# Palliative Performance Scale & Care Plan Reviews

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<tr>
<th>Resident Name:</th>
<th>Unit/Room #:</th>
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<td>Date</td>
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## 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).

#### 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.
- Consult 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.

In case of Outbreak: & no improvement in 72 hrs after onset of resident’s symptoms, conduct regular review & follow corresponding interventions.
<table>
<thead>
<tr>
<th>PPS</th>
<th>CONDITION</th>
<th>SUGGESTED INTERVENTIONS</th>
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| 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                                                            |
| 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                                                            |
| 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                                                            |
| 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                                                            |
| 0%   | **Death**                                                                 | √ Complete regular review                                                            |

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 bings, card games, exercise programs and outings.**
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>PPS Score %</th>
<th>Resident-Specific Care Plan Reviewed/Updated</th>
<th>Date next review due.</th>
<th>Signature</th>
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Domains of Issues Associated with Illness & Bereavement

**Physical**
- Pain and other symptoms
- Level of consciousness
- Cognition
- Function, safety, aids (motor, senses, physiologic, sexual)
- Fluids, nutrition
- Wounds
- Habits

**Psychological**
- Personality, strengths, behaviour, motivation
- Depression, anxiety
- Emotions
- Fears
- Control, dignity, independence
- Conflict, guilt, stress, coping responses
- Self-image

**Social**
- Cultural values, beliefs, practices
- Relationships, roles with family/friends, community
- Isolation, abandonment, reconciliation
- Safe environment
- Privacy, intimacy
- Routines, recreation, vacation
- Legal issues
- Family/caregiver protection
- Guardianship, custody issues

**Spiritual**
- Meaning, value
- Existential, transcendental
- Values, beliefs, practices, affiliations
- Spiritual advisors, rites, rituals
- Symbols, icons

**Disease Management**
- Primary diagnosis, prognosis, evidence
- Secondary diagnosis (e.g. dementia, substance use)
- Co-morbidities (e.g. delirium, seizures)
- Adverse events (e.g. side effects)
- Allergies

**Loss, Grief**
- Loss
- Grief (e.g. acute, chronic, anticipatory)
- Bereavement planning
- Mourning

**Person and Family**
- Demographics
- Culture
- Personal values, beliefs, practices and strengths
- Developmental state, education, literacy
- Disabilities

**End-of-Life Care/Death Management**
- Life closure
- Gift giving
- Legacy creation
- Preparation for expected death
- Anticipation and management of physiological changes in the last hours of life
- Rites, rituals
- Pronouncement, certification
- Peri-death care of family, handling of body
- Funerals, services

**Practical**
- Activities of daily living (e.g. personal care, household activities)
- Dependents, pets
- Telephone access, transportation

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 $\geq 4$, the issue should be added to the careplan, addressed, and monitored more frequently.

6. To determine the frequency in which the regular reviews are to be performed, refer to the “Reviews’ section on page 1.
7. 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.”
8. 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.

9. 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:


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


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


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

Many thanks to everyone for their dedication and assistance with this project!