



palliative care
outcomes collaboration



Palliative Care Routine Assessment & Response Protocol for Residential Aged Care

Introduction: Identifying palliative need and responding to palliative need

The Australian Palliative Care Outcomes Collaboration (PCOC) is a national palliative care outcomes and benchmarking program. PCOC's primary objective is to systematically improve patient and carer outcomes, including pain, symptom control and psychosocial distress.

Central to the program is a framework and protocol for routine clinical assessment and response. This works in parallel with a routine point-of-care data collection, capturing important and meaningful information that aims to improve patient and carer outcomes. This aim is advanced through feedback to individual services and by facilitating service-to-service benchmarking.

The development of the PCOC Palliative Care Routine Assessment & Response Manual for Residential Aged Care (Version 1.0) has evolved after consultation with residential aged care providers and specialist palliative care providers.

Section 1: Screening to identify palliative need

Identifying palliative need helps ensure that residents receive care informed by their needs. This is achieved through screening for palliative need (Appendix 1). Two screening steps are involved.

Step one involves screening for whether:

- The resident has an existing palliative care plan in place (*refer to definition in page 3*) **OR** has been admitted to the RACF from an interdisciplinary palliative care provider **OR** has documented palliative care needs (*raised by family, carer, staff*).
- Documented needs may include: discussion with GP regarding palliative medications and/or advance care planning; admitted from hospital and discharged with documented palliative care needs; documented plan of escalation to medical team and response; request for palliative care consult; family/carers raise palliative care issues.

If the resident has a plan or has been admitted to the RACF from an interdisciplinary palliative care provider, then the resident is likely to benefit from palliative care. Palliative assessments are likely to help with addressing this (See Section 3).

An interdisciplinary palliative care provider is a provider of comprehensive and interdisciplinary assessment, care and care coordination. It may include in the team: medical, nursing and allied health staff. Examples of interdisciplinary palliative providers include specialist palliative care inpatient units, hospices, home-based palliative care or consultative outreach specialist palliative care.

OR

Step two involves screening for whether the resident has:

- An Australia-modified Karnofsky Performance Scale (AKPS) of 40 or less or a recent decline in AKPS score **AND**
- Poor or worsening health, or supportive and palliative care needs as identified in the Supportive and Palliative Care Indicators Tool (the SPICT-4ALL), **AND**
- May be likely to die within the next 6 to 12 months (determined through the Surprise Question).

If yes to Step two then the resident is likely to benefit from receiving palliative care, and further palliative assessments may help (see Section 3).

Section 2: Monitoring and reassessing the need to screen again

In order to ensure that the needs of residents are met adequately, residents are likely to benefit from regular monitoring for palliative care need. To this end, reassessment for palliative need occurs routinely, every three months. Reassessment is also triggered if the resident has a hospital admission; has two or more falls; when a family member or a carer raises concerns about the resident's changed condition; or when the resident has weight loss and/or changes in oral intake or decreased function. A new diagnosis will also trigger reassessment. The SPICT-4ALL list of diagnosis is used for guidance on life-limiting conditions.

Section 3: Responding to palliative need

- If the resident has been identified as potentially benefiting from receiving palliative care, the next step is to complete the five validated PCOC assessment measures.
- The five PCOC tools (measures) are initially used to identify the resident's needs, which are then used to help develop a palliative care plan.
- These five tools help to create a common clinical language within RACFs and also with others that staff may communicate with (e.g., external providers).
- The PCOC tools help identify needs that require a response.
- Details on how to use the scores from the PCOC assessment measures in order to respond to identified needs are outlined within this document (see Tables pages 2–7).
- The information from the PCOC tools is useful in developing a palliative care plan for the resident. (Ideally, a resident's care plan may be developed with the resident and or their carer, where-ever possible.)

The palliative care plan

A palliative care plan starts when PCOC's five assessment measures are completed. This is because the measures are part of the care planning process and help form the care plan.

The palliative care plan may involve:

- Discussing the goals of care (via a family conference or meeting, for example);
- Asking the resident about their preferred place of death;
- Commencing or revising an Advance Care Plan/Directive and a Not For Resuscitation (NFR) plan;
- Exploring the possibility of a person for substitute decision-making (for when and if the resident loses capacity to make and or communicate their own decisions);
- Reviewing medications with the General Practitioner (GP), including a review of non-essential medications; and,
- Arranging standing orders (anticipatory medications) to be put in place.

The implementation of the palliative care plan involves repeated assessments of the PCOC measures which aims to detect any changes in the resident's needs and ensures that the care plan and interventions to address the resident's needs are timely and effective.

