

Building medical competences for excellent palliative care

U
UNIVERSITAT DE VIC
UNIVERSITAT CENTRAL
DE CATALUNYA

U **FACULTAT
DE MEDICINA**
UVIC-UCC

**Càtedra
de Cures Pal·liatives**
UVIC-UCC
ICO - INSTITUT CATALÀ D'ONCOLOGIA



MEDICINA DELLA COMPLESSITÀ E BISOGNI DI CURE PALLIATIVE

16 MAGGIO 2023

Aula Magna, Università degli Studi Milano-Bicocca, Edificio Asclepio (ex U8), Monza

Evento gratuito riservato agli studenti e ai medici in formazione specialistica
iscritti presso l'Università degli Studi di Milano-Bicocca



A livello nazionale, l'insegnamento delle Cure Palliative fa oggi parte del Core Curriculum dei Corsi di Laurea in Medicina e Chirurgia e Infermieristica, ed è stata istituita una Scuola di Specializzazione in Cure Palliative. I nostri Corsi di Laurea hanno introdotto questo insegnamento sia nelle attività frontali che nelle attività professionalizzanti di Tirocinio, ed è stata attivata la Scuola di Specializzazione con 8 posti.

Con il Convegno, vogliamo offrirvi una opportunità per avvicinarvi al tema della Medicina della Complessità e delle Cure Palliative, attraverso l'ascolto delle parole di alcuni dei maggiori esperti del settore e attraverso un momento di discussione che metta a confronto il punto di vista del bisogno formativo con quello del ruolo professionale.

PROGRAMMA

8.30 - 9.00	SALUTI ISTITUZIONALI Giovanna Iannantuoni, Pietro Invernizzi, Andrea Biondi, Francesca Crippa Floriani, Daniele Lorenzet	10.40 - 11.10	PAUSA
9.00 - 10.40	APERTURA LAVORI - L'età da inventare: vecchiaia e fragilità Mons. Vincenzo Paglia - Rispondere al bisogno di cure palliative: valori, attitudini e comportamenti professionali Xavier Gomez-Batiste - Medicina della complessità: metodi e strumenti Graziano Onder Moderano: Giuseppe Belliello, Gianlorenzo Scaccabarozzi e Paolo Mazzola	11.10 - 13.15	QUESTIONS & ANSWERS - Esiste un bisogno di conoscere le cure palliative nella formazione dei professionisti sanitari? Andrea Paleari, Stefania Spinedi, Michele Gaggini - Quale ruolo dello specialista in Medicina e Cure palliative negli ospedali e sul territorio? Silvana Casazza, Paolo Favini, Marco Trivelli Moderano: Maria Cristina Messa, Maria Carla Gilardi
		13.15 - 13.45	CONCLUSIONI E FINE DEI LAVORI

- 1. Reasons**
- 2. Building the model**
- 3. Using the model**
- 4. Evaluation**
- 5. Specific competences**

FONDAZIONE FLORIANI FORMAZIONE



- Chair of Palliative Care 2013: 1st in Spain
- Professorship Palliative Care: only two in Spain

Chair ICO/UVIC-UCC of palliative care at the University of Vic – Central University of Catalonia: an innovative multidisciplinary model of education, research and knowledge transfer

Xavier Gómez-Batiste,^{1,2,3} Cristina Lasmarías,^{1,2,3} Jordi Amblàs,^{1,3} Xavier Costa,^{1,3,4} Sara Ela,^{1,2} Sarah Mir,^{1,3} Agnès Calsina-Berna,^{1,5} Joan Espauella,^{1,3} Sebastià Santaugènia,^{3,6} Ramon Pujol,¹ Marina Geli Geli,⁷ Candela Calle⁸

► Additional material is published online only. To view please visit the journal online (<http://dx.doi.org/10.1136/bmjspcare-2018-001656>).

For numbered affiliations see end of article.

Correspondence to Dr Xavier Gómez-Batiste, Director Chair in Palliative Care, Centre for Health and Social Care Research (CESS), University of Vic-Central University of Catalonia (UVic-UCC), Vic 08500, Spain; xgomez.WHOCC@iconcologia.net

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ABSTRACT

Objectives Generation and dissemination of knowledge is a relevant challenge of palliative care (PC). The Chair Catalan Institute of Oncology (ICO)/University of Vic (UVic) of Palliative Care (CPC) was founded in 2012, as a joint project of the ICO and the University of Vic/Central of Catalonia to promote the development of PC with public health and community-oriented vision and academic perspectives. The Initiative brought together professionals from a wide range of disciplines (PC, geriatrics, oncology, primary care and policy) and became the first chair of PC in Spain. We describe the experience of the CPC at its fifth year of implementation.

Methods Data collection from annual reports, publications, training and research activities.

Results Results for period 2012–2017 are classified into three main blocks: (1) Programme: (a) The advanced chronic care model (Palliative needs (NECPAL)); (b) the psychosocial and spiritual domains of care (Psychosocial needs (PSICPAL)); (c) advance care planning and shared decision making (Advance care planning (PDAPAL)); and (d) the compassionate communities projects (Society involvement (SOCPAL)). (2) Education and training activities: (a) The master of PC, 13 editions and 550 professionals trained; (b) postgraduate course on psychosocial care, 4 editions and 140 professionals trained; and (c) workshops on specific topics, pregraduate training and online activities with a remarkable impact on the Spanish-speaking community. (3) Knowledge-transfer activities and research

projects: (a) Development of 20 PhDs projects; and (b) 59 articles and 6 books published.

Conclusion Being the first initiative of chair in PC in Spain, the CPC has provided a framework of multidisciplinary areas that have generated innovative experiences and projects in PC.

INTRODUCTION

Training and education in palliative care (PC) is essential in the development of quality PC provision and major points of a Palliative Care Public Health Programme.¹ In 1992, the PC service at the Catalan Institute of Oncology (ICO) in Barcelona—a monographic cancer institute—developed its own training strategy, implementing basic and intermediate levels, and the first master's degree in PC started in 1997, jointly with the University of Barcelona.

Additionally, due to the experience acquired in the implementation of the Catalonia WHO Demonstration Project for Palliative Care and its international impact, there were increasing demands for support for the design, implementation and evaluation of PC services and programme in Spain, Europe and Latin America.² These policy activities, establishing contracts and agreements with public or private organisations, had the support, as main partner, of the Catalan Department of Health.



HYPOTHESIS

The Institut Català d'Oncologia Model of Palliative Care: An integrated and comprehensive framework to address the essential needs of patients with advanced cancer

Jorge Maté-Méndez, Jesús González-Barboteo, Agnès Calsina-Berna, Dolors Mateo-Ortega, Núria Codorniu-Zamora, Joaquín T. Limonero-García, Jordi Trelis-Navarro, Gala Serrano-Bermúdez, and Xavier Gómez-Batiste

X Gómez-Batiste (corresponding author): Department of Palliative Care, University of Vic, Vic and QUALY Observatory/WHO Collaborating Center for Public Health Palliative Care Programs, Institut Català d'Oncologia, Avinguda de la Gran Via de l'Hospitalet, 199-203, L'Hospitalet de Llobregat, Barcelona, Spain; xgomez.whocol@iconcologia.net

J Maté-Méndez: Psycho-oncology Unit, Institut Català d'Oncologia, L'Hospitalet de Llobregat and Research Group on Stress at Faculty of Psychology, Universitat Autònoma de Barcelona, Bellaterra, Spain; **J González-Barboteo**, **A Calsina-Berna**: Palliative Service, Institut Català d'Oncologia, L'Hospitalet de Llobregat and Department of Palliative Care, University of Vic, Barcelona, Spain; **D Mateo-Ortega**: Department of Palliative Care, University of Vic and QUALY Observatory/WHO Collaborating Center for Public Palliative Care Programs, Institut Català d'Oncologia, L'Hospitalet de Llobregat, Barcelona, Spain; **N Codorniu-Zamora**, **G Serrano-Bermúdez**: Palliative Care Service, Institut Català d'Oncologia, L'Hospitalet de Llobregat, Barcelona, Spain; **JT Limonero-García**: Research Stress and Health, Faculty of Psychology, Universitat Autònoma de Barcelona, Bellaterra, Spain; **J Trelis-Navarro**: Institut Català L'Hospitalet de Llobregat, Barcelona, Spain



Contexto y modelo de competencias personales y profesionales de excelencia

Valores y comportamientos excelencia: hospitalidad, empatía, compasión, compromiso, presencia, honestidad, congruencia

Atención necesidades esenciales: espiritualidad, relaciones clave, dignidad, autonomía, esperanza, ...

Clinica:
evaluación,
planificación
terapéutica,
etc..

