Ref. no.: 2014-1-RO01-KA203-002940
Programme: Erasmus+
Action: Strategic Partnerships

# O1_A3_B_Summative EU Report

**The aim of this activity** is to research & evaluate the medical literature talking about the procedures on palliative medicine, reflect on the palliative medicine and strategies and on the current procedures used in the training of the first years students enrolled in EU medical universities or used by the professionals & volunteers active in the medical world of work.

**Objectives:**

- Identification of the operational procedures reported to be used by the students during the hospital internship in pre-clinical years; identify the needs of the target groups in connection to the use of specific procedures
- Research of specialised recent literature in connection to these procedures
- Identify the ways to introduce new & consensually agreed procedures on palliative medicine to the academic medical field (university) and the medical world of work (hospitals, hospices)
- Collect information on specific sectorial impact, country differences, cultural specific aspects, etc.
- Identify innovative solutions that have been implemented & found to be effective to meet the needs of those who use/will use procedures on palliative medicine

**Structure:**

1. Provision of **statistical data**, at national level, on the following aspects:

| Country | Population milions | Surface $km^2$ | Density inhab/ $km^2$ | GDP | Nr doctors/1000 inhabitants | Nr of nurses/1000 inhabitants |
|---|---|---|---|---|---|---|
| Romania | 19.96 | 238.391 | 84.4 | 669.5 billions RON | 2.5 | 5.8 |
| Spain | 46.81 | 505.990 | 92 | $1.407trilion | 4.6 | 5.2 |
| Italy | 60.78 | 301,338 | 201.7 | $2.066 trillion | 4.2 | 7.7 |
| Belgium | 11.32 | 30,528 | 369.7 | $481.5 billion | 4.9 | 16.8 |

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| Country | Nr of patients in palliative care services | Nr doctors in palliative care | Nr nurses in palliative care |
|---|---|---|---|
| Romania | no summative statistics | 396 | 6500 |
| Spain | 215.388 | 567 | 1016 |
| Italy | no summative statistics | | |
| Belgium | | 1/200 000 inhab. | 3-4/200 000 inhab. |

in different settings (hospitalized, institutionalized, assisted at home, etc.): Data as reported http://www.anip.ro/wp-content/uploads/2013/08/Catalog-servicii-ingrijiri-paliative-RO-2012.pdf

**2.** Is the palliative medicine/care supported by **legislation**?

| Country | Romania | Spain | Italy | Belgium |
|---|---|---|---|---|
| Legislation | O.M. nr.916/23.12.1999, OM nr 480/2005 OMECT nr. 2713 / 29.11.2007; Law nr.339/2005 HG nr 1915/2006 OUG nr.115/2004, HG 76/2008 Law nr.95/2006 | The legal foundation of information, informed consent, advanced directives and confidentiality are established at national level in the law 41/2027 Each Autonomous Region has defined the conditions related to the informed consent and advanced directives. | Regional Law n. 30-866 del 25.10.2010 "Regional network for palliative care and Pain Centers" Regional Law n. 31-1482 del 11.02.2011 | Law about rights of the patient Law about the palliative patient Law about euthanasia |

**3.** Identification of **National Strategies** in palliative care.

**Principles:**

- *Needs and Service User Preference Driven* –
- *Availability* – palliative care services should be available throughout the country even to the remotest areas.
- *Accessibility* – once the services have been made available every effort should be made to eliminate any barriers to people accessing those services.
- *Quality* – "best practice" models, standards and national protocols will be defined, promoted and adopted. High quality was thought to be determined much more by the nature of the interaction of the person needing palliative care (and their family/carers) with the professional care giver and the responsiveness of the system as a whole
- *Continuity of care* – is special challenge for palliative care as part of a busted healthcare system. We propose regional integrated networks of palliative care services.
- *Cost of care* (cost benefit/demonstrable value) – palliative care has a particular challenge with this criteria as its value is more qualitative (adding quality to life) than quantitative (adding years to life). Although there are studies which show benefits of palliative care, such as prolonging survival and reducing care costs by avoiding unnecessary treatments.

