Team Name: Regional Palliative Care Team Team Lead: Regional Director, Seniors/Palliative Care Approved by: Executive Director - West	Reference Number: CLI.5910.SG.002 Program Area: Palliative Care Policy Section: General
Issue Date: June 2, 2017 Review Date: Revision Date:	Subject: Palliative Performance Scale (PPS)

STANDARD GUIDELINE SUBJECT:

Palliative Performance Scale (PPS)

PURPOSE:

The Registered Nurses' Association of Ontario (RNAO) *Best Practice Guideline: End-of-Life Care During the Last Days and Hours* cites literature which reports that overall, level of functioning is the most important indicator of prognosis. Other research cited reports a positive association between shortened life span and a range of clinical symptoms and indicators such as anorexia, weight loss, dysphagia, dyspnea, congestive heart failure and delirium.

The Victoria Hospice Palliative Performance Scale (PPS, version 2) is a validated clinical tool which measures functional performance. This tool helps health care professionals:

- Identify and track care needs as individuals change with disease progression;
- Communicate a patient's current functional level quickly and in a standardized way;
- In their assessment or treatment of patients facing advancing illness, death or bereavement; and
- Identify patients who are approaching the last days and hours of life.

The PPS is an 11-point scale designed to measure patients' performance status in 10% decrements from 100% (healthy) to 0% (death) based on five observable parameters: ambulation, ability to do activities, self-care, food/fluid intake, and consciousness level.

PROCEDURE:

How to use the PPS

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.
2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and

generally take precedence over others.

- Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.
- Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.
- Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not 'total care.'

3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.

When to do the PPS

1. In palliative home care, it is a good practice to complete and graph the PPS at initial contact and then minimally weekly, as needed, or when the patient is contacted (if at time intervals of greater than one week) for patients in the home.
2. In hospital and personal care home settings, the PPS should be completed weekly and as needed.
3. In primary care settings, such as physician's offices, outpatient clinics, or Community Cancer Programs, the PPS should be completed as needed, likely at each visit with the palliative patient.

Who should do the PPS

1. The health care professional providing care during a care episode with a patient (e.g. home visit by a Palliative Care Nurse or a Visiting Nurse, a nurse in the hospital, a physician in an office) is best suited to do the PPS, with input from the patient, his/her family/caregivers and possibly other health care providers.

Where to document the PPS

1. The PPS should be documented on the Edmonton Symptom Assessment System Revised (ESAS-r) Graph (CLI.5910.SG.001.FORM.02), or in a similar place if documentation systems are different (e.g. in an electronic health record).
2. Documentation of the PPS should be done in such a way as to quickly and clearly communicate a patient's current functional status to other health care team members, and to document changes in the trend of a patient's functional status.

SUPPORTING DOCUMENTS:

CLI.5910.SG.002.FORM.01	Palliative Performance Scale (PPSv2) Version 2
CLI.5910.SG.001.FORM.02	Edmonton Symptom Assessment System Revised (ESAS-r) Graph

REFERENCES: *(optional)*

Registered Nurses Association of Ontario (RNAO) (2011). Clinical Best Practice Guideline: End-of-Life Care During the Last Days and Hours. Retrieved on-line June 15, 2016 from http://rnao.ca/sites/rnao-ca/files/End-of-Life_Care_During_the_Last_Days_and_Hours_0.pdf.

Victoria Hospice (2006). Palliative Performance Scale. Used with Permission.