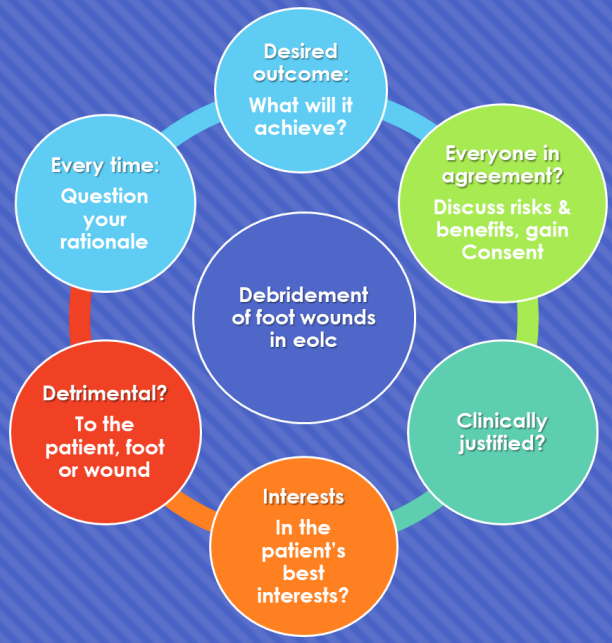


Podiatry in end of life care

Mark Povey - Clinical Lead Podiatrist

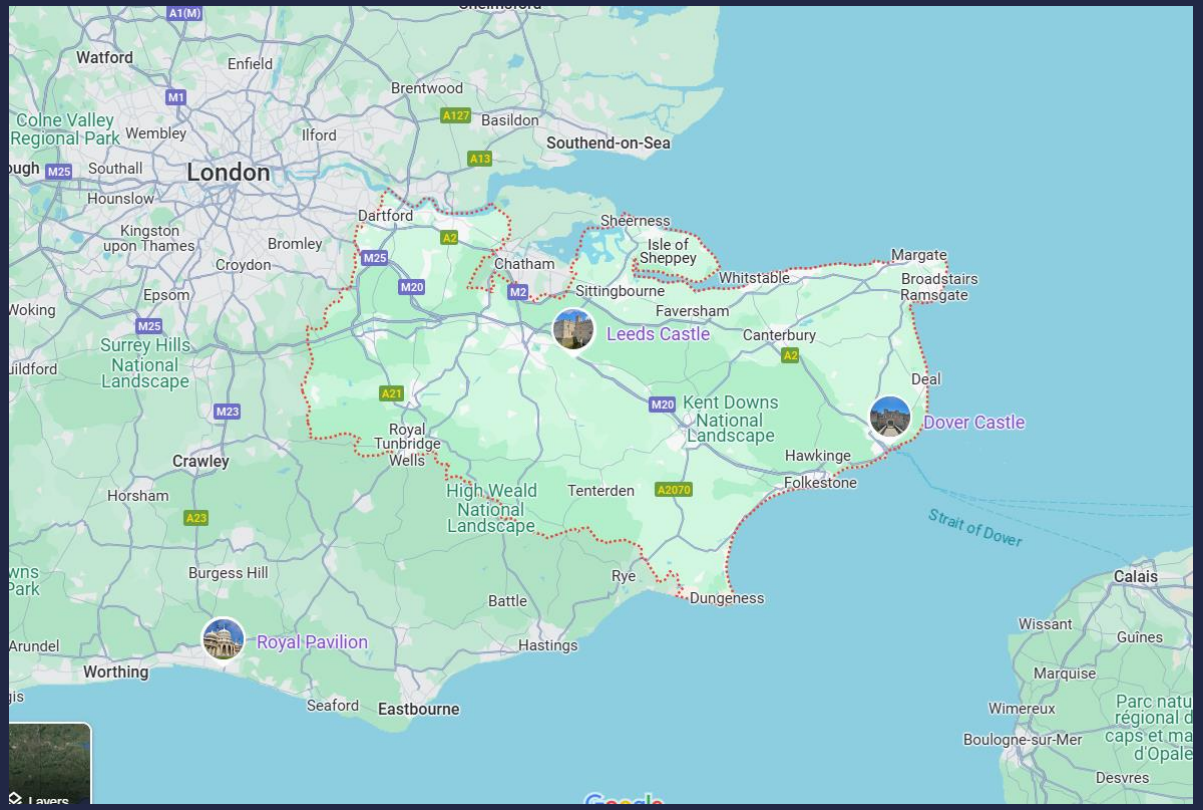
Kent Community Health NHS Foundation Trust

Friday 29th November 2024

Contents of this workshop

- Introduction
- Definition of end of life care (eolc) and palliative care
- Overview of national eolc guidance
- Identifying eol
- Advance care planning
- Podiatry in eolc: challenges, guidance, wound debridement

“Live in Kent and be content”



Introduction

- Clinical Lead Podiatrist from Kent
- Quality improvement project (2020-21) to increase confidence of Podiatrists working with eolc patients
- Training package and SOP developed
- Presented project at RCPod conference 2022
- Training given to other NHS Podiatry departments

A good ending

Knowing when – and how – to intervene during end of life care is a crucial element of patient care. We explore the nature of this decision and the skills podiatrists need for this sensitive work.

