



**SERVIZIO SANITARIO REGIONALE**

**EMILIA-ROMAGNA**

**Azienda Unità Sanitaria Locale di Bologna**

Dipartimento dell'Integrazione

UOC Rete delle Cure Palliative

Direttore: dott.ssa Danila Valenti

DATeR: Processo assistenziale nelle Cure Palliative

Responsabile: dott. Fabrizio Moggia

**Istituto delle Scienze Neurologiche**

**Istituto di Ricovero e Cura a Carattere Scientifico**

## **TOOL FOR SHARING CLINICAL AND CARE PATHWAYS BETWEEN PROFESSIONALS WORKING IN HOSPITAL AND PALLIATIVE CARE SERVICES CARING FOR COVID-19 POSITIVE PATIENTS**

### **RISK FACTORS FOR INCREASED MORTALITY**

#### **Comorbidity:**

Cardiovascular disease	Yes	No
Diabetes mellitus	Yes	No
Chronic respiratory disease	Yes	No
Cancer	Yes	No

### **CLINICAL ISSUES**

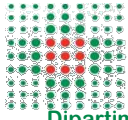
Dyspnoea at rest and/or when speaking	Yes	No
Respiratory rate > 22 breaths/min	Yes	No
PaO <sub>2</sub> < 65 mmHg or SpO <sub>2</sub> < 90%	Yes	No
Radiological evidence of worsening	Yes	No
Organ failure or dysfunction	Yes	No
Deterioration in laboratory tests	Yes	No

### **ONGOING DRUG TREATMENT**

Antiviral	Yes	No
Immunosuppressive	Yes	No
Monoclonal antibody	Yes	No
Chloroquine	Yes	No
Morphine	Yes (dose.....)	No
Other		

### **LIFE SUPPORT MEASURES**

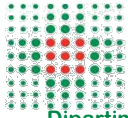
Respiratory	Yes	No
Haemodynamic support	Yes	No
Renal support	Yes	No



**COMMUNICATION**

- |  |     |    |
|--|-----|----|
| 1. Can the patient communicate independently?  | Yes | No |
| 2. Is the patient aware about his/her condition and/or have they asked to be kept personally informed? | Yes | No |
| 3. Has the patient asked for relatives to be informed about his/her clinical condition?                | Yes | No |

<b>BASIC INFORMATION</b>	<b>Physical examination:</b>					
	Pain: Yes No			Urinary incontinence: Yes No		
	Agitation: Yes No			Urinary catheter: Yes No		
	Nausea: Yes No			Faecal incontinence: Yes No		
	Vomiting: Yes No			Constipation: Yes No		
	Dyspnoea: Yes No			Expectorating independently: Yes No		
	Swallowing independently: Yes No			Other: .....		
	The patient is:					
Confused		Yes	No	Semi-conscious		Yes No
Conscious		Yes	No	Unconscious		Yes No



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<b>PSYCHOLOGICAL SUPPORT</b>	<p><b>GOAL 1: Has the psychologist on the multidisciplinary team been asked to attend?</b></p> <p><b>GOAL 2: Has the patient been offered support from the psychologist?</b></p> <p><b>GOAL3: Have the patient's family members/carers been offered support from the psychologist?</b></p> <p><b>GOAL 4: Have the health care team been offered support from the psychologist?</b></p>
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<b>TREATMENT</b>	<p><b>GOAL 1: Was treatment prescribed for the following symptoms, which may occur in the final hours/days of the patient's life?</b></p> <p>Pain <input type="checkbox"/></p> <p>Agitation <input type="checkbox"/></p> <p>Secretion management/suction <input type="checkbox"/></p> <p>Nausea/vomiting <input type="checkbox"/></p> <p>Dyspnoea <input type="checkbox"/></p> <p>Planning of treatment prevents delays in administering drugs if symptoms appear. Treatment can be discontinued if considered unnecessary.</p>
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<b>ONGOING INTERVENTIONS</b>	<b>GOAL 1: Ongoing interventions have been re-assessed and adjusted by the health care team: YES <input type="checkbox"/> PARTIALLY <input type="checkbox"/> NO <input type="checkbox"/></b>				
		Not currently appropriate (do not perform/ administer)	Discontinued Date..... Time.....	Ongoing Date..... Time.....	Started
	Routine blood tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	IV antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Monitoring of vital signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Artificial nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Administration of fluids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diagnostic imaging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Non-invasive ventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Haemodynamic support (inotropes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Renal support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>GOAL 2: The patient has clearly stated that they do not wish to be resuscitated</b>				<b>YES <input type="checkbox"/></b>

Name of doctor who provided the information:.....

Date.....

Signature and stamp.....