ID-PALL© version 1.0, 2020

Instructions for use and glossary for the ID-PALL instrument

IDentification of patients requiring general or specialized PALLiative care.

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Practice recommendations for general palliative care.

Document intended to be used by medical and nursing teams non-specialized in palliative care.

Dr. Fabienne Teike Lüthi
PD Dr. Mathieu Bernard
PD Dr. Claudia Gamondi
Prof. Anne-Sylvie Ramelet
Prof. Gian Domenico Borasio

UNIL | Université de Lausanne
Faculté de biologie et de médecine
Ecole doctorale

Introduction

ID-PALL is a tool that has been developed and validated to help you identify patients requiring general or specialized palliative care (PC). General PC is the care provided by non-specialized PC professionals, to patients with an incurable, progressive, life-limiting illness, but whose situation is stable, in order to help improve their quality of life. Specialized PC is provided by professionals specialized in palliative care, i.e., who have specific training and practice within a mobile team, a specialized consultation or a PC unit. Specialized care is intended for patients whose situation is unstable and/or complex, either due to difficulties assessing and managing physical symptoms, or due to acute levels of psychosocial and/or existential suffering. Specialized PC teams can also provide teams with help in developing specific assessment, communication and advance care planning skills, as well as support the writing of advance care planning documents with patients, or provide support when health care professionals feel helpless and expereince difficulty.

It is therefore important to be able to quickly identify patients who need PC, and to be able to differentiate between those who need general PC and those who need specialized PC. in order to do this, the use of a screening instrument by health professionals has been recognized as beneficial.

Once a patient has been identified, it is also necessary for teams to have specific good practice recommendations to guide them in their daily practice.

Purpose

The purpose of this document is to :

- introduce ID-PALL and explain how to use it
- provide a glossary clarifying important terminology
- provide good practice recommendations for the clinical management of patients requiring general palliative care.

[1] Teike Lüthi F, Bernard M, Beauverd M, Gamondi C, Ramelet AS, Borasio GD. Identification of patients in need of general and specialised palliative care (ID-PALL©): item generation, content, and face validity of a new interprofessional screening instrument. BMC Palliat Care. 2020;19:1-11.

[2] Teike Lüthi F, Bernard M, Vanderlinden K, Ballabeni P, Gamondi C, Ramelet AS, Borasio GD. Measurement properties of ID-PALL, a new instrument for the IDentification of patients in need of general or specialised PALLiative care. JPSM. 2021.

[3] La terminologie « patient » est utilisée à titre épicène et regroupe également d'autres appellations telles que : résident, client, bénéficiaire de soins ou autre

Introduction and use of ID-PALL

Who assesses?
ID-PALL is a screening instrument that can be used by nurses and physicians.

When is it used?
ID-PALL should be completed within 48 hours of the patient's admission or if any significant changes in their condition occur.

How does it work?
ID-PALL is divided into two parts. ID-PALL G is be filled out to identify general PS needs. If ID-PALL G is positive, ID-PALL S needs to be completed to identify specialized PC needs.

ID-PALL is scored as follows:

- For ID-PALL G, if the answer is 'no' to question 1 or 'yes' to at least one of statements 2, 3, or 4, the patient most likely requires general palliative care. In this case, please complete ID-PALL S next and refer to the recommendations for general palliative care practice.
- For ID-PALL S, if the answer is 'yes' to at least one of the statements, the patient would most likely benefit from a consultation with a specialized palliative care team.

ID-PALL is a screening tool. The purpose of this tool is to elicit discussions and build a therapeutic palliative care plan with the patient and an interprofessional team, based on the recommendations for general PC practice and, if necessary, with the support of a specialized PC team.

Below you will find:

- the ID-PALL instrument
- a glossary clarifying important concepts and terminology
- recommendations for general palliative care practice. These recommendations are to be implemented according to the patient and their family's situation.

ID-PALL© G

IDentification of patients in need of General PALLiative Care.
General palliative care is provided by professionals without specialised palliative care training in all care settings and contexts.