Words Jess Connett

When Mark Povey trained to be a podiatrist 24 years ago, he remembers receiving only one lecture about death. He works as a clinical specialist podiatrist for the vulnerable foot at Kent Community Health NHS Foundation Trust (KCHFT), across community settings and vascular, renal and stroke wards. The reality is that many of his high-risk patients' wounds may never fully heal. 'We'll see a lot of these people until they die,' Mark says. 'That's the point at which they get discharged.'

But when services had to be prioritised during the Covid-19 pandemic, community nurses were increasingly asking Kent's podiatry teams to perform foot care at the end of life. While Mark and his colleagues were experienced in wound care and debridement, active dying added extra complexity.

'We were questioning ourselves: How do we actually recognise end of life? And how does that impact on our choices, in terms of how we're going to treat the patient? Is debridement appropriate? I think that's what made me more interested in end of life care [EOLC],' Mark says. 'It's so relevant to the care we provide for our high-risk caseload in the NHS.'

Intuition

EOLC is treatment given to a patient judged to be in the final 12 months of life (NHS England, 2022). Palliative care can be given outside this time, especially for people with life-limiting conditions, and largely involves managing pain and relieving distressing symptoms (NHS, 2022).

End of life may be judged when a patient has an incurable illness including dementia or cancer, are elderly and frail, have a chronic condition that suddenly becomes acute, or have a new life-threatening condition brought on by a catastrophic event including stroke.

There is also an intuitive element. The 'surprise question' – asking a healthcare practitioner if they would be surprised if the patient died in the next 12 months – is an established test. When used alone it performs only moderately well as a predictive tool (Downar et al, 2017), but the Royal College of General Practitioners (2016) incorporates it, along with other signs of decline, into its gold standards framework.

High risk

Two common conditions requiring palliative foot care are diabetes and renal disease – and rates are increasing. Almost 3.5 million people in England were registered with their GP as having diabetes in 2020-21, and hospital admission rates for diabetic foot disease have risen consistently in England since records began in 2012-13 (Office for Health Improvement and Disparities, 2022). Population growth, ageing and diabetes prevalence are strong indicators of chronic kidney disease in adults (Hounkpatin et al, 2020).

Nicola Mullan has worked as an advanced renal podiatrist at Western Health and Social Care Trust in Northern Ireland for 17 years. About 50% of her patients with end-stage renal disease also have diabetes. 'Because these patients are so high risk, they can deteriorate quickly,' she says. Emergencies including embolism are not uncommon; nor are infections or vascular disease. Diabetic foot ulcer has a five-year mortality rate worse than some common cancers (Armstrong et al, 2007).

Nicola says: 'When patients are approaching the end of their life, they frequently shut down from the peripheries first. We do have success stories where we get wounds healed and amputations are successful. But often, down the line, and as length of time on dialysis increases, these patients re-ulcerate. It is more challenging to get them healed as their vascular supply has deteriorated further, mainly due to arterial calcification. A lot of the time it is palliative: you're keeping them comfortable or trying to prevent wounds from getting any worse.'

A way of the future

As Mark's workload changed, he felt he needed a better understanding of EOLC. He embarked on a quality improvement (QI) project in May 2021, beginning with a survey of his podiatry colleagues' knowledge. Only 30% of the 32 people surveyed could correctly define end of life, and overall confidence about EOLC was low. Understanding when to debride wounds was a key issue, which led Mark to develop the DECIDE tool (see page 39).

Supported by Lisa Dennis, formerly a consultant nurse in EOLC at KCHFT and now director of a hospice (see panel), Mark also created a training package. This was piloted and then rolled out to Kent's podiatry teams in 2022; to date, Mark has trained 40 colleagues.

