Who Needs Supportive & Palliative Care?

Identifying patients for palliative care needs assessment and anticipatory care planning

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When does “palliative care” begin?

- Once it is “certain” the patient is dying
- If the subject of dying is raised by the patient
- If symptoms such as uncontrolled pain develop

- When “not for” treatment decisions are made
- At referral to specialist palliative care
- When the patient is admitted to a care home
- When the patient is sent home from hospital

When the patient is identified as being at risk of dying within 12 months....
**Prognosis: art and science**

“End of life care should encompass all people judged sick enough to die, even though some will live in fragile health several years”

Dy S, Lynn J BMJ 2007;334:511-513

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**End of Life Care**

People are ‘approaching the end of life’ when they are **likely to die within the next 12 months**. This includes people with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events.

General Medical Council, UK 2010
UK policies reflect commitment to better palliative care....

• Equity – any patient with a life limiting condition
• Focus - living well with an advanced condition/ dying in preferred place
• Target – specialist resources for those with most complex needs/ improve generalist care

**Identification is key**

**Identification: tools & triggers**

- Numeric scores:
  - Best developed in cancer but tried in non-malignant illnesses:
    - Palliative performance scale (PPS) – modified Karnofsky scale
      - Ambulation, activity, self care, intake, level of consciousness
    - Other measures use inflammatory markers or albumin
- Disease specific mortality risk tools
- Qualitative descriptors:
  - Surprise question
  - Gold Standards Framework – Prognostic Indicator Guidance
  - RADPAC, NEEDPAL

**Supportive & Palliative Care Indicators Tool**

**SPICT™**
Screening using the SPICT™

- Clinical indicators & triggers from mortality tools
- Refined descriptors – peer review
- Single page summary
- 3 key questions
  - General indicators of deteriorating health
  - Clinical indicators of one or more advanced, life-limiting conditions
  - Team think this person is at risk of dying
- Prompts assessment and appropriate planning

Supportive and Palliative Care Indicators Tool (SPICT™)

Cancer
- Functional ability deteriorating due to progressive metastatic disease.
- Too frail for oncology treatment or treatment is for symptom control.

Dementia/ frailty
- Unable to dress, walk or eat without help.
- Choosing to eat and drink less;

Urinary and faecal incontinence.
- Unable to communicate meaningfully; little social interaction.

Fractured femur; multiple falls.
- Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease
- Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- Speech problems with increasing progressive dysphagia.
- Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart/ vascular disease
- NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:
  - At rest or on minimal exertion.
- Severe, inoperable peripheral vascular disease.

Respiratory disease
- Severe chronic lung disease with:
  - Between exacerbations.
- Needs long term oxygen therapy.
- Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease
- Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.
- Kidney failure complicating other life-limiting conditions or treatments.
- Stopping dialysis.

Liver disease
- Advanced cirrhosis with one or more complications in past year:
  - Portal hypertension.
  - Acute liver failure.
  - Ascites.
  - Intractable ascites.
- Liver transplant is contraindicated.

The SPICT™ is a guide to identifying people at risk of dying within the next 12 months.

Look for two or more general indicators of deteriorating health.
- Performance status poor or deteriorating, with limited reversibility.
  (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (> 10%) over the past 3-6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Some in training care homes or MDT caring for care and or needs care to be made at home.
- Patient requests supportive and palliative care, or treatment withdrawn.

Look for any clinical indicators of advanced conditions

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or
  - Agreed current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (e.g., with a primary care register).

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Screening for unmet needs: SPICT™

- Unplanned hospital admissions
- Increasing care needs/ care home setting
- Performance status deteriorating
- Persistent weight loss/low body weight
- Persistent troublesome symptoms despite optimal treatment

- Patient choice
- Disease related indicators

Using the SPICT™ in a region

coordinate my care
Using the SPICT™ in your practice

Assess and plan supportive & palliative care
- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).
- Review – significant event analysis of deaths

What matters – goals and concerns

- What do you understand about your health?
- What problems are troubling you and your family at present?
- What worries you about the future?”

Hope for the best but have a plan just in case....
Better identification = better outcomes

- Avoid crises at home
- Prompt review/discussion about goals of care
- Allow time for legal/family planning ahead
- Reduce unplanned admissions if no gain from hospital type care
- Rationalise medication & treatments
- Improve continuity and quality of care

I did it my way…

Who Needs Palliative Care?

Identifying patients for palliative care needs assessment & anticipatory care planning
How can you do this in your own situation?

www.spict.org.uk