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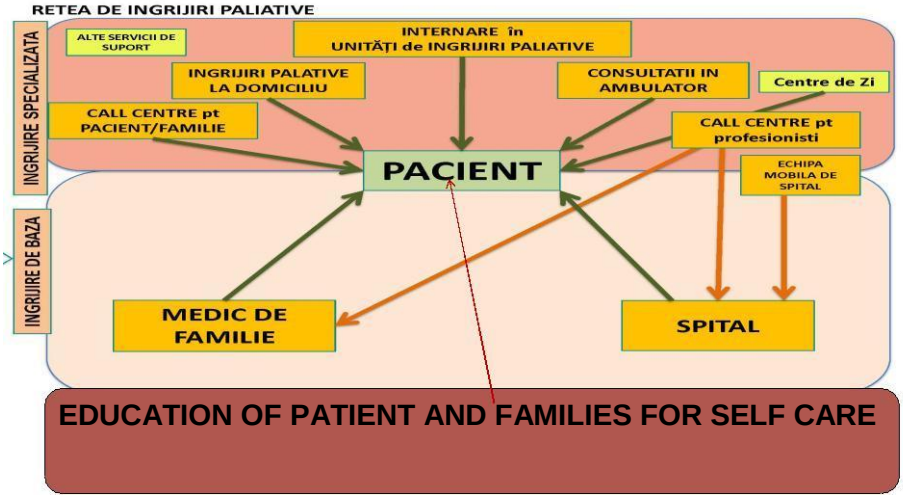
Romania model of care




According to **complexity of needs** these structures will be developed according to include different levels of competencies, as follows:

1. *Level 1*: **Support for self-care**: offered to patients and their families by community medical assistance team with basic palliative care education, but also by specialized palliative care teams. This level assures that the patient and his family gain knowledge, abilities and self-confidence for self-care and for proper care in between medical staff interventions.
    a. Non-pharmacological methods for control different symptom
    b. Communication
    c. Food and feeding
    d. Bodily care
    e. Mobilization techniques
    f. Negotiation goals of care with professionals etc.

2. *Level 2*: **Palliative approach** represents direct care offered to patients and their families/carers by clinical staff with basic instruction in palliative care, having a certificate that confirms participation to different programs accredited by competent institutions.

3. *Level 3*: **Specialized palliative care** assures direct care offered to patients and their families/carers, but also includes consultancy for level 1 and 2 of competence. It is provided by professional interdisciplinary teams with specialized studies in palliative care field: doctors with palliative care competence, nurses, social workers, psychologists, therapists, clerics and other staff with palliative care competence, according to national standards of palliative care.

**Territorial**

**Local :** as much as possible the care should be offered to patients in the places where they live through

- primary care services but with some training in palliative (palliative care approach)
- specialized palliative care services
    - Home care, day centers
    - After hours call service for patients

**Regional**

Specialized palliative care services

- Inpatient units
- Coordination of services

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- Palliative care networks

- Consultancy for level 1 and 2 ( call centers for professionals, education centers for patients and families with hotline)

**National**

- *Producing and dissemination of standards and clinical protocols*
- *Professional review of quality of care*
- *National data collection/statistics concerning use of resources, cost, etc.*
- *Advocacy, education, research*
- *National awareness campaigns*

**National strategy about palliative care in Spain**

Spanish Society for Palliative Care (SECPAL) was created in 1992. It is the body that brings together more than 1800 professionals working in the field. Since 1994, SECPAL publishes the "Palliative Medicine" magazine (Medicina Paliativa. Scored with 0,162 in Journal Citation Reports-2013. Indexed journal in: Science Citation Index, Scopus, ScienceDirect) which is the only Spanish publication specialized in hospice-palliative care so that shows the work carried out in Spain and Latin America. This multidisciplinary journal aims to share knowledge and experiences in order to respond to the multidimensional patient care and his/her immediate environment. Training programs, congresses and meetings organized by this body have increasingly greater impact on Spanish society. In 2001 Núñez Olarte published an article[52] about the key ethical issues in clinical practice in palliative and end-of-life care in Spain and how these issues are influenced by Spanish culture. Although there is a general consensus that a new philosophy of care is needed, the interpretation and application of this general philosophy are different in diverse sociocultural contexts. The Spanish palliative care movement has shifted its focus from starting new programs to consolidating and expanding the training of the professionals already working in the existing programs. Still, as said above, half of the terminally ill does not receive the required assistance. Universities have not incorporated palliative medicine at the undergraduate levels and the current lack of specialists in this field is still not alleviated. Despite that mass media coverage has greatly increased in the last years (see below), Spain needs a law to ensure a dignified death for all patients. The current law requires that doctors offer palliative care but the formulation of this obligation is extremely ambiguous. Andalusia is the first region that regulated dignified death with the approval of the Bill of Rights and Guarantees of the Dignity of Persons in the Process of Death[53]. This law prohibits aggressive therapy and allows patients to refuse treatment that artificially prolong their life permitting palliative sedation to alleviate the suffering of the sick. Navarra and Aragon in 2011 passed similar laws. The foremost national newspapers and public access information sources have extensively faced the topic in the last five years. Accordingly, in the library of the best-selling newspaper in Spain (El País), for the period 2010-2015 there is more than 800 news and opinion articles related to palliative care and end-of-life issues. Since January 2015, the Spanish public television has addressed the issue of palliative care with two documentaries, an interview with a specialist and a movie. All were broadcasted around February 4, World Cancer Day.