Lisa says: 'Through the training, we were able to teach podiatrists how you might identify that somebody is at the end of their life, what treatment options are more appropriate for that individual, and how you communicate that

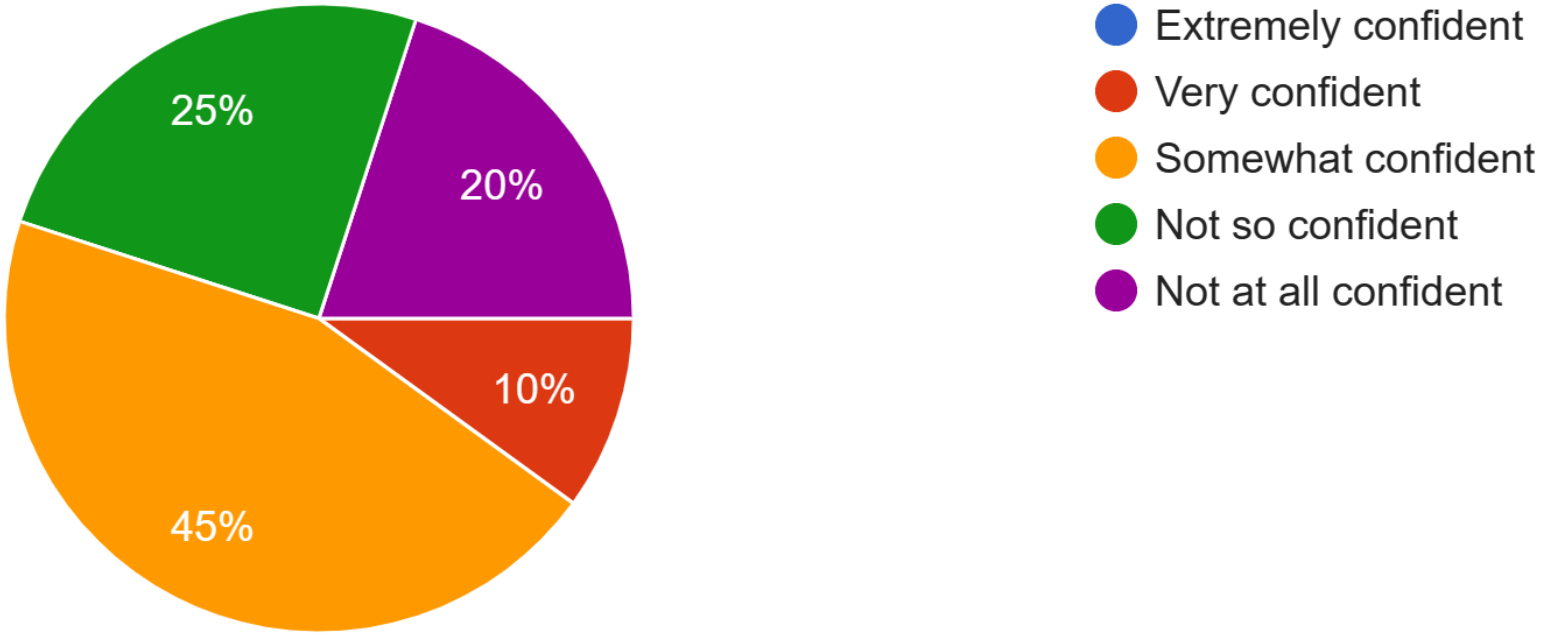
EOLC champions

KCHFT is one of the largest providers of NHS care for patients in their own homes and in the community (CQC, 2019). Rather than having a stand-alone service for EOLC, staff are supported in this role by nurse consultants, like Lisa Dennis. EOLC champions are an additional source of support and expertise.

