Palliative care competencies: is it for all?

Khon Kaen International Conference in Palliative Care 2018
Definition

• Competence
  – The ability to do something successfully or efficiently

• For us it means reaching a standard of care and maintaining it for our discipline or generally in health care

• It determines how good we are in our patient centred care
Competencies

• To develop standards in
  – Skills
  – Knowledge
  – Attributes
  – Attitudes

• We need to develop a culture of always working to standards
WHO definition of Palliative Care

• "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psycho-social and spiritual."
The Palliative Approach

• Palliative care principles should be practiced by all health care professionals

• The palliative care approach should be a core skill of every clinician
  – at hospital and community level
  – the majority of patients would be managed satisfactorily without needing to be referred to specialist palliative care services
Figure

Palliative care in conjunction with curative therapy

Focus/goals of care

Therapy to modify disease

Palliative care
Therapy to prevent and relieve suffering and/or improve quality of life

Presentation/diagnosis

Time >>>>

Illness

Chronic

Acute

Patient’s death

Bereavement

Advanced life-threatening

End-of-life care

Core Competency for all

• Person-centred approach
• Develop a holistic model of care
• To alleviate the distress caused by advancing disease
• Manage basic symptom control
All patients suffered from at least one symptom frequently and almost constantly with an average of 6 symptoms.  

Oechsle 2014 JPSM
Core Competency for all

• Prognosticate in their own specialty
• Develop Advance Care Plans with their patients
Assessment

• To recognise palliative care needs
• Assessing symptoms
• Assessing distress
• Assessing family and carer needs
• Assessing prognosis
• This has to be holistic: physical, psychosocial, spiritual needs
Planning Care

• Prognosticating
• Advance care planning
• Communication skills around this
Basic Symptom Control

- Pain management
  - Assessment
  - Diagnosis of cause
  - Treatment with multi-modality treatments
  - Understanding opioids (morphine) and their side effects
  - Using adjuvant medications
  - Psychological aspects to pain management
Other symptoms

• Using the same principles as in pain management
  – Dyspnoea
  – Nausea/vomiting / bowel obstruction
  – Constipation / diarrhoea
  – Anorexia
  – Fatigue etc
  – Psychological and spiritual needs
Recognising end of life

• Diagnosing dying and implementing care around this phase
• Terminal care needs
  – Caring for patients who are actively dying
• Recognising grief and loss
• Understanding ethical framework to underpin care
Limitations

• Recognise one's own expertise and limitations and when the needs are more complex, to know the appropriate referral pathways for specialist palliative care
2.2 The Royal Australian College of General Practitioners Curriculum for Australian General Practice (2011) – Palliative Care

- The report details the training outcomes of the following five domains of general practice:
  - 1. Communication skills and the patient-doctor relationship
  - 2. Applied professional knowledge and skills
  - 3. Population health and the context of general practice
  - 4. Professional and ethical role
  - 5. Organisational and legal dimensions
Tools to assist with prognostication
Gold Standard Framework (UK)
GSF Prognostic Indicator Guidance
4th Edition 2011

• Three triggers that suggest that patients are nearing the end of life are:
• The surprise Question: Would you be surprised if this patient were to die in the next few months, weeks, days?
• Three triggers that suggest that patients are nearing the end of life are:
  1. The surprise Question: Would you be surprised if this patient were to die in the next few months, weeks, days?
  2. General indicators of decline – deterioration, increasing need or choice for no further active care
  3. Specific clinical indicators related to certain conditions
• Earlier recognition of possible illness trajectories
• Better to anticipate and address patients needs
• Rather than just predicting exact timescales
Summary of suggested three steps for earlier identification

Step 1

Ask the Surprise Question
Would you be surprised if the patient were to die in next months, weeks or days?

NO

Don’t Know

YES

Step 2

Do they have General Indicators of Decline?

NO

Reassess regularly

YES

Step 3

Don’t Know

Do they have Specific Clinical Indicators?

