PALLIATIVE AND END OF LIFE CARE

PALLIATIVE CARE

LIVING AND DYING WELL

'palliative care is not just about care in the last months, days and hours of a person's life'

OXFORD TEXTBOOK OF PALLIATIVE CARE

' palliative medicine is the study and management of patients with active, progressive, far-advanced disease for who the prognosis is limited and the focus of care is the quality of life '

1987

END OF LIFE

- LAST FEW DAYS
- LAST FEW WEEKS
- LAST FEW MONTHS
- LAST YEAR [OR MORE]

END OF LIFE

GMC	WITHIN 12 NEXT MONTHS
RCN	USUSALLY REFERS TO THE LAST YEAR OF LIFE ALTHOUGH FOR SOME PEOPLE THIS WILL BE SIGNIFICANTLY SHORTER
RCGP	FINAL YEARS AND MONTHS OF LIFE AS WELL AS THE DYING PHASE
NICE	LIKELY TO DIE WITHIN 12 MONTHS

END OF LIFE

WIKIPEDIA

FINAL HOURS OR DAYS

BMJ : 2008

IMPROVING GENERALIST END OF LIFE CARE: NATIONAL CONSULTATION WITH PRACTITIONERS, COMMISSIONERS, ACADEMICS AND SERVICE USER GROUPS

'definitions of end of life care need clarification and standardisation'

QUOTE

‘ BUT I HAVE PROMISES TO KEEP AND MILES TO GO BEFORE I SLEEP ’

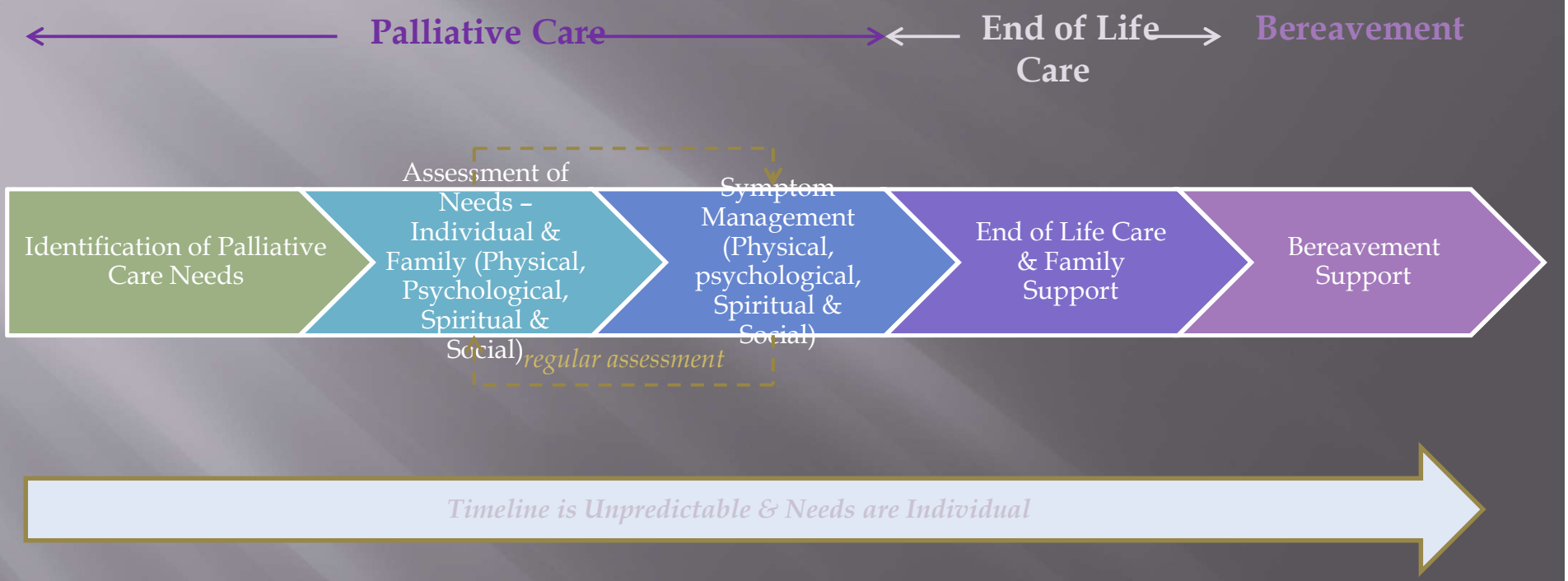
ROBERT FROST

1874-1963

PALLIATIVE CARE

- PHILOSOPHY OF CARE
- HOLISTIC
- PRINCIPLES ARE INTEGRAL TO ALL GOOD CARE
- WHATEVER THE NATURE OR STAGE OF AN ILLNESS
- IDENTIFYING AND ADDRESSING NEEDS
- QOL MAINATINED OR MAXIMISED

High Level Pathway of Care



NHS Grampian

NHS Grampian **Palliative & Supportive** Care Plan **2017**

Supportive and Palliative Care Indicators Tool (SPICT™)

NHS Lothian

www.spict.org.uk

The SPICT™ is a guide to identifying people at risk of deteriorating and dying.

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.

No longer able to communicate using verbal language; 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.