**In Italy**, the continuing development of palliative care must be accompanied by an extraordinary attention on some strategic points, to make them available to all patients who need them, and to ensure that they best express the level of social and health care evolution, so that they are developing not only in number, but in quality too. The first aspect is the **appropriateness** of care: to get better systems to recognize the need of care, the timing of care, and to develop quality assessment and performance improvement. The second aspect is the attention to **human** factor, (someone called the Palliative Care the Science of Compassion - The National Institute of Nursing Research Summit, USA, 2011): to bring to patient's home technology but also *good skills in helping relationship*, and this means to

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improve strategies and programs to provide health professionals with specific personal training and team training, education and support. The third aspect is the attention to **multidisciplinary approach** in palliative care: through cooperation among physicians, nurses, psychologists and other health professionals, and no less important are social workers, chaplains and every other allied people who can contribute to diminish patient's suffering. This means *promoting and implementing a specific and firm network which needs maintenance and updating* to be appropriate to the needs of the patient and of the care team.

Finally, the fourth aspect is the indispensability of involving all the patient's family in the process of care; through a **family centered approach** that embraces all the family members, (and the family is defined by the patient), during the patient's illness and after his death, in the bereavement process.

The WHO definition of Palliative Care and the Guidelines published all over the world stress this aspect, that becomes particularly necessary and complex when the dying patient is a mother or a father of young children, or when the patient is a child. Specific, affordable and flexible guidelines of care are needed.

**Guidelines for Palliative Care in Primary Care Settings and Specialty Level Palliative Care need to be better identified**

Moreover, a palliative care organization must be able to look beyond the formal systems of care, and have to research in the community other resources, *such as self-help or mutual aid*, or other non-formal systems of care, whose extraordinary effectiveness was observed in many fields, like addiction, disability, and so on. Of strategic importance appear *to be a multicultural approach in Palliative Care*, and not only to a multi-professional care strategy. Palliative care is the result of the work of many different professionals, but also of many different components of society.

**In Belgium**, the palliative care offer is equitably distributed in the different regions of the country, regardless of the care location of the patient (home, hospital, specialised retirement home, etc.). A coherent plan equipped with a comprehensive legislative framework was developed in 1997, thanks to the consultation and combined efforts of the experts in palliative care united in federations, and the Authorities.

The first palliative care service and palliative home care team were created more than 25 years ago (first initiative dates 1985). From 1991 onwards the Ministry of Social Affairs financed experiments for palliative care at home, in hospitals and in nursing homes.