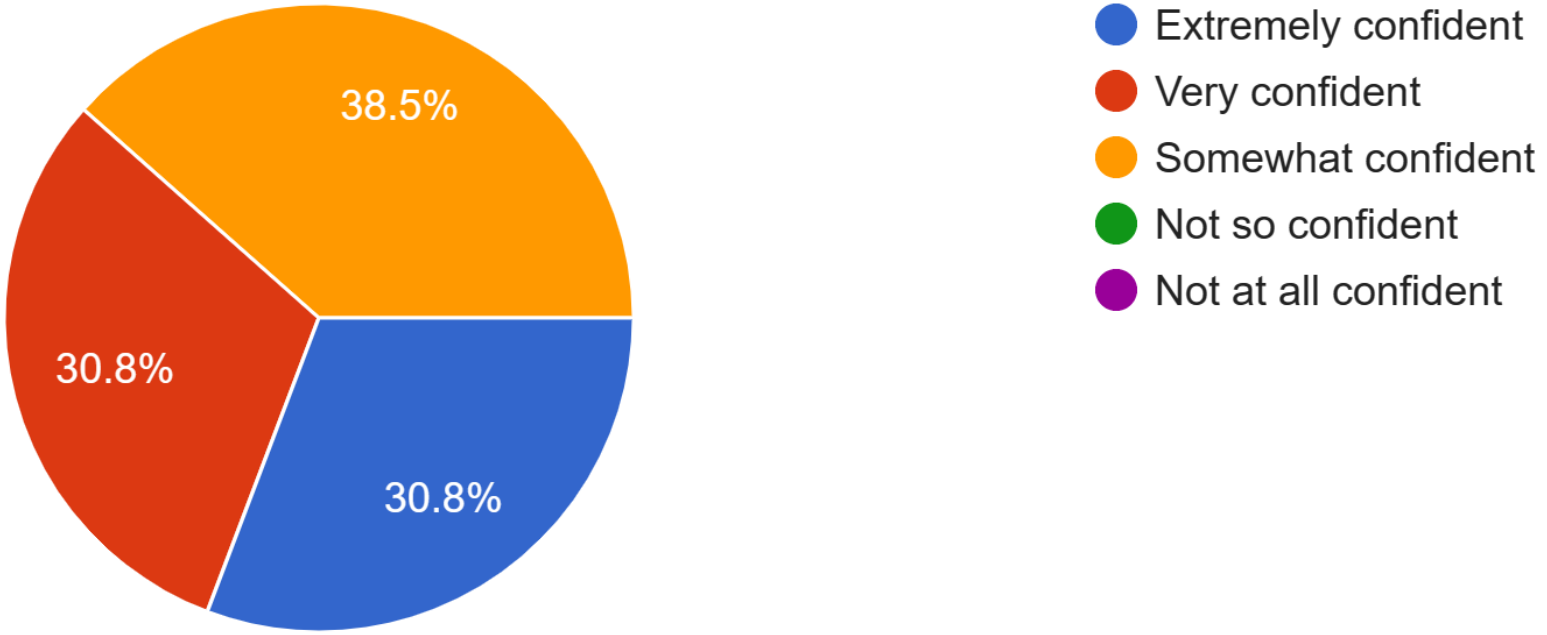
Mark Povey trained as an EOLC champion in 2021. 'I go to meetings regularly – partly for my own interest and personal development, but also to share any updates with my colleagues,' he says. One such new tool is ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) created by the Resuscitation Council UK. Clinicians can use it to create personal recommendations for a patient's care in an emergency situation – such as cardiac arrest – where they don't have the capacity to make choices. This includes their wishes about whether to perform CPR.

For Mark, the role has opened doors and allowed him to share his expertise in areas like wound debridement. 'I presented my work at our recent QI conference,' he says. 'As a result of that, I'm going to be sharing my project with our local tissue viability nurses, and the EOLC champions as well. Again, it promotes how valuable podiatry can be in EOLC.'

Pre-course:
How confident are you in deciding when to debride foot ulcers in eolc patients?



