Predicting prognosis within a Palliative Approach Framework

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Most of the residents we care for will die from complications of progressive chronic and/or advanced disease. It is difficult to accurately predict the rate at which a resident's condition will deteriorate or when they will die. There are, however, disease-related signs as well as functional and cognitive changes that can indicate disease progression and may be used to estimate prognosis[1,2]. Clinicians working in residential aged care facilities (RACFs) require the skills to recognise indicators of disease progression. This enables proactive management of the disease process including the formation of a care plan that addresses current and potential issues and supports the expressed wishes, values, and care preferences of the resident and their family.

Prognostic information:

- Helps residents and/or their family make healthcare decisions that align with their preferences.
- Allows the care team to plan care that is focused on the specific needs of the resident and/or their family to ensure **the right care is given in the right place at the right time.**
- Allows residents to seek spiritual support if desired and provides an opportunity to address unfinished business, share fears and concerns about dying, and say goodbye[3].

Identifying residents requiring a palliative approach

There is no foolproof way of estimating prognosis for residents; however, the following triggers[1-6] can assist.

The 'surprise question': *Would you be surprised if the resident dies within the next six months?* is a simple screening question widely used in the UK[1,4]. The response can alert clinicians to review the resident's condition and their care needs and to plan future care. This intuitive question should be used in combination with a broader assessment of co-morbidities and physical and psychosocial factors.

Choice: The resident and/or their substitute decision maker may choose comfort care rather than pursuing curative disease management options.

Clinical indicators: There are general and specific indicators of advanced disease that can be used in combination to prognosticate (see Table 1).

Palliative Approach Framework for Residential Aged Care

The Palliative Approach (PA) Toolkit is underpinned by a framework that consists of three trajectories based on prognosis (Module 2, pg. 4-6). Each trajectory is associated with a key clinical process. All residents living in RACFs can be placed in one of these trajectories depending on their current state of health.

Trajectory A: the resident is stable and responding to therapeutic interventions to manage their co-morbidities and the response to the 'surprise question' is likely to be "yes". The resident would continue to receive their normal care and monitoring. The key clinical process for Trajectory A is advance care planning (ACP; Module 2 pg. 9).

Trajectory B: the resident is deteriorating and is no longer responding as well to therapeutic interventions. The response to the 'surprise question' is likely to be "no". The key clinical process for Trajectory B is the palliative care case conference (PCCC; Module 2 pg. 15).

Trajectory C: the resident is rapidly deteriorating regardless of therapeutic intervention. Possible reversible factors, such as sepsis and delirium, should be treated if in accordance with the resident's wishes. If the GP and multidisciplinary team consider the resident to be in the terminal phase, the resident is moved to Trajectory C where the key clinical process is commencement of an end of life care pathway (RAC EoLCP; Module 2 pg. 27). If the resident's condition improves, they may be returned to Trajectory B.

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Case study George lives in a RACF and has multiple co-morbidities including advanced chronic obstructive pulmonary disease (COPD). In the last 12 months his condition has deteriorated and he has had several admissions to hospital for severe exacerbation of COPD. In recent months, George has responded poorly to medical interventions to manage his COPD. He is fatigued, wheelchair bound, on continuous oxygen, and frequently states he feels short of breath, even at rest. He requires full assistance for all activities of daily living. George's mood has altered and he is more anxious and withdrawn. He says he has had enough and is tired of living.

These indicators of disease progression coupled with a negative response to the 'surprise question' triggered a comprehensive medical and nursing assessment. After reviewing the findings, the care team agreed that George may have a prognosis of less than 6 months and should be moved from Trajectory A to Trajectory B. A palliative care case conference (PCCC) was initiated, so the multidisciplinary team, George, and his family could discuss problems associated with disease progression and treatment options, and make informed decisions about the care George wishes to receive. The PCCC provides an opportunity for George and his family to contribute to a care plan that focuses on their anticipated physical, psychosocial, and spiritual needs, and feel prepared for what may lie ahead as George approaches the end of his life.

Table 1: Clinical prognostic indicators for estimating the last 6-12 months of life for residents with advanced disease[1,2,6]

General indicators

Nutritional: progressive, irreversible weight loss (>10% over 6 months); decreasing serum albumin not related to an acute event.

Functional: progressive, irreversible decline despite therapeutic interventions and increased assistance with activities of daily living.

Extreme frailty: persistent Stage III-IV pressure ulcers; recurrent infections; delirium; persistent dysphagia; falls.

Psychosocial: sustained emotional distress.

Additional: two or more urgent admissions to hospital; need for complex/intense continuing care.

Co-morbidities: two or more concurrent diseases.

Disease-specific indicators

Chronic heart disease: two or more of the following: CHF NYHA Stage III or IV; breathlessness at rest or on minimal exertion; difficult physical or psychological symptoms despite optimal management.

COPD: assessed to be severe (e.g. FEV1<30%); breathlessness at rest or on minimal exertion; fulfils long-term oxygen therapy criteria; symptomatic heart failure; recurrent hospitalisation for exacerbation of COPD.

Renal failure: symptomatic renal failure: nausea and vomiting, anorexia, pruritus, intractable fluid overload.

Cancer: confirmed diagnosis of metastatic cancer no longer amenable to treatment; poor performance status and functional ability; persistent, troublesome symptoms despite optimal treatment of underlying conditions.

Chronic neurological diseases: 1) CVA – acute and sub-acute phase (3 months post-CVA); persistent vegetative state for >3 days. During chronic phase – persistent medical complications, such as aspiration pneumonia, recurrent infections, and pressure ulcers, despite optimal treatment. **2) MND, MS, PD** – progressive deterioration in physical and cognitive function despite optimal treatment; complex and difficult symptoms; dysphasia; dysphagia; recurrent aspiration pneumonia; breathlessness or respiratory failure.

Dementia: full assistance with all activities of daily living; incontinence; no meaningful communication; <6 intelligible words; poor oral intake; dysphagia; recurrent hospitalisation; aspiration pneumonia; recurrent urinary tract infections.

CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease; CVA = cerebrovascular accident; FEV1 = forced expiratory volume; MND = motor neurone disease; MS = multiple sclerosis; NYHA = New York Heart Association; PD = Parkinson's disease

1. Thomas K et al. Prognostic Indicator Guidance, 4th ed., October 2011. The Gold Standards Framework Centre in End of Life Care CIC.
2. Highet et al. (2013). *BMJ Supportive & Palliative Care*, doi:10.1136/bmjspcare-2013-000488.
3. Kapo & Casarett (2006). *Annals of Long-Term Care*, 14(2), 18-23.
4. Murray & Boyd (2011). *Palliative Medicine,* 25(4), 382.
5. Gómez Batiste et al. (2014). *Palliative Medicine,* 28(4), 302-11.
6. Morrison & Meier (2003). *Geriatric Palliative Care*. Oxford University Press: New York.

Access PA Toolkit resources at: www.caresearch.com.au/PAToolkit

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