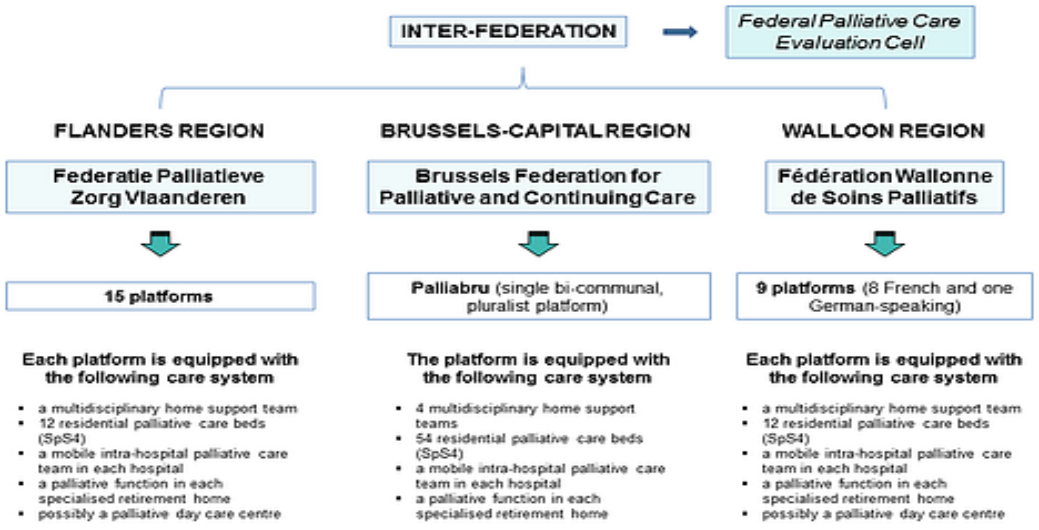


**Figure 1: distribution of palliative care offer in Belgium**

Palliative networks were created in 1997 (Royal Decree of June 19, 1997) (KB 1997a).

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Today there are 25 networks (1 network/300.000 inhabitants). These networks cover the entire Belgian territory (15 networks in Flanders, 1 bilingual network in Brussels, 8 networks in Wallonia and 1 network in the German-speaking community). The networks develop the following activities:

- to heighten public awareness;
- to organize palliative care trainings for health caregivers and for volunteer persons;
- to coordinate different local actions like defining cooperation protocols to guarantee an optimal complementarity between organisations and services;
- to give advice and logistic support in order to enhance the efficiency of the actions and the support to patients;
- to evaluate the palliative services and to estimate the gap between needs and services.

4. Identification of **specialized services** in palliative care.

| Country | specialized services in palliative care |
|---|---|
| Romania | Types of patients cared for: children with life limiting diseases, adults mainly with cancer but also with non cancer diseases like dementia and different organ failure<br>Mechanisms of funding for the services in different settings: state funds, private funds, donations, campaigns.<br>Number/Types of services: In 2013: inpatient units: 38; homecare: 19; day centres: 4; outpatient: 5 |
| Spain | Standard resources related to palliative care: a) a support team available for each kind of area of palliative care, i.e. primary medicine, specialized or tertiary; b) a home care service team available per 100-150.000 inhabitants, c) hospital service and day hospital or ambulatory service in the hospital. |
| Italy | Hospital services<br>Outpatient services<br>Pediatric services – see table |
| Belgium | The palliative home care teams are the extra-mural component of the Belgian PC system. They were created to support caregivers in the first line of care. The Royal Decree of Oct 13, 1998 (KB 1998) defined minimal criteria for the agreements between these teams and the 'Comité van de Verzekering voor Geneeskundige Verzorging' of the National Institute for Health and Disability Insurance (INAMI–RIZIV). Today, 28 teams signed such an agreement (at least 1 per regional network),<br>1 per 200,000 inhabitants. Typical constitution of a palliative home care team is 2.6 fte per team; for 100 patients per year, as follows: 1 physician (part-time); 1 coordinator; 3-4 nurses, 1 psychologist, 1 adm. co-worker<br>The missions of palliative home care team were defined in the conventions with INAMI-RIZIV. |

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**5.** Identification of support.

| Country | specialized literature or organizations |
|---|---|
| Romania | https://eapcnet.wordpress.com/2015/05/13/new-beginnings-all-change-at-the-eapc/ |
| Spain | National Program about Palliative Care (Plan Nacional de Cuidados palliativos) and National Strategy about Palliative Care (Plan Nacional de Cuidados Palliaitivos) promoted by the National Health System |
| Italy | www.fremedicaljournals.com<br>www.academicjournals.org www.biomedcentral.com<br>www.bmj.com.bvs.cilea.it www.ncbi.nlm.nih.gov www.sciencedirect.com<br>ACCD Sito dell'Associazione cremonese per la cura del dolore<br>ACP - Bergamo Sito Associazione Cure Palliative Bergamo<br>ANLAIDS Associazione nazionale per la lotta all'AIDS<br>Associazione Antea Sito di Antea<br>Associazione Volontari Presenza Amica Collegamento al Sito dell'Associazione<br>Federazione Cure Palliative (FCP) Onlus Federazione che riunisce oltre 70 organizzazione No Profit Italiane<br>Fondazione Floriani Sito della Fondazione<br>Fondazione italiana di leniterapia Collegamento al sito ufficiale della Fondazione Italiana di Leniterapia<br>Fondazione Maruzza Lefebvre D'Ovidio Onlus Sito Fondazione Maruzza Lefebvre D'Ovidio Onlus<br>Fondazione Lu.V.I. Sito della Fondazione<br>Fondazione Maria Teresa Chiantore Seràgnoli Sito della fondazione<br>Lega italiana per la lotta contro i tumori Collegamento al sito della Lega Tumori<br>S.A.M.O.T. Onlus Sito Società per l'Assistenza al Malato Oncologico Terminale |
| Belgium | money for training via part C of the health insurance allowance (MB 2001; 2003). From the first of July 2008, an additional budget is available for a part-time palliative reference person |

