Palliative Care

*Early is Better Than Late*

Louise Mason
Consultant in Palliative Medicine

@PallMedMD
Overview

• Why palliative care is for the dying and for those living with advancing disease
• How palliative care can benefit patients and acute medicine teams
• How to develop an effective early joint working initiative between acute medicine and palliative care
“She’s our new Palliative Specialist!”
Treatment and care towards the end of life:
good practice in decision making

Guide on the decision-making process regarding medical treatment in end-of-life situations

General Medical Council
Regulating doctors
Ensuring good medical practice
Palliative care is...?

Common views:
• What you do when everything else has failed
• What you do when you can’t refer to anyone else
• Instead of life prolonging treatment
• Giving up
• “Brink of death” care
Over the next 20 years the number of people in England aged 65-84 will grow by over a third and those over 85 will more than double.
# Symptoms of people with serious and life-threatening illness

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Cancer (%)</th>
<th>Other (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>84%</td>
<td>67%</td>
</tr>
<tr>
<td>Trouble breathing</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>51%</td>
<td>27%</td>
</tr>
<tr>
<td>Sleepiness</td>
<td>51%</td>
<td>36%</td>
</tr>
<tr>
<td>Confusion</td>
<td>33%</td>
<td>38%</td>
</tr>
<tr>
<td>Depression</td>
<td>38%</td>
<td>36%</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>71%</td>
<td>38%</td>
</tr>
<tr>
<td>Constipation</td>
<td>47%</td>
<td>32%</td>
</tr>
<tr>
<td>Bed sores</td>
<td>28%</td>
<td>14%</td>
</tr>
<tr>
<td>Incontinence</td>
<td>37%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Seale and Cartwright, *The year before death.* 1994
Non malignant disease ➝ physical and psychological burden

Ryan et al. BMC Palliative Care 2013, 12:11
http://www.biomedcentral.com/1472-684X/12/11

RESEARCH ARTICLE
Symptom burden, palliative care need and predictors of physical and psychological discomfort in two UK hospitals

Tony Ryan¹*, Christine Ingleton¹, Clare Gardiner², Chris Parker¹, Merryn Gott³ and Bill Noble⁴
Living with advancing chronic disease

- High unmet symptom burden
- Unmet psychological and social needs
- High carer burden and stress
- Poorly coordinated care
- Poor planning for the end of life
  - 48.9% deaths occur in hospital England (ONS 2012)
  - 30% of hospital in-patients have entered the last year of their life (Clark et al, Pall Med 2014)
- Huge health and social care costs
Average hospital cost/day in final 90 days of life (n=1.22M)

Old model of palliative care
Old versus new model of palliative care

The evolving model for palliative care

Life prolonging therapy

Palliative care

Bereavement care

Time →

Advanced illness

Death
Most referrals for palliative care

Life prolonging therapy

Palliative care

Bereavement care

Advanced illness

Death

Time →
Up stream palliative care to meet need

Life prolonging therapy

Palliative care

Bereavement care

Advanced illness

Death
When to consider palliative care?
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; breathlessness or respiratory failure.

**Heart/ Vascular disease**
- NYHA Class II/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).
The SPICT™ is a guide to identifying people at risk of dying within the next 12 months.

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**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.

### 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.
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### Kidney disease
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- Systemic inflammatory disorder.
### Look for any clinical indicators of advanced conditions

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Stopping dialysis. |
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What can we bring to the table?

• Support and education of others
• Symptom control
• Emotional/psychological support
• Family support
• Prognostication, preparation and Advance Care Planning
• Negotiators in really challenging conversations
• Care coordination, including Rapid Discharge for those who do not want to die in hospital
• Care of the actively dying
ONE CHANCE TO GET IT RIGHT

Improving people’s experience of care in the last few days and hours of life.

Published June 2014 by the Leadership Alliance for the Care of Dying People
Palliative care can...

- Reduce costs in-patient care

- Reduce length of stay

- Change patterns of acute service use
  - (Seow et al, BMJ 2014)

- Improve symptoms

- Improve quality of life

- Improve satisfaction with care

- Improve survival
  - (Temel et al, NEJM Aug 2010)
How can palliative care and acute medicine work together?

• Find your champions
• Understand each others pressures and drivers
• Look at the evidence
• Consider your resources
• Consider the most pressing needs
• Review those who might benefit and decide on triggers for automatic referral

See: http://www.capc.org/ipal/ipal-em
Possible automatic referral triggers?

• Metastatic/locally advanced cancer
• Care home with nursing and ≥2 co-morbidities
• Advanced dementia
• Prior palliative care referral e.g. hospice, CPCT
• End stage organ disease

• What will work best for your unit?
Case example
Our success

• ED/AMU referrals must be seen the same day
• Palliative care consultant attends AMU handovers each morning
  • 50% increase in referrals
• See patients meeting SPICT criteria
• See those who are at high risk of dying
• Educate MP team and workforce on what can be done without specialist input
• Service evaluation
Take home message

• Hospital admissions are common in people living in the last year of life
• Many of these patients will have unidentified and/or unmet palliative care need
• Target your at risk populations
• **Palliative Care: Early Is Better Than Late**
Palliative Care

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