Comunicación /
Emocional /
Counselling

Ética/
Planificación
decisiones
avanzadas

Continuidad /
Gestión caso
Atención
integrada

Cooperación
Trabajo
equipo

5 Competencias básicas

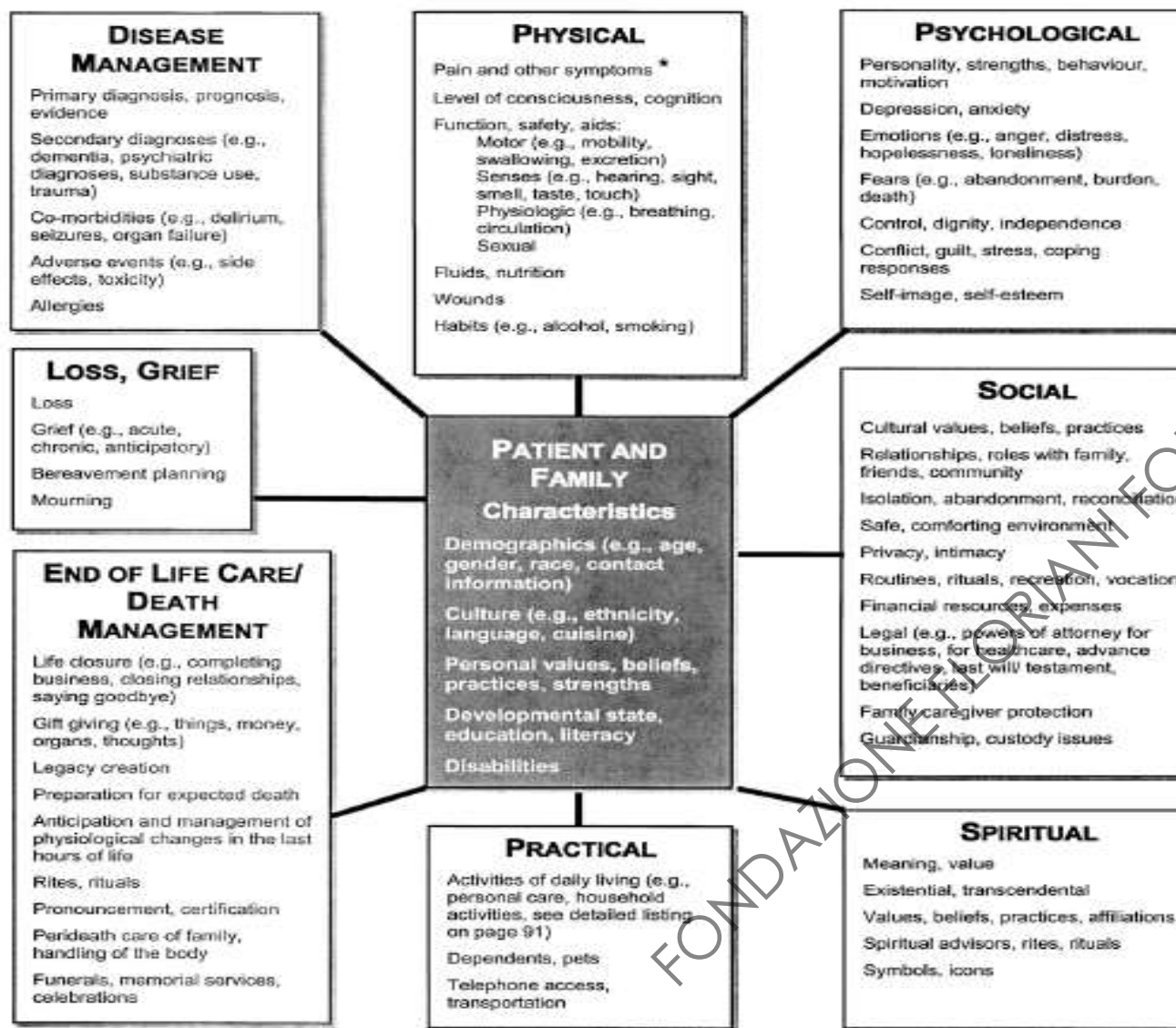
Valores y comportamientos personales: educación y respeto

Contexto Organizacional : Valores, liderazgo, equipo, trabajo en red

Valores sociales y políticas: derechos humanos, Cobertura universal, Acceso, equidad, calidad,

Compromiso ético máximo

Maté-Méndez J, González-Barboteo J, Calsina-Berna A, Mateo-Ortega D, Codorniu-Zamora N, Limonero-García JT, Trelis-Navarro J, Gómez-Batiste X. The Institut Català d'Oncologia Model of Palliative Care: An integrated and comprehensive framework to address the essential needs of patients with advanced cancer. J Palliat Care 2013; 29(4): 237-243



* Other common symptoms include, but are not limited to:

Cardio-respiratory: breathlessness, cough, edema, hiccups, apnea, agonal breathing patterns

Gastrointestinal: nausea, vomiting, constipation, obstipation, bowel obstruction, diarrhea, bloating, dysphagia, dyspepsia

Oral conditions: dry mouth, mucositis

Skin conditions: dry skin, nodules, pruritus, rashes

General: agitation, anorexia, cachexia, fatigue, weakness, bleeding, drowsiness, effusions (pleural, peritoneal), fever/chills, incontinence, insomnia, lymphoedema, myoclonus, odor, prolapse, sweats, syncope, vertigo

A Model to Guide Patient and Family Care: Based on Nationally Accepted Principles and Norms of Practice

Frank D. Ferris, MD, Heather M. Balfour, BA (Adv), Karen Bowen, MD,
Justine Farley, MD, Marsha Hardwick, RN, BScN, CON(C),
Claude Lamontagne, MD, Marilyn Lundy, RN, PHN,
Ann Syme, RN, MSN, and Pamela J. West, RN, MSc, ACNP, CON(C)

Fig. 2. Issues common to illness and bereavement.

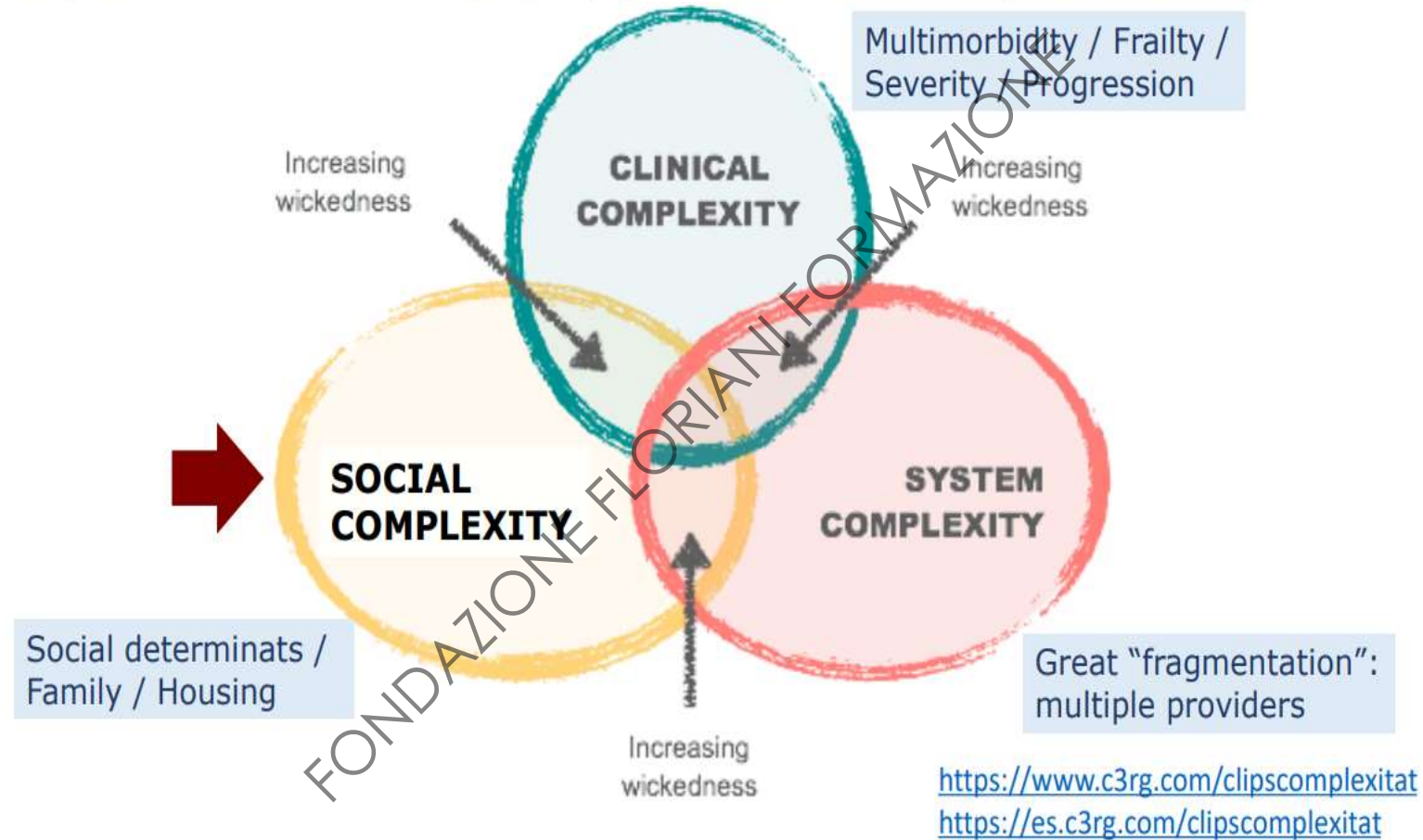


Conditions to live in peace the end of life (Expert's group WHOCC / Chair)

