Hospital Palliative Care Team Referrals for People with Advanced Liver Disease

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Background

There is growing evidence of improved outcomes for people with advanced liver disease who are referred to a specialist palliative care team (1).

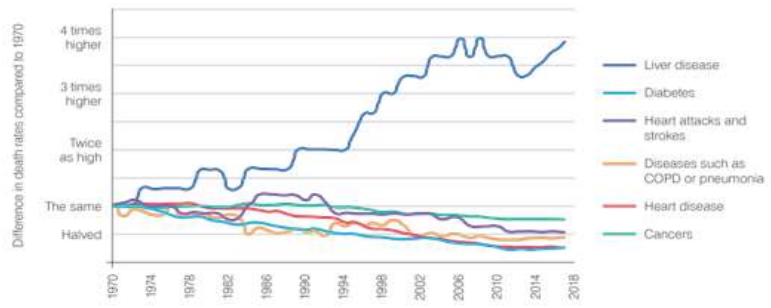
Aim

To audit referrals to the Hospital Palliative Care Team (HPCT) for people with advanced liver disease, using recently published British Society of Gastroenterology (BSG) criteria (2).

Advanced Liver Disease

Mortality Rates (3)

- >10,000 deaths each year
- 1,237 deaths in Scotland in 2022
- Since 1970 deaths increased by 64%
- All other major diseases death rates are declining



Role of Palliative Care Team

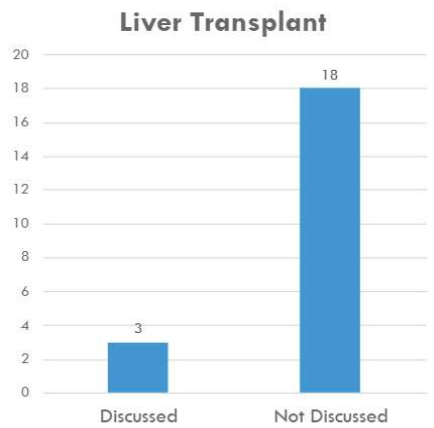
- Historically underutilised, now deemed best practice to involve early on.
- Parallel planning, "hoping for the best but planning for the worst"
- Optimise symptom management and improve QOL
- Support discussions about disease trajectory and ACP, high level of uncertainty
- Often high burden of social, psychological (inc stigma) and financial stressors
- Assessing palliative care needs now recommended as part of transplant assessment ~ 50% assessed are declined and 20 % die whilst waiting (4,5,6)

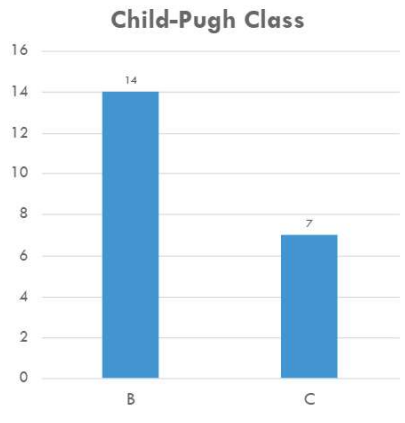
Demographics

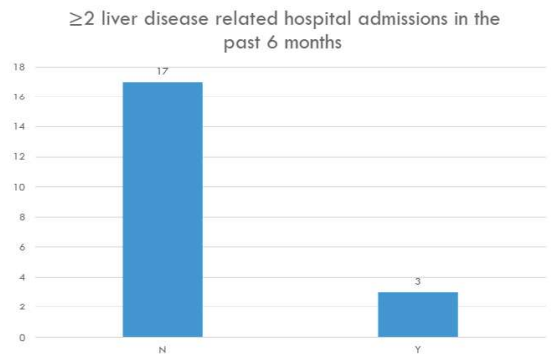
Total number of people in audit: 21 (10 men and 11 women)

Age range: 38 – 87 years old

Mean age: 60 years old







We found it particularly challenging to find documentation of discussions with patients about their eligibility for liver transplant assessment. The three patients that had documented discussions were all deemed unsuitable for transplant.

