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Palliative Care Collaborative Care Plans
CCPs

Condensed Version

What are the Condensed Collaborative Care Plans

The Condensed Collaborative Care Plans (CCPs) are a quick reference tool for healthcare providers to use when developing care plans for cancer patients. The plans are designed to be used when providing palliative care services across all care settings. A patient's functional status is assessed using the Palliative Performance Scale (PPS)[1] and is used to determine the care for patients in the Stable (PPS 70-100%), Transitional (PPS 40-60%), and End-of-Life (PPS 0-30%) stages.

The Canadian Hospice Palliative Care Association's (CHPCA) Model[2] is used as a framework. Each "Domain of Issue" from the Model is listed on a separate page and is broken down by the Essential and Basic Steps During a Therapeutic Encounter. The full version of the Collaborative Care Plans (CCPs) provides a separate Plan for each stage; Stable, Transitional and End-of-Life and provides additional detailed information (insert weblink).

How to use the Condensed CCPs

Within each Domain considerations for care planning common to all cancer patients (e.g., in the Stable, Transitional or End-of-Life phase) are listed first. **Additional** considerations that should be included for patients in the Transitional and/or End-of-life phases are listed next. The Edmonton Symptom Assessment System (ESAS) [3] is being used as a common symptom self screening tool for cancer patients in Ontario and therefore is referenced throughout the document.

NOTE: The Collaborative Care Plans builds on the work of the Kingston Frontenac Leeds and Addington Palliative Care Integration Project[4] and align with the CHPCA Model for Hospice Palliative Care. These revised CCPs were developed by a provincial working group[5] that was tasked with developing a tool targeted at the generalist provider that would improve the quality of patient care by increasing consistency across providers and settings.

Disclaimer

Care was taken in the preparation of the information contained in this report. Nonetheless, any person seeking to apply or consult the report is expected to use independent clinical judgment in the context of individual clinical circumstances or seek out the supervision of a qualified clinician. Cancer Care Ontario makes no representation or guarantees of any kind whatsoever regarding the report content or use or application and disclaims any responsibility for its application or use in any way.

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Palliative Performance Scale (PPSv2) version 2 (developed by Victoria Hospice Society)

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

Stable
70 – 100 %

Transitional
40 – 60%

End-of-Life
0 -30 %

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Disease Management	
Stable, Transitional and End-of-Life (100% - 0%)	
Step 1: Assessment • Understanding of disease, possible/ expected co-morbidities and prognosis • Relevance of current disease management protocols e.g. plan of treatment • Monitor PPS scores as appropriate for setting of care **Step 2: Information Sharing** • Determine need for translation • Confirm confidentiality limits • Address any deficits in understanding of disease and management **Step 3: Decision Making** • Assess capacity to make decisions • Determine the legal substitute decision maker	**Step 4: Care Planning** • Develop an appropriate plan of treatment based on the person's values and mutually determined goals of care **Step 5: Care Delivery** • Identify the most responsible physician • Determine the health care professional who will coordinate activities of the team • Provide family and informal caregivers with pertinent information • Facilitate communication of the plan of care when there is a transfer to a new setting **Step 6: Confirmation** • Determine the person/family/team's understanding of the disease and satisfaction with the current plan of treatment
Transitional (60% - 40%) & End-of-Life (30% - 0%)	

Step 1: Assessment
• Reassess investigations, clinic visits, goals of care and the plan of treatment
• Confirm if the physician will make home visits
Step 3: Decision Making
• Identify the decision maker and determine appropriateness of:
  • Setting for care
  • Resuscitation status
  • Having, withholding and or withdrawing of treatments	

Physical

Stable, Transitional and End-of-Life (100% - 0%)

Step 1: Assessment
- Use ESAS to screen for and monitor symptoms
- Assess person and family's ability to use ESAS independently
- Conduct a comprehensive physical assessment
- Symptoms will require further in depth assessment using validated assessment tools (e.g., comprehensive pain assessment)
- Assess for urinary retention/infection, oral intake, skin integrity, mobility and need for assistive devices

Step 2: Information Sharing
- Share information related to symptoms in a suitable manner

Step 3: Decision Making
- Assess capacity to make decisions
- Facilitate identification of goals and prioritize
- Obtain informed consent for treatments