Space reserved for patient's ID label

Please respond to all of the statements below relative to the patient's **current situation**:

1. Would you be surprised if this patient died in the next **12** months?	☐ Yes ☐ No
2. The patient has a progressive illness or group of illnesses or comorbidities that **limits their life expectancy**	
AND presents (select all that are applicable):	
a decline in general functioning (with limited reversibility and an increase in need for support in day to day activities)	☐ Yes ☐ No
OR	
a pronounced instability over the last 6 months (defined by: one uncontrolled symptom from the patient's point of view OR a pressure ulcer category ≥3 OR more than one acute delirium episode, infection, unscheduled hospitalisation or fall)	☐ Yes ☐ No
OR	
psychosocial or existential suffering (of the patient or people close to them)	☐ Yes ☐ No
OR	
the need for support in making decisions during the final stages of life	☐ Yes ☐ No
3. Current or planned interruption of treatments with curative intent or **vital support measures** (eg: artificial ventilation, dialysis, artificial feeding or hydration)	☐ Yes ☐ No
4. Request for **comfort care or palliative care** from the patient, people close to them or health professionals	☐ Yes ☐ No

If you have ticked
NO to question 1 OR YES to at least ONE of the statements 2, 3, or 4,
the patient is likely to require general palliative care.
Please complete the ID-PALL S questionnaire on the next page and refer to the general palliative care practice recommendations.

ID-PALL© S

CHUV Palliative and Supportive Care Service

IDentification of patients in need of Specialist PALLiative Care.
Specialised palliative care is provided by or with professionals specialized in palliative care.
Please respond to all of the statements below, relative to the patient's **current situation, only when the response to the ID-PALL G is positive:**

1. Presence of **at least one severe and persistent symptom**, including pain, that has not responded satisfactorily to treatment within 48 hours.	☐ Yes ☐ No
2. **Difficulties in evaluating** physical symptoms or psychological, social difficulties or spiritual distress	☐ Yes ☐ No
3. **Disagreement or uncertainty** on the part of the patient, people close to them or health professionals regarding, for example, medical treatments, resuscitation code or complex decisions	☐ Yes ☐ No
4. The patient has **severe psychosocial or existential suffering** (eg: marked symptoms of anxiety or depression, feelings of isolation or of being a burden, loss of meaning or hope, desire to die, or has made a request for assisted suicide)	☐ Yes ☐ No
5. People close to the patient experience **severe psychosocial or existential suffering** (eg: marked symptoms of anxiety or depression, major feelings of exhaustion, major disruption to the functioning of the family system, loss of meaning or hope)	☐ Yes ☐ No
6. **Palliative sedation** is envisaged (to relieve an intolerable refractory symptom by decreasing the level of consciousness using specific medication)	☐ Yes ☐ No
7. **Advance care plan or advance directives** are difficult to establish with the patient and/or people close to them	☐ Yes ☐ No
8. In your opinion, the patient, people close to them or health professionals could benefit from **the intervention of palliative care specialists.**	☐ Yes ☐ No

If you have ticked
YES to ONE of the above statements, the patient is likely to require consultation of a specialist palliative care team.

ID-PALL© v1, 2020, F. Teike Lüthi et al.

ID-PALL© G : glossary

1. Would you be surprised if this patient died in the next 12 months ?	Described as «surprise question,» this question requires your intuitive response, based on what you know about the patient and their current situation.
2. The patient has a progressive illness or group of illnesses or comorbidities that **limits their life expectancy** **AND** presents:	This question is divided into two parts. When caring for a patient, the first question to ask oneself is whether the patient has a progressive life-limiting illness. Combining this criteria with one of the following elements will determine the need for general palliative care.
a decline in general functioning (with limited reversibility and an increased need for support in day to day activities) (e.g., symptom of anxiety and depression; family, financial, cultural or life concerns; lack of meaning) OR **a pronounced instability over the last 6 months** (defined by: one uncontrolled symptom from the patient's point of view OR a pressure ulcer category ≥3 OR more than one acute delirium episode, infection, unscheduled hospitalisation or fall) OR	Functional decline is a decrease in the ability to perform personal care, often associated with a deterioration in mobility and the ability to perform activities of daily living.
psychosocial or existential suffering (of the patient or people close to them) OR	When a person's sense of completeness is compromised, he or she may feel unwell. This feeling may stem from multiple sources: psychological, social, spiritual and/or existential. In a holistic vision of the person, these dimensions are interrelated and influence each other.
the need for support in making decisions during the final stages of life	In some situations, patients and their loved ones may have difficulty making decisions about which treatments/care to accept or where to go for care/end of life care, for example. Initiating Advance Care Planning can help them clarify their values and use these to guide them in their decision-making.
3. Current or planned interruption of treatments with curative intent or vital support measures (eg: artificial ventilation, dialysis, artificial feeding or hydration)	
4. Request for comfort care or palliative care from the patient, people close to them or from health professionals	