**6.** Is the palliative care **visible/debated** at national level?

| Country | Visibility of palliative care at national level |
|---|---|
| Romania | https://eapcnet.wordpress.com/2015/05/13/new-beginnings-all-change-at-the-eapc/<br>National Conference of Palliative Care 1998 - 2015<br>http://www.studiipaliative.ro/calendar/<br>Governmental Commission for Palliative Care, regularly meetings with NAPC members;<br>National PC journal Paliatia.ro http://www.paliatia.eu/new/<br>since may 2014 a palliative care column in the national medical magazine Viata medicala with a palliative care article published every second week<br>https://www.facebook.com/media/set/?set=a.635455646535881.1073741830.1982 47400256710&type=3 |

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|---|---|
| Spain | Cancer Pain Release, www.WHOcancerpain.wisc.edu<br>Hospice Information, www.hospiceinformation.info<br>IAHPC, www.hospicecare.com<br>World Hospice Palliative Care Online, avril@hospiceinformation.info<br>Palliatif (en francés), irzpalli@vtx.ch<br>Medicina Paliativa, www.secpal.com/medicina_paliativa/index.php |
| Italy | Many examples of National conferences/events on palliative care<br>Many examples of Scientific journals on palliative care |
| Belgium | Specialized recent literature in palliative care: In Medline(PubMed) we could identify 78 publications on palliative care from Belgian authors published in the last 5 years<br>http://www.belgium.be/nl/gezondheid/gezondheidszorg/levenseinde/palliatieve_zorgen/<br>www.portal4care.be<br>Palliative care (Palliatieve zorg): http://www.palliatief.be<br>Early planning of your care (vroegtijdige planning van je zorg): www.delaatstereis.be<br>Children and teenagers confronted with palliative care (kinderen en jongeren geconfronteerd met palliatieve zorg): www.palliatieve-zorg-en-kinderen.be<br>Guidelines palliative care (richtlijnen palliatieve zorg): www.pallialine.be<br>Brussels Federation of Palliative care (Fédération Bruxelloise de Soins Palliatifs et Continus): www.fbsp-bfpz.org/<br>Palliative care in the Walloon Region (Fédération Wallonne des Soins Palliatifs): www.soinspalliatifs.be<br>Pluralistic association of palliative care in Brussels Capital Region (Pluralistische Vereniging voor Palliatieve Zorg van het Brussels Hoofdstedelijk Gewest): www.palliabru.be<br>Life information forum LEIF (Levenseinde Informatie Forum): www.leif.be<br>Cancer center (Kankercentrum): www.e-cancer.be<br>Cancer Foundation (Stichting tegen Kanker): www.kanker.be<br>Flemish League against Cancer (Vlaamse Liga tegen Kanker): www.vlk.be |

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**7.** Identification of the **operational procedures on palliative care reported to be taught** to the students during the hospital internship in pre-clinical years.