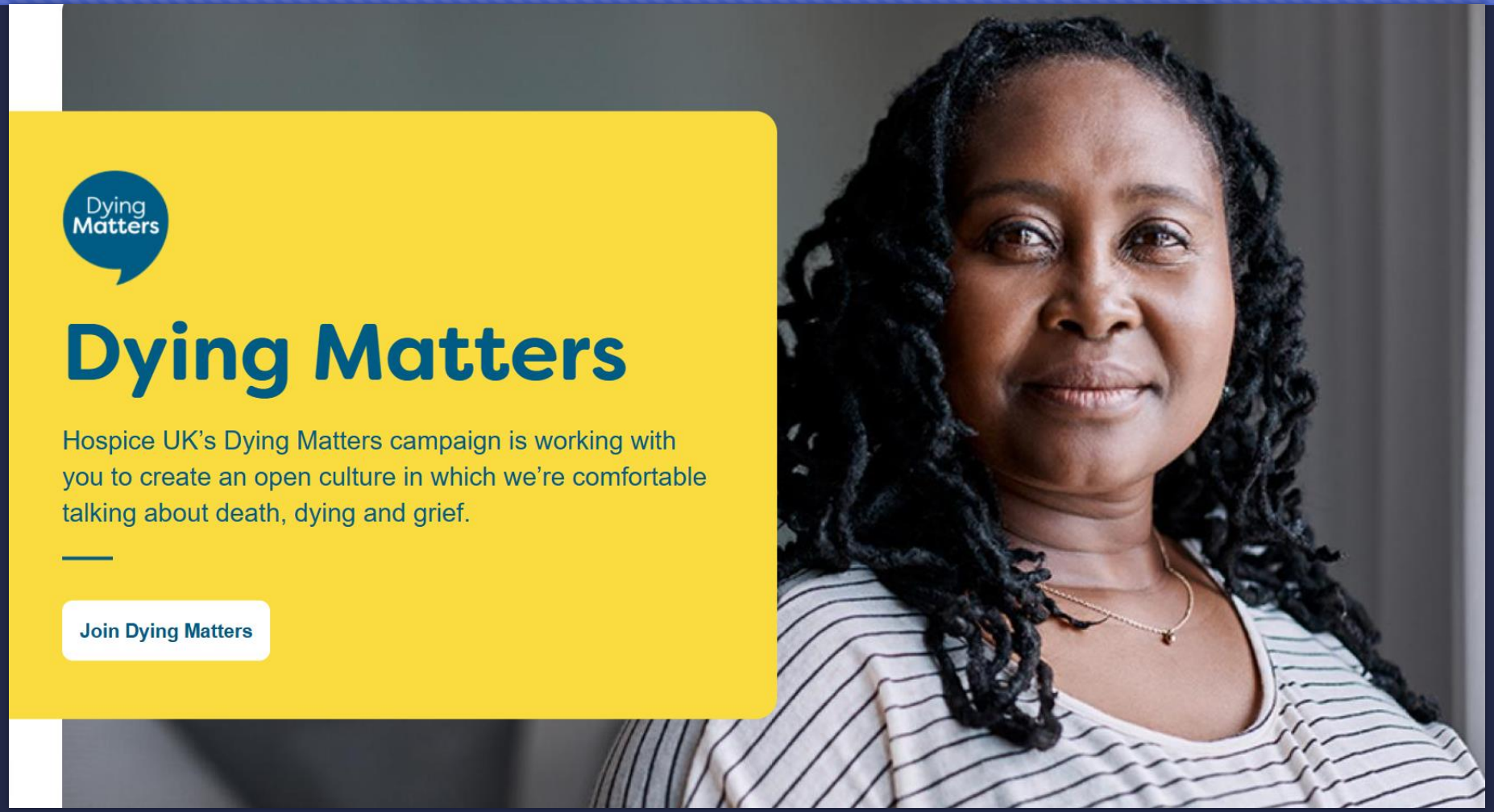
Post-course:
How confident do you now feel about deciding when to debride foot ulcers in eolc patients?



Talking about death and dying

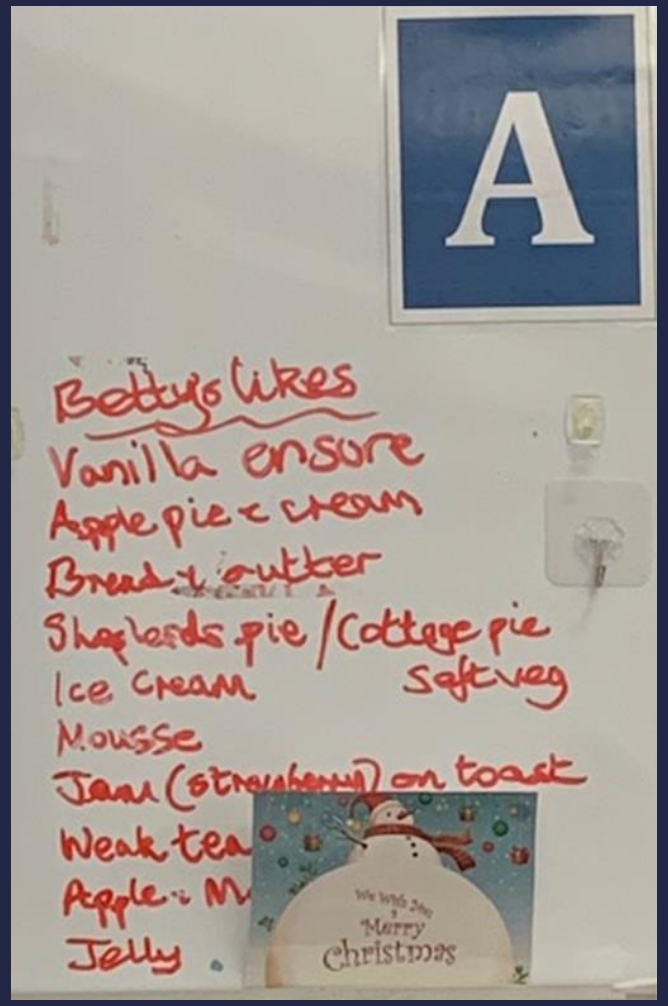
- How comfortable are you with talking about death and dying with your patients, your friends and family members?

www.hospiceuk.org/our-campaigns/dying-matters



Warning!

- Emotive topic
- Memories of loved ones & patients who have died
- Trauma
- Pain
- Beliefs



Death of long-term Podiatry patients

- Think about some of your long-term patients (Private or NHS) and how many years you have treated them for!
- Podiatrist/Patient relationships are quite unique within healthcare
- Many Podiatrists develop long term patient-practitioner relationships, due to the nature of managing high risk foot pathologies with a high mortality rate (Morbach et al 2012).