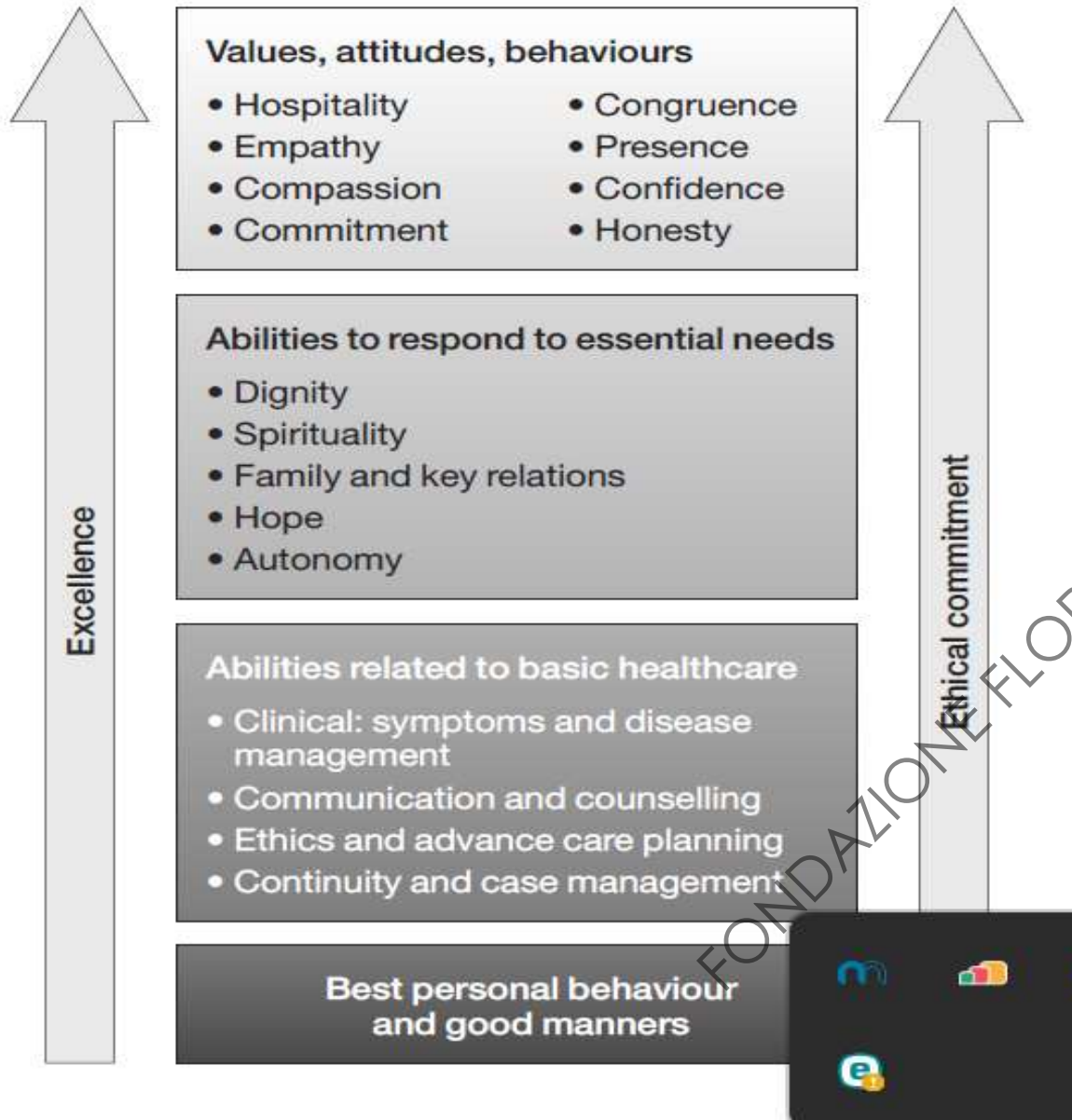
- Spirituality, transcendence, beliefs, values, meaning of life, connection with God, to Self, to Nature
- Love, support, company of beloved (family and friends), social support and relations
- Legacy: family, heritage, professional, society
- Autonomy and control on decisions: placement, treatment choices, service choice
- Personal and behavioral resources: hope, positive thinking, optimism, humor, generosity
- General resources: context, security, economic, ...
- Symptom control
- Guarantee and access to good care



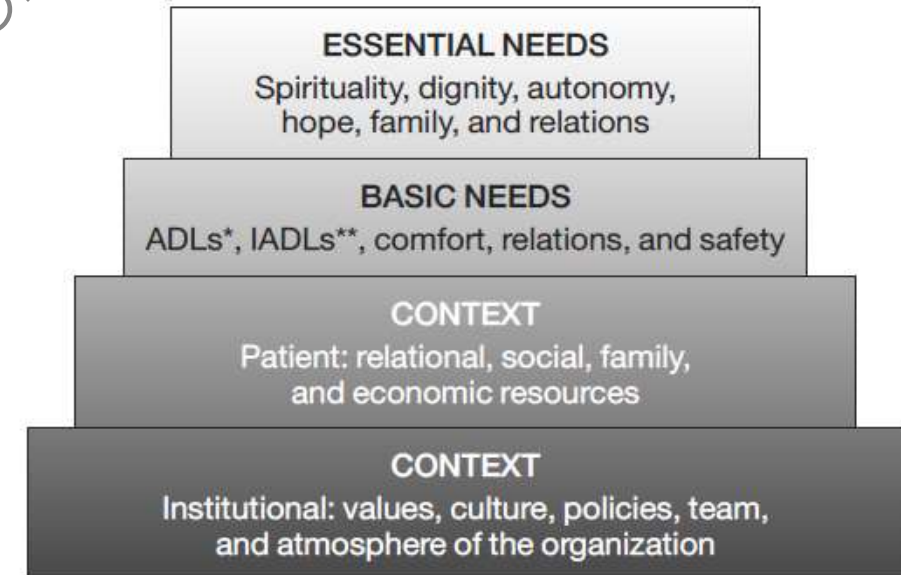
Conceptual model of complexity (the second conceptualization)



Adapted by **Jordi Amblas** of Kuipers P et al. Complexity and Health care: health practitioners' services, roles, skills and training, to respond to patients with complex needs (2011)



**“Basic”
vs/+
“Essential”
needs**



* Activities of daily living.

** Instrumental activities of daily living.

Essential needs:

- Spirituality
 - Dignity
 - Autonomy
 - Love and care
 - Hope
- +
- Security



Basic concepts

- **Values:** principios que rigen presiden la actuación y comportamiento (humanismo, respeto, compromiso, generosidad, honestidad, transparencia, integridad, congruencia...)
- **Aptitudes:** personales innatas (creatividad, persuasión, flexibilidad, ...)
- **Attitudes:** cómo responder a situaciones o retos (compromiso, dedicación, ...)
- **Skills:** capacidad de realizar tareas
- **Behaviours:** conjunto de respuestas en relación con entorno (lo que los otros ven o reciben), relacionado con anteriores
- **Competencies:** el conjunto de aptitudes, actitudes, habilidades y comportamientos para realizar función o tarea

Antecedentes y Modelos



A. Maslow, (1943)	Jerarquía de Necesidades (5): El 5ª nivel; la autorrealización o nivel de plena felicidad o armonía.
C. Saunders (1964)	Modelo de atención multidimensional: "DOLOR TOTAL"
E. Casell (1982)	"Los que sufren no son los cuerpos, son las personas"
I. Yalom (1984)	4 preocupaciones existenciales básicas: ➤ Muerte – Libertad – Soledad – Ausencia de Sentido V
A. Stedeford (1984)	Modelo circular de adaptación al Cáncer // Crisis de Conocimiento.
G Twycross (1990)	Dimensiones del Dolor: "moduladas por el <i>ánimo, la moral y el significado</i> ". Introduce el factor de percepción e impacto como clave en la percepción subjetiva del dolor.
D. Callahan (2000)	Tan importante como curar a las personas es conseguir que mueran en paz

R. Bayés, P. Arranz, P. Barreto y J. Barbero, (1996)	Modelo "AMENAZAS-RECURSOS"
Diego Gracia (2001)	Desarrolló el Método deliberativo y método del "sándwich" para la discusión y resolución de los dilemas éticos
F. Ferris (2002)	Cuadro de Cuidados y de intervención sistemática (<i>Square of Care</i>): 10 dimensiones
W. Breitbart (2003)	Psicoterapia centrada en el Significado, derivada de los conceptos de Sentido y Significado V. Frankl. → objetivo: Aceptar la Muerte
HM. Chochinov (2002)	Dignity Therapy: Los componentes del modelo "A, B, C, y D" del cuidado centrado en la dignidad – actitud, comporta-miento , compasión y diálogo → LEGADO
C Puchalski (2000+)	Espiritualidad / FICA / Consensus / International project
Grupo de San Diego	Propone 4 dimensiones que permiten afrontar y aceptar el proceso de morir en paz: Sentido – Paz y Perdón – Relaciones y Esperanza
Van Roen,/Von Gunten	Reframing Hope

Table 4 / Definitions of Attitudes, Values, and Behaviours Related to Palliative Care Excellence

Hospitality	The ability to create a context in which to offer patients a sense of safety, confidence, and comfort.
Empathy	The capacity to perceive, understand, appreciate, and share the affective, cognitive, existential, and experiential components of patients' needs and to express this within the therapeutic relationship.
Compassion	Empathy applied to sharing and understanding patient suffering.
Commitment	Interest in and involvement with the patient, characterized by the phrase "You matter"; availability and accessibility.
Confidence	The result of applying all of the behaviour patterns and emphasizing the role of the reference professional, who acts as an advocate for patients, especially in situations when difficult decisions must be made.
Congruence	Coherence between explicitly expressed — in verbal, nonverbal, and emotional language — personal feelings and values.
Presence	Active attention and active listening.

FONDAZIONE FIORIANI FORMAZIONE



Table 1 / Recommended Attitudes and Behaviours of Healthcare Professionals toward Patients at the First Meeting

1.	Introduce yourself, your colleagues or team members, and your service.
2.	Always be formally respectful in verbal and nonverbal personal exchanges.
3.	Always ask for permission to question or explore, to enter the room, and so on ("Do you mind if...?").
4.	Establish the objective and the purpose of the visit/consultation.
5.	Guarantee the patient privacy and intimacy, especially when conducting more serious conversations or explorations.
6.	Start with general, open, noninvasive questions.
7.	Always conclude by asking the patient if he or she has any doubts, has understood the information provided, or feels that there is something more that can be done by you and your colleagues or team members.
8.	Always clarify the decisions that have been made and the follow-up that is proposed.

Table 3 / Key Questions for Exploring Essential Needs

1.	"How do you feel?"
2.	"How do you see the current status of your condition?"
3.	"What are you worried about?"
4.	"How do you think things might go in the future?"
5.	"What helps you to cope with this situation?"
6.	"What would you like us to do for you?"

Table 2 / Steps to Exploring and Covering Patients' Essential Needs

1.	Create a context in which to enact basic personal interactions and care competence: privacy, safety, comfort, symptom control, communication, active listening, counselling, ethical decision making, advance care planning, and case management and continuity.	6.	Explore the quality of family and social relationships and promote high-quality relationships.
2.	Start to gradually, gently, and slowly explore by asking open questions.	7.	Promote and explore reflection on unfinished business, forgiveness, and guilt.
3.	Establish a common language, understanding, and goal orientation; ensure that the patient has confidence in the relationship.	8.	Promote and explore religious expression and practice.
4.	Explore the information on, the experience of, and the meaning of the disease; explore the patient's adjustment to the disease.	9.	Review and readjust goals, language, and expectations in order to prevent misunderstandings and promote hope.
5.	Promote and explore a life review; identify goals, meaning, values, beliefs, legacy, and previous crises and experiences.	10.	Prevent crises and explore decision-making scenarios.
		11.	Offer and guarantee support and accessibility.

Source: Adapted from Breitbart W (24); Chochinov HM, Hack T, McClement S, et al. (26); Gómez-Batiste X, Buisan M, Gonzalez MP, et al. (41); Walling A, Lorenz KA, Dy SM (53); Von Roenn JH, von Gunten CF (54).

