Interpreting the results of an interRAI Palliative Care assessment

A factsheet for Aged Residential Care and Community users

Aged Residential Care providers and Community interRAI users may have a palliative care assessment record transferred to them. The following information is designed to help readers who are unfamiliar with the interRAI Palliative Care assessment interpret the results in order to develop a care plan.

The interRAI Palliative Care assessment is accepted by the Ministry of Health for entry into a residential facility. After admission to an aged care facility Registered Nurses will not be required to complete a Palliative Care assessment. They will use the interRAI Long Term Care Facilities (LTCF) assessment.

Background

The Palliative Care assessment is used with persons who have a palliative diagnosis and would previously have had a Home Care assessment completed with them to determine services and supports they require.

When viewing the Palliative Care assessment you will notice that the questions are explicit to the needs of the person relating to the palliative care they require.

- The Palliative Care assessment is much more 'fit for purpose' for this very special population capturing the unique aspects of palliative care.
- The symptom list is more indicative of the conditions this group are experiencing.
- Capturing feelings about end of life, acknowledges the reality this group's journeys and offers a completeness.

Clinical Assessment Protocols (CAPs) and Outcome Scores in the interRAI Palliative Care assessment

Although the outcome scales and many of the CAPs will look familiar to interRAI users, the focus of responses for care planning are different for the person receiving palliative care. The key aspects for such a person, is to identify those who may benefit from care and support in each of the end-of-life areas of concern using the triggered PC CAPs.

There are nine CAPs in the PC assessment, whereas there are 27 in the HC assessment. You will notice three new palliative specific CAPs – Dyspnoea, Fatigue and Sleep. The 'Undernutrition' CAP has changed to 'Nutrition' to acknowledge the different emphasis on nutritional support for this group.

These CAPs aid the clinician in prioritising issues likely affecting the person's quality of life at the time of the assessment.

There are eight outcome scores in the PC assessment, whereas there are 17 in the HC assessment. The assessment items used to calculate these scores remain the same across both assessments.

Following is a list of the PC assessment outcome scales and CAPs including the overall goals of care. These are considered when developing a plan of care when supporting this group of people.

Outcome Scales Produced by the Palliative Care Assessment

- ADL Hierarchy Scale
- Body Mass Index (BMI)
- ADL Short Form
- Cognitive Performance Scale
- Depression Rating Scale
- Pain Scale
- Change in Health, End-stage Disease, Signs and Symptoms (CHESS)
- Pressure Ulcer Risk Scale

ADL Self-Performance Hierarchy Scale (Scale Range: 0-6)

Measure of functional performance and is particularly useful in grading the level of progression of a person's disability over a long time periods.

It is based on the concept of 'early', 'middle' and 'late' loss of ADLs.

This scale (0 to 6) aims to describe the disablement process rather than to simply provide a summary of functional impairment.

The scale is based on four ADL short items showing a level of difficulty for:

MDS Item	Description
Personal hygiene	Early loss
Locomotion	Middle loss
Toilet use	Middle loss
Eating	Late loss

Score	Description
0	Independent
1	Supervision required
2	Limited assistance
3	Extensive assistance required
4	Maximal assistance required
5	Dependent
6	Total dependence

Body Mass Index (BMI)

The BMI is a measurement which represents the ratio between the height and weight of an individual.

BMI = Weight (kg) / Height (m)^2

In the Palliative Care older adult this outcome measure is one of the triggers for the Nutrition CAP.

It should be recognised that a person's total weight reflects both the body's mass and any abnormal fluid collection, such as might be present in the extremnities, the abdomen and the pleural space. It may be an unsatisfactory measure of nutritional status and a poor guide to determining caloric and protein requirements for a person receiving palliative care.

ADL Short Form Scale (Scale Range: 0-16)

This scale provides a measure of ADL status that is more sensitive to change over time than the ADL Hierarchy Scale. It is calculated from four ADL items: personal hygiene (early loss), locomotion and toilet use (middle loss), and eating (late loss).The ***higher*** the score the ***greater*** the difficulty in performing activities. Validated by Morris, Fries, and Morris (1999).

Cognitive Performance Scale (CPS) (Scale Range: 0-6)

This scale provides a score from 0 to 6 that indicates a person's cognitive status. The table also shows how it relates to other commonly used cognition scales.