Death of long-term Podiatry patients

- There is a lack of research into the impact of the death of long-term patients upon Podiatrists, but there can be a deep emotional impact and Podiatrists may be ill-equipped to cope with the death of such patients
- This can have a cumulative effect as it is likely to occur throughout our careers
- Clinicians should be encouraged to be open about their feelings of grief and sadness, to employ coping strategies and to have open discussions, in order to prevent professional burnout (Robson and Williams 2017)


This certificate is awarded to
Lisa Day
in recognition of
20 years' service
2024
This certificate is awarded to
Angela Merser
in recognition of
25 years' service
2024
This certificate is awarded to
Mark Povey
in recognition of
25 years' service
2024
This certificate is awarded to
Martyn Ballard
in recognition of
30 years' service
2024

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If someone is considered to be “end of life” in what period of time are they likely to die?

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Definition of End of Life Care
General Medical Council, UK 2010

People are 'approaching the end of life' when they are **likely to die within the next 12 months**. This includes people whose death is imminent (expected within a few hours or days) and those with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events.

Definition of palliative care

- What is your understanding of the term “palliative care”?
- non-curative treatment, symptom management

It doesn’t mean “no care” or withdrawal of care

Reversible signs of deterioration

Overview of national eolc guidance

End of life care – NICE guidance

- NICE: End of Life Care for Adults
- NICE guidance NG31 | Care of dying adults in the last days of life
- NICE guidance 96 | Care and support of people growing older with learning disabilities | Guidance | NICE
- Palliative care for adults - strong opioids for pain relief:
- https://www.nice.org.uk/guidance/cg140/resources/palliative-care-for-adults-strong-opioids-for-pain-relief-pdf-35109564116677

Podiatry has a role to play in eolc

- 1.9 Providing ***multipractitioner**** care
- 1.9.1 Provide access to the ***expertise of highly skilled health and social care practitioners***, when needed, for adults approaching the end of their life, their carers and other people important to them. They should have the skills to:

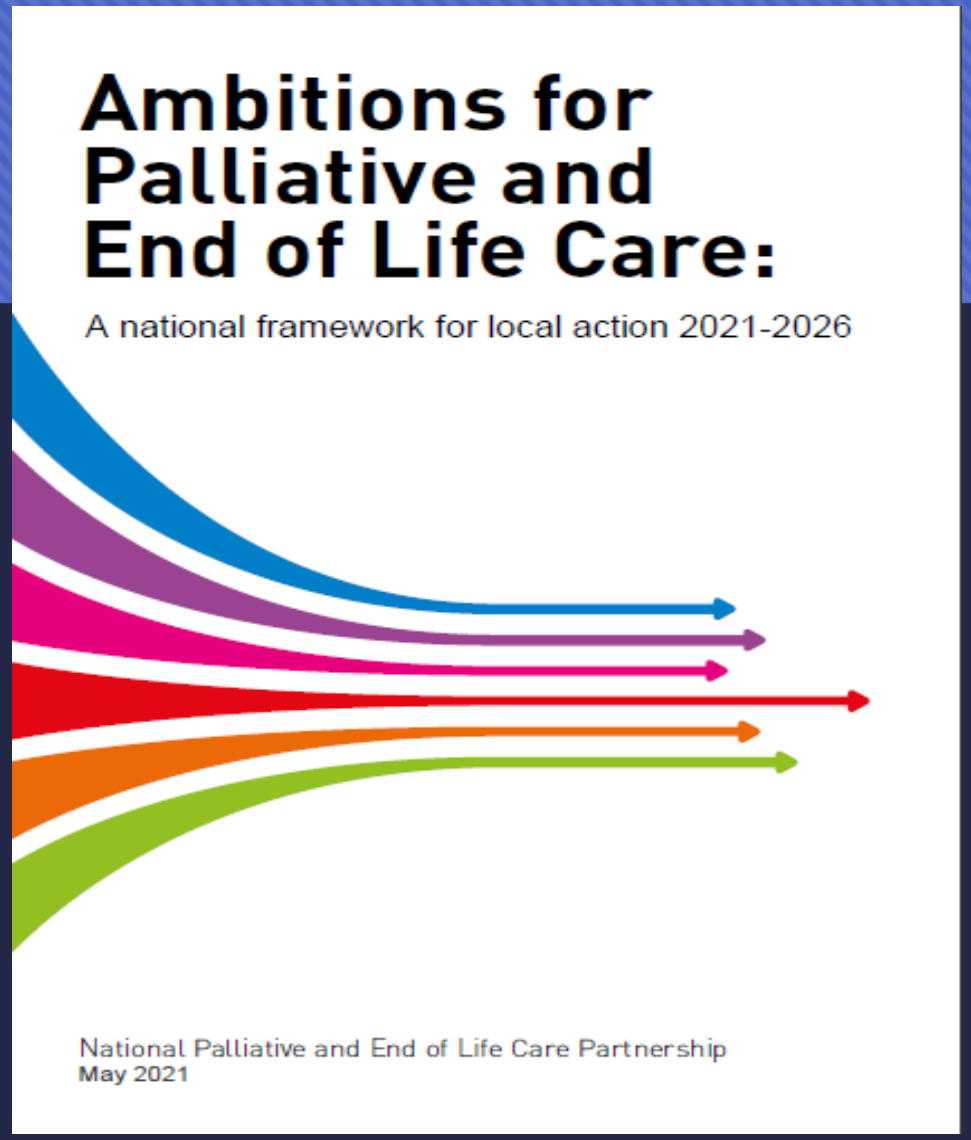
• meet ***complex care*** and support needs

