# Early Identification Guide for patients that would benefit from a Palliative approach to care.

**Step 1**

**Ask the Surprise Question:**
"Would you be surprised if the patient were to die in the next year?"

- No
- Not Sure
- Yes → Reassess Patient regularly

**Step 2**

**Do they have General Indicator(s) of Decline?**

**General Indicator(s) of Decline:**

- Advancing disease: unstable, deteriorating complex symptom burden
- Decreasing response to treatments, decreasing reversibility or choice to have no further disease modifying treatment(s).
- General physical decline i.e. reduced ambulation, increasing dependence
- Repeated unplanned/crisis hospital admissions
- Diagnoses and Complex Symptoms with High Risk of going to ER (may mimic EOL Sx):
  SEPSIS, PNEUMONIA, UTI, DYSPNEA, FATIGUE, ABDO DISORDER (i.e. constipation / pain etc.)
- COPD and CHF are the two disease comorbidities with highest predictors of morbidity and mortality.
- Sentinel event, e.g. serious fall.
- Weight loss - >10% in past six months

- Yes
- No → Reassess patient regularly / discuss goals of care and advance care planning

Always Ask Yourself: Am I creating an environment that is culturally safe and acceptable?

**Step 3**

**IDENTIFY**
Flag in patient's medical record with identified palliative care needs; engage with primary care, Are they able to manage pt. care needs independently, E.g. complex physical or psychosocial symptoms? If not, consider referral to Palliative Care Specialist consultative team.

**Consider Referral to Palliative Care Outreach Team (PCOT)**
**Referral Criteria:**

- Diagnosed with a life-limiting progressive disease
- Complex symptoms
- Meets the Gold Standard Framework "surprise" question: *Would you be surprised if this person were to die within the next 12 months? Are there general signs of decline?*
- Complex needs (e.g., social determinants of health)
- Challenges with goals of care discussions/care planning
- Declining functional status
- Complex or potentially complex psychosocial/ spiritual needs for the patient and/or family/ caregiver

Continue conversations with Primary care Practitioner.

Do they Need Generalist or Specialist Level of Care.

Liaise with Care Coordinator

**ASSESS**
Assess patient and family needs (e.g. disease management, physical, psychological, spiritual, functional status), assess understanding of illness and goals of care, record goals of care/ advance care planning discussions

Use Standardized assessment tools SICG / SICG for pt.'s and caregivers OPCN approaches to goals of care discussions - look in education folder

Ask Yourself, would pt. benefit from additional support services, e.g. day wellness programs, visiting volunteer, music therapy etc.
Assess Patient environment – can pt. be supported in their preferred environment. If not, would pt. benefit from OT/PT, plan for changing needs

**PLAN / IMPLEMENT / ONGOING EVALUATION**
Participate as a member of the core care team. If patient/family complexity increases, discuss role of Palliative Care Specialist consultative team

**Serious Illness Conversation Guide**

1. **Understanding:** What is your understanding now, of where you are with your illness?
2. **Information Preferences:** How much information about what is likely to be ahead with your illness would you like from me / your health care team?
3. **Prognosis:** Inquire if patient is aware of prognosis, explore willingness to receive, if able, share prognosis as a range, i.e. weeks to months, days to weeks
4. **Goals:** If your health situation worsens, what are your most important goals?
5. **Fears/Worries:** What are your biggest fears and worries about the future with your health?
6. **Function:** What abilities are so critical to your life that you can't imagine living without them?
7. **Trade-offs:** If you become sicker, how much are you willing to go through for the possibility of gaining more time?
8. **Family:** How much does your family know about your priorities and wishes? How much do you want them to know? Explore families understanding.

**Other Resources:**
**Local Resources:**

**OPCN goals of care discussions**
**Indigenous Ally Ship Toolkit**