Competencies at the Faculty of Medicine University of Vic / Central Catalonia

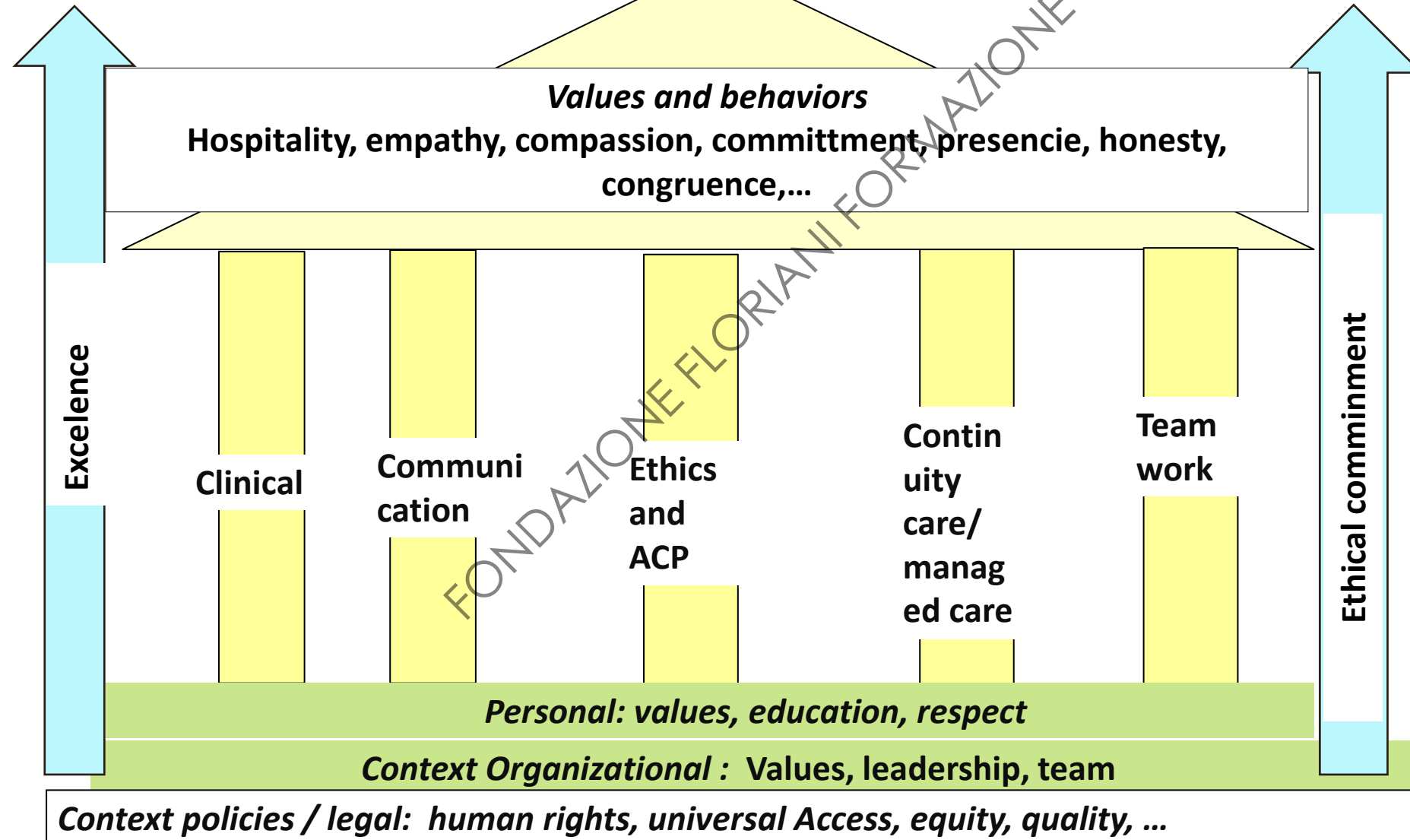


- “The job of the doctor of excellence”:
 - 2nd year:
 - compulsory
 - 60 hours
 - 3 parts: “ufizio da medico”: values and behaviours, instruments to do so (communication, ethical decisions, uncertainty, spirituality, care of the family, complex decisions, spirituality, teamwork, ...) , and the doctor within the system
- Palliative care:
 - 3-4th years, 50 hours
- End of life workshops in every specialty



**The ICO Model of professional competences for comprehensive care:
values, knowledge, attitudes, behaviors, ...**

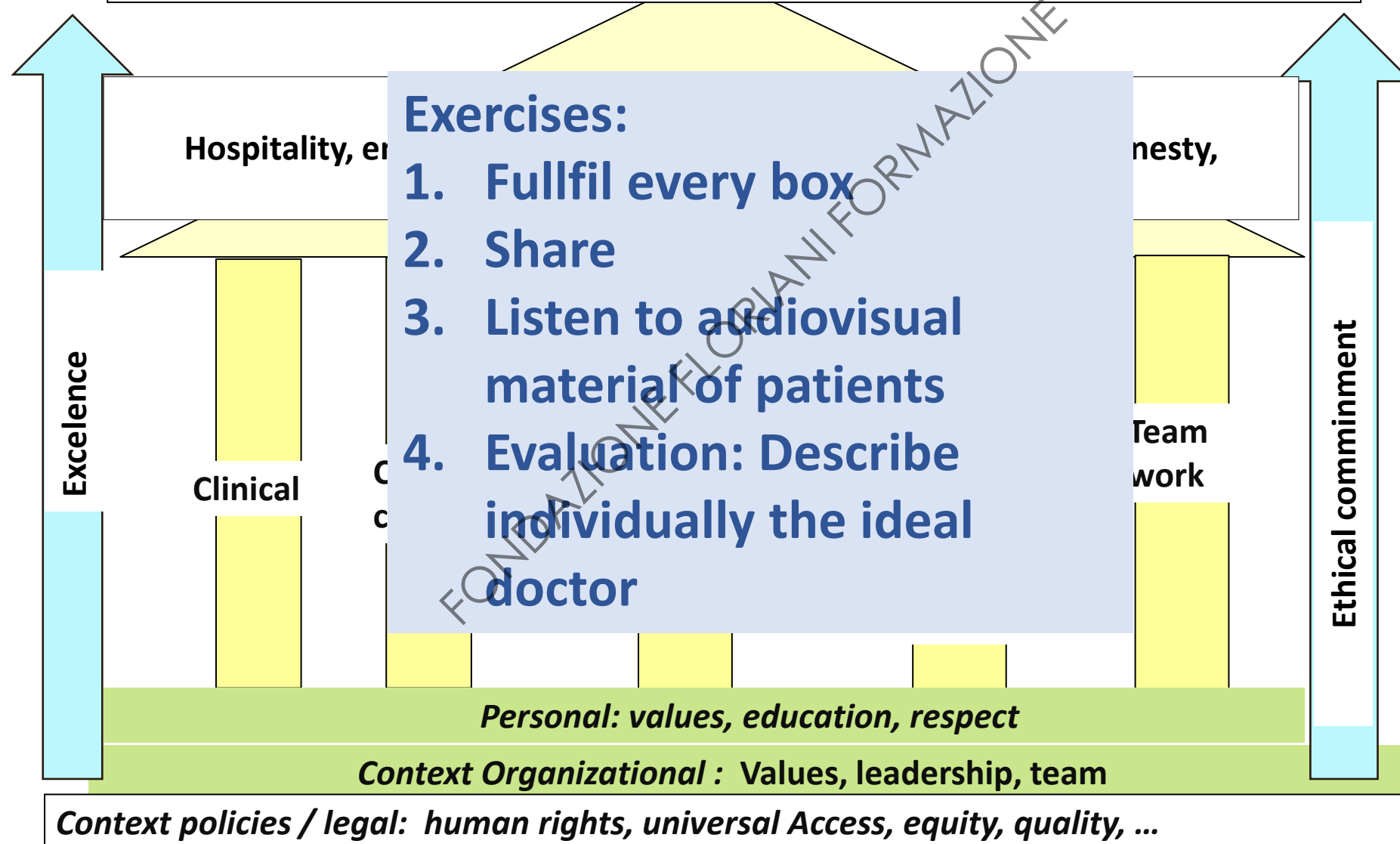
5 “cs”: Competent, Committed, conscious, compassionate, cooperative