Step 4: Care Planning
- Consider consult to Palliative Care Team for complex symptom management issues
- Initiate other interdisciplinary referrals
- Customize a flexible plan of treatment that:
  - addresses identified symptoms
  - respects the person's choices, culture and values
  - addresses emergent issues (e.g., escalating symptoms)
  - anticipates potential complications

Step 5: Care Delivery
- Provide information, resources and supplies required to manage physical care (e.g., contact information list)
- Teach and evaluate the care giver's skill necessary to execute the plan of treatment (e.g., medication administration)

Step 6: Confirmation
- Determine satisfaction with the plan of treatment

Transitional (60 % - 40%) & End-of-Life (30% - 0%)

Step 1: Assessment
- Assess need for caregiver assistance with completion of ESAS
- Reevaluate the need for routine assessments (e.g., vital signs, blood glucose)
- Assess swallowing ability

Step 2: Information Sharing
- Provide information regarding physiological changes with progression of disease (e.g., appetite, hydration, fatigue)

Step 3: Decision Making
- Use an ethical framework to guide decision making around end-of-life care (e.g., palliative sedation, artificial hydration)

Step 4: Care Planning
- Adjust the care plan to individual need (e.g., turn q2h only if tolerated, frequent mouth care, supportive surfaces)

Step 5: Care Delivery
- Anticipate the need for alternative routes of medication administration (e.g., PO to SC)
- Anticipate the need for crisis management (e.g., symptom response kit, dark towels available for hemorrhage)

Psychological

Stable, Transitional and End-of-Life (100% - 0%)

Step 1: Assessment

- Use ESAS to screen for and monitor depression, anxiety and well-being
- Identify:
  - strengths & vulnerabilities
  - emotional and behavioural responses
  - methods of coping
  - realistic and unrealistic expectations
  - previous losses
  - level of tolerance for inconsistency and changes in the plan of treatment
  - conflicted relationships
- Conduct a comprehensive assessment using validated assessment tools (e.g., depression assessment tools)

Step 2: Information Sharing

- Respect confidentiality limits as defined by the person
- Provide privacy for sensitive discussions

Step 3: Decision Making

- Recommend individualized complementary therapeutic interventions with informed consent (e.g., music therapy, massage, guided imagery)

Step 4: Care Planning

- Customize a flexible plan of care that:
  - addresses identified psychological issues (e.g., fears, anger, etc.)
  - respects the person's choices, culture, values, beliefs, personality
  - supports the desire for control, independence, intimacy
- Consider referral to Social Work/Mental Health/Spiritual/ Pastoral Care Consultant, Hospice and other volunteers

Step 5: Care Delivery

- Promote a comfortable and private setting
- Be sensitive to changes that may cause anxiety

Step 6: Confirmation

- Determine satisfaction with the plan of treatment as it relates to the management of psychological issues

Transitional (60 % - 40%) & End-of-Life (30% - 0%)

Step 1: Assessment

- Review ESAS scores for anxiety, depression and well being daily to identify any psychological issues of concern
- Listen for subtle cues in conversation that reflect anxiety, depression and fear (e.g., "I am tired of this …")
- Observe for behavioural cues (e.g., withdrawn, facial expression)

Step 2: Information Sharing

- Be prepared for open discussion of topics such as euthanasia, assisted suicide, withdrawal of treatment, etc.
  - Provide clear and consistent responses
  - Identify need for team meetings
- Foster realistic hopes as illness progresses

Social

Stable, Transitional & End-of-Life (100% - 0%)

Step 1: Assessment

- Assess changes in roles and the impact within the family unit
- Identify issues related to;
    - conflicted relationships
    - mental health
    - socio economic status
- Identify need for assistance with financial, legal affairs
- Identify current and potential support systems
- Consider in-depth assessment

Step 2: Information Sharing

- Provide information about available local resources
- Share information about advance care planning

Step 3: Decision Making

- Facilitate identification of goals and social priorities (e.g., financial, relationship, legal)

Step 4: Care Planning

- Encourage activities that will strengthen family bonds
- Consider referral to Social Work, Legal/Financial Consultant, Hospice and other volunteer programs, First Nations and other cultural groups

Step 5: Care Delivery

- Respect culture, values, beliefs, personality and preferences

Step 6: Confirmation

- Determine satisfaction with the plan of treatment as it relates to the management of social issues

