Palliative and end of life care on the Acute Medical Unit

L Clemans, T Cooksley & M Holland

Abstract

Introduction

Early and appropriate recognition of patients requiring palliative care is essential to delivering high quality management and Acute Medical Units have a pivotal role to play in ensuring its implementation.

Aim

To identify the prevalence of patients admitted to Acute Medical Unit (AMU) who met palliative criteria, the overall prevalence of terminal diagnoses and the frequency of appropriate referrals to the units Palliative Care in reach team.

Methods

An audit was performed at a University Hospital AMU to examine these issues. The NHS Supportive and Palliative Care Tool (SPCIT) was used to identify palliative patients. 409 patients were admitted to the AMU during the study period.

Results

66 (16.1%) of patients were identified as palliative. Two-thirds of these patients had a non-malignant diagnosis. 30% of palliative patients were referred to the palliative care team of which 85.4% had a diagnosis of cancer. 88% of patients that received ongoing palliative care review had a diagnosis of cancer.

Conclusion

There is a high prevalence of patients with a terminal diagnosis presenting to the AMU reflecting an aging population and increasingly complex co-morbidities. Palliative patients with a non-cancer diagnosis are less likely to be referred to the palliative care team, which has the potential to disadvantage their care.

Keywords

Palliative Care, Acute Medical Units, Elderly Patients.

Key points

- There is a high prevalence of patients with a terminal diagnosis presenting to the AMU reflecting an aging population and increasingly complex co-morbidities.
- Palliative patients with a non-cancer diagnosis are less likely to be referred to the palliative care team, which has the potential to disadvantage their care.
- It is essential that Acute Physicians and Palliative Care services work together to ensure appropriate utilisation of resources.

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Introduction

The majority of deaths in England occur in hospital despite repeated research that suggests patients would prefer to die at home.[1-3] An increasing proportion of deaths are from chronic conditions with increasing age and co-morbidities adding to the complexity of end of life care.

A significant proportion of patients dying in acute hospitals receive poor care and there is poor recognition of patients approaching the end of their life.[1,4] The identification of patients who may benefit from palliative care is difficult and there are no validated criteria for the recognition of patients requiring this type of care.[5]

Early and appropriate recognition of palliative patients is essential to delivering high quality management. Acute Medical Units, as the initial inpatient destination for the majority of patients, have a pivotal role to play in ensuring the implementation.

Methods

A prospective audit was performed at a 56 bedded University Hospital Acute Medical Unit (AMU) in the Northwest of England for 3 weeks between 20th May and 4th June 2013. The unit receives in-reach on a daily basis from specialist palliative care nurses who take referrals from medical and nursing staff. The palliative care nurses are supported by a palliative care Consultant and Nurse Consultant. Once referred by the AMU team, they are assessed by the palliative care team for further management.

The aim of the audit to identify the prevalence of patients admitted to AMU who met palliative criteria, the overall prevalence of terminal diagnoses and the frequency of appropriate referrals to the unit's Palliative Care in reach team. The NHS Supportive and Palliative Care Tool (SPCIT) was used to identify palliative patients. Palliative diagnosis and palliative indicators, such as poor care or increasing care needs, were recorded.

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Table 1: Comparison of ages of palliative and non-palliative patients

	Number	Percentage	Minimum	Maximum	Mean Age	Standard Error of Mean	Median Age
Palliative	66	16.1%	48	102	75.15	1.51	78
Non-Pal.	343	83.9%	16	100	66.39	1.05	69
Total	409	100%	16	102	67.80	0.93	72

Data were collected onto anonymised paper proformas and included the patient's age, gender, presenting complaint, diagnoses, whether the patient was identified as palliative, palliative indicators, referral to palliative in-reach team and whether the patient received further palliative care follow up. The data were transferred to SPSS for analysis.

Results

409 patients presented to the AMU during the study period. The mean age of the patients was 67.8 years with a median age of 72 years (Figure 1). The majority of the patients were in their 70s and 80s with 25% of the patients over the age of 82. 194 (47.4%) of the patients were male with 215 (52.6%) female. The mean age of the men was 67.06 years and for women was 68.47 years.

66 (16.1%) of patients met the SPCIT criteria and were therefore classified as palliative of which 39 were male and 27 female. Palliative patients were older (p=0.003) (Table 1).

Malignancy was the most frequent terminal diagnosis among the group who met palliative criteria (Figure 2). 20 patients had 2 terminal diagnoses which were severe enough to meet the criteria.

Table 2. Mean age by terminal diagnosis

Terminal Diagnosis (not yet palliative)	Mean	Number
Malignancy	70.60	30
Heart Disease	78.88	16
Respiratory Disease	74.48	33
Renal Disease	76.43	7
Liver Disease	56.44	9
Neurological Disease	66.09	11
Dementia	83.00	11
Malignancy Co-morbid	76.08	12
Heart D. Co-morbid	75.91	11
Respiratory D. Co-morbid	74.20	5
Renal D. Co-morbid	82.67	3
Total	73.57	148

Figure 3 shows the frequency of clinical palliative indicators among the patients identified as palliative with poor or reducing performance status the most prevalent. 25 of the patients had 3 indicators.

148 (36%) of the patients had a terminal diagnosis which did not fulfil the SPCIT criteria for being classified as palliative. These patients had a mean age of 73.57 years, higher than the overall study population. Heart failure and dementia tended to affect older patient whilst terminal liver disease affected younger patients (Table 2).

