

Inpatient Unit Palliative Care Form

Team name (ward/unit), if required _____

Individual Health Identifier _____

UPI/ URN/ MRN/ Patient ID: _____ (affix label here)

Surname: _____

First name: _____

DOB: ____ / ____ / ____ Sex: Male Female Other

Integrated Health Area: _____ Eircode: _____

PATIENT INFORMATION

Country of birth Ireland Other _____
Preferred language English Other _____

Ethnicity (Select one)

- | | |
|---|---|
| <input type="checkbox"/> Irish | <input type="checkbox"/> Asian or Asian Irish |
| <input type="checkbox"/> Irish Traveller | <input type="checkbox"/> Indian/Pakistani/Bangladeshi |
| <input type="checkbox"/> Roma | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Any other white background | <input type="checkbox"/> Any other Asian background |
| <input type="checkbox"/> Black or black Irish | <input type="checkbox"/> Arabic |
| <input type="checkbox"/> African | <input type="checkbox"/> Mixed |
| <input type="checkbox"/> Any other black background | <input type="checkbox"/> Other |

Principal Life-Limiting Diagnosis (Select one)

Malignant

- | | |
|--|---|
| <input type="checkbox"/> Bone & Soft Tissue | <input type="checkbox"/> Head & Neck |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Central Nervous System | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Colorectal | <input type="checkbox"/> Other Urological |
| <input type="checkbox"/> Pancreas | <input type="checkbox"/> Gynaecological |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Other Gastro-Intestinal Tract | <input type="checkbox"/> Unknown Primary |
| <input type="checkbox"/> Haematological | <input type="checkbox"/> Other Malignancy |

Non-Malignant

- | | |
|---|---|
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Respiratory Failure |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> End-Stage Liver Disease |
| <input type="checkbox"/> End-Stage Kidney Disease | <input type="checkbox"/> Diabetes & its complications |
| <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> Sepsis |
| <input type="checkbox"/> Motor Neuron Disease | <input type="checkbox"/> Multiple Organ Failure |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Other Non-Malignancy |
| <input type="checkbox"/> Other Neurological Disease | |

COMPREHENSIVE ASSESSMENT: Complete at the start of palliative care

ADMISSION INFORMATION

Referral provider type Where did the referral come from? (Select one)

- | | |
|---|--|
| <input type="checkbox"/> Public hospital | <input type="checkbox"/> General practice |
| <input type="checkbox"/> Private hospital | <input type="checkbox"/> SPC Community service |
| <input type="checkbox"/> Outpatient clinic | <input type="checkbox"/> Residential Care facility |
| <input type="checkbox"/> Specialist Palliative Care Service | <input type="checkbox"/> Other |

Referral speciality Which speciality referred the patient? (Select one)

- | | |
|---|--|
| <input type="checkbox"/> Palliative care | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Medical oncology | <input type="checkbox"/> Rehabilitation medicine |
| <input type="checkbox"/> Radiation oncology | <input type="checkbox"/> Surgical |
| <input type="checkbox"/> Respiratory medicine | <input type="checkbox"/> General medicine |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> General practice |
| <input type="checkbox"/> Haematology | <input type="checkbox"/> Other primary care |
| <input type="checkbox"/> Geriatric medicine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Emergency medicine | |
| <input type="checkbox"/> Renal | <input type="checkbox"/> Not Recorded/Invalid |

Date & time patient referred ____ / ____ / ____ : ____

Date Ready for Care ____ / ____ / ____ : ____

Date & time of assessment ____ / ____ / ____ : ____

Setting of Care (Select one)

- Overnight Admitted Specialist Palliative care bed
 Overnight Admitted Non-designated palliative care bed

Patient's usual accommodation (Select one)

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Private residence | <input type="checkbox"/> Prison |
| <input type="checkbox"/> Residential Care facility | <input type="checkbox"/> Other |
| <input type="checkbox"/> Group home/Disability Residence | <input type="checkbox"/> Not Recorded |

Does the patient have a carer (see definitions) who is available to provide care? (Select one)

- Yes
 No
 Not assessed

**Proceed to clinical
assessment →**

SEPARATION ASSESSMENT: Complete at death, discharge, or prior to changing setting of care

SEPARATION INFORMATION

Date & time of separation ____ / ____ / ____ : ____

Patient location after separation. Where is the patient being discharged to?