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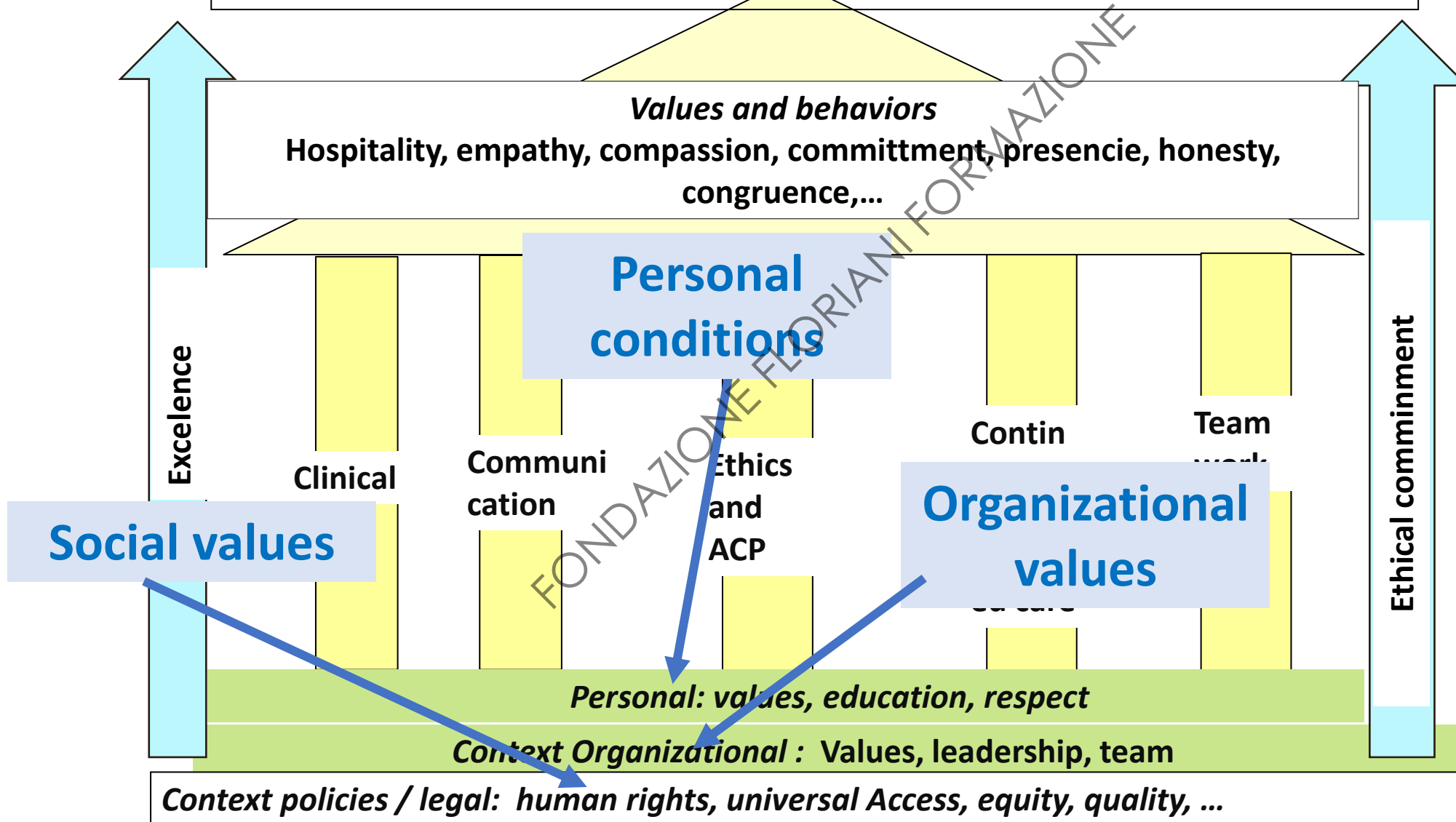
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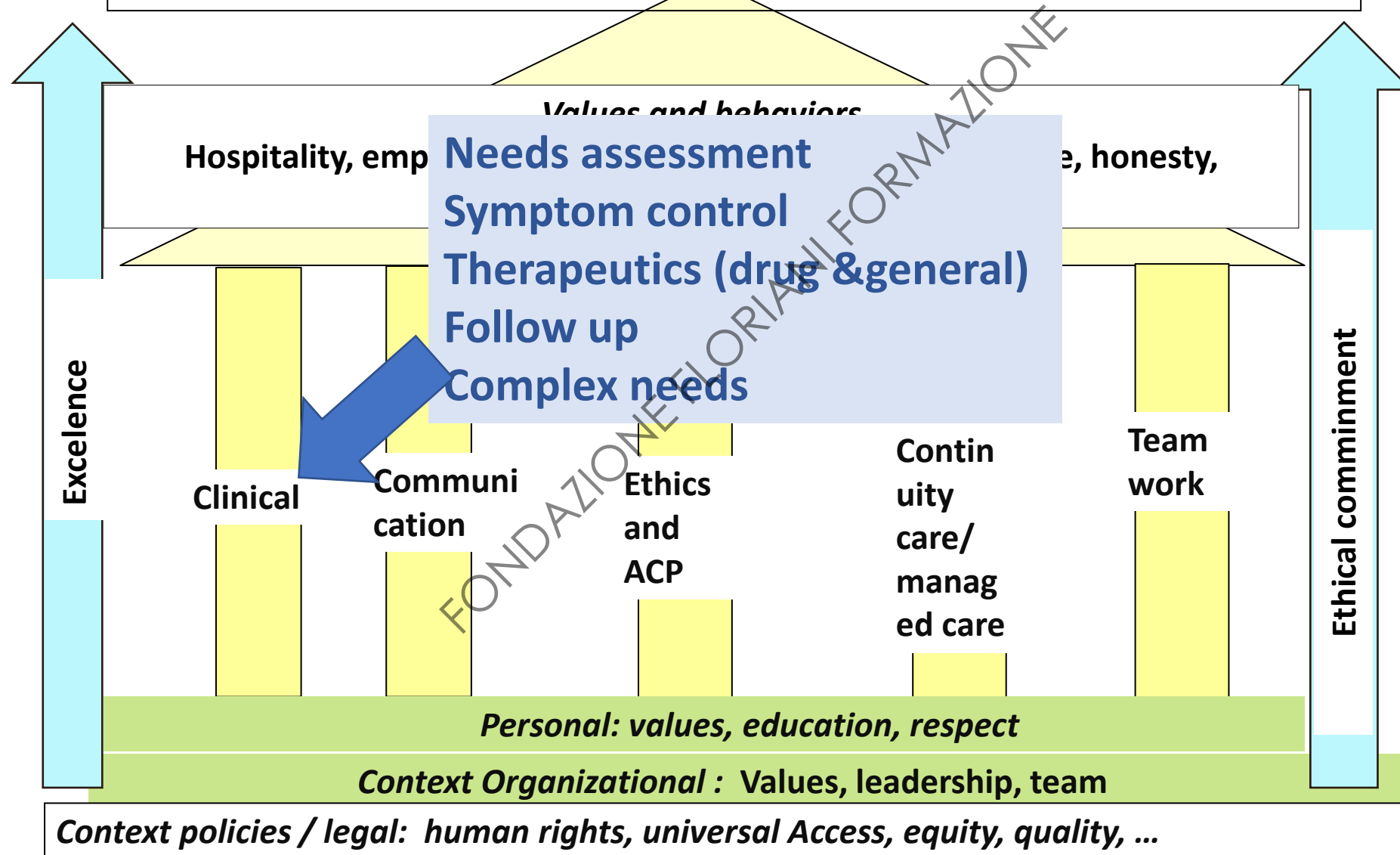
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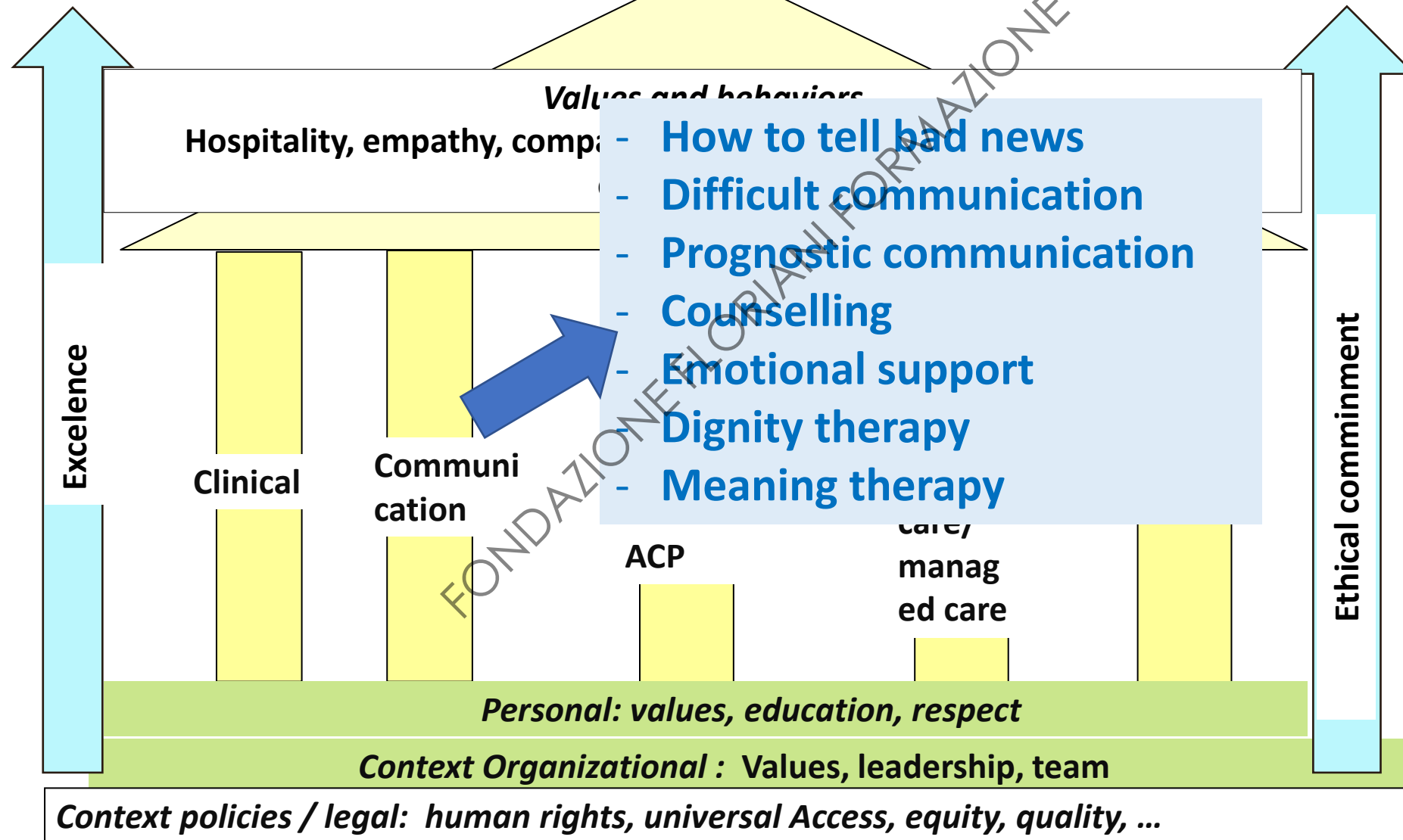
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values, knowledge, attitudes, behaviors, ...**

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The ICO Model of professional competences for comprehensive care: Values, knowledge, attitudes, behaviors, ...

1. Preparación

- Equipo
- Paciente
- Familia

2. Inicio: propuesta / preparación / setting

- Paciente
- Familia
- Equipo

3. Desarrollo: Areas

- Experiencias
- Valores, creencias y recursos
- Conocimiento y vivencia situación
- Percepción evolutiva
- Preocupaciones
- Expectativas,

4. Escenarios

- Situaciones previsibles
- Decisiones

5. Conclusiones

6. Compartir con familia

7. Compartir con equipo

8. Registro

9. Seguimiento

10. Actualización en nuevos escenarios

Committed, conscious, compassionate, cooperative

Values and behaviors

Integrity, compassion, commitment, presence, honesty, congruence,...