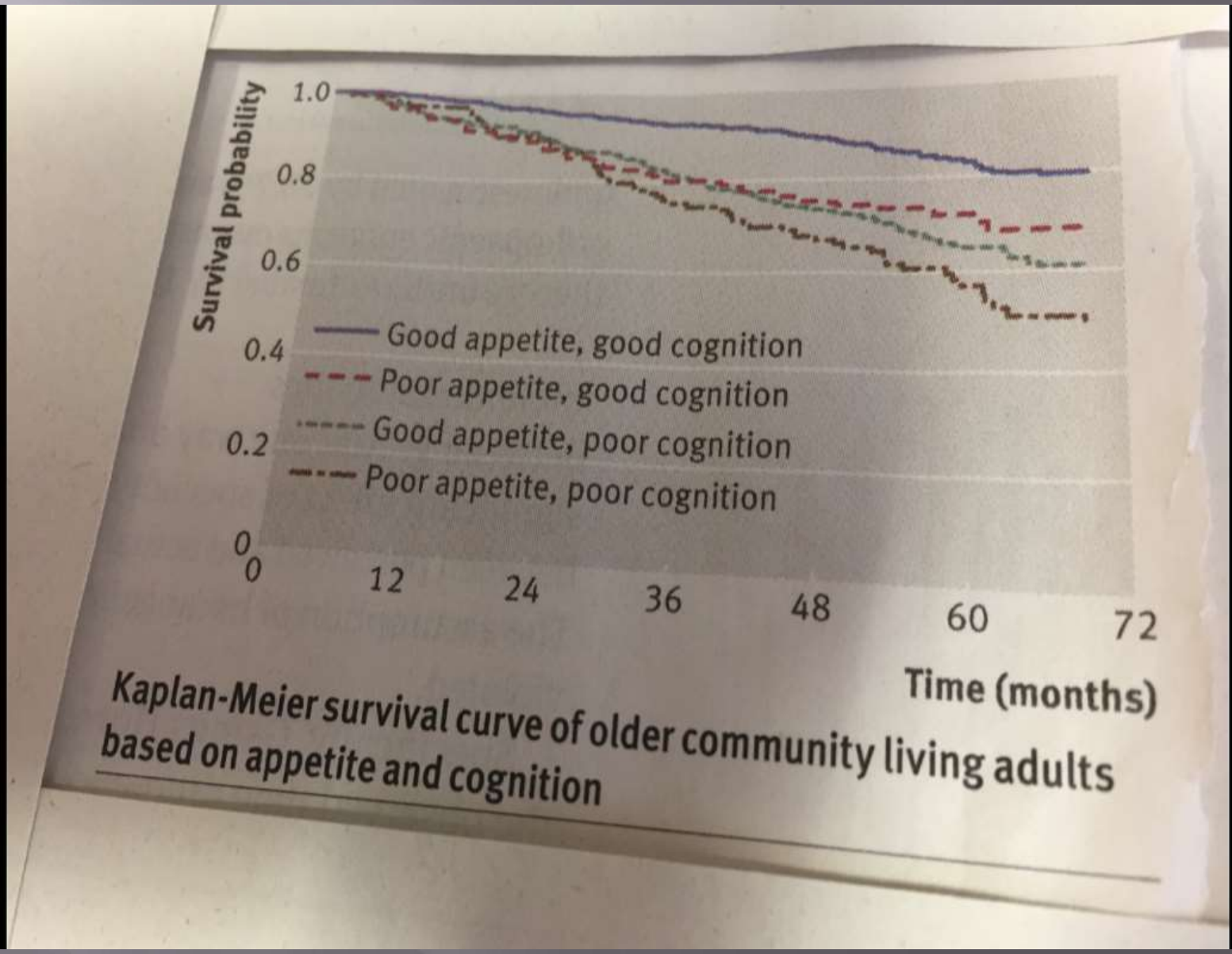
Assess and plan supportive & palliative care

- 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™, June 2013

HIPPOCRATES

‘ IT AUGURS WELL, IF THE PATIENT’S MIND IS SOUND AND HE ACCEPTS ALL FOOD THAT’S OFFERED HIM; BUT IF THE CONTRARY CONDITIONS DO PREVAIL, THE CHANCES OF RECOVERY ARE SLIM’



Kaplan-Meier survival curve of older community living adults based on appetite and cognition

AGE AT DEATH

AGE	NUMBER	PERCENTAGE
<40	3	
41-50	8	
51-60	19	8%
61-70	44	18.4%
71-75	31	13%
76-80	37	15.5%
81-85	45	18.8%
86-90	31	13%
91-100	21	8.8%

- 87.5% of deaths occur in > 60yrs
- 69% of deaths occur in > 70yrs

CHORUS

ALWAYS REMEMBER THE LONGER YOU LIVE

THE SOONER YOU'LL BLOODY WELL DIE

PROJECTED POPULATION OF GRAMPIAN

	2002	2012	2022	2032
65-74	43,761	51,476	62,600	70,800
75+	36,076	42,574	54,900	73,300
TOTAL	79,837	94,050	117,500	144,100

GROS

SO

- BY 2032 ALMOST ¼ OF THE POPULATION WILL BE OVER 65 YEARS OLD
- COMPARED WITH 2012 THIS REPRESENTS A PERCENTAGE INCREASE OF :--

  34.7% IN OVER 65s

  65.1% IN OVER 75s

HOWEVER

IN GRAMPIAN 89.3% OF THE LAST 6 MONTHS

OF LIFE IS SPENT AT HOME OR IN A COMMUNITY SETTING

[2018]

PREVALENCE OF SYMPTOMS IN PALLIATIVE CARE

- FATIGUE 91%
- PAIN 79%
- BREATHLESSNESS 58%
- NAUSEA 58%

DRY MOUTH 78%
ORAL DISCOMFORT 46%
TASTE ALTERATION 44%

ORAL CARE IN ADVANCED DISEASE, DAVIES/FINLAY

3 PERSONAL IRRITATIONS

- POVERTY OF ORAL CARE
- INCORRECT USE OF NYSTATIN
- GLANDOSANE