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

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

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

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