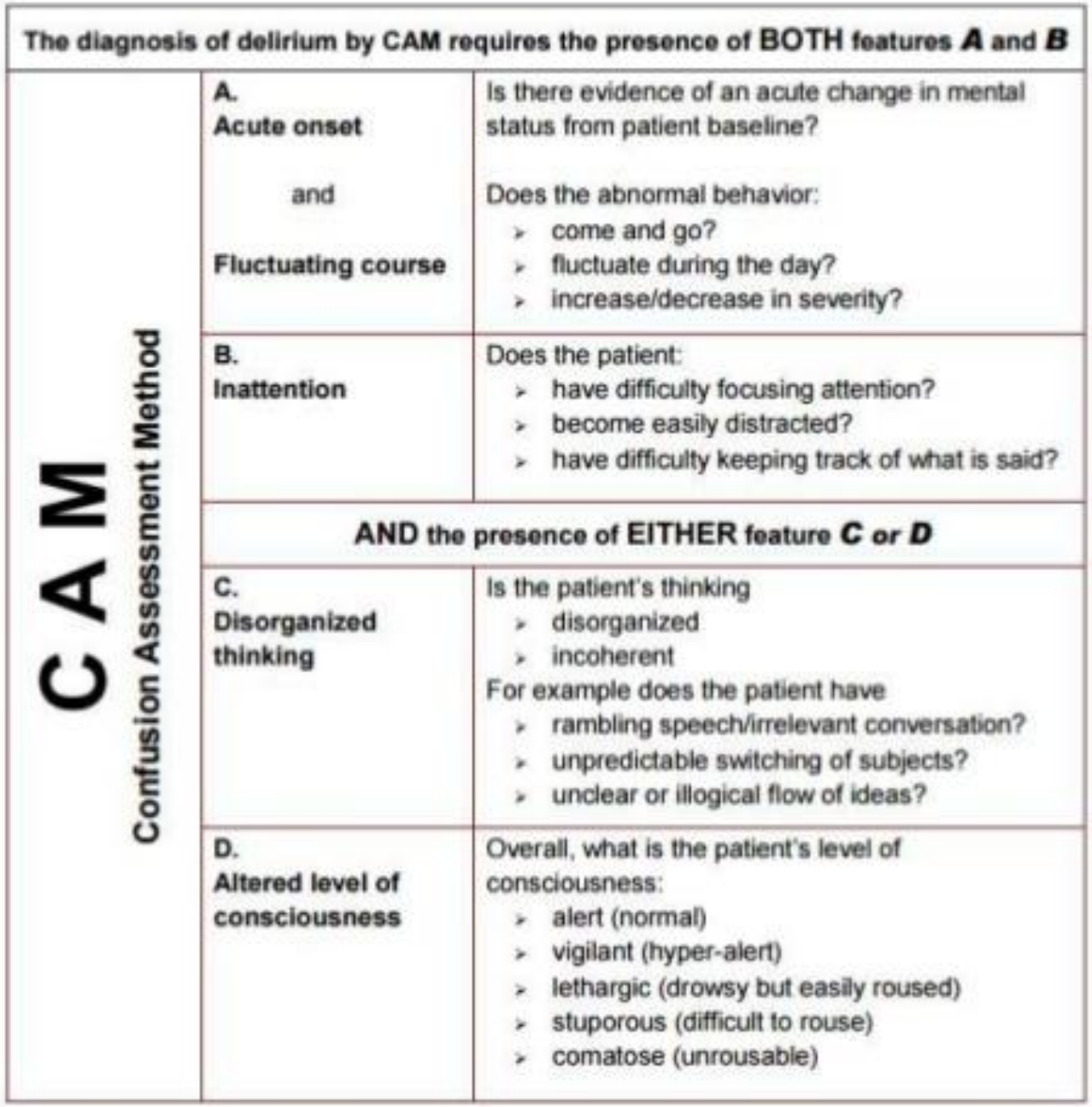
STABLE

TRANSITIONAL

END OF LIFE

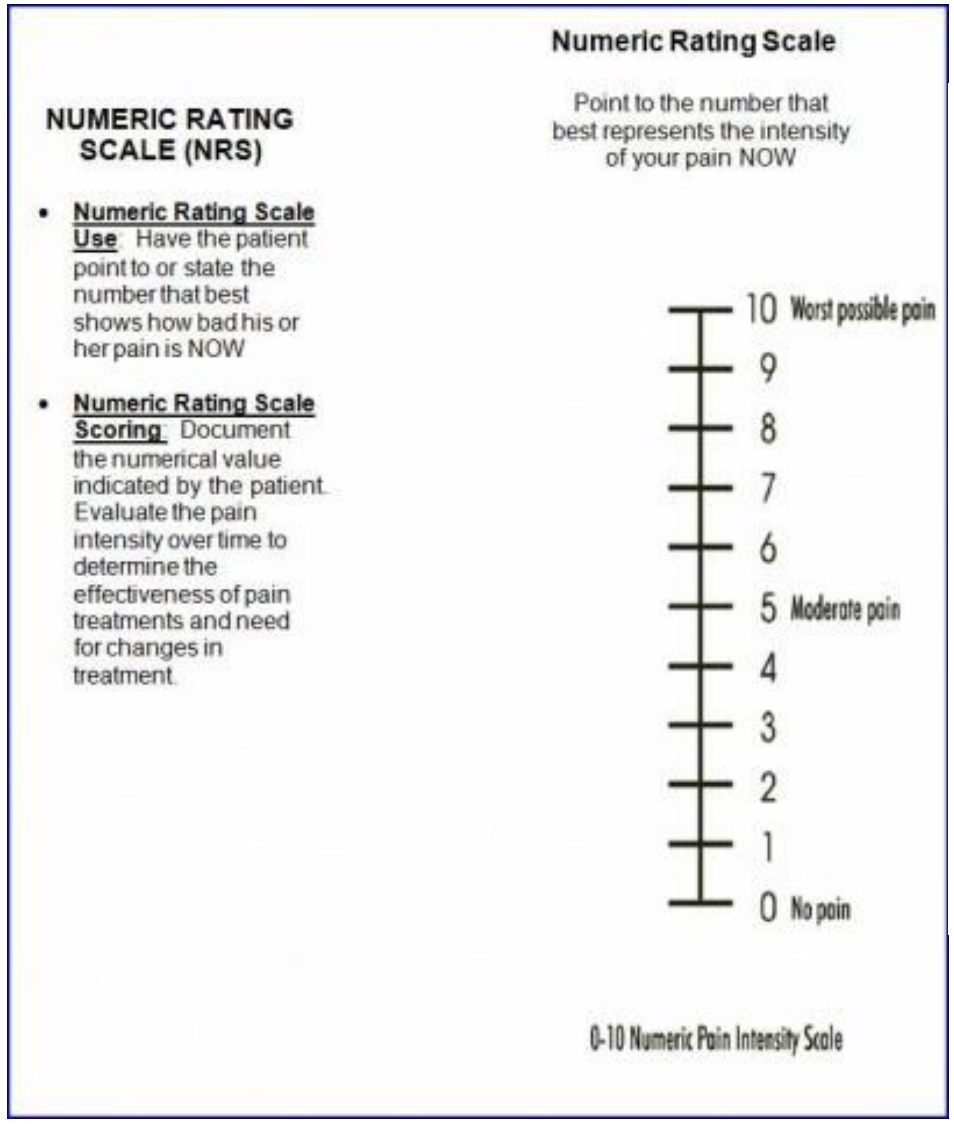
PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Confusion Assessment Method



The diagnosis of delirium by CAM requires the presence of BOTH features ***A*** and ***B***		
C A M Confusion Assessment Method	**A.** **Acute onset** and **Fluctuating course**	Is there evidence of an acute change in mental status from patient baseline? Does the abnormal behavior: ➢ come and go? ➢ fluctuate during the day? ➢ increase/decrease in severity?
	B. **Inattention**	Does the patient: ➢ have difficulty focusing attention? ➢ become easily distracted? ➢ have difficulty keeping track of what is said?
	AND the presence of EITHER feature *C or D*	
	C. **Disorganized thinking**	Is the patient's thinking ➢ disorganized ➢ incoherent For example does the patient have ➢ rambling speech/irrelevant conversation? ➢ unpredictable switching of subjects? ➢ unclear or illogical flow of ideas?
	D. **Altered level of consciousness**	Overall, what is the patient's level of consciousness: ➢ alert (normal) ➢ vigilant (hyper-alert) ➢ lethargic (drowsy but easily roused) ➢ stuporous (difficult to rouse) ➢ comatose (unrousable)

Pain Screening (NRS and PAIN AD)



Behavior	0	1	2	Score
Breathing Independent of vocalization	• Normal	• Occasional labored breathing • Short period of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative vocalization	• None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	• Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body language	• Relaxed	• Tense • Distressed pacing • Fidgeting	• Rigid • Fists clenched • Knees pulled up • Pulling or pushing away • Striking out	
Consolability	• No need to console	• Distracted or reassured by voice or touch	• Unable to console, distract, or reassure	
			TOTAL SCORE	

(Warden et al., 2003)

Pain Assessments

Assessment using Acronym O, P, Q, R, S, T, U and V [1,2,3,4,5,6,7,8,9]

Onset	When did it begin? How long does it last? How often does it occur?
Provoking / Palliating	What brings it on? What makes it better? What makes it worse?
Quality	What does it feel like? Can you describe it?
Region / Radiation	Where is it? Does it spread anywhere?
Severity	What is the intensity of this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Right now? At best? At worst? On average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom?
Treatment	What medications and treatments are you currently using? How effective are these? Do you have any side effects from the medications and treatments? What medications and treatments have you used in the past?
Understanding / Impact on You	What do you believe is causing this symptom? How is this symptom affecting you and / or your family?
Values	What is your goal for this symptom? What is your comfort goal or acceptable level for this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Are there any other views or feelings about this symptom that are important to you or your family?