NO

Reassess regularly

YES

Begin GSF Process

Identify: Include the patient on the GP's GSF/QOF palliative care register or locality register if agreed. Discuss at team meeting.

Assess: Discuss this with patient and carers, assess needs and likely support and record advance care planning discussions.

Plan: Plan and provide proactive care to improve coordination and communication.
Step 2 General Indicators

Are there general indicators of decline and increasing needs?

- Decreasing activity – functional performance status declining (e.g. Barthel score) limited self-care, in bed or chair 50% of day) and increasing dependence in most activities of daily living
- Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity
- General physical decline and increasing need for support
- Advanced disease - unstable, deteriorating complex symptom burden
- Decreasing response to treatments, decreasing reversibility
- Choice of no further active treatment
- Progressive weight loss (>10%) in past six months
- Repeated unplanned/crisis admissions
- Sentinel Event e.g. serious fall, bereavement, transfer to nursing home
- Serum albumen <25g/l
- Considered eligible for DS1500 payment
Step 2 General Indicators

Functional Assessments
Barthel Index describes basic Activities of Daily Living (ADL) as ‘core’ to the functional assessment. E.g. feeding, bathing, grooming, dressing, continence, toileting, transfers, mobility, coping with stairs etc.
PULSE ‘screening’ assessment - P (physical condition); U (upper limb function);
L (lower limb function); S (sensory);
E (environment).
Karnofksy Performance Status Score
0-100 ADL scale.
WHO/ECOG Performance Status
0-5 scale of activity.
a) Cancer – rapid or predictable decline

- Metastatic cancer
- More exact predictors for cancer patients are available e.g. PiPS (UK validated Prognosis in Palliative care Study). PPI, PPS etc. ‘Prognosis tools can help but should not be applied blindly’
- ‘The single most important predictive factor in cancer is performance status and functional ability’ - if patients are spending more than 50% of their time in bed/lying down, prognosis is estimated to be about 3 months or less.

b) Organ Failure – erratic decline

**Chronic Obstructive Pulmonary Disease (COPD)**
At least two of the indicators below:
- Disease assessed to be severe (e.g. FEV1 <30% predicted)
- Recurrent hospital admissions (at least 3 in last 12 months due to COPD)
- Fulfils long term oxygen therapy criteria
- MRC grade 4/5 – shortness of breath after 100 metres on the level or confined to house
- Signs and symptoms of right heart failure
- Combination of other factors – i.e. anorexia, previous ITU/NIV resistant organisms
- More than 6 weeks of systemic steroids for COPD in preceding 6 months.

**Heart Disease**
At least two of the indicators below:
- CHF NYHA Stage 3 or 4 - shortness of breath at rest on minimal exertion
- Patient thought to be in the last year of life by the care team - The ‘surprise question’
- Repeated hospital admissions with heart failure symptoms
- Difficult physical or psychological symptoms despite optimal tolerated therapy.
Renal Disease
Stage 4 or 5 Chronic Kidney Disease (CKD) whose condition is deteriorating with at least 2 of the indicators below:
- Patient for whom the surprise question is applicable
- Patients choosing the ‘no dialysis’ option, discontinuing dialysis or not opting for dialysis if their transplant has failed
- Patients with difficult physical symptoms or psychological symptoms despite optimal tolerated renal replacement therapy
- Symptomatic Renal Failure – nausea and vomiting, anorexia, pruritus, reduced functional status, intractable fluid overload.

General Neurological Diseases
- Progressive deterioration in physical and/ or cognitive function despite optimal therapy
- Symptoms which are complex and too difficult to control
- Swallowing problems (dysphagia) leading to recurrent aspiration pneumonia, sepsis, breathlessness or respiratory failure
- Speech problems: increasing difficulty in communications and progressive dysphasia. Plus the following:
c) Frailty / Dementia – gradual decline

**Frailty**
Individuals who present with Multiple co morbidities with significant impairment in day to day living and:
- Deteriorating functional score e.g. performance status – Barthel/ECOG/Karnofsky
- Combination of at least three of the following symptoms:
  - weakness
  - slow walking speed
  - significant weight loss
  - exhaustion
  - low physical activity
  - depression.