Ethics
and
ACP

Contin
uity
care/
manag
ed care

Team
work

Ethical commitment

Personal: values, education, respect

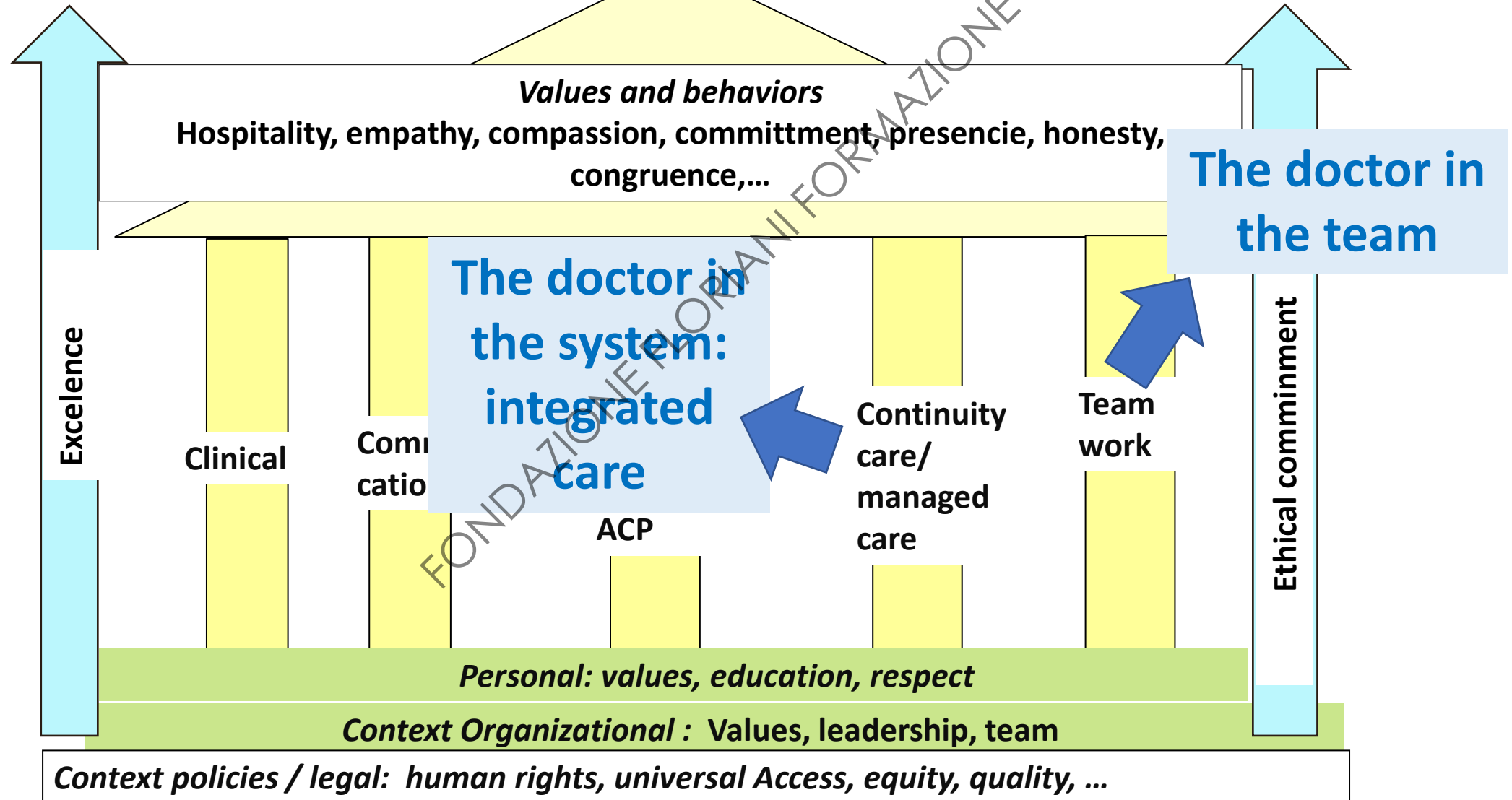
Context Organizational : Values, leadership, team

Context policies / legal: human rights, universal Access, equity, quality, ...



**The ICO Model of professional competences for comprehensive care:
values, knowledge, attitudes, behaviors, ...**

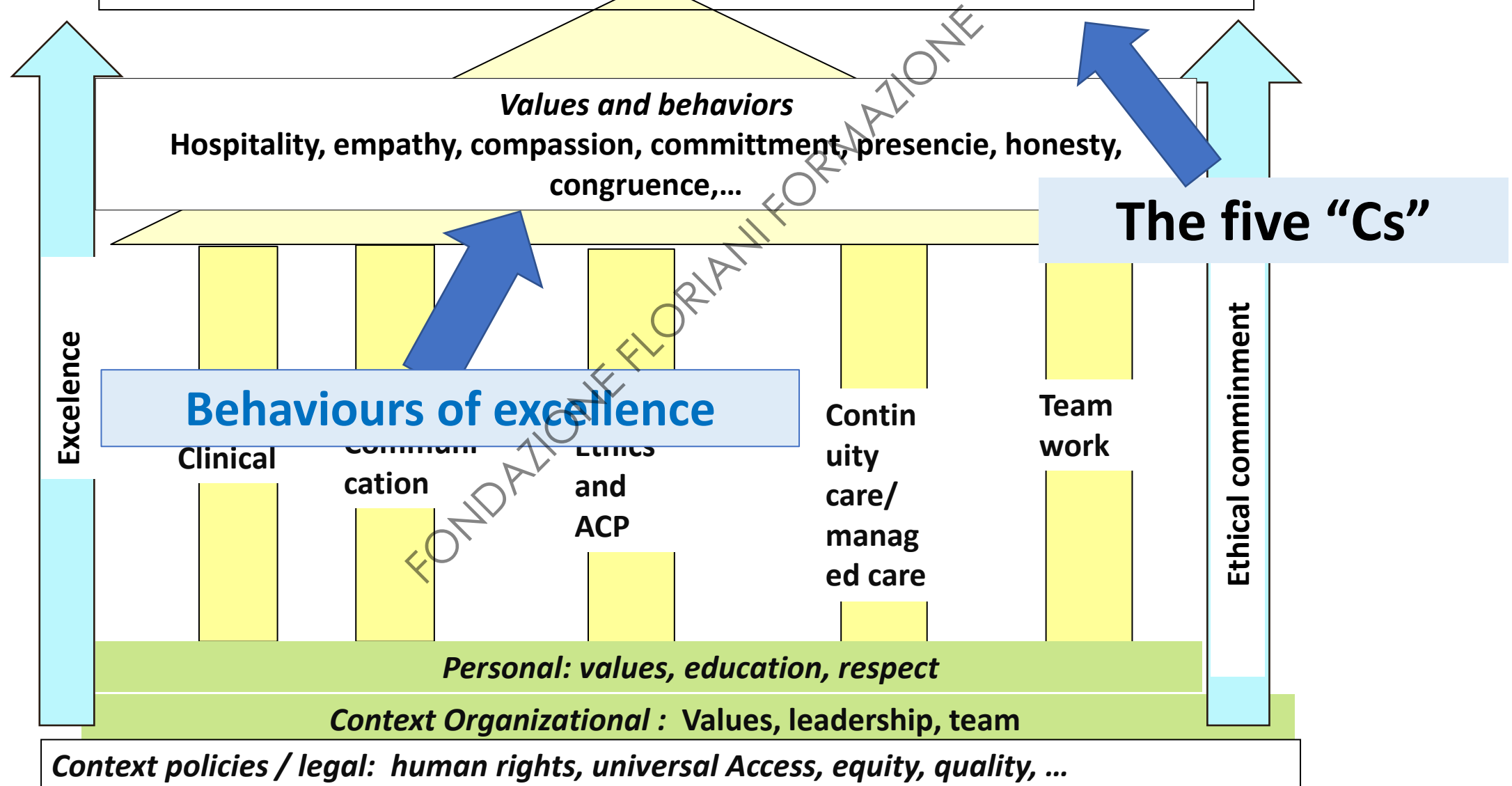
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Conditions to live in peace the end of life (Expert's group WHOCC / Chair)

- Spirituality, transcendence, beliefs, values, meaning of life, connection with God, to Self, to Nature
- Love, support, company of beloved (family and friends), social support and relations
- Legacy: family, heritage, professional, society
- Autonomy and control on decisions: placement, treatment choices, service choice
- Personal and behavioral resources: hope, positive thinking, optimism, humor, generosity
- General resources: context, security, economic, ...
- Symptom control
- Guarantee and access to good care

Learning methodologies and actions: Always combined

- **Knowledge**
- **Technical**
- **Personal experience**
- **Professional experiences**
- **Sharing in the teams**
- **Self-learning**
- **“Modelling”**
- **“Tutorship”**



Estudiantes de 2º Curso Medicina UVIC/UCC construyendo competencias del medico ideal con pacientes, ciudadan@s y profesionales salud