During the period of the audit, 41 patients were referred to the palliative care in-reach team of which only 20 (48.8%) met the SPCIT criteria. 46 (69.7%) palliative patients were not referred. The majority of referrals to palliative care in-reach were for patients with cancer (85.4%) (Table 3). There no significant difference in the age of patients referred to the team (mean of those referred was 71.59 years vs 67.38 years). 88% of the patients who had further reviews by the palliative care team had a diagnosis of cancer.

During the audit period, 22 patients had a documented "Do Not Attempt Resuscitation" decision and 3 patients were placed on the end of life care pathway. In hospital mortality for the patients in the audit was 1% and 28 day mortality was 2.4%. All the patients who died in hospital within 28 days had a non-malignant diagnosis.

Discussion

This audit, consistent with similar other studies, shows that the majority of patients admitted to an AMU are elderly, with complex and multiple

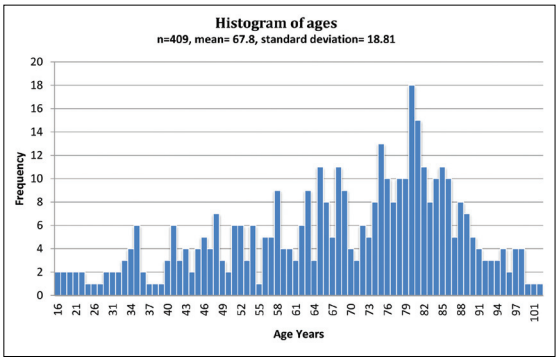

Figure 1: Histogram of ages for all patients

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Table 3: Number of referrals to the palliative care team for palliative and non-palliative patients by diagnosis of cancer or other, non-malignant diagnosis

Number		Referred to palliative team		Total
		Yes	No	
Identified as palliative	Malignancy	19	9	28
	Non-Malignant	1	36	37
Not Identified as palliative (with a terminal diagnosis)	Malignancy	16	24	40
	Non-Malignant	5	100	105
Total		41	169	210

pathologies. It also demonstrates that a significant percentage meet palliative care criteria. This trend has significant implications for future resourcing and management of frail elderly patients who will increasingly have palliative care needs.

Our audit suggests that patients were not referred to our palliative care in reach team on the basis of whether they were approaching the end of their life but whether or not they had a diagnosis of cancer. This reflects other studies that have found that patients with non-malignant disease are disadvantaged with regards to accessing specialist palliative care services.[6-8] The need for patients with progressive terminal diseases, such as liver failure and severe COPD for specialist palliative care is clear but may be under-recognized by general and acute physicians.[9,10]

There are challenges in providing palliative care to non-cancer patients. There can be difficulty for clinicians in identifying those who have palliative care needs partly due to a potential unpredictable trajectory of some conditions.[11,12] This difficulty is exacerbated by a lack of validated scoring systems to identify these patients.

There are concerns that older patients are disadvantaged in accessing specialist palliative care.[1,13] This population is increasingly going to form the majority of the palliative care workload within AMU and the acute hospital setting in general.

There can be a reluctance among Acute Physicians to offer anything other than life-prolonging treatments and this may be detrimental in facilitating referral to palliative care services.[14] This can result in inappropriate investigations and management with poorer outcomes in quality of life terms for the patient and their families.

In reach specialist palliative care services to the AMU are essential, not only to help facilitate the management of patients in the terminal phase of life, but also in helping identify and support palliative frail, complex patients.

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Conflict of Interest

The authors have no conflict of interest to declare.

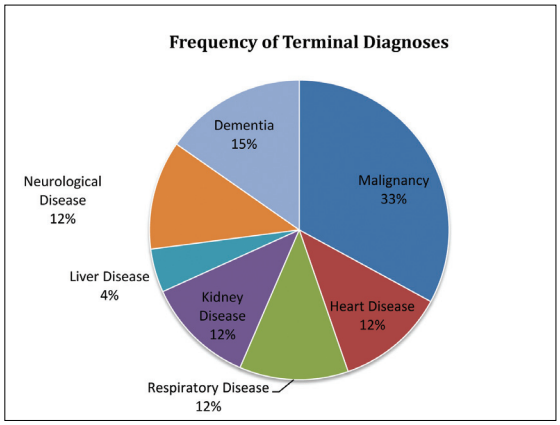

Figure 2: Pie chart showing frequency of terminal diagnoses within the group of patients identified as palliative

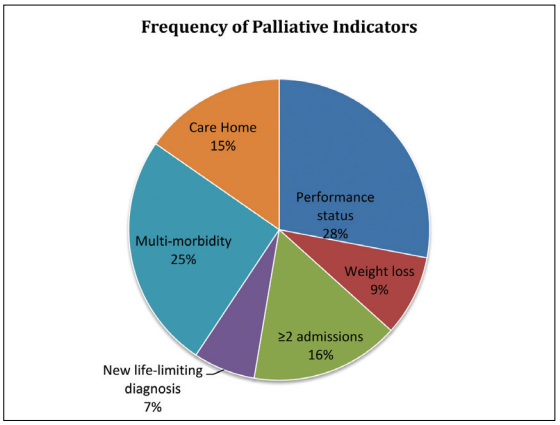

Figure 3: Pie chart showing frequency of general clinical palliative indicators amongst the group of patients identified as palliative

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