Frequency of PCOC assessments

Assessments are therefore routinely undertaken. They are completed at the following times:

- At start of palliative care plan use all five PCOC assessments
- Daily use of the Symptom Assessment Scale (SAS)
- As per PCOC's guide to clinical response
- At discharge from palliative care
- At discharge from the RACF
- Transfer to hospital

PCOC's guide to clinical response: Using the assessment scores to respond to need

PCOC provides a guide to clinical response for each assessment tool, which is outlined in Tables 1–4. The routine assessment and response is integral to the resident's palliative care plan.

Assessment and response: Forms and lanyard cards

The assessment response protocol is used in combination with the PCOC lanyard cards (Figure 1), the Assessment and Response form (Appendix 2) and the Symptom Assessment Scale form (Appendix 3). This package supports the appropriate response and action to the resident's and family/carer needs.

There are three lanyard cards: the abbreviated definitions, a summary of the guide to clinical response and the Symptom Assessment Scale. This card is shown to residents as a visual prompt to help with assessing symptom distress.

Supporting documents to this protocol include the PCOC Clinical Manual for Residential Aged Care and the Implementing PCOC- A guide for services.

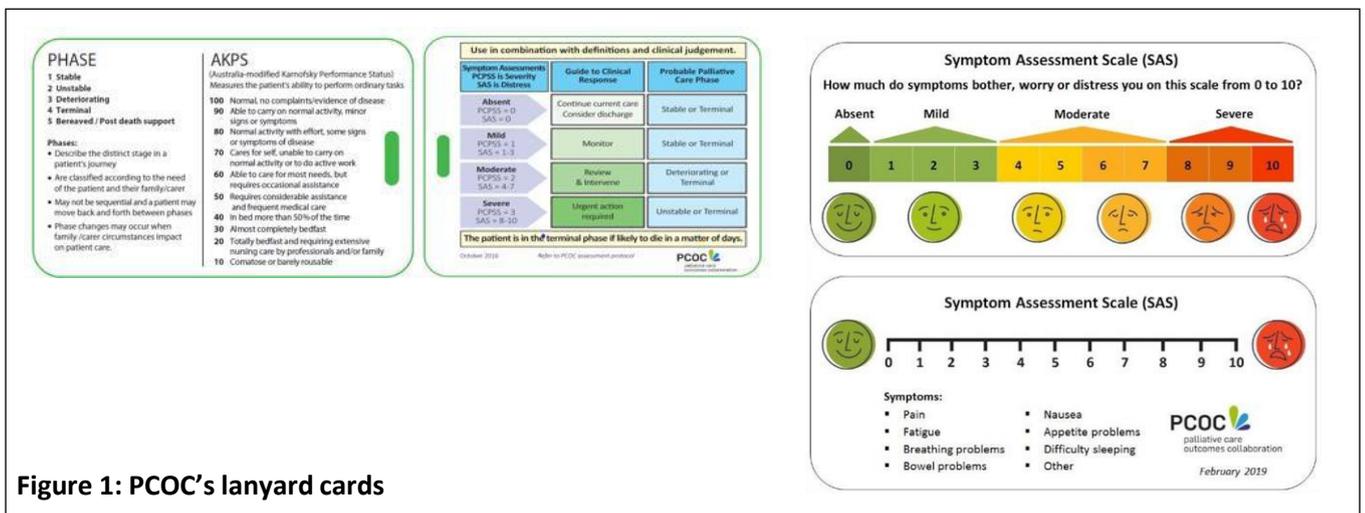


Figure 1: PCOC's lanyard cards

Table 1: SAS and PCPSS guide to clinical response

Symptom Assessment Scale (SAS) & Palliative Care Problem Severity Score (PCPSS)		
Definitions		
<p>The PCPSS and SAS assessments are used to measure symptoms and problems experienced by the resident and their family and or carer(s).</p> <p>The SAS is resident-rated (where possible). The SAS helps assess level of distress relating to seven common symptoms (difficulty sleeping, appetite problems, nausea, bowel problems, breathing problems, fatigue and pain). SAS is an 11-point numerical rating scale (0-10).</p> <p>The PCPSS is clinician-rated and supports the global screening for the overall degree of problems within four key domains (pain problems, other symptom problems, psychological / spiritual problems and family / carer problems). PCPSS is a four-point numerical rating scale (0-3).</p>		
Use		
<p>SAS is completed daily. The SAS triggers more frequent assessments, as per the guide to clinical response below.</p> <p>The PCPSS is undertaken as per PCOC's guide to clinical response.</p>		
Scores	Level	Guide to clinical response
SAS 8-10 And/or PCPSS 3	Severe	<ul style="list-style-type: none"> ▪ Change the phase to unstable and assess the resident daily using PCOC's five assessment tools or more often if needed ▪ Urgent clinical intervention - pharmacological and non-pharmacological ▪ Referral (to internally and externally provided services) and escalation required (GP, Nurse Practitioner (NP), Specialist Palliative Care (SPC), Ambulance, medical specialists e.g.: local geriatrician) ▪ Communicate and provide information to residents/families/carer(s) ▪ Document, review and implement new interventions
SAS 4-7 And/or PCPSS 2	Moderate	<ul style="list-style-type: none"> ▪ Clinical intervention - pharmacological and non-pharmacological ▪ Referral (internally and externally) and escalation if no improvement ▪ Communicate and provide information to residents/families/carer(s) ▪ Document, review and implement new interventions
SAS 1-3 And/or PCPSS 1	Mild	<ul style="list-style-type: none"> ▪ Monitor for changes in symptoms, including escalation or decrease in distress or symptom severity ▪ Review and modify care plan as required
SAS 0 And/or PCPSS 0	Absent	<ul style="list-style-type: none"> ▪ Continue with existing interventions, until indicated otherwise