Score	Description	MMSE *approx. equiv.	3MS *approx. equiv.
0	Intact	25	83
1	Borderline intact	22	73
2	Mild impairment	20	63
3	Moderate impairment	15	50
4	Moderate / severe impairment	7	23
5	Severe impairment	5	17
6	Very severe impairment	1	3

*This cross validation was conducted during the development of the Cognitive Performance Scale

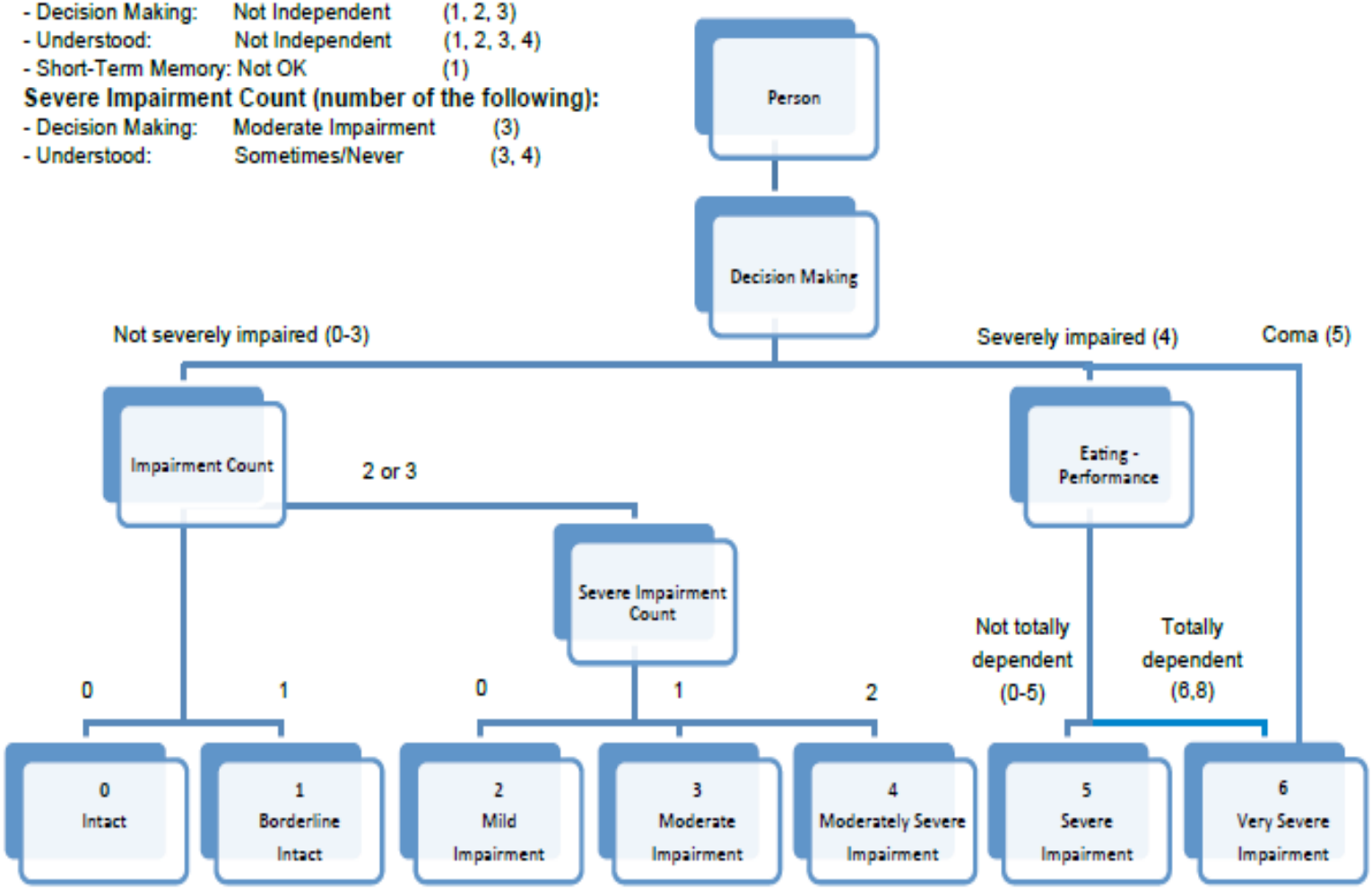
Cognitive Performance Scale

Impairment Count (number of the following):

- Decision Making: Not Independent (1, 2, 3)
- Understood: Not Independent (1, 2, 3, 4)
- Short-Term Memory: Not OK (1)

Severe Impairment Count (number of the following):

- Decision Making: Moderate Impairment (3)
- Understood: Sometimes/Never (3, 4)



Source: Morris JN, Fries BE, Mehr DR, Hawes C, Philips C, Mor V, Lipsitz L. (1994) MDS Cognitive Performance Scale. Journal of Gerontology: Medical Sciences 49 (4): M174-M182.