| rank | ***points*** | ***country partner Brasov*** | ***country partner Belgium*** | ***country partner Italy*** | ***country partner Spain*** | ***country partner Iasi*** | **Results** | |
|---|---|---|---|---|---|---|---|---|
| *1.* | *50* | To evaluate the awareness level of patient about his/her disease and illness | Pain assessment (cognitive impairment also) | *To evaluate the awareness level of patient about his/her disease and illness* | Communicating the diagnosis of severe illness (bad news) | Male/Female patient – urethro-vesical catheterisation | Communicating the diagnosis of severe illness (bad news) **Total = 213** | Bv = 48; Be = 43; It = 40; **Sp = 50**; Is = 32 |
| *2.* | *48* | Communicating the diagnosis of severe illness (bad news) | *Pain prescribing according to WHO ladder* | *Pain assessment (cognitive impairment also)* | To evaluate the awareness level of patient about his/her disease and illness | Oxigenotherapy | *To evaluate the awareness level of patient about his/her disease and illness* **Total = 213** | **Bv = 50**; Be = 45; **It = 50;** Sp = 48**;** Is = 20 |
| *3.* | *45* | Approach to the conspiracy of silence | *To evaluate the awareness level of patient about his/her disease and illness* | *Pain prescribing according to WHO ladder* | Approach to the conspiracy of silence | Paracentesis | Pain assessment (cognitive impairment also) **Total = 209** | Bv = 40; **Be = 50;** It = 48; Sp = 28**;** Is =43 |
| *4.* | *43* | Active listening and empathic response | *Communicating the diagnosis of severe illness (bad news)* | *Approach to the conspiracy of silence* | Burn out syndrome prevention (debriefing) | Pain assessment (cognitive impairment also) | End of life care - discussion about (place of care, aggressive treatment, DNR) **Total = 160** | Bv = 30; Be = 38; It = 36; **Sp = 40;** Is = 16 |
| *5.* | *40* | Pain assessment (cognitive impairment also) | *Active listening and empathic response* | *Communicating the diagnosis of severe illness (bad news)* | End of life care - discussion about (place of care, aggressive treatment, DNR, ) | Nutrition /Feeding patient in bed | Active listening and empathic response **Total = 158** | **Bv = 43;** Be = 40; It = 38; Sp = 34**;** Is = 3 |
| *6.* | *38* | Pain prescribing according to WHO ladder | *End of life care - discussion about (place of care, aggressive treatment, DNR)* | *Active listening and empathic response* | Mapping patients network | Transferring patient in bed + Medical positions of a patient in bed | *Pain prescribing according to WHO ladder* **Total = 150** | Bv = 38; **Be = 48;** It = 45; Sp = 1**;** Is =18 |

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| *7.* | *36* | Spiritual assessment | *Mapping patients network* | *End of life care - discussion about (place of care, aggressive treatment, DNR, )* | How to address the needs of caregivers | Patient bath | Approach to the conspiracy of silence **Total = 147** | **Bv = 45;** Be = 10; It = 43; **Sp = 45;** Is = 4 |
| *8.* | *34* | How to address the needs of caregivers | *How to address the needs of caregivers* | *Terminal phase-management* | Active listening and empathic response | Terminal phase-management | Mapping patients network **Total = 144** | Bv = 32; Be = 36; It = 32; **Sp = 38;** Is = 6 |
| *9.* | *32* | Mapping patients network | *Burn out syndrome prevention (debriefing)* | *Mapping patients network* | Spiritual assessment | Communicating the diagnosis of severe illness (bad news) | How to address the needs of caregivers **Total = 141** | Bv = 34; Be = 34; It = 26; **Sp = 36;** Is = 11 |
| *10.* | *30* | End of life care - discussion about (place of care, aggressive treatment, DNR, ) | *Transferring patient in bed + Medical positions of a patient in bed* | *Burn out syndrome prevention (debriefing)* | Terminal phase-management | Colostomy maintenance | Burn out syndrome prevention (debriefing) **Total = 122** | Bv = 10; Be = 32; It = 30; **Sp = 43;** Is = 7 |
| *11.* | *28* | Oral Care | *Prevention/management of pressure ulcers & skin lesions* | *Oral Care* | Pain assessment (cognitive impairment also) | Lower limb lymphedema drainage + Elastic tights application | *Terminal phase-management* **Total = 119** | Bv = 1; Be = 20; **It = 34;** Sp = 30**;** Is = 34 |
| *12.* | *26* | Automatic syringe - subcutaneous perfusion | *Patient bath* | *How to address the needs of caregivers* | Nutrition /Feeding patient in bed | Upper limb lymphedema drainage | Spiritual assessment **Total = 116** | **Bv = 36;** Be = 24; It = 22; Sp = 32**;** Is = 2 |