Table 2: Phase guide to clinical response

Palliative Care Phase	
<p>Definition The Palliative Care Phase (Phase) is an assessment tool that classifies the clinical situation of the resident and their family/carer(s). Phase is determined by a holistic assessment of the needs of the resident and their family and/or carer(s). The Palliative Care Phase of the resident is informed by other assessment tools in the PCOC suite of tools.</p>	
<p>Use</p> <ul style="list-style-type: none"> ▪ Complete at start of palliative care ▪ Complete every seven days (weekly) or more frequently as per the guide to clinical response below ▪ Complete at discharge from palliative care ▪ Complete at discharge from RACF 	
Palliative Care Phase	Guide to clinical response
<p>Stable resident problems and symptoms are adequately controlled by established plan of care and:</p> <ul style="list-style-type: none"> ▪ Further interventions to maintain symptom control and quality of life have been planned and ▪ Family/carer(s) situation is relatively stable and no new issues are apparent <p>The Stable phase ends when: The needs of the resident and/or their family/carer(s) increase, requiring changes to the existing plan of care</p>	<ul style="list-style-type: none"> ▪ Continue as per plan of care ▪ Monitor and review to ensure care plan is effective and anticipates future care needs of Resident and their family and or carer(s)
<p>Unstable Phase An urgent change in the plan of care or emergency treatment is required because the:</p> <ul style="list-style-type: none"> ▪ resident experiences a new problem that was not anticipated in the existing plan of care, and/or ▪ resident experiences a rapid increase in the severity of a current problem; and/or ▪ Their family and or carer(s)' circumstances change suddenly impacting on resident care. <p>The Unstable phase ends when: The new plan of care is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care (i.e. resident is stable or deteriorating) and/or death is likely within days (i.e. resident is now terminal).</p>	<ul style="list-style-type: none"> ▪ Assess daily using PCOC's five assessment tools or more often if needed ▪ Urgent intervention and escalation required ▪ Change plan of care ▪ Urgent medical review and or review by allied health services ▪ Monitor assessment scores for resident/family/carer(s) change in condition; improvement in scores suggests plan is working ▪ When no further changes to the care plan are required, change phase
<p>Deteriorating Phase The care plan is addressing anticipated needs but requires periodic review because the:</p> <ul style="list-style-type: none"> ▪ resident's overall functional status is declining and/or ▪ resident experiences a gradual worsening of existing problem and/or ▪ resident experiences a new but anticipated problem and/or ▪ Their family and or carer(s) experience gradual worsening distress that impacts on the resident care. <p>The Deteriorating phase ends when</p> <ul style="list-style-type: none"> ▪ The resident's condition plateaus (i.e. resident is now stable) or 	<ul style="list-style-type: none"> ▪ Assess weekly (every seven days) using PCOC's five assessment tools ▪ Change in plan of care required to address increasing needs (not- urgent) ▪ Referral to medical (e.g. GP or local geriatrician) or allied health (e.g. OT, physiotherapist, social worker, spiritual care) likely. Family and/or carer(s) support may increase ▪ When no further changes to the care plan are required, change phase