- | | |
|--|--|
| <input type="checkbox"/> Inpatient Hospice | <input type="checkbox"/> Other |
| <input type="checkbox"/> Inpatient Hospital | <input type="checkbox"/> Not applicable – patient died |
| <input type="checkbox"/> Community - usual accommodation | |
| <input type="checkbox"/> Community -not usual accommodation | |
| <input type="checkbox"/> Community – not usual accommodation private residence | |

Place of death (If applicable)

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Private residence | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Residential Care Facility | <input type="checkbox"/> Other |
| <input type="checkbox"/> Group Home/Disability Residence | |
| <input type="checkbox"/> Prison | |

**Proceed to clinical
assessment**

Inpatient Unit Palliative Care Clinical Assessment Form

Team name (ward/unit), if required _____

UPI/ URN/ MRN/ Patient ID: _____ (affix label here)	
Surname: _____	
First name: _____	
DOB: ____ / ____ / ____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Integrated Health Area: _____	Eircode: _____

ONGOING ASSESSMENT:
Complete at initial contact; at each contact; at phase change; and prior to separation If not assessed, enter N/A

Year:	Date														
	Time														

Delirium

Clinician-assessed Is delirium present? (Yes / No)															
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Guide to clinical response	If delirium is suspected, confirm with a validated tool. Consider patient's goal of care and plan care accordingly
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Edmonton Symptom Assessment System (ESAS-PCOC)

Patient (or proxy) reported symptom and problem severity in the last 24 hours

PATIENT- REPORTED

Pain (0 = No pain, 10 = Worst possible)															
Tiredness (lack of energy) (0 = No tiredness, 10 = Worst possible)															
Drowsiness (feeling sleepy) (0 = No drowsiness, 10 = Worst possible)															
Nausea (0 = No nausea, 10 = Worst possible)															
Appetite* (0 = Best appetite, 10 = Worst possible)															
Shortness of breath (0 = No shortness of breath, 10 = Worst possible)															
Constipation (0 = No constipation, 10 = Worst possible)															
Sleep* (0 = Best sleep, 10 = Worst possible)															
Depression (feeling sad) (0 = No depression, 10 = Worst possible)															
Anxiety (feeling nervous) (0 = No anxiety, 10 = Worst possible)															
Wellbeing (how you feel overall)* (0 = Best wellbeing, 10 = Worst possible)															
Other symptom (D = Dry or sore mouth; I = Itch; S = Swallowing; Ot = Other; N = No other symptom)															
Other symptom score (0 = Absent symptom; 10 = Worst possible)															

Guide to clinical response	0 to 3: Anticipate & monitor, modify as required	4 to 7: Review, intervene & refer as required	8-10: Urgent action
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ESAS-PCOC Rated by (P=Patient, F=Family/carer, C=Clinician, O=Other)															
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*Please note 0 represents 'best' for appetite, sleep and wellbeing. Continue to next page

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UPI/ URN/ MRN/ Patient ID: _____(affix label here)
 Surname: _____
 First name: _____
 DOB: ____ / ____ / ____ Sex: Male Female Other
 Integrated Health Area: _____ Eircode: _____

Team name, if required _____

ONGOING ASSESSMENT (Continued) If not assessed, enter N/A

Year:	Date																			
	Time																			

Resource Utilisation Groups – Activities of Daily Living (see scoring guide)

Bed mobility (1, 3, 4, 5)																				
Toileting (1, 3, 4, 5)																				
Transfers (1, 3, 4, 5)																				
Eating (1, 2, 3)																				
Total RUG-ADL (4 to 18)																				
Guide to clinical response	If total score is 10 or more, consider equipment needs, case/family conference, staff requirements, carer burden, referral																			

Australia-modified Karnofsky Performance Status (see scoring guide)

AKPS (10 to 100)																				
Guide to clinical response	If score 60 or lower, consider referral as appropriate. If score 40 or lower, consider also equipment needs, staffing, falls risk, pressure injuries, and carer burden																			