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| *13.* | *24* | Paracentesis | *Spiritual assessment* | *Prevention/management of pressure ulcers & skin lesions* | Transferring patient in bed + Medical positions of a patient in bed | Oral Care | *Prevention/management of pressure ulcers & skin lesions* **Total = 112** | Bv = 16; **Be = 28;** It = 24; Sp = 22**;** Is = 22 |
| *14.* | *22* | Thoracocentesis | *Nutrition /Feeding patient in bed* | *Spiritual assessment* | Prevention/management of pressure ulcers & skin lesions | Prevention/management of pressure ulcers & skin lesions | Nutrition /Feeding patient in bed **Total = 112** | Bv = 4; Be = 22; It = 20; Sp = 26**;** **Is = 40** |
| *15.* | *20* | Male/Female patient – urethro-vesical catheterisation | *Terminal phase-management* | *Nutrition /Feeding patient in bed* | *Assessment of families for bereavement* | To evaluate the awareness level of patient about his/her disease and illness | *Transferring patient in bed + Medical positions of a patient in bed* **Total = 107** | Bv = 5; Be = 30; It = 10; Sp = 24**;** **Is = 38** |
| *16.* | *18* | Tracheostomy maintenance | *Assessment of families for bereavement* | *Tracheostomy maintenance* | Automatic syringe - subcutaneous perfusion | Pain prescribing according to WHO ladder | Oral Care **Total = 104** | **Bv = 28;** Be = 8; **It = 28;** Sp = 16**;** Is = 24 |
| *17.* | *16* | Prevention/management of pressure ulcers & skin lesions | *Assessment and prevention of fatigue* | *Colostomy maintenance* | Oral Care | End of life care - discussion about (place of care, aggressive treatment, DNR, ) | Male/Female patient – urethro-vesical catheterisation **Total = 100** | Bv = 20; Be = 12; It = 11; Sp = 7**;** **Is = 50** |
| *18.* | *14* | Management and prevention of cachexia | *Oxigenotherapy* | *Assessment of families for bereavement* | Assessment and prevention of fatigue | Automatic syringe - subcutaneous perfusion | *Patient bath* **Total = 86** | Bv = 6; Be = 26; It = 6; Sp = 12**;** **Is = 36** |

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| *19.* | *12* | Colostomy maintenance | *Male/Female patient – urethro-vesical catheterisation* | *Automatic syringe - subcutaneous perfusion* | Patient bath | Tracheostomy maintenance | Automatic syringe - subcutaneous perfusion **Total = 81** | **Bv = 26;** Be = 11; It = 12; Sp = 18**;** Is = 14 |
| *20.* | *11* | Assessment and prevention of fatigue | *Automatic syringe - subcutaneous perfusion* | *Male/Female patient – urethro-vesical catheterisation* | Managing massive hemorrhage | How to address the needs of caregivers | Paracentesis **Total = 77** | Bv = 24; Be = 2; It = 3; Sp = 3**;** **Is = 45** |
| *21.* | *10* | Burn out syndrome prevention (debriefing) | *Approach to the conspiracy of silence* | *Transferring patient in bed + Medical positions of a patient in bed* | Lower limb lymphedema drainage + Elastic tights application | Thoracocentesis | *Oxigenotherapy* **Total = 71** | Bv = 3; Be = 14; It = 2; Sp = 4**;** **Is = 48** |
| *22.* | *9* | Assessment of families for bereavement | *Tracheostomy maintenance* | *Managing massive hemorrhage* | Colostomy maintenance | Management and prevention of cachexia | *Colostomy maintenance* **Total = 70** | Bv = 12; Be = 3; It = 16; Sp = 9**;** **Is = 30** |
| *23.* | *8* | Lower limb lymphedema drainage + Elastic tights application | *Oral Care* | *Assessment and prevention of fatigue* | Tracheostomy maintenance | Assessment and prevention of fatigue | *Assessment of families for bereavement* **Total = 66** | Bv = 9; Be = 18; It = 14; **Sp = 20;** Is = 5 |
| *24.* | *7* | Upper limb lymphedema drainage | *Management and prevention of cachexia* | *Management and prevention of cachexia* | Male/Female patient – urethro-vesical catheterisation | Burn out syndrome prevention (debriefing) | Tracheostomy maintenance **Total = 65** | **Bv = 18;** Be = 9; **It = 18;** Sp = 8**;** Is = 12 |

