A QUICK GUIDE to Identifying Patients for Supportive and Palliative Care

Do they have a life-limiting, incurable condition?

What clues exist… to suggest they might be suitable for your register? *These cut across all disease groups*

1. The **Surprise** questions.
    a. No Surprise if they were to die in the next 6-12months.
    b. A surprise if they were to live longer than 6-12 months. Higher priority.
2. **General decline**. Symptomatic with low level activity**.**

Formal measures of poor or deteriorating performance status include

a. Limited self-care; in bed or chair over 50% of the day
b. MRC Breathlessness scale 4/5
c. NYHA Grade 3/4
d. WHO Performance Grade 3/4

Remember "…before they shuffle off this mortal coil they just shuffle[4]".

3. Two or more unplanned **hospital admissions** in the last 6 months.
4. Progressive **weight loss** > 10% over last 6 months.
5. **Co-morbidities.** More than one life-threatening illness.
6. **Burden of illness** - physical, psychological, financial or other.

Who will benefit… from their inclusion on the register?

1. The **Patient**
    - Increased focus on symptom control and burden of illness.
    - Chance to explore wishes, worries and priorities - now and for the future.
2. The **Practice**
    - Improved team awareness, planning and working for patients most likely to have acute events or crises
    - Reduced unplanned secondary care spends.
3. The **Patient's Support**
    - Support for the patient's carers and family through e.g. carer assessment, referral to a carers' organisation

What next… if you think they are suitable for your register?

1. Optimal Care

Are they receiving best practice care for their disease group e.g. heart failure or COPD? This is good for both long term prognosis and palliation of symptoms.

2. Tell the Patient: e.g.

- We have a practice 'GSF/priority/gold/Supportive and Palliative Care' register of people with the greatest health needs.
- The register helps us to focus our best efforts on improving your quality of life and symptoms, and to support those who care for you.
- We will discuss your case as a team and put an alert on your record so that everyone is aware of your priority status if your record is brought up.
- We will take a step back and consider whether we can improve your treatment, to ensure that you are receiving 'best practice' care for your condition.
- We will give you the opportunity, where you wish, to discuss any preferences you might have if your health was to deteriorate in the future.

Specific disease related indicators
Look for two or more of the following

Heart disease	Respiratory disease	Cancer
NYHA Class III/IV heart failure, severe valve disease or extensive coronary artery disease.	Severe airways obstruction (FEV1<30%) or restrictive deficit (vital capacity < 60%, transfer factor <40%).	Performance status deteriorating due to metastatic cancer and/ or co-morbidities.
Breathless or chest pain at rest or on minimal exertion.	Meets criteria for long term oxygen therapy (PaO2 < 7.3 kPa).	Persistent symptoms despite optimal palliative oncology treatment or too frail for oncology treatment.
Persistent symptoms despite optimal tolerated therapy.	Breathless at rest or on minimal exertion between exacerbations.	**Neurological disease**
Systolic blood pressure <100mmHg and /or pulse > 100.	Persistent severe symptoms despite optimal tolerated therapy.	Progressive deterioration in physical and/or cognitive function despite optimal therapy
Renal impairment (eGFR <30 ml/min).	Symptomatic right heart failure.	Symptoms which are complex and difficult to control.
Cardiac cachexia.	Low body mass index (< 21).	Speech problems; increasing difficulty communicating; progressive dysphagia.
Two or more acute episodes needing intravenous therapy in past 6 months.	Increased emergency admissions for infective exacerbations and/or respiratory failure.	Recurrent aspiration pneumonia; breathless or respiratory failure.
Kidney disease	**Liver disease**	**Dementia**
Stage 5 chronic kidney disease eGFR< 15ml/min).	Advanced cirrhosis with one or more complications: • intractable ascites, • hepatic encephalopathy, • hepatorenal syndrome, • bacterial peritonitis, • recurrent variceal bleeds.	Unable to dress, walk or eat without assistance; unable to communicate meaningfully.
Conservative kidney management due to multimorbidity.	Serum albumin < 25g/l and prothrombin time raised or INR prolonged.	Increased eating problems; now needing pureed/ soft diet or supplements or tube feeding.
Deteriorating on renal replacement therapy; persistent symptoms and/or increasing dependency.	Hepatocellular carcinoma.	Recurrent febrile episodes or infections; aspiration pneumonia.
Not starting dialysis following failure of a renal transplant.		Urinary and faecal incontinence.
New life limiting condition or kidney failure as a complication of another condition or treatment.		

Reference
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