Palliative Care Problem Severity Score (0 = absent 1 = mild 2 = moderate 3 = severe)

Pain																				
Other symptoms																				
Psychological / spiritual																				
Family / carer																				
Guide to clinical response	0 to 1: Anticipate & monitor, modify as required					2: Review, intervene & refer as required					3: Urgent action									

Palliative Care Phase

	Phase Type																			
	Stable (S)	Unstable (U)					Deteriorating (D)					Terminal (T)								
Definition	Adequate symptom and problem control. No change in care plan required.	Urgent change in care plan or emergency treatment required to address severe needs.					Non-urgent change in care plan required to address increasing needs.					Death likely in a matter of days.								
Guide to clinical response	Continue current care. Anticipate & monitor for changing needs.	Urgent action.					Review & intervene; Refer as required.					Adjust care plan to address end of life needs.								

Clinician initials																				
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CLINICIAN - ASSESSED

DEFINITIONS & SCORING GUIDE

Refer to PCOC Clinical Manual for the complete definitions

Carer Availability

- *Definition of Carer:* paid and/or unpaid person who provides care, support and assistance. May include family, friends, a neighbour, or a paid nursing/carer service. A carer can be different from next of kin/person responsible.
- *Available* means able to support the patient if required.

Delirium: Clinician-assessed presence of delirium in the last 24 hours

- *Definition:* an acute, fluctuating disturbance in attention, awareness, and cognition that often reflects an underlying medical, psychological, or pharmacological cause.
- *Characteristics:* disturbances in consciousness, attention, cognition and perception that develop over a short period of time (usually hours to a few days). Patients with delirium may be agitated and restless (hyperactive delirium), or quiet and withdrawn (hypoactive delirium). Patients may also move between these two subtypes (mixed delirium). The onset of delirium is quick (over hours to a few days) in comparison to dementia.

Edmonton Symptom Assessment System (ESAS-PCOC): Patient-reported severity of symptoms and problems in the last 24 hours

- *Best-practice:* patient rates their own symptoms, which is key to delivering person-centred and value-based care.
- *How to use this tool:* Elicit ratings from patient through conversations to understand the symptoms from the patient's perspective, then conduct a more in-depth clinical assessment as needed. Provide intervention/escalation if necessary.
- If a patient is unable to provide a score, e.g. due to confusion, unconsciousness, communication difficulties, then a proxy can be used. When using a proxy, consider a family/carer first. If family/carer unavailable, then a clinician may score.
- Patient information leaflet 'Let's talk about your care' is available to support clinician and patient discussion.

Resource Utilisation Groups - Activities of Daily Living: Clinician assessment of functional dependence over a 24 hour period

Scoring guide:

For Bed Mobility, Toileting & Transfers

- 1 Independent or supervision only
- 3 Limited physical assistance
- 4 Other than two-persons physical assist (1 person & aid)
- 5 Two or more persons physical assist

For Eating

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

Australia-modified Karnofsky Performance Status: Clinician assessment of performance relating to work, activity and self-care over a 24 hour period

Scoring guide:

- 100 Normal; no complaints; no 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 Cares for self; unable to carry on normal activity or to do active work
- 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 and requiring extensive nursing care by professionals and/or family
- 10 Comatose or barely rousable

Palliative Care Problem Severity Score: Clinician assessment of problems in the last 24 hours

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

- *Pain:* overall severity of pain problems for the patient
- *Other Symptoms:* overall severity of problems relating to one or more symptoms other than pain
- *Psychological/Spiritual:* severity of one or more problems relating to the patient's psychological or spiritual wellbeing
- *Family/Carer:* severity of one or more family/carer problems associated with a patient's condition or palliative care needs. Written, verbal or observational information can be used to assess needs if family/carer are not present

Palliative Care Phase Type: A classification of clinically meaningful periods in an individual's care trajectory

The palliative care phase is determined by a holistic clinical assessment which considers all the above assessments.

Stable (S)

Adequate symptom and problem control. No change in care plan required

Unstable (U)

Urgent change in care plan or emergency treatment required to address severe needs

Deteriorating (D)

Non-urgent change in care plan required to address increasing needs

Terminal (T)

Death likely in a matter of days. Adjust care plan to address end of life needs.