SPICT-LIS™

THE UNIVERSITY of EDINBURGH

SPICT-LIS™ helps identify people in low-income settings with advanced, progressive illnesses.
Offer the best available appropriate treatment. Assess unmet supportive and palliative care needs. Plan care.

Look for general indicators of poor or deteriorating health. May have one or more of these indicators.

- Performance status is poor or deteriorating. (e.g., person stays in bed or a chair more than half the day.)
- Depends on others for care needs due to increasing physical and/or mental health problems. Person's carer needs more help and support.
- Progressive weight loss; remains underweight; weight gain from persistent fluid retention.
- Persistent symptoms despite the best available appropriate treatment; cannot access treatment due to costs or distance to travel.
- Person wishes to focus on quality of life; chooses to reduce, stop or not have treatment; asks for palliative care.
- Unplanned hospital admissions; increased visits to hospital, clinic or health facility with progressive illness or complications.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

- Progressive or metastatic cancer with symptoms and functional decline.
- Too frail for cancer treatment. Cancer treatment is for symptom control only, or is not available.

Dementia and frailty

- Unable to dress, walk or eat without help.
- Eating and drinking less; swallowing difficulties.
- Urinary or faecal incontinence.
- Little social interaction or communication.
- Frequent falls; fractured femur.
- Recurrent infections; aspiration pneumonia.

Neurological disease and stroke

- Progressive deterioration in physical and/or cognitive function despite available therapy.
- Increasing difficulty speaking and/or progressive swallowing difficulties.
- Episodes of aspiration pneumonia; breathless or respiratory failure.
- Ongoing severe disability after stroke despite best available rehabilitation.

Heart/vascular disease

- Heart failure or extensive, untreatable coronary artery disease; breathlessness or chest pain at rest or on minimal effort.
- Severe, inoperable peripheral vascular disease.

Respiratory disease

- Severe chronic lung disease; breathlessness or chest pain at rest or on minimal effort.
- Persistent hypoxia needing long term oxygen, if available.
- Severe respiratory failure during exacerbations.

Kidney disease

- Stage 4 or 5 chronic kidney disease with deteriorating health.
- Kidney failure complicating other life-limiting conditions or treatments.
- Stopping or not starting dialysis.

Liver disease

- Cirrhosis with one or more complications in the past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - variceal bleeds

Infections

- Advanced TB: deteriorating health despite best available TB drug regimen.
- HIV: deteriorating health or complications not responding to best available treatment.
- Other infections not responding to best available treatment and health deteriorating.

Surgical conditions and trauma

- Severe burns with predicted poor outcome.
- Serious condition with no access to surgery; condition or health too poor for surgery.
- Brain injury with clinical deterioration and no benefit from surgical intervention.

Other conditions

- Deteriorating with other illnesses and/or complications that are not reversible (e.g. diabetes, haematological disease).
- Deteriorating with multiple conditions or general frailty in older age despite best available treatment.

Review current care and care planning.

- Review current treatment and medication; continue making sure person receives the best available appropriate treatment; minimise polypharmacy.
- Consider referral for specialist palliative care review (if available) and/or other relevant specialist services when problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, share, and review care plans regularly.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT-LIS™ October 2021

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Why use SPICT-LIS™?

The SPICT-LIS™ helps identify people with one or more general indicators of poor or deteriorating health and clinical signs of life-limiting conditions for assessment and care planning.

Offer the best available appropriate treatment integrated with a holistic palliative care approach. SPICT-LIS™ looks for changes in health status, burden of illness and increasing care needs. Timely identification avoids harm and improves treatment and care of patients and families.

Using SPICT-LIS™ to assess people's needs and plan care.

■ **Poorly controlled symptoms**: give the best available appropriate treatments for underlying conditions, stop medicines/tests not of benefit; use effective palliative symptom control measures.

■ People who are **increasingly dependent on others** due to deteriorating functional ability, physical frailty and/or mental health problems often need additional care and support.

■ Unplanned **hospital admission,** more clinic **visits** or a **decline in health status**: review current care, treatment and medication; discuss future options; plan for managing further deterioration.

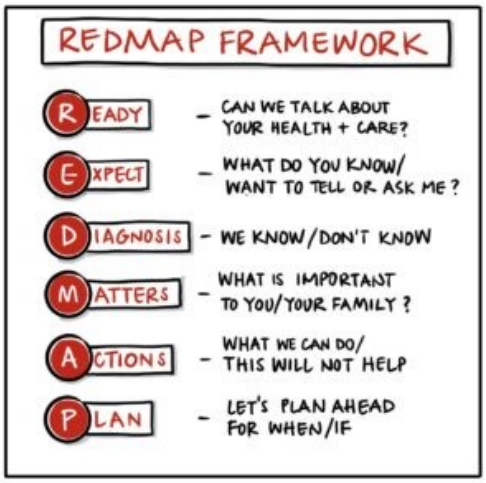
■ **Complex symptoms** or other patient/family **needs**; consider specialist palliative care review or involve another appropriate specialist or service, if available.

■ Plan **proactive, coordinated care** at home from the primary care team and/or other community services or workers. Involve the local community. Support family carers.

■ Assess **decision-making capacity**. Plan ahead if this will deteriorate. Record details of close family/friends and any legal proxies. Involve them in decision-making if capacity is impaired.

■ Agree, record, share, and plan to review a **care plan;** include plans for urgent/emergency care and treatment if the person's health deteriorates or their care and support at home changes.

Talking about future care planning



■Talk about:

- Benefits, harms and costs of hospital admission, outpatient visits, tests and treatments (e.g. IV antibiotics/fluids; surgery; cancer treatments, interventions for heart or kidney disease; tube feeding; oxygen/ventilation.
- Treatments that will not work or have a poor outcome for this person. (eg. cardiopulmonary resuscitation)
- Choosing legal proxy decision-makers in case the person's decision-making capacity is lost in the future.
- What a person would like; anything they do not want.
- Help and support for family/ informal carers.

Tips on starting conversations about care planning

- ***I wish*** *we had a treatment for… Could we talk about what* ***we can do*** *if that's not possible?*
- *I am glad you feel better and* ***I hope*** *you will stay well, but* ***I am worried*** *that you could get ill again…*
- ***Can we talk*** *about how we manage* ***not knowing exactly*** *what will happen and when?*
- ***If*** *you got less well in the future, what would* ***be important*** *for you? What* ***would she say*** *about this?*
- ***Some people*** *want to talk about whether to go to hospital or be at home if they are very ill….*