Depression Rating Scale (DRS) (Scale Range: 0-14)

Scale ranging from 0 to 14 that is a predictor of the presence of depression. The ***higher*** the score, the ***stronger*** the clinical indicator.

This scale does not affect the trigger threshold of the Mood CAP for this group of people.

A score of 3 or more indicates a high likelihood that the person is suffering from a degree of depressive disorder.

Validation studies were based on a comparison of the DRS with the Hamilton Depression Rating Scale and the Cornell Scale for Depression.

Items which are scored from the assessment include:

MDS Item	Description
H1a	Made negative statements
H1b	Anger
H1c	Unrealistic fears
H1d	Repetitive health complaints
H1e	Anxious complaints
H1f	Sad facial expression
H1g	Crying

Source: Burrows A, Morris JN, Simon S, Hirdes JP, Phillips C. (2000) Development of a Minimum Data Set-based Depression Rating Scale for Use in Nursing Homes. Age and Aging 29(2): 165-172

Pain Scale (Scale Range: 0-4)

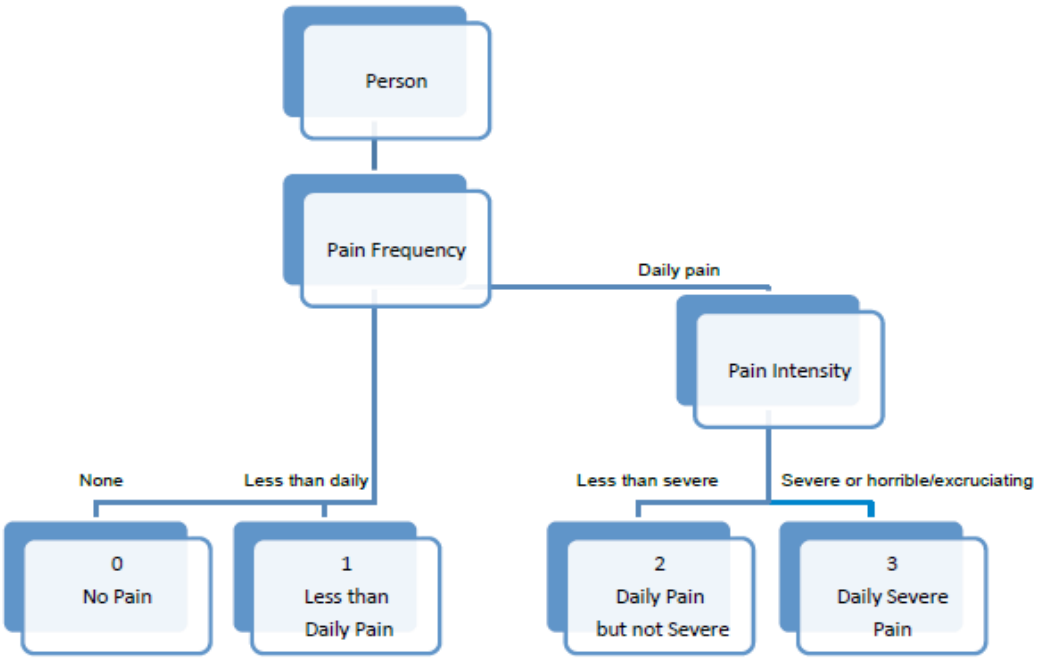
This is a scale from 0 to 4 that describes a person's level of pain. It is derived from assessment items that include the frequency and intensity of pain.

Score	Description
0	No pain
1	Less than daily pain
2	Daily pain but not severe
3	Daily severe pain
4	Daily excruciating pain

Validated against the 'Visual Analogue Scale'.

Pain Scale

interRAI™



Source: Fries BE, Simon SE, Morris JN, Flodstrom C, Bookstein FL. 2001. Pain in U.S. Nursing Homes: Validating a Pain Scale for the Minimum Data Set. *Gerontologist* 41(2): 173–79.

Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS) (Scale Range: 0-5)

This scale ranges from 0 to 5 and attempts to identify those individuals who are at risk of serious decline and level of medical instability.

Higher scores are associated with a shorter lifespan.

Scores range from 0 (no symptoms of instability) to 5 which is highly indicative of mortality, hospitalisation and caregiver stress.

The score is calculated by adding signs and symptoms variables up to a maximum of two, then adding three other variables (change in decision making, change in ADL status and end stage disease). (Hirdes et al, 2003).

Palliative Care Item	Description
One point for each of these items if triggered	
iG8a	Change in ADL status (0-2,8)
J5	Change in ADL status
F6	Change in decision making
iJ6c	End-stage disease
One point for any three of these items if triggered	
C6h	Vomiting
C6s	Peripheral oedema
C2	Dyspnoea
D2a	Weight loss
D2d	Fluid intake
D2d	Dehydrated
iK2g	Decrease in food or fluid
D2f	Fluid output exceeds input

Score	Description
0	No symptoms
1	Minimal health instability
2	Low health instability
3	Moderate health instability
4	High health instability
5	Highest level of instability

Pressure Ulcer Risk Scale (PURS) (Scale Range: 0-8)

The scale generates 9 levels, based on 7 MDS items. This scale complements the Pressure Area CAP and should always be reviewed when that CAP is triggered.

This scale considers such things as any history of pressure ulcers, impaired bed mobility, impaired walking, bowel incontinence, weight loss and Dyspnoea. This has been validated against the Braden Scale for pressure sore risk.

MDS Item	Description
J2c	Walking -Performance
J2g	Bed mobility performance
K3	Bowel continence
C2	Dyspnoea
C1a	pain
D2a	Weight loss
E2	Prior pressure ulcer

Score	Pressure Ulcer RISK
0	Very low risk
1 or 2	Low risk
3	Moderate risk
4 or 5	High risk
6 to 8	Very high risk

Clinical Assessment Protocols (CAPs) Produced by the Palliative Care Assessment

Clinical Assessment Protocols (CAPs) can be used to inform caregivers and guide comprehensive care and service planning for persons near the end of life.

They identify the areas for focus:

- Specific aspects of a person's function
- Quality of life
- Focus on a person's needs, strengths and preferences
- Potential for change

Although the interRAI PC CAPs review a number of the most common conditions experienced by persons near the end of life, they do not address all such conditions. When a troubling symptom is present other than those identified within the CAPs, appropriate professional advice should be sought to address the condition.

The goal of the palliative care provider is to use the information provided in the CAP guidelines to consider options, and to ultimately create a responsive plan of care. Wherever possible, the preferences and the priorities of the person and the caregivers should be the starting point for developing a person centred care plan.

When care planning for the CAPs triggered, consideration should be given to: the severity of the symptoms; the overall clinical status of the person and the person's/Whanau's preference for care.

Number	CAP	Overall Goals of Care for this CAP
1	Delirium	• Monitor and address delirium symptoms and related issues, such as pulling out tubes and unsafe activity • Prevent secondary complications such as those associated with falls, dehydration and the unnecessary use of psychotropic drugs • Maximise comfort and quality of life
2	Dyspnoea	• Determine the severity of the symptom and the need for emergency intervention • Determine the cause(s) and address them to the extent possible • Optimise the person's ability to be comfortable at all times and to perform activities of daily living
3	Fatigue	• Determine the degree to which fatigue is a burden to the person • Eliminate or reduce the causes of fatigue, such as pain, dyspnea, depression, severe anemia
4	Mood	• Identify and address any immediate threats to the person's well-being posed by depression/anxiety • Improve the person's psychological well-being to support engagement and participation in end-of –life decision making
5	Nutrition	• Ensure that the person and caregivers understand the unique issues and conditions related to nutrition in palliative care • Reduce anxiety about not eating / alleviate hunger • Optimise energy and protein intake
6	Pain	• Relieve suffering to the maximum extent possible • Optimise the person's ability to be comfortable at all times and to perform ADLs • Monitor treatment efficacy and adverse effects and make appropriate adjustments to the therapeutic regime
7	Pressure Ulcer	• Educate informal support members on preventative methods to reduce the risk of pressure ulcers, to the extent possible • Treat appropriately all existing pressure ulcers, including the management of drainage, elimination of odour and address any associated pain.
8	Sleep Disturbance	• Determine the underlying causes • Reduce the sleep disturbance • Maximise the person's comfort and function