Trying to predict the future - the challenge of identifying who should be added to the palliative care register

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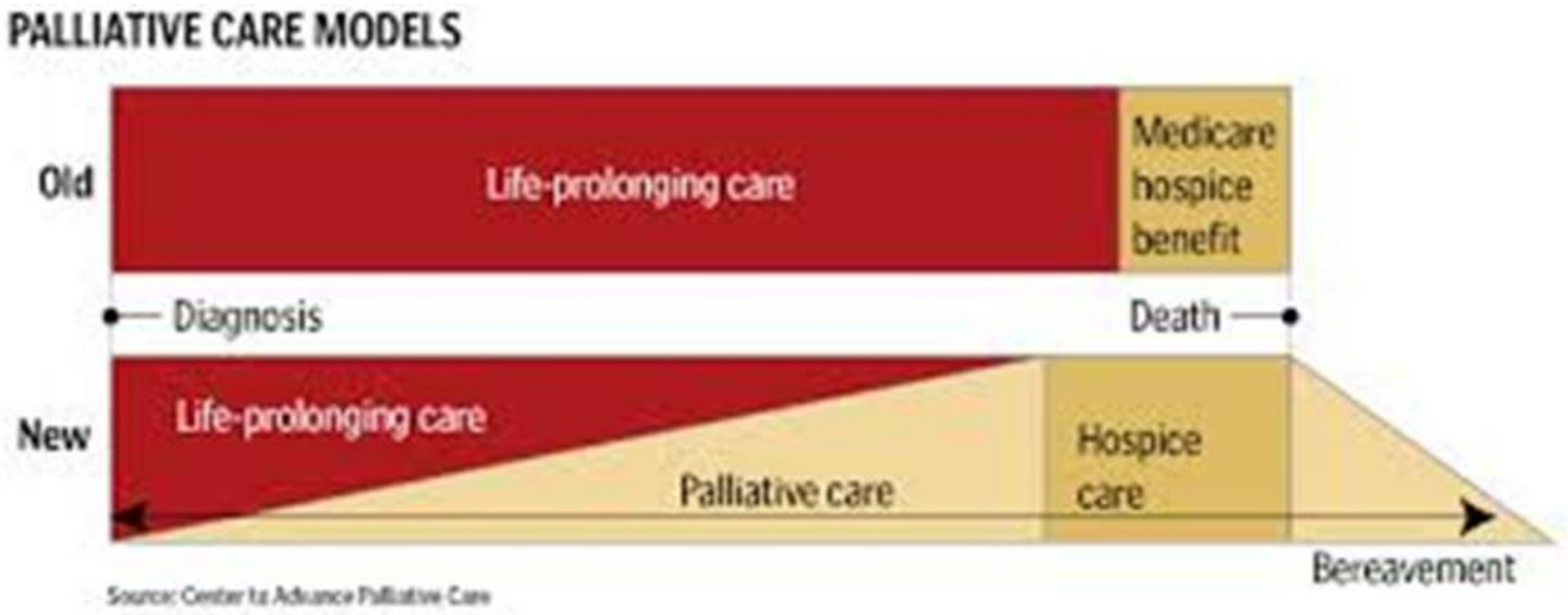
The Challenge…….

OR……
Is it more about…..

…identifying when people would benefit from a palliative approach

"Palliative Care is an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems"

WHO 2002


PALLIATIVE CARE MODELS
Old
Life-prolonging care
Medicare hospice benefit
Diagnosis
Death
New
Life-prolonging care
Palliative care
Hospice care
Bereavement
Source: Center to Advance Palliative Care

How to identify when a palliative approach may be needed / when to add to register

- Illness that cannot be cured
- Prospect of recovery uncertain
- “The surprise question”
- Tools, e.g. SPICT tool
- Patient requests no further active treatment and / or palliative approach to care
- When identified in secondary care setting (NB Communication)

“The Surprise Question”

“Would you be surprised if this patient were to die in the next few months, weeks, days?”

A way of tapping into clinical instinct??

Used to say “….next 6- 12 months”

Although has not been proven to accurately estimate actual life expectancy, evidence appears to show an answer of “no” is a good predictor of palliative care need

SPICT Tool

Supportive and Palliative Care Indicators Tool (SPICT ™)

NHS Lothian

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 (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

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; difficulty maintaining nutrition.

