Using the Supportive and Palliative Care Indicators Tool (SPICT™) to prioritise frail inpatients for Anticipatory Care Planning (ACP)

K Boothroyd 1; A Nicholson 1; E Tevendale 1
1 Bishop Auckland Hospital, County Durham and Darlington NHS Foundation Trust

Intro

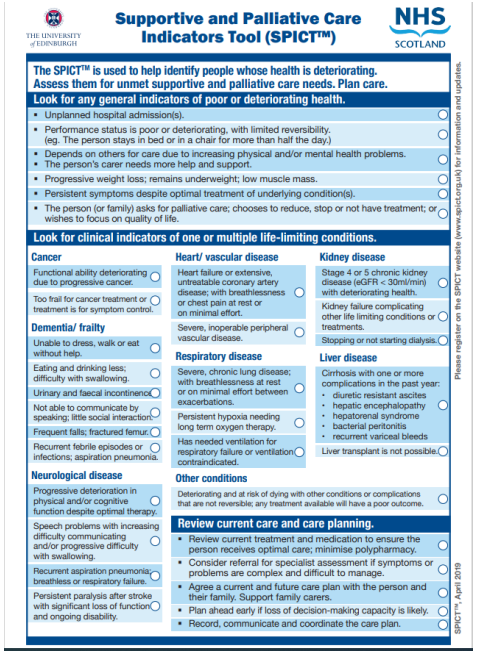
Frail inpatients are at high risk of mortality and recurrent hospital admissions

Clinician time capacity for What Matters Most conversations and ACP preparation is limited

We conducted a prospective study of patients with hospital admissions > 72 hours

Method

1 day survey—66 patients on 3 wards in Bishop Auckland Hospital were assessed using CFS and SPICT™. Patients who had ≥ 2 general indicators and ≥ 2 clinical indicators were deemed "SPICT positive". The cohort was followed up for 9 mths



Supportive and Palliative Care Indicators Tool (SPICT™)

NHS SCOTLAND

THE UNIVERSITY of EDINBURGH

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

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

Cancer
- Functional ability deteriorating due to progressive cancer.
- Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty
- Unable to dress, walk or eat without help.
- Eating and drinking less; difficulty with swallowing.
- Urinary and faecal incontinence.
- Not able to communicate by speaking; little social interaction.
- Frequent falls; fractured femur.
- 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 difficulty with swallowing.
- Recurrent aspiration pneumonia; breathless or respiratory failure.
- Persistent paralysis after stroke with significant loss of function and ongoing disability.

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

Respiratory disease
- Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.
- Persistent hypoxia needing long term oxygen therapy.
- Has needed ventilation for respiratory failure or ventilation contraindicated.

Other conditions
- Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

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 or not starting dialysis.

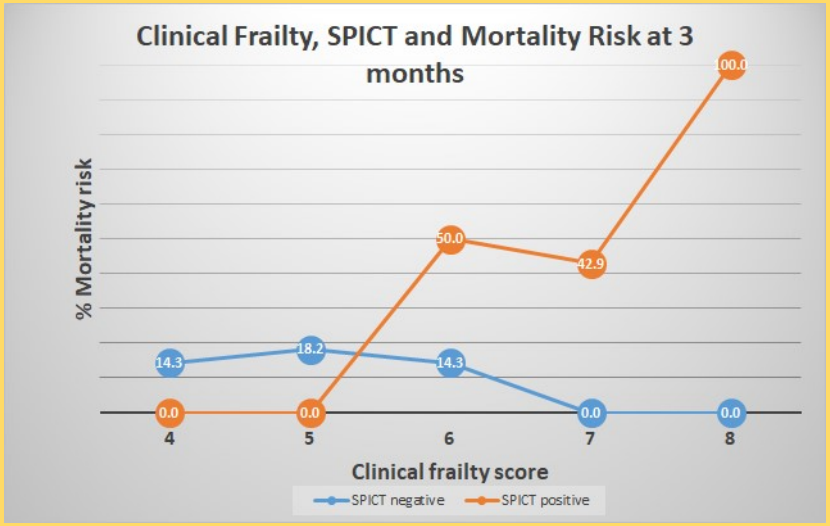
Liver disease
- Cirrhosis with one or more complications in the past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - recurrent variceal bleeds
- Liver transplant is not possible.

Review current care and care planning.
- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or 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, communicate and coordinate the care plan.

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

SPICT™, April 2019

Identify patients most likely to benefit from in-hospital **Anticipatory Care Planning** using the Supportive and Palliative Care Indicators Tool **(SPICT™)** and the Clinical Frailty Score **(CFS)**



NHS
County Durham and Darlington
NHS Foundation Trust

Results

58 (87.9%) were aged ≥ 65 years and had a CFS ≥ 4

32 (55.2%) were SPICT positive; 26 (44.8%) SPICT negative.

At 3 months follow-up SPICT had Positive Predictive Value (PPV) 40.6% and Negative Predictive Value (NPV) 84.6% for mortality.

At 6 months PPV = 56.3%; NPV = 80.8%.

At 9 months PPV = 59.4%; NPV = 76.9%.

SPICT negative patients with CFS 6 had mortality risk of 14.3% at 3, 6 and 9 months follow-up respectively.

SPICT positive patients with CFS 6 had mortality risks of 50% at 3 months and 62.5% at 6 and 9 months.

All patients discharged with ACPs died in their preferred setting.

Conclusion

SPICT is a predictor of mortality in patients with frailty who have unplanned admissions to hospital of ≥ 72 hours duration. It is now used alongside CFS for all patients admitted to our Specialist Frailty Unit, identifying patients most likely to benefit from inpatient ACP on discharge.

Why does it matter?

Patients discharged with a good quality ACP go on to die in their preferred setting

Screening frail inpatients with SPICT™ and CFS enables clinicians to have What Matters Most conversations and ACP discussions with those most likely to benefit soonest from ACPs

This could improve patient and carer experience and reduce unbeneficial hospital admissions

Our practice has changed—numbers of ACPs written for our patients has more than tripled