Transitional (60% - 40%) & End-of-Life (30% - 0%)

Step 1: Assessment

- Address changes in roles and the impact within family unit (e.g., caregiver strain and fatigue, lack of privacy/intimacy)
- If children living with person assess their level of comfort with person's presence in home
- Identify issues of isolation, abandonment, conflicted relationships

Step 2: Information Sharing

- Facilitate family members' awareness of compassionate care benefits

Step 3: Decision Making

- Encourage family/close friends to organize shifts for respite

Step 4: Care Planning

- Scheduling of visitors: usually restricted at this time to close family and friends
- Encourage activities that will strengthen family bonds (e.g., reminiscence, life review)

Step 5: Care Delivery

- Maintain a calm, peaceful and comfortable environment in all settings
- Maintain meaningful interactions with the person without the expectation of a response

Spiritual	
Stable, Transitional & End-of-Life (100% - 0%)	
Step 1: Assessment ▪ Monitor ESAS scores (e.g., anxiety, depression, well being, fatigue, pain) ▪ Utilize comprehensive spiritual assessment tools ▪ Explore: • meaning of life, death and preparedness for illness process • relationships • the concept of anticipatory grieving • hopes and fears • sustaining and supportive beliefs and practices **Step 2: Information Sharing** ▪ Facilitate timely and uninterrupted interactions ▪ Encourage expression of fears and suffering ▪ Discuss goals **Step 3: Decision Making** ▪ Offer options in support of spiritual healing (e.g., journaling, meditation, music) ▪ Identify and incorporate meaningful rituals and devotional practices	**Step 4: Care Planning** ▪ Customize a flexible plan of treatment that: • respects culture, values, beliefs • incorporates meaningful icons, symbols, rites and rituals • promotes an environment conducive to reflection, compassion, transcendence and peace • acknowledges hope • reframes goals into achievable tasks ▪ Consider referral to Pastoral/Spiritual Advisor or other appropriate team member **Step 5: Care Delivery** ▪ Employ the appropriate communication skills that are key to sensitive discussions (e.g., avoid quick fix responses and religious clichés) ▪ Listen; meaning comes from within the person and is best discovered by the person telling his or her story **Step 6: Confirmation** ▪ Determine satisfaction with the plan of treatment as it relates to the management of spiritual issues

Practical

Stable, Transitional & End-of-Life (100% - 0%)

Step 1: Assessment

- Assess practical needs:
  - Functional assessments (e.g., activities of daily living)
  - Children's needs
  - Caregiver's needs

Step 2: Information Sharing

- Facilitate family members' awareness of available local community resources

Step 3: Decision Making

- Determine what services/resources the person/family are prepared to accept

Step 4: Care Planning

- Develop a plan of treatment intended to maintain independent functioning for as long as possible (e.g., transfer techniques)
- Facilitate timely access to equipment (e.g., raised toilet seat, walker)
- Facilitate appropriate referrals (e.g., physiotherapy, occupational therapy)

Step 5: Care Delivery

- Avoid unnecessary changes in care plan
- Promote a consistent, consensual and coordinated care plan

Step 6: Confirmation

- Determine satisfaction with the plan of treatment as it relates to the management of practical issues

Transitional (60% - 40%) & End-of-Life (30% - 0%)

Step 4: Care Planning

- Anticipate equipment, support needs and follow-up with change in setting of care (e.g., hospital to home)

Step 5: Care Delivery

- Facilitate communication of the most current plan of care when there is a transfer to a new setting

