In- Home Chart: Maximizing Palliative Practice

Educational Sessions presentation by Hospice Palliative Care Teams for Central LHIN

October 2009
In-Home Chart

**Purpose**

- To share client information with palliative care team members, including the family.
- To assess client needs, concerns, and manage salient client/family issues.
- To record & document care in one central location to be accessed by all care service providers and family members.
Goals of the In-Home Chart

- Improve communication among team members
- Reduce duplication of information collected
- Integrate Edmonton Symptom Assessment System (ESAS) and Palliative Performance Scale (PPS) tools
Initiating the Record of Care

The Primary Nurse will:

1. Initiate the In-Home Chart

and

2. Explain the purpose and use of the Chart to the client/caregivers
Initiating the Record of Care

- The In-Home Chart is a legal document and communication tool
- Client/caregiver/care providers will be able to document symptoms and concerns in progress notes in the home

Upon discharge:
The entire chart will be returned to the agency
# Primary Nurse Responsibilities

At each visit the Primary Nurse will:

- **Sign in**
- Ensure the Clinical Assessment Tool is completed *within the first three nursing visits*
- Label appropriate flow sheets for use
- Instruct the Client to use ESAS
- Assess and document PPS
### Primary Nurse Responsibilities (cont)

- ✓ Assess, monitor, record, address client concerns and status
- ✓ Check Progress Notes for updates
- ✓ Update Demographics and Advance Care Planning as needed
- ✓ Report as required to the CCAC Case Manager / MD
- ✓ Reorder chart forms and flow sheets from own agency (CADD, wound care, etc.) as required
Record of Care

Highlights of Sections

A Partnership for Caring:
Central CCAC, Southlake Regional Health Centre & Temmy Latner Centre for Palliative Care
Care Team Contact Sheet:

- Contact information for the client’s care team is listed for easy access
- Client’s Name, Phone & BRN #
- Pharmacy Contact #
- Main Caregiver Contact #
Sign In Sheet

Sign In Sheet:

➢ Every team member is to ‘sign in’

➢ The most current sheet on top
Section 1: Demographics & Initial Clinical Assessment

**Demographics:**

- Includes pertinent contact and client information
- To be filled out by the nurse on the first visit
- Advanced care planning
Section 1: Demographics & Initial Clinical Assessment (cont)

Initial Assessment Tool:

- A comprehensive tool to guide your care plan
- Mandated to be completed within the first three (3) visits*
- ESAS and PPS are new additions

*(Source: Preferred Practice Guidelines for Palliative Care Nursing)
## Section 2: Doctor’s Orders

<table>
<thead>
<tr>
<th>Allergy List</th>
<th>Doctor’s Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Initial Allergy List located on the <em>left</em> of MD orders</td>
<td>➢ MDs will document orders with the most current orders filed on top</td>
</tr>
<tr>
<td>➢ A detail list of allergies is checked regularly and updated by all team members</td>
<td>➢ RNs will check &amp; initial orders</td>
</tr>
<tr>
<td>➢ Precautions and Risk/Infectious Diseases</td>
<td></td>
</tr>
</tbody>
</table>
Section 3: Medication List

<table>
<thead>
<tr>
<th>Regular &amp; PRN Medication List</th>
<th>MAR for Regular &amp; PRN Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ List of all past, current and PRN medications</td>
<td>➢ Documentation of every drug administered by an RN</td>
</tr>
<tr>
<td>➢ Update MAR with every new medication order</td>
<td></td>
</tr>
<tr>
<td>➢ Document with the most current sheet on top</td>
<td></td>
</tr>
</tbody>
</table>

**Additional forms from your agency can be added to this section for your patient’s needs (e.g. CADD flow)**
Section 4: Nursing

**Clinical Assessment Flow Sheet**

- A comprehensive flow sheet to capture the client’s health status
- Abnormal findings should be documented in the Progress Notes*
- The most current sheet on top

**Additional forms from your agency can be added to this section for your patient’s needs (e.g. Wound care, etc)**
Edmonton Symptom Assessment System (ESAS) is a gold standard for symptom assessment.

It is the client’s opinion of the severity of the symptoms.

The severity at the time of assessment of each symptom is rated from 0 to 10 on a numerical scale; with 0 meaning that the symptom is absent and 10 that it is the worst possible severity.

Edmonton Symptom Assessment System (ESAS)

Please circle the number that best describes:

- No pain
- Not tired
- Not nauseated
- Not depressed
- Not anxious
- Not drowsy
- Best appetite
- Best feeling of wellbeing
- No shortness of breath
- Other problem

<table>
<thead>
<tr>
<th>Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worst possible pain</td>
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<tr>
<td>Worst possible tiredness</td>
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<td>Worst possible nausea</td>
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<td>Worst possible depression</td>
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<td>Worst possible anxiety</td>
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<td>Worst possible drowsiness</td>
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<tr>
<td>Worst possible appetite</td>
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<td>Worst possible feeling of wellbeing</td>
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<tr>
<td>Worst possible shortness of breath</td>
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<tr>
<td>Other problem</td>
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</tbody>
</table>
Palliative Performance Scale is a reliable communication tool used by HCPs for palliative care clients that guides the assessment of a patient’s functional performance.

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

A Partnership for Caring:
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Section 4: Nursing (cont)

**Common Assessment Tool (CAT Form)**

- Documentation of the ESAS and PPS to be completed at each visit
- If there are no significant changes can be charted weekly at nurse’s discretion
- Mark PPS score with * if Progress Note is written
- Fax completed forms to your agency every month
Section 4: Nursing (cont)

**Interdisciplinary Symptom Management Guidelines**

- Used as assessment tool for ESAS scores ≥ 4
- Document extraordinary/abnormal findings, and actions/interventions in Care Plan and Progress Notes
Section 4: Nursing (cont)

**Care Plan**

- To record client’s concerns
- The Collaborative Care Plan *is a guide for the health care team to address patient-centred interventions* and states expected outcomes for care.*
- Mandated to be completed by HCPs and consent confirmed with client
- Must be continually assessed and update

* Refer to: *Collaborative Care Plans: PCIP Collaborative Care Plans – “Lite” Version*
Section 5: Progress Notes

Care Team Progress Notes

- A communication space for EVERY team member including family, caregivers, and hospice volunteers to communicate with each other regarding client’s concerns, changes in status, etc.
- Document by exception
- The most current sheet on top
- To be checked by all team members at each visit for updates

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The DNR Confirmation Form or the EDITH protocol is to be inserted on the inside pocket of the chart for easy access.
Key Points

• Increase communication!
• Streamline documentation
• First step to including interdisciplinary team
• Standardization of palliative practice
• No change in policy and procedure – Contact manager with further questions
Evaluation

We are dedicated to continuous quality improvement and want your feedback!

We would greatly appreciate your comments and suggestions regarding the improvement of the In-Home Chart.

Please e-mail or fax us any issues, concerns, Suggestions - big or small!

We want this to work for everyone!

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