• ***anticipate and prevent or minimise crises***

• ***support people's preferences*** for where they would like to be cared for and die, if possible.

(*__bold__/*italics* is my own emphasis)

End of life care for adults: service delivery (nice.org.uk) Page 15 of 37



01 **Each person is seen as an individual**

I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

02 **Each person gets fair access to care**

I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

03 **Maximising comfort and wellbeing**

My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

04 **Care is coordinated**

I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

05 **All staff are prepared to care**

Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

06 **Each community is prepared to help**

I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

https://learninghub.nhs.uk/catalogue/ambitionspartnership

Married 'soulmates' spent final days side by side

Chris and Lynne Johnson were able to hold hands and comfort each other, family members said

By Isaac Ashe
BBC News, Derby

13 July 2024

Two married "soulmates" who died from terminal cancer within days of each other were able to spend their last moments together side by side.

Chris and Lynne Johnson, from Bolsover in Derbyshire, had been married for 52 years before both were diagnosed with cancer and eventually moved to Ashgate Hospice in February.

Identifying people who are eol

- Principal barrier to palliative care is the lack of recognition that the individual could be in the last twelve months of their life.

- Tools to predict end of life care have been developed:
  - Gold Standards Framework – Proactive Identification Guidance Tool (GSF-PIG)

GSF – PIG tool

- Why is it important to identify that people are nearing the end of their life?
- Leads to improved planning and co-ordinated care
- Predicting needs rather than predicting death, so timely care can be provided
- Proactive care in line with personal preferences

Gold Standard Framework - Proactive Identification Guidance (PIG) (goldstandardsframework.org.uk)

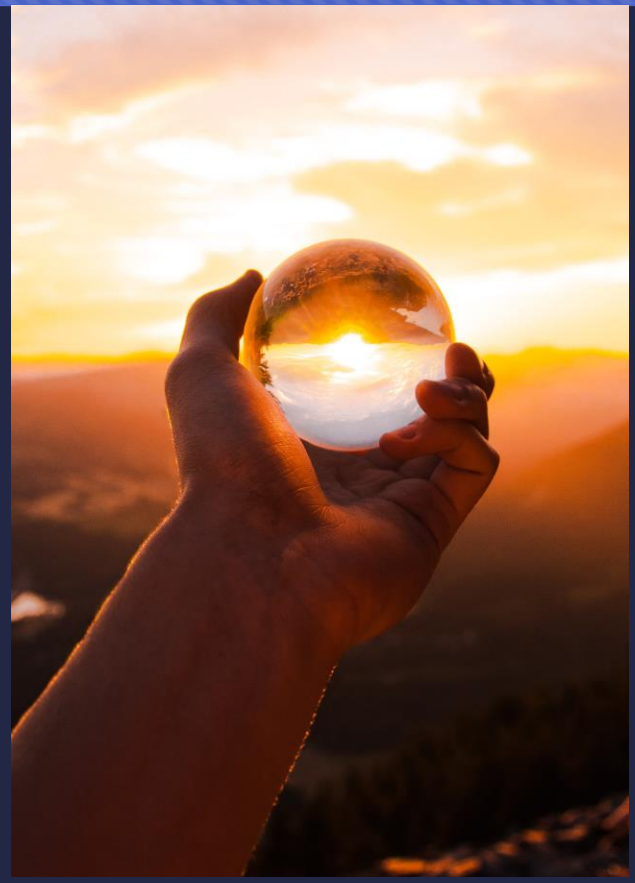


Photo by Arthur Ogleznev on Unsplash

GSF – PIG

- 3 triggers that may suggest someone is nearing the end of their life:

Step 1 - The Surprise Question:

"**Would I be surprised if this person were to die in the next 12 months?"**

- How many patients in your practice or on your caseload spring to mind?

