“My mother’s health became worse but we felt safe thanks to the palliative plan about what to do when challenges appeared. This was good for us and for our mother. As the plan was made early, her wishes that was important to her was included.”

Relative

“I’d never heard of a Palliative care plan, but I thought it was a good idea. I was being worried because of my health and thought, ’if I collapse, my family will have to pick up the pieces and they will not know what to do’. My kids thought it was difficult to talk about a Palliative care plan. I explained to them that they might have to make decisions on my behalf, so they needed to know what was important to me. Now, they’re pleased I have it.”

Patient

Municipalities in Møre og Romsdal, Norway

Utviklingssenter for sykehjem og hjemmetjenester
Møre og Romsdal

HELSE MØRE OG ROMSDAL

www.palliativplan.no

Here you can get contact information from members of the resource group Palliativ Plan in Møre and Romsdal.

EKH GRAFISK miljømerket trykksak 2041 0690

PALLIATIVE CARE PLAN/ PLAN FOR BEST RELIEF CARE

A living tool to take care for people with incurable disease

“What is important to you?”

Resource group Palliativ plan in Møre and Romsdal, Norway

PALLIATIVE CARE PLAN/ PLAN FOR BEST RELIEF CARE

The Palliative care plan is a document that is shared between patients, possibly relatives and healthcare professionals.

It aims to be ahead of any potential challenges so that the patient and their family can experience the best possible quality of life through collaboration, planning and individual arrangements. It provides guidance to the family and healthcare providers, and reduces their decisional burden by following the patient's goals, values, and beliefs.

The palliative plan builds on continuous communication and an advance care discussion between all parties involved. To prevent misunderstandings, it brings together the patients choices and possible advance directives; reflecting a person's treatment preferences and current medical condition.

The palliative plan has to be updated consecutively as the person's health condition progresses.

The plan can last over several years, or for shorter periods. The general practitioner (GP) or geriatric GP and the primary nurse formulate the plan after an advance care discussion with the patient, relatives and healthcare providers involved. Relatives only join this discussion with permission from the patient or on behalf of the patient if they have limited cognitive abilities.

The palliative plan is offered to anyone who has an incurable disease, in parallel with other treatment.

PURPOSE AND CONTENT

The plan should be made as early in the disease process as possible after a patient gets a diagnosis with limited life expectancy.

The plan ensures:

- Security for patient, relatives and healthcare professionals
- Patient participation (what is important to you?)
- To treat the patient in line with the patient's wishes
- As far as possible, avoid unnecessary use of emergency care and hospital admissions

The plan should include:

- Telephone numbers to get answers to upcoming questions 24/7
- Contact information about available help from health services 24/7
- Relevant diagnoses
- Individual arrangements/statements and plans for the treatment of possible symptoms
- The patient's life story and family resources
- The patients (and relatives') wishes, hopes and concerns
- Ethical guidelines/advance directives

If you wish to have a Palliative care plan/Plan for best relief care you should contact your GP/geriatric GP or a nurse form the nursing home or home care service.

If there is need for guidance/training, the healthcare provider can contact one of the palliative care teams in Møre and Romsdal county.