

## Palliative Care Needs Assessment

Green	<p><b>Patient identified as having palliative care needs but currently stable</b></p> <ul style="list-style-type: none"> <li>● Patient has a stable social situation</li> </ul> <p><b>Prompts</b></p> <ul style="list-style-type: none"> <li>● Initial assessment organised or completed</li> <li>● Holistic review carried out monthly</li> <li>● Patient is registered on end of life register</li> <li>● Patient has an identified key worker</li> <li>● Consider Advanced Care Planning (ACP) with supporting documentation (e.g Preferred Priorities of Care)</li> <li>● Patient or significant other aware of out of hours advice and contact information</li> </ul>
Amber	<ul style="list-style-type: none"> <li>● Patient's needs are changing or patient's condition slowly deteriorating</li> <li>● Social situation has potential to breakdown</li> <li>● Patient has just been discharged from an alternative care setting (<i>within two weeks</i>)</li> <li>● Patient lives alone</li> </ul> <p><b>Prompts</b></p> <ul style="list-style-type: none"> <li>● Holistic review completed at least once a week</li> <li>● Consider increasing level of care provision – consider fast track Continuing Care package.</li> <li>● Consider financial reassessment</li> <li>● Organise “Just in Case” pre-emptive medication and non-syringe driver instructions</li> <li>● Review equipment needs</li> <li>● Consider a medical review</li> <li>● Carer assessed and needs met</li> <li>● PPC or ACP revisited, DNA CPR status established.</li> <li>● Patient or significant other aware of out of hours advice and contact information.</li> </ul>
Red	<ul style="list-style-type: none"> <li>● Patient's condition is rapidly changing or deteriorating, complex symptom management</li> <li>● There is a social crisis (carer breakdown)</li> <li>● Patient is identified as being in the dying phase</li> </ul> <p><b>Prompts</b></p> <ul style="list-style-type: none"> <li>● Holistic review completed at least once a day</li> <li>● Patient has been seen by a medic within two weeks</li> <li>● Other services , including Out of Hours GP service are alerted of patient's status via the <a href="#">End of Life coordinator</a>.</li> <li>● “Just in Case” pre-emptive medication in place with up to date non-syringe driver instructions</li> <li>● Appropriate equipment in place</li> <li>● PPC/ACP revisited</li> <li>● End of life care plan initiated if appropriate</li> <li>● Carer assessed and needs met</li> <li>● Patient or significant other aware of out of hours advice and contact information.</li> </ul>

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RDASH-Palliative needs Assessment adapted from Somerset's End of Life Care Framework as part of the Somerset Delivery Choice Programme