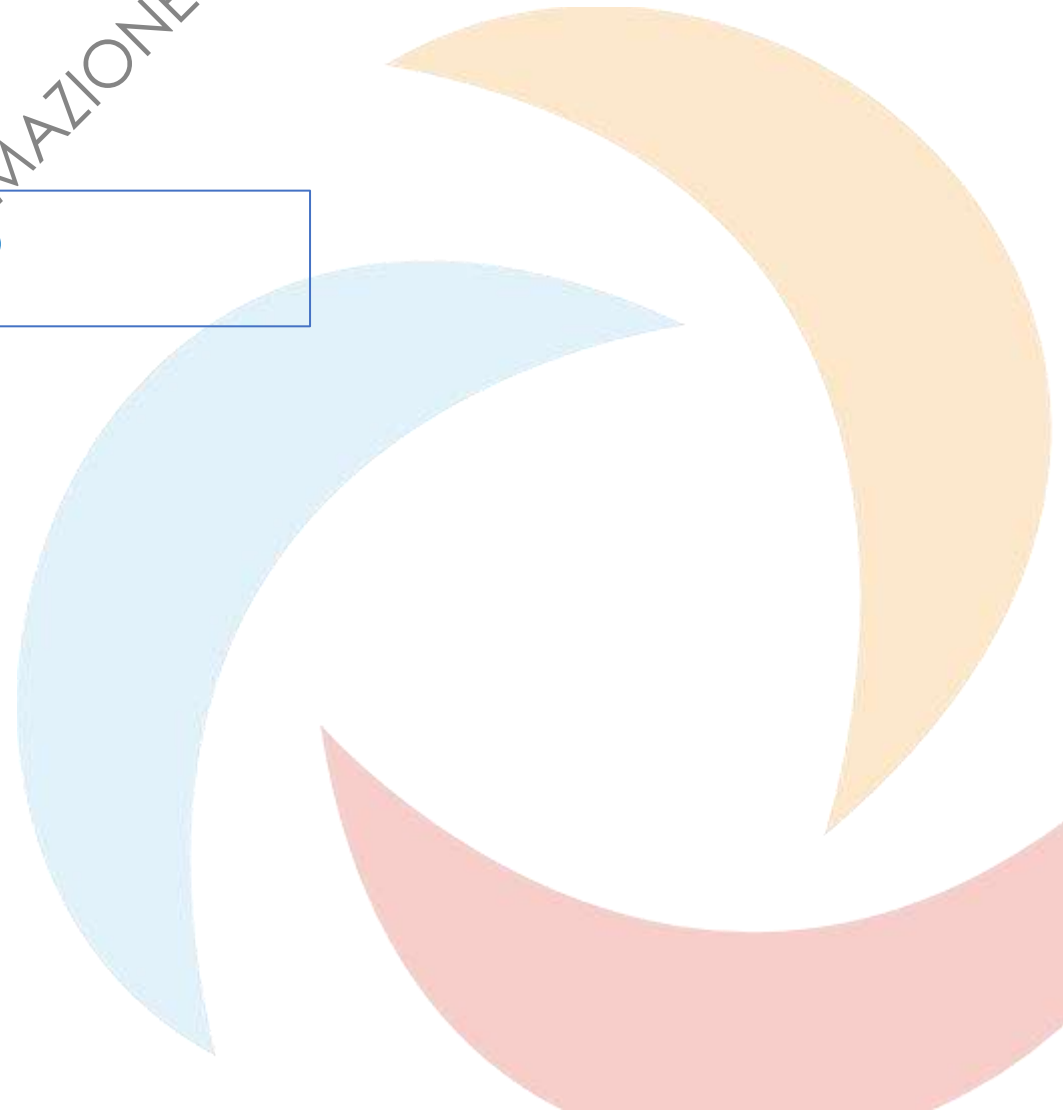
Specific competencies:

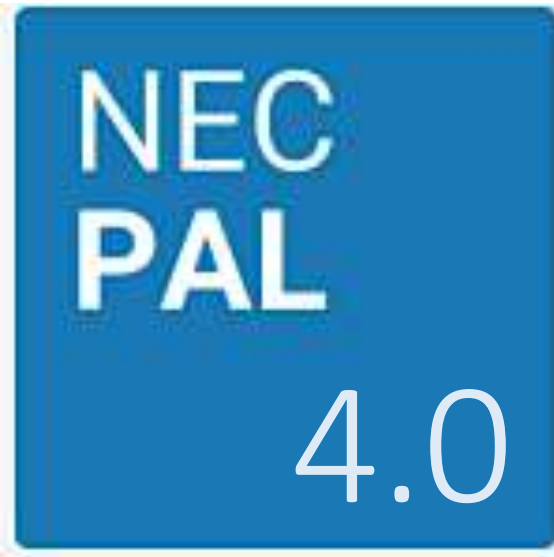
- How to identify
- How to assess needs
- How to look after
- How to improve quality

FONDAZIONE FIORANI FORMAZIONE

How to identify?

FONDAZIONE FLORIANI INFORMAZIONE





From

IDENTIFICATION

of people with palliative care needs

...to the

PROGNOSTIC APPROACH



Xavier Gómez-Batiste, Jordi Amblàs, Pamela Turrillas, Agnès Calsina, Cristian Tebé, Judit Peñafiel



**PRACTICAL RECOMMENDATIONS
FOR IDENTIFYING
AND ESTABLISHING PROGNOSTIC
APPROACH OF PEOPLE WITH
ADVANCED CHRONIC CONDITIONS
AND PALLIATIVE CARE NEEDS
IN HEALTH AND SOCIAL SERVICES
NECPAL 4.0 PROGNOSTIC (2021)**

Authors and researchers: Xavier Gómez-Batiste, Jordi Amblàs,
Pamela Turrillas, Cristian Tebé, Judit Peñafiel, Agnès Calsina,
Xavier Costa, Josep Maria Vilaseca, Rosa Maria Montoliu
Collaboration team: Sarah Mir, Elba Beas, Marina Geli

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 Generalitat de Catalunya
Programa de prevenció i atenció
a la cronicitat

 Generalitat de Catalunya
Pla interdepartamental d'atenció
i interacció social i sanitària



3. IDENTIFICATION OF PARAMETERS WITH PROGNOSTIC VALUE

Original research

NECPAL tool prognostication in advanced chronic illness: a rapid review and expert consensus

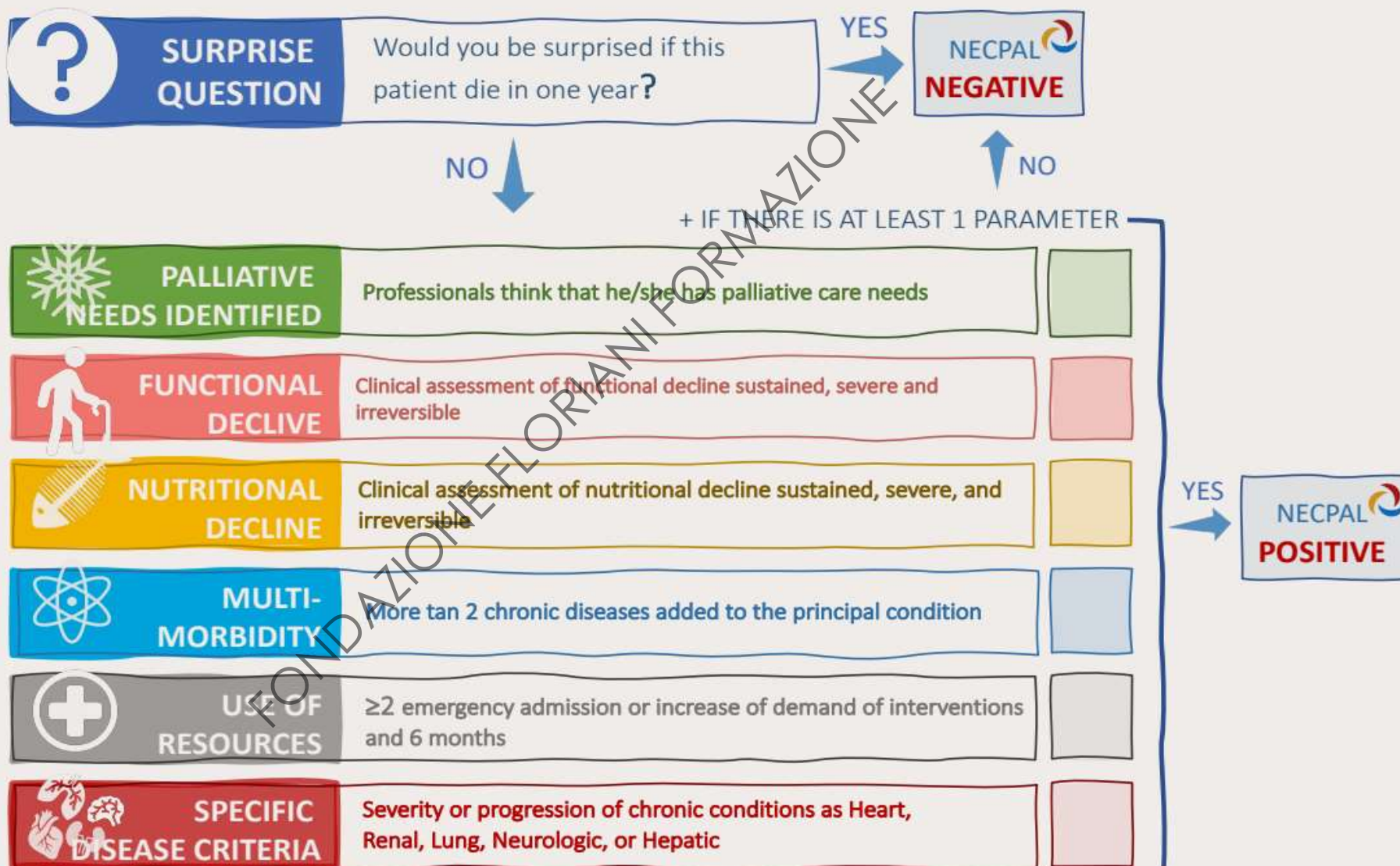
Xavier Gómez-Batiste^{1,2}, Pamela Turrillas^{1,2}, Cristian Tebé³,
Agnès Calsina-Berna^{1,2}, Jordi Amblàs-Novellas^{2,4}

What does this paper add?

- The combination of the Surprise Question and some individual parameters of the NECPAL tool may have potential prognostic utility for mortality in patients with advanced chronic diseases and PCNs.
- Selected parameters might be common prognostic factors for a general model for different clinical conditions and end-of-life trajectories.
- The proposed prognostic tool is intended to be a simple and feasible instrument in daily practice and all clinical settings.

EXPERT'S SELECTED PARAMETERS:

- Surprise question
- Palliative care needs identified by professionals
- Functional decline
- Nutritional decline
- Multimorbidity
- Increase in use/demand of services
- Disease-specific indicators





3. IDENTIFICATION OF PARAMETERS WITH PROGNOSTIC VALUE

Original research

NECPAL tool prognostication in advanced chronic illness: a rapid review and expert consensus

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EXPERT'S SELECTED PARAMETERS:

- Surprise question
- + • Palliative care needs identified by professionals
- Functional decline
- Nutritional decline
- Multimorbidity
- Increase in use/demand of services
- Disease-specific indicators



> **Need's Checklist: Identification of palliative care needs to insert a palliative approach**

1. Realize a rapid checklist of the need's dimensions.
2. Complement with additional indicators and parameters if needed.
3. Elaborate aims and actions to respond to the identified needs.
4. Elaborate a comprehensive therapeutic plan.