<ul style="list-style-type: none"> ▪ An urgent change in the care plan or emergency treatment and/or their family and or carer(s) experience a sudden change in their situation that impacts on Resident care, and urgent intervention is required (i.e. Resident is now unstable) or ▪ Death is likely within days (i.e. Resident is now terminal). 	
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<p>Terminal Death is likely within days.</p> <p>The Terminal phase ends when: The resident dies or the resident’s condition changes and death is no longer likely within days (i.e. resident is now stable or deteriorating).</p> <p>Signs of the terminal phase may include:</p> <ul style="list-style-type: none"> ▪ AKPS ≤ 20 ▪ Progressive or rapid day-to-day deterioration that is not reversible ▪ Resident requiring more frequent interventions ▪ Decreasing oral intake and/or refusing or unable to take food, fluids or oral medications ▪ Increasing loss of ability to swallow ▪ An acute event has occurred requiring revision of treatment goals ▪ Profound weakness ▪ Increasing sleep and decreasing alertness ▪ Becoming semi-conscious with lapses into unconsciousness ▪ Changes in breathing patterns ▪ Increasing respiratory secretions ▪ Incontinence ▪ Change in body temperature 	<ul style="list-style-type: none"> ▪ Assess daily using PCOC’s five assessment tools or more often if needed ▪ Provide end-of-life care as per plan of care ▪ Continue to assess Resident and family and/or carer(s) using assessment suite, responding as appropriate ▪ Communicate changes to family and others important to the Resident ▪ If Resident not likely to die within days re-assess Phase
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Guide to terminal care plan

<ul style="list-style-type: none"> • In line with the resident’s preferences, ensure there is a clear care plan (consider ACD) • In line with the resident’s preferences, ensure a Not For Resuscitation (NFR) plan is completed (check if this is specified in any existing ACD) • Complete a comprehensive assessment • Clinical intervention - pharmacological and non-pharmacological • Review oral medications, consider de-prescribing and change essential medications to alternative route if swallow compromised i.e. sub cut, PR • Care staff and health care professional review completed each hour • Communicate and provide information to resident, their family and / or carer(s) to ensure everyone understands that the resident’s death may be likely to occur soon • Document, review and implement any new interventions • Ambulance may be required if: <ul style="list-style-type: none"> ▪ Family/resident request this (unless ACD states does not want to go to hospital then first discuss this request with resident and their family and or next of kin and or other primary carer(s) ▪ No medication orders for worsening symptoms ▪ No access to GP, NP, SPC for review of intervention ▪ Interventions ineffective and resident is in distress
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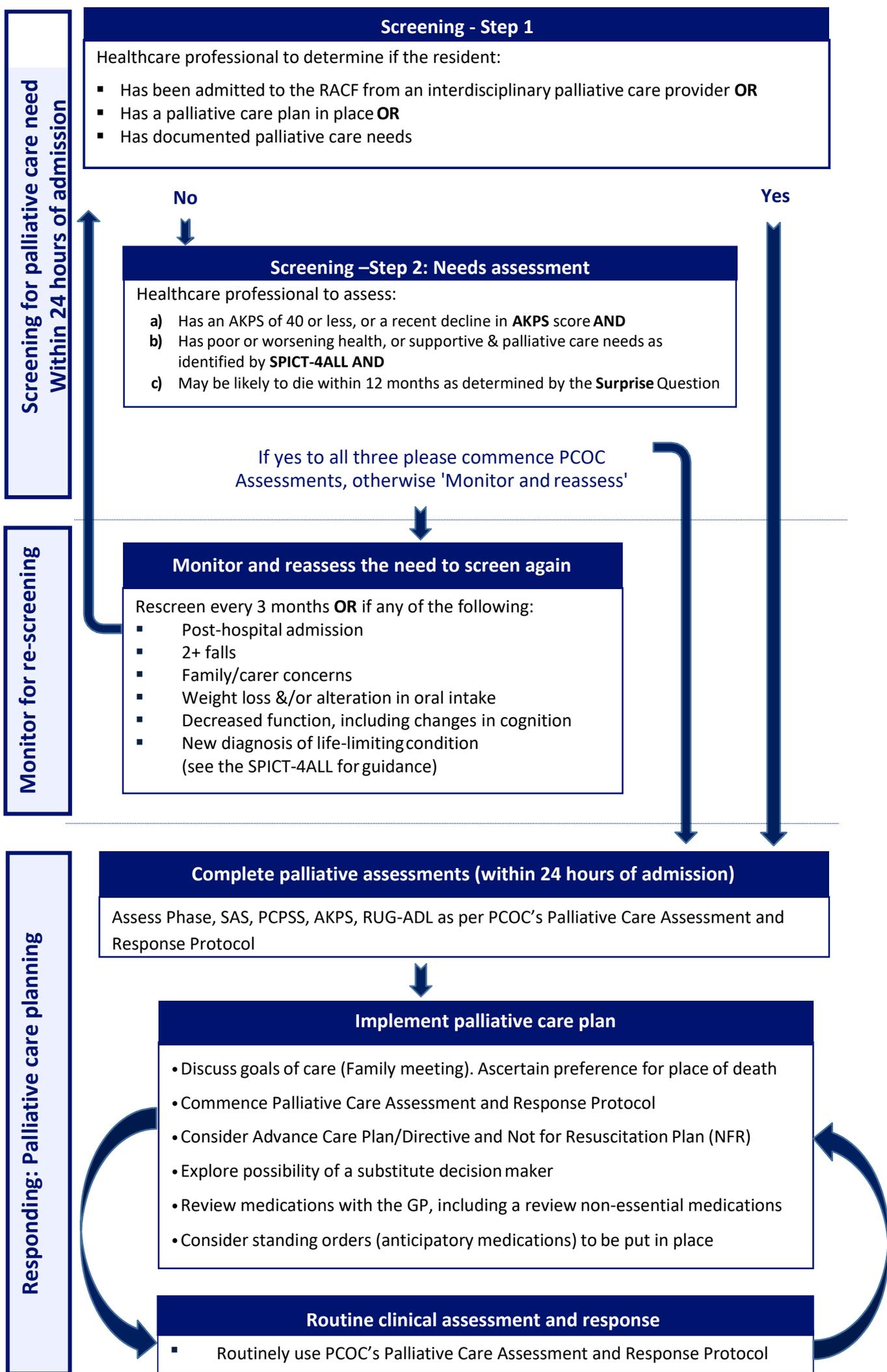
Table 3: Australia-Modified Karnofsky Performance Score (AKPS)

