Identifying patients with advanced conditions for supportive and palliative care using a clinical indicators tool: SPICT™

THE UNIVERSITY of EDINBURGH

NHS Lothian

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Background

- Systematic identification of patients with advanced conditions who are at risk of dying within 12 months is a prerequisite for effective end of life care.
- Interventions to improve the current and future care of these people and their families depend on better and earlier identification.
- Prognostication requires clinical judgement based on multiple sources of evidence and is an informed estimate that a patient's health is deteriorating.

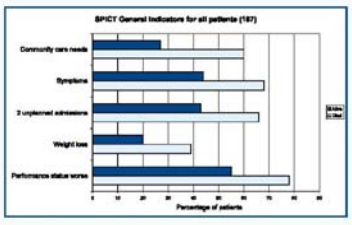
"The physician's goal is to formulate an individualised prognosis for the patient starting with a generalised prognosis and modifying it using clinical observations, performance status, symptoms, co-morbidities, will-to-live and knowledge of illness trajectories."

Glare P. Journal of Palliative Medicine 2008:11(1):84-103.

Aims

SPICT™ is designed to:

- Include evidence-based clinical indicators of advanced conditions and multimorbidity
- Be used by a range of professionals in all care settings; community, care homes and hospitals
- Provide clear guidance, in accessible language, that can be discussed with patients and families and communicated between professionals
- Use a one-page format
- Prompt assessment and review of the current and future care needs of patients and their families
- Promote early supportive and palliative care in parallel with optimal management of the patient's underlying condition(s)



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 contraindicated.

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 2012

Methods

SPICT™ has been developed using three integrated, participatory approaches within an overall quality improvement framework:

- **Literature review:**
  - Consensus documents and research studies describing clinical indicators of advanced illness and a limited prognosis
- **Peer review:**
  - Publication in the British Medical Journal[1]
  - Open website access to SPICT™
  - Partnership working with collaborators using SPICT™ in primary and secondary care;
    - electronic anticipatory care plan in London (*Coordinate My Care*)
    - hospital electronic patient record in Coventry (www.c-a-s-t-l-e.org.uk)
    - primary care registers (NHS Scotland)
- **Prospective, case finding study in SE Scotland:**
  - SPICT™ checklist used to screen patients soon after an unplanned, hospital admission to renal, liver, cardiac, respiratory, cancer and acute medicine units
  - Six month follow-up of SPICT™ identified patients
  - Analysis of service use in the last 6 months of life by SPICT™ identified patients
  - SPARRA scores for patients identified by SPICT™ screening [2]
  - Qualitative study of assessment and care planning for SPICT™ identified patients with liver, renal, cardiac or respiratory disease

Results

- Clinicians successfully used the SPICT to identify 187 patients with advanced conditions, mainly multimorbidity. Identified patients had:
  - multiple admissions with acute complications of their illnesses or treatments, and unmet palliative care needs
  - SPARRA scores indicating a high risk of further unplanned hospital admissions (median risk 60%)
  - high bed occupancy in the last 6 months of life (median 28 days, range 1-135)
  - a high mortality rate (45% at 6 months); most died in hospital (65%), particularly non-cancer patients (85%)
  - little anticipatory care planning; 47% of patients who died had a DNA CPR form at initial screening

Conclusions

- The SPICT can aid clinical decision making by identifying patients at risk of dying within 12 months and prompting earlier supportive and palliative care
- Rapid patient throughput, limited continuity of care between primary and secondary care, and complex attitudes to "palliative care" are barriers to systematic identification and proactive anticipatory care planning.

Further information

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References

1. Boyd K, Murray SA. Recognising and managing key transitions in end of life care. BMJ 2010; 341:c4863
2. Scottish Patients at Risk of Readmission and Admission (SPARRA): algorithm from the Scottish Information Services Division – predicts a patient's risk of emergency hospital admission in a particular year. (Version 3, 2011, ISD) www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/