SPICT-LIS™

THE UNIVERSITY of EDINBURGH

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.

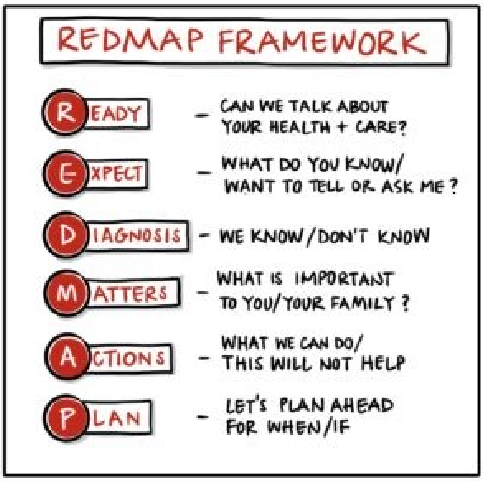
■ **Complex symptoms** or other patient/family **needs**; consider specialist palliative care review or involve another appropriate specialist or service, if available.

■ 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….*