Australia-Modified Karnofsky Performance Score (AKPS) assessment		
Definition		
The AKPS is a measure of the resident’s performance across the dimensions of activity, work and self-care		
Use		
<ul style="list-style-type: none"> ▪ Complete at start of palliative care ▪ Complete every seven days (weekly) or more frequently as per the guide to clinical response below ▪ Complete at discharge from palliative care ▪ Complete at discharge from RACF ▪ Complete at transfer to hospital 		
AKPS Scale	Description	Guide to clinical response
Resident has AKPS of 90, 80 or 70 at episode start	90 - Able to carry on normal activity, minor signs or symptoms of disease 80 - Normal activity with effort, some signs or symptoms of disease 70 - Care for self, unable to carry on normal activity or to do active work	<ul style="list-style-type: none"> ▪ Consider advance care planning (ACP)/advance care directive (ACD) with the resident and their substitute decision- makers, where applicable ▪ Identify and discuss goals and wishes ▪ Communicate and provide information to resident, their family and or carer(s)
Resident has AKPS of 60	60 - Requires occasional assistance but is able to care for most needs	<ul style="list-style-type: none"> ▪ Consider referral (internal & external) to allied health if resident is able to care for most needs in the RACF but requires occasional assistance ▪ ACP/ACD discussions ▪ Communicate and provide information to resident, their family and or carer(s)
Resident has AKPS of 50	50 - Requires considerable assistance and frequent medical care	<ul style="list-style-type: none"> ▪ Consider discussion at case conference/ team meeting and review care plan ▪ ACP/ACD discussions ▪ Communicate and provide information to resident, their family and or carer(s) ▪ Provide appropriate equipment as required
Resident has AKPS of 40 or 30	40 - In bed more than 50% of the time 30 - Almost completely bedfast	<ul style="list-style-type: none"> ▪ Discussion at case conference/team meeting to review care plan – resident commencing deterioration and further supports required ▪ Refer to OT, PT, DT, SW when available/needed ▪ ACP/ACD completion/discussions ▪ Explore Not for Resuscitation (NFR), especially if no ACD ▪ Communicate and provide information to resident, their family and or carer(s) ▪ Routine pressure area care ▪ Provide appropriate equipment as required (for example, alternating pressure mattress)
Resident has AKPS of 20 or 10	20 - Totally bedfast and requiring nursing care by professionals and/or family 10 - Comatose or barely rousable	<ul style="list-style-type: none"> ▪ Commence end-of-life care planning ▪ If death is likely in days, change to Terminal Phase ▪ Communicate and provide information to resident, their family and or carer(s)