Criteria for Specialist Palliative Care Referral

British Society of Gastroenterology Best Practice Guidance:

Based upon the Supportive and Palliative Care Indicators Tool (SPICT) and Bristol Screening Tool (2)

Patients who meet 1 or more of the below criteria should be considered for referral to palliative care.

A. Patients with Child Pugh C cirrhosis.
B. Patients undergoing assessment for liver transplant or who are on the waiting list.
C. Patients with decompensated ARLD with ongoing alcohol use.
D. Patients with irreversible decompensated disease not deemed to be a suitable candidate for liver transplant.
E. Patients with two unplanned liver-related admissions within the past 6 months.
F. Patients with hepatocellular carcinoma for best supportive care.

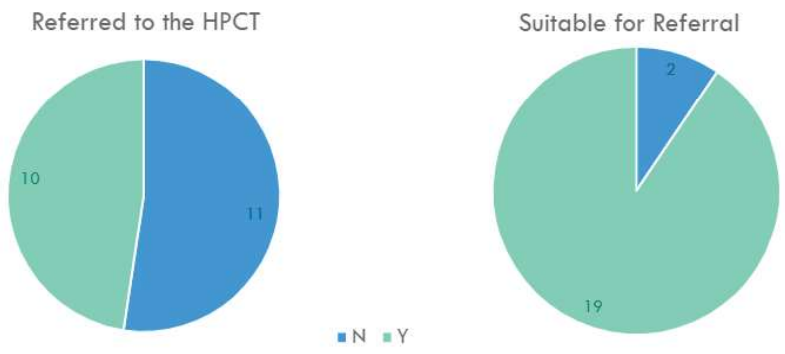
Method

- Point prevalence audit on a single day (29/11/2023)
- Inclusion Criteria: all patients with a diagnosis of liver disease admitted to the 2 liver wards at a university teaching hospital.
- Ward notes and electronic patient records analysed: demographic data, including aetiology of liver disease, alcohol use, admission history, Child Pugh score (7) (below), transplant status and referral to specialist palliative care services, were collected.

PARAMETER	1	2	3
Serum Bilirubin (mg/dl)	**2.0**	2–3	>3.0
Serum Albumin (g/dl)	>3.515	2.8–3.5	<2.8
Prothrombin Time (Prolongation(s))	1–4	5–6	>6
Hepatic Encephalopathy	None	Minimal	Moderate
Ascites	None	Slight	Moderate
1 and 2-years survival based on CTP Score Class	**1 yr**	**2 yr**	
A (5–6 points)	100%	85%	
B (7–9 points)	80%	60%	
C (10–15 points)	45%	35%	

Results

90% of patients admitted to hospital with advanced liver disease to the liver wards met the criteria for referral to the palliative care team however only 48% were referred.



Potential reasons why a referral was not made:

- **first presentation** with advanced liver disease
- awaiting **diagnostic** confirmation
- **limited patient engagement** with outpatient services

Conclusion

A significant proportion of patients admitted to hospital with advanced liver disease will meet the criteria for a referral to palliative care, therefore we should consider referral to hospital palliative care teams early on in admission. With a high mortality rate and complex symptom management advanced liver disease patients benefit from early future planning discussions and symptom control.

Next Steps:

After discussion with our local hepatology team, we plan to work collaboratively to create an educational resource and further improve the pathway for inpatient hospital palliative care team referrals for people with advanced liver disease.

We would also like to investigate further into why some patients who were deemed appropriate for HPCT referral were not referred also taking into account the palliative care provided by the hepatology ward team.

We hope to complete a second cycle of the audit; there is potential for a single assessment to benefit both patient outcomes and strengthen reciprocal understanding of hepatology and palliative care roles in advanced liver disease care.

References

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