

## The Prompt Sheet for Patients and Families

Based on the SENS structure, a worksheet or "Prompt Sheet" for patients and families was developed. It can be used by them as a checklist or preparation script that enhances active participation in developing the care plan, and as preparation for family conferences / round tables. It may also serve as basis for discussing the contents of advance directives or a living will.

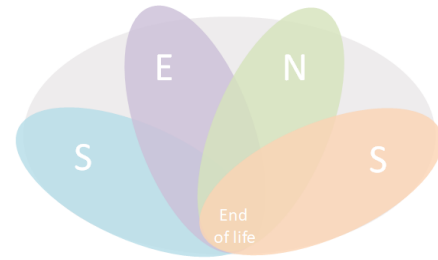
### Application in practice

- ✓ Initial basic and follow-up palliative-specific assessment
- ✓ Patient and family prompt sheet for preparation of discussions about their concerns and resources
- ✓ Content structure for shared care plan including distribution of tasks for carers (incl. family carers, home care team)
- ✓ Tool for coordination within regional care network
- ✓ Evaluation of care plan concerning focus/ priorities
- ✓ Documentation of care (incl. health insurers) and financial reimbursement
- ✓ Structure for case reflections and teaching



### More Information

[www.sens-plan.com](http://www.sens-plan.com) or contact [palliativzentrum@insel.ch](mailto:palliativzentrum@insel.ch)



## SENS Pocket Card

SENS<sup>1</sup> is a patient-oriented thematic structure for assessment and treatment planning in situations of chronic progressive and/or potentially life-threatening diseases outlining current areas of concern.

### SENS stands for

- Symptom management
- End of life decisions / expectations
- Network - organization
- Support for the carers

SENS focuses on challenges as well as on everyday resources. SENS strengthens self-efficacy through a participative approach. SENS can be used concurrently and complementary to medical-diagnostic and therapeutic procedures. It highlights palliative care content in a comprehensible and simple structure. The aim is to create a patient centered "map" of current areas of concern and resources.

## SENS areas of concern and resources

### Symptoms and Symptom Management

Physical symptoms	General well-being, pain, nausea, dyspnoea, fatigue, appetite, digestion, constipation, pruritus, oedema
Psychological symptoms	Cognition, depression, demoralization wish to die, anxiety, main coping mechanism
Social impact of the disease	Impact on relationships (partners, family, friends) or social activities, loneliness
Spiritual - cultural needs	Religion, areas of meaning and preservation, spiritual needs / sources of energy, dignity, values
Personal handling of symptoms	Own strategies / resources

### End of life decisions/ Expectations

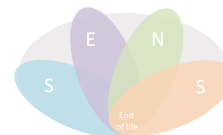
Individual wishes/ Expectations	Preferences and goals for the coming days, weeks and months
Medical/nursing decisions	Knowledge and understanding of current medical situation; definition of DNR- status, Advance directive; preferences about current medical treatment; care needs or wishes
Personal history	Professional situation; essential aspects of life; hobbies; responsibilities (e.g. project, finances, pets etc.)
Other End of life topics (usually not during initial assessment)	“Unfinished business” - last wishes; desired place of dying; autopsy; Living will/ testament; funeral wishes

### Network- organization

Private network	Relatives/ friends/ volunteers for support/ care; if necessary weekly plan of support;
Professionals Network	Family doctor, involved services, specialist palliative care team; social work, psychological service; clarification of leadership
Living situation	Type of building, access to home (stairs?), bathroom etc.; cohabitants
Available emergency plan	Out of hours plan: what, who and where will be support be available

### Support for the carers

Concerns of the patient in regard of family and friends	Distress capacity/ tolerance of the carers; Acute burden
Sources of Support	Possibilities for time-out and resources for relatives / family members, also in the mourning phase
Financial concerns of family carers	Options for compassionate work leave? Insurance status?



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