Table 4: RUG-ADL guide to clinical response

Resource Utilisation Group RUG-ADL assessment			
Definition			
The RUG-ADL assesses the level of functional dependence, based on what a resident actually does, rather than what they are capable of doing			
Use			
<ul style="list-style-type: none"> ▪ Complete at start of palliative care ▪ Complete every seven days (weekly) or more frequently as per the guide to clinical response below ▪ Complete at discharge from palliative care ▪ Complete at discharge from RACF ▪ Complete at transfer to hospital 			
Item	Description	Score	Guide to clinical response
Bed mobility, Toileting, Transfer	Independent / supervision only	1	<ul style="list-style-type: none"> ▪ Provide equipment if required (e.g., walking stick) ▪ Monitor for changes
	Limited physical assistance	3	<ul style="list-style-type: none"> ▪ Ensure care plan clearly describes the assistance required by staff ▪ Consider a Falls Prevention Plan ▪ Provide equipment if required
	Other than two person physical assist	4	<ul style="list-style-type: none"> ▪ Provide equipment / device as required ▪ Ensure care plan clearly describes the assistance required by staff and instructions regarding use of device ▪ Provide clear instructions to the Resident regarding use of the device
	Two or more person physical assist	5	<ul style="list-style-type: none"> ▪ Ensure care plan clearly describes the assistance required by staff ▪ Provide equipment
Eating	Independent / supervision only	1	<ul style="list-style-type: none"> ▪ Monitor for changes
	Limited assistance	2	<ul style="list-style-type: none"> ▪ Provide assistance required according to service guidelines / protocols ▪ Ensure care plan clearly describes the assistance required by staff
	Extensive assistance / total dependence / tube fed	3	<ul style="list-style-type: none"> ▪ Ensure care plan clearly describes the assistance required by staff ▪ Provide mouth care according to service guidelines / protocols ▪ Allocate for resident who is totally dependent for all care, including those in the terminal phase with no oral intake
Total Score Range		Recommended Actions for Total Score	
Total Score of 4-5		Independent. Monitor	
Total Score of 6-13		Requires assistance. May be at risk of falls and pressure areas	
Total Score of 14-17		Requires assistance of one plus equipment. Greater risk of falls and pressure areas	
Total Score of 18		Requires two assist for all care. Greater risk of pressure areas	

Flowchart: Identifying palliative need & responding to palliative need



AUSTRALIA-MODIFIED KARNOFSKY PERFORMANCE (AKPS)

100	Normal with no complaints or evidence of disease
90	Able to carry on normal activity but with minor signs of illness present
80	Normal activity but requiring effort. Signs and symptoms of disease more prominent
70	Able to care for self, but unable to work or carry on other normal activities
60	Able to care for most needs, but requires occasional assistance
50	Considerable assistance and frequent medical care required
40	In bed more than 50% of the time
30	Almost completely bedfast
20	Totally bedfast requiring extensive nursing care by professionals and/or family
10	Comatose or barely rousable
0	Dead



Supportive and Palliative Care Indicators Tool (SPICT-4ALL™)

The SPICT™ helps us to look for people who are less well with one or more health problems. These people need more help and care now, and a plan for care in the future. Ask these questions:

Does this person have signs of poor or worsening health?

- Unplanned (emergency) admission(s) to hospital.
- General health is poor or getting worse; the person never quite recovers from being more unwell. (This can mean the person is less able to manage and often stays in bed or in a chair for more than half the day)
- Needs help from others for care due to increasing physical and/ or mental health problems.
- The person's carer needs more help and support.
- Has lost a noticeable amount of weight over the last few months; or stays underweight.
- Has troublesome symptoms most of the time despite good treatment of their health problems.
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Does this person have any of these health problems?

<p>Cancer</p> <p>Less able to manage usual activities and getting worse.</p> <p>Not well enough for cancer treatment or treatment is to help with symptoms.</p>	<p>Heart or circulation problems</p> <p>Heart failure or has had attacks of chest pain. Short of breath when resting, moving or walking a few steps.</p> <p>Very poor circulation in the legs; surgery is not possible.</p>	<p>Kidney problems</p> <p>Kidneys are failing and general health is getting poorer.</p> <p>Stopping kidney dialysis or choosing supportive care instead of starting dialysis.</p>
<p>Dementia/ frailty</p> <p>Unable to dress, walk or eat without help.</p> <p>Eating and drinking less; difficulty with swallowing.</p> <p>Has lost control of bladder and bowel.</p> <p>Not able to communicate by speaking; not responding much to other people.</p> <p>Frequent falls; fractured hip.</p> <p>Frequent infections; pneumonia.</p>	<p>Lung problems</p> <p>Unwell with long term lung problems. Short of breath when resting, moving or walking a few steps even when the chest is at its best.</p> <p>Needs to use oxygen for most of the day and night.</p> <p>Has needed treatment with a breathing machine in the hospital.</p>	<p>Liver problems</p> <p>Worsening liver problems in the past year with complications like:</p> <ul style="list-style-type: none"> fluid building up in the belly being confused at times kidneys not working well infections bleeding from the gullet <p>A liver transplant is not possible.</p>

Other conditions

People who are less well and may die from other health problems or complications. There is no treatment available or it will not work well.

What we can do to help this person and their family.