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| *25.* | *6* | Patient bath | *Managing massive hemorrhage* | *Patient bath* | Upper limb lymphedema drainage | Mapping patients network | *Assessment and prevention of fatigue* **Total = 57** | Bv = 11; **Be = 16;** It = 8; Sp = 14**;** Is = 8 |
| *26.* | *5* | Transferring patient in bed + Medical positions of a patient in bed | *Lower limb lymphedema drainage + Elastic tights application* | *Lower limb lymphedema drainage + Elastic tights application* | Management and prevention of cachexia | *Assessment of families for bereavement* | Lower limb lymphedema drainage + Elastic tights application **Total = 56** | Bv = 8; Be = 5; It = 5; Sp = 10**;** **Is = 28** |
| *27.* | *4* | Nutrition /Feeding patient in bed | *Upper limb lymphedema drainage* | *Upper limb lymphedema drainage* | Oxigenotherapy | Approach to the conspiracy of silence | Upper limb lymphedema drainage **Total = 47** | Bv = 7; Be = 4; It = 4; Sp = 6**;** **Is = 26** |
| *28.* | *3* | Oxigenotherapy | *Colostomy maintenance* | *Paracentesis* | Paracentesis | Active listening and empathic response | Management and prevention of cachexia **Total = 42** | **Bv = 14;** Be = 7; It = 7; Sp = 5**;** Is = 9 |
| *29.* | *2* | Managing massive hemorrhage | *Paracentesis* | *Oxigenotherapy* | Thoracocentesis | Spiritual assessment | Thoracocentesis **Total = 36** | **Bv = 22**; Be = 1; It = 1; Sp = 2**;** Is = 10 |
| *30.* | *1* | Terminal care | *Thoracocentesis* | *Thoracocentesis* | Pain prescribing according to WHO ladder | Managing massive hemorrhage | Managing massive hemorrhage **Total = 28** | Bv = 2; Be = 6; It = 9; **Sp = 11;** Is = 1 |

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8. Provision of **examples of best practices/ projects** on innovative solutions that have been implemented and found to be effective to meet the needs of those who use / will use medical procedures. *(at least 2 examples, provide a short presentation, link if available)*

| Country | **examples of best practices/ projects** |
|---|---|
| Romania | IZERZO: "Integration of medical oncology and palliative care procedures in various institutional and economical settings: Development of tailored interventions based on patient needs and testing of its preliminary efficacy on patient reported outcomes, tumour control and costs" financed by Romanian-Swiss Research Programme – IZERZO 142226<br>Swiss-Romanian Cooperation Programme: Overcoming disparities on access to quality basic palliative care in the community |
| Spain | Universidad Autónoma de Madrid: máster en Cuidados Paliativos y Tratamiento de Soporte del Enfermo con Cáncer http://www.uam.es/ss/Satellite/es/1242654675830/1242656616884/estudiopropio/estudioPropio/Master_en_Cuidados_Paliativos_y_Tratamiento_de_Sop orte_del_Enfermo_con_Cancer.htm<br>Universidad de Valladolid: máster en cuidados paliativos http://www.enclaveformacion.com/master-paliativos/<br>Universidad de La Rioja: máster universitario en cuidados paliativos pediátricos: http://www.unir.net/master-cuidados-paliativos-pediatricos.aspx<br>Máster universitario en enfermería en cuidados paliativos (Univ. de Navarra): http://www.universia.es/estudios/unav/unav-master-universitario-enfermeria-cuidados-paliativos/st/193269#<br>Enfermería en los Cuidados Paliativos. Hospitalización Domiciliaria (Escuela de Ciencias de la Salud. Centro adscrito a la UCM). http://www.emagister.com/enfermeria-cuidados-paliativos-hospitalizacion-domiciliaria-cursos-2576225.htm |
| Italy | www.cure-domiciliari.it/files/Testimonianza.pdf<br>www.aniarti.it<br>Osservatorio delle Buone Pratiche nelle Cure Palliative<br>Federazione Cure Palliative |
| Belgium | Starting with early identification of palliative care patients by general practitioners (GPs), the **Care Pathway for Primary Palliative Care** (CPPPC) is believed to help primary health care workers to deliver patient- and family-centered care in the last year of life. The care pathway has been pilot-tested, and will now be implemented in 5 Belgian regions: 2 Dutch-speaking regions, 2 French-speaking regions and the bilingual capital region of Brussels. The overall aim of the CPPPC is to provide better quality of primary palliative care, and in the end to reduce the hospital death rate (Leysen B, 2015). |

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