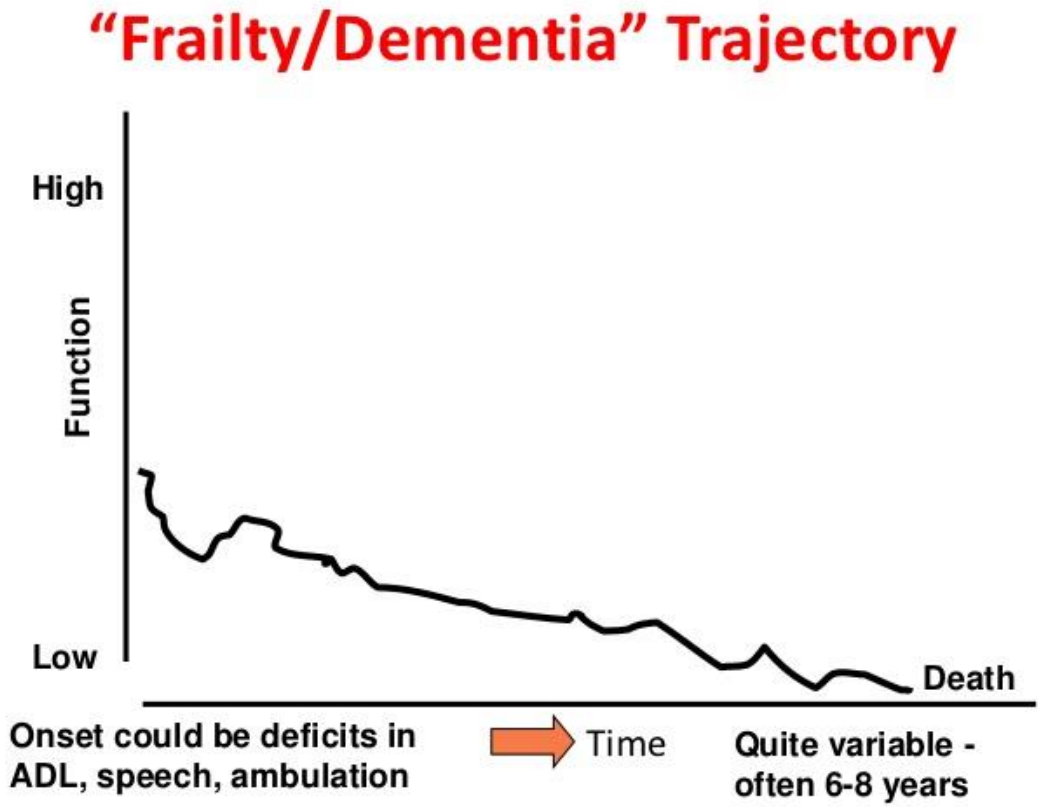
* Physical Assessment (as appropriate for symptom)

Case Study: Resident R.B.

- 86 year old female with advanced Alzheimer's dementia
- Personal Medical History:
  - left MCA ischemic stroke
  - Hypertension
  - Hypercholesterolemia
- She has lived in your LTC home for 3 years. She is showing functional decline, incontinence, worsening cognitive impairment, falls and worsening mobility
- These concerns were discussed during comfort rounds with the PPSMC

Case Study: Resident R.B. (cont'd)

- "Would you be surprised if the resident were to die in the next year?"
- What other pieces of information do you need?
- Would this resident benefit from a palliative approach to care?



Scenario # 1

Sam is totally bed bound with end-stage metastatic colon cancer. He is totally dependent and is unable to tolerate sips of fluid. He requires good mouth care. He is cheyne-stoking and this condition remains guarded.

What is his PPS?

Scenario # 1

1. Totally bed bound & dependent
2. Unable to tolerate sips of fluid
3. Mouth care

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
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0%	Death	-	-	-	-

Scenario # 2

Matilda is a markedly confused lady with dementia, end-stage heart disease and peripheral vascular disease. She has lost weight over the past few months but at a faster rate the past couple of weeks. She is in bed due to weakness and is dependent on staff for total care. She has a good appetite. The staff note that she is sleeping more.

What is her PPS?

Scenario # 2

1. Bed due to weakness
2. Dependent on staff for total care
3. Good appetite
4. Sleeping more/confused

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
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0%	Death	-	-	-	-

Scenario # 3

Theresa a 64 year old with advanced lung cancer who requires oxygen therapy constantly. She is able to sit up in a chair for a couple of hours daily. She finds her personal care requires too much energy and she is exhausted, so more recently the staff have been doing it for her. Her breathlessness increases with the slightest exertion. Her appetite is fair and she remains alert and cheerful.

What is her PPS?

Scenario # 3

1. Sit up in a chair for a couple of hours daily
2. Staff doing her care/ extensive disease
3. Appetite is fair
4. Alert and cheerful

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
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0%	Death	-	-	-	-

Changing My Practice

- ✓ Identify residents early
- ✓ Have conversations about palliative care early
- ✓ Incorporate “Surprise Question” in every day practice

Thank you!

NSMHPCN
North Simcoe Muskoka Hospice Palliative Care Network

Mississauga Halton Palliative Care Network

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