- Start talking with the person and their family about why making plans for care is important.
- Ask for help and advice from a nurse, doctor or other professional who can assess the person and their family and help plan care.
- We can look at the person's medicines and other treatments to make sure we are giving them the best care or get advice from a specialist if problems are complicated or hard to manage.
- We need to plan early if the person might not be able to decide things in the future.
- We make a record of the care plan and share it with people who need to see it.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT-4ALL™, June 2017

Palliative Assessment and Clinical Response: RAC		(Please complete or affix Label here)
[Insert Service Name Here]		UPI: _____
		Surname: _____
		First name: _____
		DOB: _____

Instructions: Record PCOC assessment scores below.
 Commence **weekly** assessments when palliative care starts and increase to **daily** if any severe scores &/or in Unstable or Deteriorating phase.
 If a resident receives a SPC consult, record Yes in SPC Consult box, and complete assessments at time of SPC consult.
 If a resident is transferred to hospital, complete assessments immediately prior to transfer.

Year 20	Date										
SPC Consult	(Yes / No)										

Resident-rated score	PCOC Symptom Assessment Scale (0-10) Rate experience of symptom distress over a 24-hr period 0 = absent 10 = worst possible										
	0 = Continue care 1-3 = Monitor and record 4-7 = Review/change plan of care; referral, intervention as required 8-10 = Urgent action										
	Distress from Pain										
	Distress from Fatigue										
	Distress from Breathing										
	Distress from Bowels										
	Distress from Nausea										
	Distress from Appetite										
	Distress from Sleeping										
	Distress from Other Symptom										
Record who completed the SAS: R=Resident, F=Family or unpaid carer, H=Health Care Professional											

Health Care Professional rated score	Palliative Care Problem Severity Score Actions (0-3) Refer to complete definition and rate each domain										
	0 = Continue care 1 = Monitor and record 2 = Review/change plan of care; referral, intervention as required 3 = Urgent action										
	Pain										
	Other Symptoms										
	Psychological / Spiritual										

Health Care Professional rated score	Australia-modified Karnofsky Performance Status Scale (10-100) Refer to complete definition										
	AKPS										
	RUG-ADL Refer to complete definition										
	4-5 = Monitor 10+ = Assist x 1, consider equipment, staff requirements, falls risk, referral 6-10 = Assist x 1 15+ = As above, pressure area risk, consider carer burden and MDT review 18 = As above, full care assistance x 2										
	Bed mobility										
	Toileting										
	Transfers										
	Eating										
	Total RUG-ADL (4-18):										
	Palliative Care Phase (1. Stable 2. Unstable 3. Deteriorating 4.Terminal) Refer to complete definition										
Stable = Monitor Unstable = Urgent action required Deteriorating = Review plan of care Terminal = Provide terminal care											
Palliative Care Phase											

Staff initials										
Time of PC assessment (24-hr format i.e., hh:mm e.g., 13:15)										

PCOC Symptom Assessment Scale

Complete definition

Resident-rated distress relating to symptoms over a 24-hr period

The PCOC Symptom Assessment Scale describes the resident's level of distress relating to individual physical symptoms. The symptoms and problems in the scale are the seven most common.

Usage:

- Best practice is for the resident to rate distress either independent or with the assistance of a HCP or family/unpaid carer using a visual of the scale such as the *Symptom Assessment Scale Form for Residents*.
- Symptom distress may be rated by proxy. This only occurs when the resident is unable to participate in conversation relating to symptom distress i.e. Terminal phase.

Proxy: a family / unpaid carer or HCP who rates symptom distress on behalf of the resident through observational assessment. Use the following codes to describe Resident = R, Family or unpaid carer= F, or Health Care Professional = HCP

Instructions: resident to consider their experience of the individual symptom or problem over the last 24 hours and rate distress according to

A score of 0: means the symptom or problem is absent

A score of 1: means the symptom or problem is causing minimal distress.

A score of 10: means the symptom or problem is causing the worst possible distress.

SAS translations available on the PCOC website www.pcoc.org.au

Problem Severity Score

Complete definition

HCP-rated assessment of problems over a 24-hr period

Global assessment of four palliative care domains to summarise palliative care needs and plan care.

The severity of problems are rated and responded to following using the scale:

0 = Absent; 1 = Mild; 2 = Moderate; 3 = Severe

Pain: overall severity of pain problems for the resident

Other Symptoms: overall severity of problems relating to one or more symptoms other than pain

Psychological / Spiritual: severity of problems relating to the resident's psychological or spiritual wellbeing. May be one or more issues.

Family / Carer: problems associated with a resident's condition or palliative care needs. Family / Carer do not need to be present to assess needs as written, verbal or observational information may be used.