The result of this procedure permits to identify palliative care needs and elaborate a comprehensive therapeutic plan:

Actions for the comprehensive care of people identified

1. Multidimensional assessment
2. Assessment of the stage of diseases and conditions and possible evolution
3. Identify values, preferences, and start advance care planning
4. Identify and care principal career
5. Identify and activate referent profesional
6. Multidimensional Therapeutic Plan
7. Case management and integrated care with other services

Two very difficult issues to learn:

1. **Advanced/shared care planning**
2. **Prognostic issues**

Competences needed:

- **Clinical**
- **Ethical**
- **Communication**
- **Case management**

DESCARGA EL PDF CON TODA LA INFORMACIÓN DETALLADA DEL MÓDULO:

How to identify
How to look after
How to improve quality
How talk about prognosis

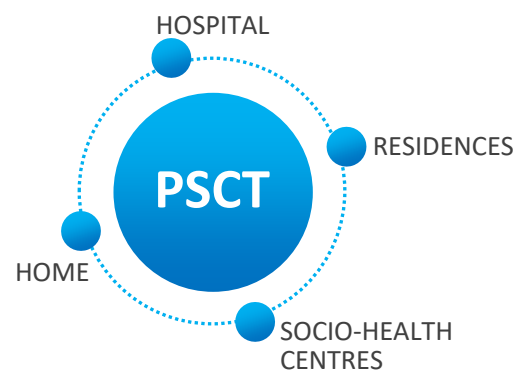
Learning psychosocial and spiritual care and community involvement

FONDAZIONE FLORIANI FORMAZIONE



**COMPREHENSIVE CARE FOR PEOPLE WITH
ADVANCED ILLNESSES**

CURRENT SITUATION OF THE PROGRAM IN SPAIN



65	Psycho-social care teams (PSCT)
135	Health centres
140	Home visit teams
145	Residences

CARE VOLUME



PATIENTS



FAMILY
MEMBERS

2021

29.499

32.917

2022

32.803

37.047

2009-2022
(cumulative)

267,057

346,905

FONDAZIONE FLORIANI FORMAZIONE



4. END OF LIFE AND LONELINESS

END OF LIFE AND LONELINESS PROJECT PROJECT JUSTIFICATION

In Spain, **1,960,900**
people over 65 years
live alone

Source: INE (Spanish National Statistics Institute): 2016

From the age of **65** years, **14.4%** of men and
28.8% of women live alone

From the age of **85** years, **23.9%** of men and
40.2% of women live alone

Source: "A profile of the elderly in Spain". Scientific
Research Council. Human and Social Sciences Centre
(2018).

OBJECTIVE

Relieve the experience of suffering caused by loneliness
in people that are suffering an advanced illness through
accompaniment

*"Avoid the avoidable suffering and
accompany the inevitable suffering"*



CARE VOLUME



ACCOMPANIED
PEOPLE

2021



5.171

2022



5.757

From the start
of the
Programme

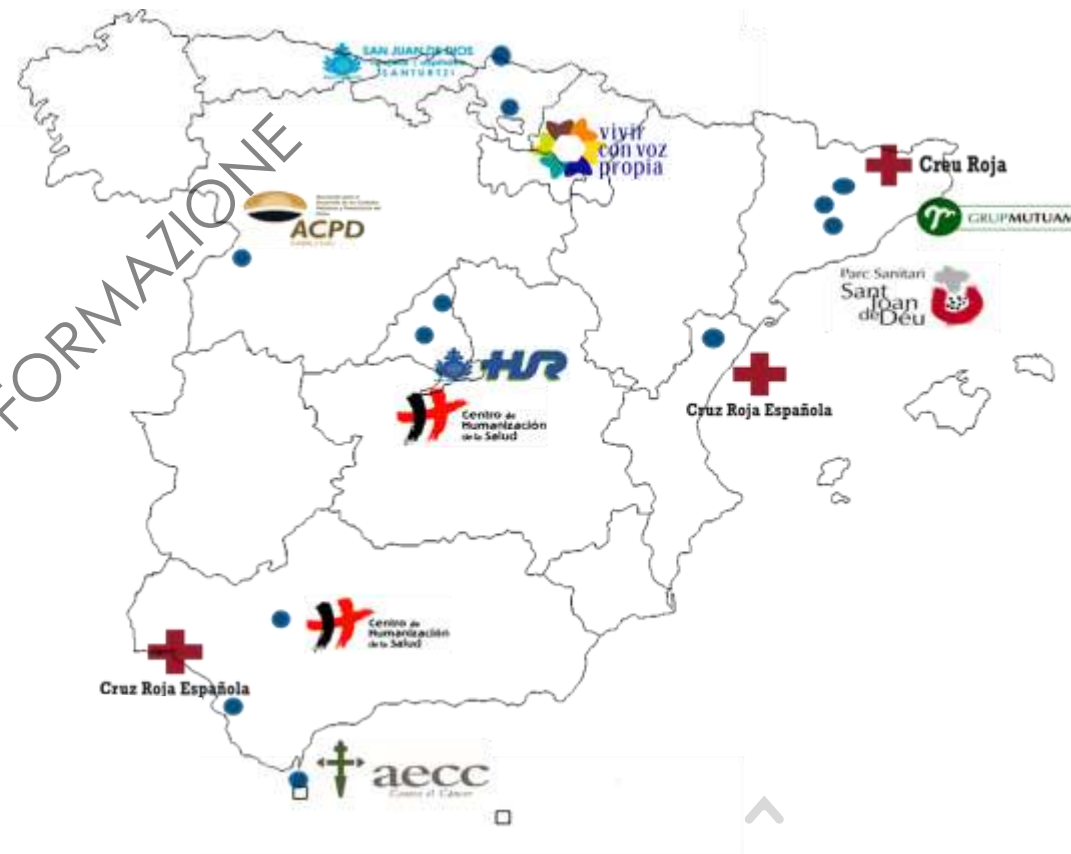


23.084



ACTIVE
VOLUNTEERS

More than 800



13 entities committed to
attention to suffering
generated by the perception
of loneliness at the end of life

Máster en Atención Psicosocial y Espiritual a Personas en Situación de Enfermedad Avanzada



Modalitat
Online

Edició
10ª

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1 de Novembre 2023

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Juny 2024

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1ª EDICIÓN MASTER EN ATENCIÓN PSICOSOCIAL Y ESPIRITUAL A PERSONAS EN SITUACIÓN DE ENFERMEDAD AVANZADA. Octubre de 2023 a Junio de 2024

MODULOS	ECTS	COORDINACIÓN
MÓDULO 1: ASPECTOS GENERALES DE LA SITUACIÓN DE ENFERMEDAD AVANZADA	2	Cruz Sánchez-Julvé
MODULO 2: IMPACTO DE LA ENFERMEDAD AVANZADA EN PACINETE, FAMILIA Y PROFESIONALES	5	Silvia Viel Sinto
MÓDULO 3: INVESTIGACIÓN EN ATENCIÓN PSICOSOCIAL	6	Joaquim T Limonero
MÓDULO 4: EVALUACIÓN E INTERVENCIÓN PSICOLÓGICA Y SOCIAL EN CONTEXTO DE ENFERMEDAD AVANZADA	5	Cruz Sánchez-Julvé
MODULO 5: BIOÉTICA Y NECESIDADES ESPIRITUALES AL FINAL DE LA VIDA	3	Cruz Sánchez-Julvé
MODULO 6: ÉTICA Y ASPECTOS PROFESIONALES ESPECÍFICOS	6	Lori Thompson
MÓDULO 7: INTERVENCIONES PSICOLÓGICAS Y SOCIALES ESPECÍFICAS.	6	Elisabeth Barbero
MÓDULO 8: INTERVENCIÓN BÁSICA Y ESPECÍFICA EN EL PROCESO DE DUELO	6	Silvia Viel Sinto
MÓDULO 9: MODELOS DE ORGANIZACIÓN, LAS INSTITUCIONES, EL ÁMBITO ASISTENCIAL Y LOS EQUIPOS	3	Elisabeth Barbero
MÓDULO 10: INVOLUCRANDO A LA SOCIEDAD Y LA COMUNIDAD EN LA ATENCIÓN AL FINAL DE LA VIDA	3	Xavier Gómez-Batiste
MÓDULO 11: TRABAJO FINAL DE MÁSTER	6	Joaquim T Limonero + Cruz Sánchez-Julvé
MÓDULO 12: PRACTICUM	9	Cruz Sánchez-Julvé
	60	
HORARIO: Miércoles, Jueves y Viernes de 15:30h a 20:30h Sábados de 9h a 14h		AULA ZOOM

MOST SIGNIFICANT FINDINGS



PROFESSIONALS

High **satisfaction and utility** for:

1. Professionals / teams (4/5)
 2. Advisers and planners
 3. Administration
- 482 healthcare professionals** of the **recipient teams value the work performed by the PSCT**, on a general level with a **8.9** out of **10**.

Specifically:

9.17

CARE

The care provided to the **patient** and to the **family** is quality care, due to its competency, **timetable availability** and involvement

9.18

SATISFACTION

Positive valuation by medical **professionals**, nurses and the remaining **recipient teams**



IMPACT ON SCIENTIFIC KNOWLEDGE

- / Training
- / Manuals / publications
- / Evaluation instruments
- / Notifications
- / Scientific publications
- / Doctoral thesis



Source: Catalan Oncological Institute

Grazie tante!!!!

@xgba
xavier.gomez@uvic.cat

Càtedra de Cures Pal·liatives
catedracurespal@uvic.cat

FONDAZIONE FLORIANI FORMAZIONE


UNIVERSITAT DE VIC
UNIVERSITAT CENTRAL
DE CATALUNYA

 **FACULTAT
DE MEDICINA**
UVIC-UCC

 **Càtedra
de Cures Pal·liatives**
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