**Dementia**
There are many underlying conditions which may lead to degrees of dementia and these should be taken into account. Triggers to consider that indicate that someone is entering a later stage are:
- Unable to walk without assistance and
- Urinary and faecal incontinence, and
- No consistently meaningful conversation and
- Unable to do Activities of Daily Living (ADL)
- Barthel score <3.

Plus any of the following:
- Weight loss
- Urinary tract Infection
- Severe pressures sores – stage three or four
- Recurrent fever
- Reduced oral intake
- Aspiration pneumonia.

It is vital that discussions with individuals living with dementia are started at an early to ensure that whilst they have mental capacity they can discuss how they would like the later stages managed.

**Stroke**
- Persistent vegetative or minimal conscious state or dense paralysis
- Medical complications
- Lack of improvement within 3 months of onset
- Cognitive impairment / Post-stroke dementia.
Illustrative Prototypical Death Trajectories

Scenario A: Sudden Death from Unexpected Cause

Scenario B: Steady Decline from a Progressive Disease with a "Terminal" Phase

Scenario C: Advanced Illness with Slow Decline, Periodic Crises and "Sudden Death"

Scenario D: Slow Decline of Frail Patient with Multi-System Disease
Specialist Palliative Care

• Higher training of staff
• Interdisciplinary team
• To provide for complex needs of patients and their carers/families
• Meet standards (national standards)
  – Knowledge/skills
  – Academic growth
  – Research development
• In all settings: hospital, community and hospice
Chapter of Palliative Medicine RACP

• DOMAIN 1: COMMUNICATION
  – Theme 1.1: Physician–patient Communication
  – Theme 1.2: Communicating with a Patient’s Family and/or Carers
  – Theme 1.3: Communicating with Colleagues and Broader Health Care Team
  – Theme 1.4: Communicating with the Broader Community

• DOMAIN 2: QUALITY AND SAFETY
  – Theme 2.1: Using Evidence and Information
  – Theme 2.2: Safe Practice
  – Theme 2.3: Identifying, Preventing and Managing Potential Harm

• DOMAIN 3: TEACHING AND LEARNING (SCHOLAR)
  – Theme 3.1: Ongoing Learning
  – Theme 3.2: Research
    • Theme 3.3: Educator

• DOMAIN 4: CULTURAL COMPETENCY
  – Theme 4.1: Cultural Competency
Chapter of Palliative Medicine RACP

- **DOMAIN 5: ETHICS**
  - Theme 5.1: Professional Ethics
  - Theme 5.2: Personal Ethics
  - Theme 5.3: Ethics and Health Law

- **DOMAIN 6: CLINICAL DECISION MAKING**
  - Theme 6.1: Clinical Decision Making

- **DOMAIN 7: LEADERSHIP AND MANAGEMENT**
  - Theme 7.1: Self-Management
  - Theme 7.2: Leadership and Managing Others

- **DOMAIN 8: HEALTH ADVOCACY**
  - Theme 8.1: Advocacy for the Patient
  - Theme 8.2: Individual Advocacy
  - Theme 8.3: Group Advocacy

- **DOMAIN 9: THE BROADER CONTEXT OF HEALTH**
  - Theme 9.1: Burden of Disease
  - Theme 9.2: Determinants of Health
  - Theme 9.3: Prevention and Control
  - Theme 9.4: Priority Population Groups
  - Theme 9.5: Economics of Health
Specialist Palliative Care

• Education
  – Curriculum development
  – Interdisciplinary
  – Core competencies inbuilt into curriculum
  – Continuous medical education

• Training
  – Accreditation of sites
  – Supervision and mentoring

• Research
Looking towards the future in Thailand!

Thank you.