ID-PALL© S : lexique

1. Presence of **at least one severe and persistent symptom**, including pain, that has not responded satisfactorily to treatment within 48 hours	Patients with palliative care needs commonly experience multiple symptoms. Pain is the most commonly identified symptom, but patients may experience dyspnea, nausea, fatigue, anxiety, or other sources of discomfort that do not respond to standard treatments. After 48 hours of unrelieved pain, it becomes clear that other strategies should be considered.
2. **Difficulties in evaluating** physical symptoms or psychological, social difficulties or spiritual distress	Difficulties may be encountered in assessing patients, either due to cognitive or linguistic difficulties, unfamiliarity with certain instruments, or difficulty in broacing certain topics. This can increase the level of complexity of the situation.
3. **Disagreement or uncertainty** on the part of the patient, people close to them or health professionals regarding, for example, medical treatments, resuscitation code or complex decisions	
4. **The patient** has **severe psychosocial or existential suffering** (eg: clinically relevant symptoms of anxiety or depression, feelings of isolation or being a burden, loss of sense of meaning or hope, desire to die, or has made a request for assisted suicide)	
5. **People close to the patient** experience **severe psychosocial or existential suffering** (eg: clinically relevant symptoms of anxiety or depression, major feelings of exhaustion, major disruption to the family system, loss of meaning or hope)	
6. **Palliative sedation** is envisaged (decreasing the level of consciousness using specific medication to relieve a refractory symptom)	A refractory symptom is a symptom that cannot be controlled to the patient's satisfaction despite properly conducted specialized palliative management. An intolerable symptom is determined by the patient as a symptom or condition that he or she can no longer tolerate.
7. **Advance care planning** or **advance directives** are difficult to establish with the patient or people close to them	
8. In your opinion, the patient, people close to them or health professionals could benefit from **the intervention of palliative care specialists.**	If it seems that you, the patient or their loved ones could use the support of palliative care specialists, but you feel that may not be able to express the need more explicitly, follow your intuition. Whether it's helping you cope with feelings of helplessness, arranging a complicated homecoming, supporting you through a difficult conversation, or assisting you with some care, palliative care specialists can be a resource.

ID-PALL© Recommendations for General Palliative Care Practice

IDENTIFY

Symptoms
Assess pain and other symptoms (dyspnea, nausea, anxiety, etc.) using an appropriate instrument (e.g., ESAS), alleviate identified symptoms and reassess regularly

Communication
Initiate a discussion about the patient's and family's understanding of the disease and its progression, as well as their choices for further care

Needs
Assess the patient and family's psychosocial and existential needs and resources

Anticipation
Consider possible complications and develop plans for addressing them

Grief
Assess the grief support needs of family members and refer them to specific assistance if needed

Patient and family

Demographics, diagnosis, treatments

PLAN

Advance care planning
Discuss the values and preferences of the patient and their family, in order to define their choices for the future.
Provide information about advance care planning and help with filling out documents

Educational support
Provide patients and their families with information, support and guidance in developing strategies for managing the effects of disease progression and end of life

End of life
Provide end of life care that respects the patient's values and preferences while supporting their family

COLLABORATE

Working together
Organize, in collaboration with other professionals, support and care that is adapted to the needs of the patient and their family

DOCUMENT

Seamless care
Record the patient's choices presence of advance directives and/or advance care planning documents in their medical file.
Communicate, with the patient's consent, important information to the relevant professionals involved

If assistance is needed in implementing one or more of the recommendations, the advice of a specialized palliative care team may be required.

ID-PALL© recommendations v1, 2020, F. Teike Lüthi et al.

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