Australia-modified Karnofsky Performance Status

Complete definition

HCP-rated assessment of performance relating to work, activity and self-care over a 24-hr period

100. Normal, no complaints or evidence of disease
90. Able to carry on normal activity, minor signs or symptoms of disease
80. Normal activity with effort, some signs or symptoms of disease
70. Care for self, unable to carry on normal activity or to do active work
60. Occasional assistance but is able to care for most needs
50. Requires considerable assistance and frequent medical care
40. In bed more than 50% of the time
30. Almost completely bedfast
20. Totally bedfast & requiring nursing care by professionals and/or family
10. Comatose or barely rousable

Resource Utilisation Group – Activities of Daily Living

Abbreviated definition

HCP-rated assessment of dependency over 24-hr period

For Bed Mobility, Toileting & Transfers

1. Independent or supervision only
3. Limited physical assistance
4. Other than two person physical assist
5. Two or more person physical assist

For Eating

1. Independent or supervision only
2. Limited assistance
3. Extensive assistance / total dependence / tube fed

Complete RUG-ADL definitions available on the PCOC website www.pcoc.org.au

Palliative Care Phase

Abbreviated definition

HCP rated assessment

1. **Stable** Symptoms and problems are adequately controlled by established management. Monitor, review, anticipate & respond.
2. **Unstable** An urgent change in the plan of care or emergency treatment is required due to development of a new problem &/or a rapid increase in the severity of existing problems &/or family/carer problems. Urgent response required.
3. **Deteriorating** The plan of care is addressing anticipated needs but requires periodic review due to gradual functional decline &/or worsening of existing symptoms &/or the development of new but expected problems &/or family/carer problems. Review & change care plan
4. **Terminal** Death likely in a matter of days. Monitor, review & respond

Complete Phase Definitions available on the PCOC website www.pcoc.org.au

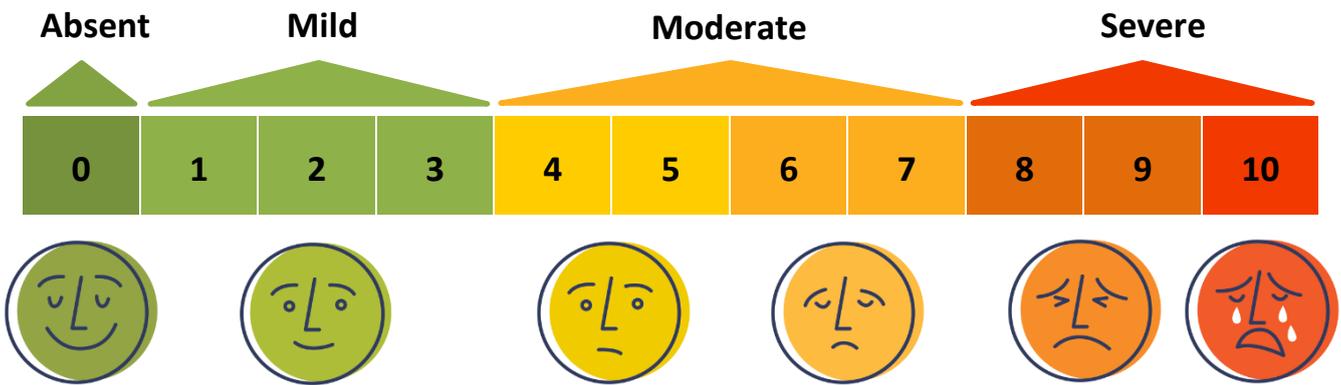


(Please complete or affix Label here)

UPI:
Surname
First name:
DOB:

Symptom Assessment Scale

Please use this form to ask the Resident about the symptoms that bother, worry or distress them. This information will help us to meet their needs.



1. Write the day or date in the first row.
2. Use the scale above to choose a number between 0 and 10 that shows how bothered, worried or distressed the resident is.
3. You can add other symptoms in the blank space at the bottom of the list.

Date and time										
Distress from Pain										
Distress from Fatigue										
Distress from Breathing problems										
Distress from Bowel problems										
Distress from Nausea										
Distress from Appetite problems										
Difficulty Sleeping										
Distress from Other Symptom (<i>specify</i>)										
Scored by R=Resident F=Family or unpaid carer C=care worker H= Health Care Professional										

Prepared by Sabina Clapham, Malene Ahern, Gaye Bishop, Natalie Joseph, Claire Johnson and Jane Connolly on behalf of the Palliative Care Outcomes Collaboration (PCOC)

Version control and change history

Version	Implemented by	Date effective	Approved by	Amendment
1.0	Sabina Clapham	23 August 2019	Barbara Daveson	Not applicable as first version
1.1	Gaye Bishop	8 October 2019		Language corrections and updated SAS form
1.2	Gaye Bishop	26 November 2019		Updated assessment and response form
1.3	Malene Ahern	17 July 2020		Updated section 1 screening to identify need and appendix 1
1.4	Malene Ahern Claire Johnson	17 August 2020		Added referral to local geriatricians to Table 1 and 2
1.5	Malene Ahern	24 th August 2020		Updated Appendix 2 Palliative care Assessment and Response form and Appendix 3 SAS form