End-of-Life Care/Death Management	
Stable, Transitional & End-of-Life (100% - 0%)	**End-of-Life (30% - 0%)**
Step 1: Assessment ▪ Assess level of burden and stress being experienced by the caregivers ▪ Assess and review resuscitation status ▪ Explore what the person and family know and what they don't know (e.g., prognosis, dying process) **Step 2: Information Sharing** ▪ Explore and discuss questions **Step 3: Decision Making** ▪ Identify goals and expectations of care **Step 4: Care Planning** ▪ Develop a plan with the family regarding access to 24/7 telephone support ▪ Confirm the resuscitation status and completion of the Do Not Resuscitate Confirmation Form (DNRC) in Ontario ▪ Discuss the (in)appropriateness of calling 911 **Step 5: Care Delivery** ▪ Promote a calm, peaceful and comfortable environment regardless of the setting ▪ Encourage and support life review, when appropriate **Step 6: Confirmation** ▪ Determine satisfaction with the plan of treatment as it relates to the management of end-of-life care/death issues	**Step 1: Assessment** ▪ Assess understanding of and preparedness for death (i.e., assess needs of child of dying family member) **Step 2: Information Sharing** ▪ Discuss physiological changes expected to occur in the last hours of life ▪ Explore beliefs about the benefits and burdens of interventions such as artificial nutrition or hydration, antibiotics, transfusions **Step 3: Decision Making** ▪ Review desired setting for ongoing care delivery and determine family/caregiver ability/willingness to participate in care at end-of-life **Step 4: Care Planning** ▪ Develop a plan of treatment that addresses symptoms such as upper airway secretions, restlessness, delirium ▪ Develop a plan for expected death which includes: • the desired setting of care, rites and rituals around death (e.g., bathing and dressing, prayers) • how and to whom the death will be communicated • plan for pronouncing and certifying the death • funeral, celebration of life service, memorial • notification of the funeral home **Step 5: Care Delivery** ▪ At the time of death: • implement the pre-determined plan • arrange time with the family for a follow-up call or visit, if appropriate • provide bereavement resources (e.g. booklet)

Loss, Grief

Stable, Transitional & End-of-Life (100% - 0%)

Step 1: Assessment
- Identify previous losses
- Identify previous and current coping (e.g., exercise, substance use)
- Assess for evidence of suicidal ideation
- Identify those who are at risk for complicated grief (e.g., multiple unresolved losses, death of a child)
- Utilize comprehensive assessment tools

Step 2: Information Sharing
- Encourage expression of feelings and emotions
- Discuss the grieving process and anticipatory grief
- Provide examples of rituals that can facilitate healthy grieving
- Provide age and culturally appropriate information about grief responses

Step 3: Decision Making
- Determine and facilitate support for loss and grief

Step 4: Care Planning
- Incorporate meaningful cultural, spiritual rites and rituals (e.g., gift giving, legacy creation, memory boxes, hand casts)
- Refer to appropriate Health Care Providers for advanced interventions (e.g., suicidal ideation)
- Consider referral to Spiritual Advisor, Grief Counselor, Hospice, etc.

Step 5: Care Delivery
- Provide age specific resources for those who are grieving

Step 6: Confirmation
- Determine satisfaction with the plan of treatment as it relates to the management of loss and grief issues

Transitional (60 % - 40%) & End-of-Life (30% - 0%)

Step 1: Assessment
- Determine understanding of and preparedness for death

Step 4: Care Planning
- Consider referral to address anticipatory grief
- Consider referral for bereaved family member to appropriate local resources
- Encourage the bereaved to make an appointment with an appropriate health care provider within weeks of the death
- Encourage the bereaved to make an appointment with the family physician within weeks of the death

References

1. Victoria Hospice, 2003 Palliative Performance Scale (PPSv2)
2. Ferris FD, Balfour HM, Bowen K, Farley J, Hardwick M, Lamontagne C, Lundy M, Syme A, West P. A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice. Ottawa, ON: Canadian Hospice and Palliative Care Association, 2002 http://www.chpca.net/
3. Alberta Health Services (previously Capital Health) Regional Palliative Care Program. Edmonton Symptom Assessment System (ESAS)
4. Kingston Frontenac and Leeds Palliative Care Integration Project, Collaborative Care Plans, Palliative Care Medicine Queen's University March 2006
5. Refer to the Full Version of the current CCPs for a complete list of the Working Group members

Regional Educational Programs

CAPCE - Comprehensive Advanced Hospice Palliative Care Education Program for Nurses **-** The program focuses on developing a Hospice Palliative Care Resource Nurse within the health care provider organization in which they work – long-term care homes, hospices, hospitals, Community Care Access Centres` and community nursing agencies.

LEAP- Learning Essential Approaches to Palliative and End-of-Life Care - The 2.5 day LEAP course offers an opportunity for active learning about current best-practice in caring for patients with life-threatening and life-limiting illness, with a special focus on family practice and community settings.