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 difficulty communicating and/or 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:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion 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:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible.

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).

SPICT™, September 2010

SPICT Tool

People at risk of deteriorating health or dying have:

- 2 or more general indicators of deteriorating health
- Any clinical indicators of 1 or more advanced conditions

Although no plans to officially roll out or mandate this tool, it may be a useful resource if unsure of whether or not someone should be on a palliative care register

SPICT – General Indicators of deteriorating health

- Performance status poor of deteriorating
- Dependent on others for most care needs
- 2 or more unplanned hospital admissions in the last 6 months
- Significant weight loss (5-10%) over the past 3-6 months and / or low BMI
- Persistent troublesome symptoms despite optimal treatment of underlying condition
- Patient asks for supportive and palliative care or treatment withdrawl

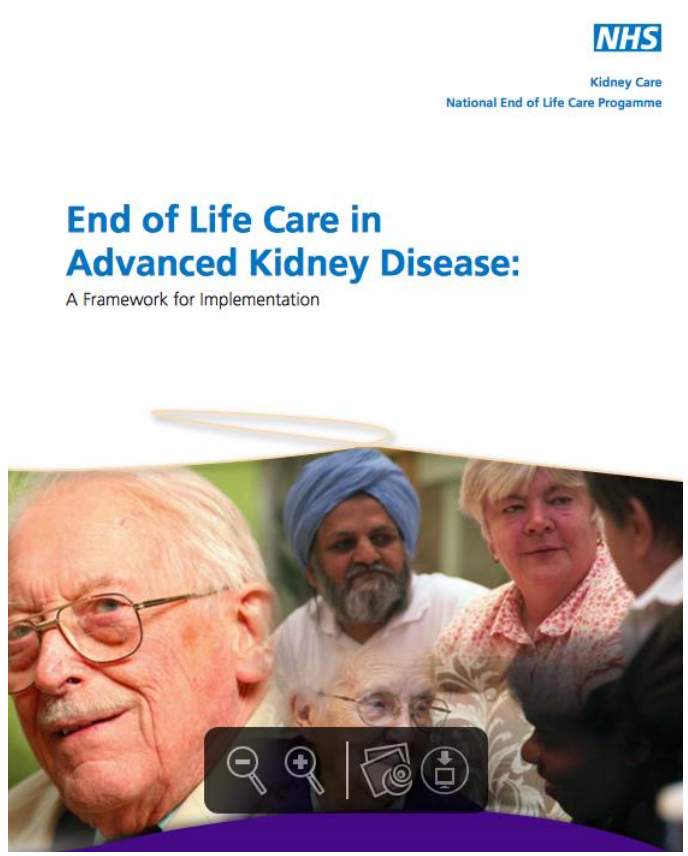
SPICT – Dementia / Frailty

- Unable to dress, walk or eat without help
- Eating and drinking less, swallowing difficulties
- Urinary and faecal incontinence
- No longer able to communicate using verbal language, little social interaction
- Fractured femur, multiple falls
- Recurrent febrile episodes or infections / aspiration pneumonia

Identification in Secondary Care

Example of “Renal outreach service”

Background



(2009)

(2012)

What did we do?

- “Cause for concern” register of dialysis patients at RLH, identifying those at risk of deterioration using GSF prognostic indicators
- Monthly renal / palliative care MDM attended by dialysis team, attended by dialysis team, hospital SPCT, St Joseph’s Hospice
- Advise on all patients
- For most complex patients, see jointly in OPD clinic and / or refer to community palliative care team
- Template created for GP letter to be generated post each MDT discussion, advising to add to pall care register where relevant

Evaluation – after 15 months

- Significant increase in offers of ACP discussion, and documented ACP
- Significant increase in CMC records created
- Increase in number of people with dialysis stopped in a planned way
- Increase in SPC referrals
- Positive feedback from renal staff

- GP's not included in evaluation but 1 GP wrote back to give positive feedback and report that patient had been added to palliative care register

Summary

- Prognostication difficult – should not beat ourselves up
- Suggest prioritising identification of palliative care need rather than trying to accurately prognosticate
- SPICT tool may be useful
- Further work needed on information transfer between primary and secondary care

Thank you

Questions?