Step 2 – General indicators of declining health

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What signs or symptoms could indicate that someone is eol?

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Step 2 – General indicators of declining health

- Decreasing physical activity (immobility) eg in Bed/Chair >50% of the day
- General physical decline (< ADL)
- Increasing need for support
- Repeated unplanned/crisis admissions
- Progressive weight loss ie >10% in previous 6 months
- "Sentinel event" eg Bereavement, Falls, Transfer to Nursing home

Step 3 - Specific clinical indicators related to certain conditions

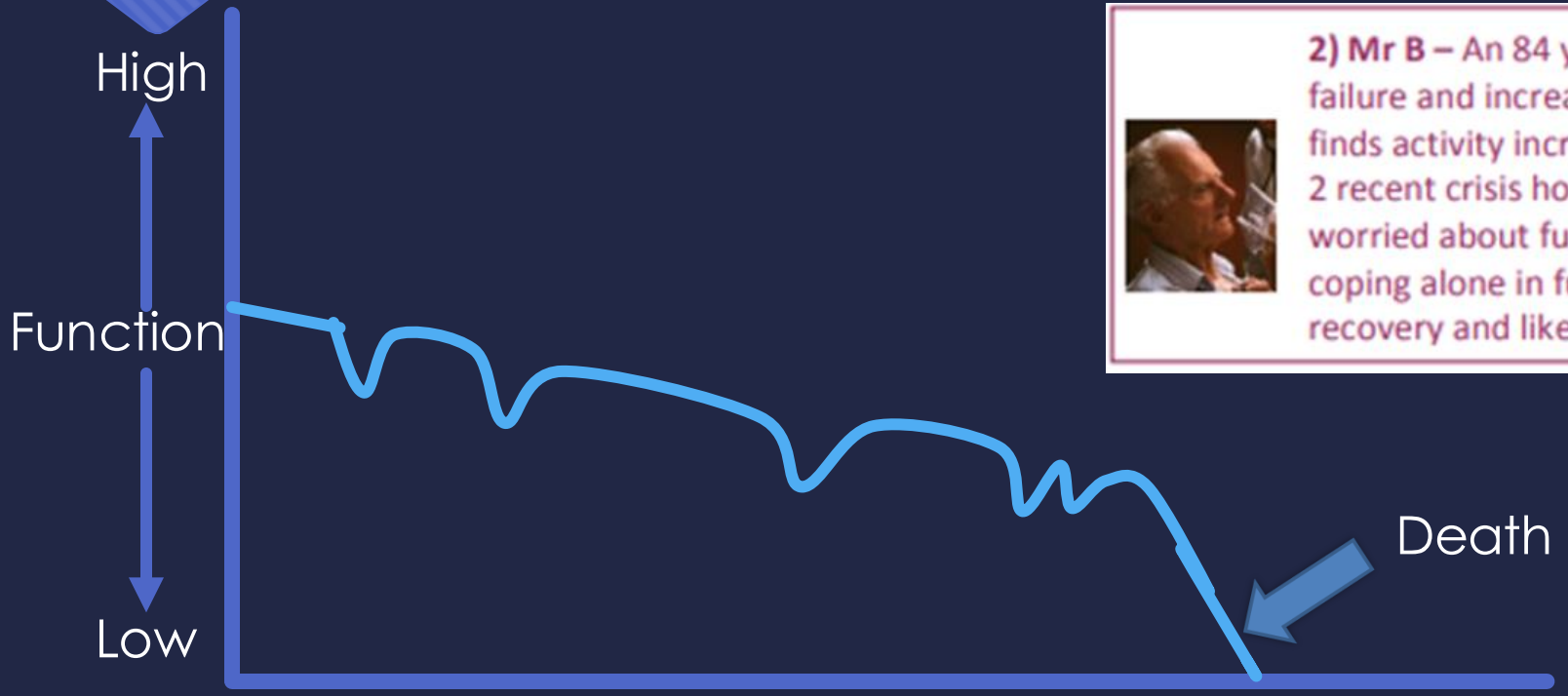
a) Cancer
b) Organ failure eg Renal, Cardiac, COPD, Neurological disease
c) Frailty, CVA & Dementia

Gold Standard Framework - Proactive Identification Guidance (PIG) (goldstandardsframework.org.uk)

Rapid Cancer Trajectory – Diagnosis to Death

1) Mrs A - A 69 year old woman with cancer of the lung and known liver secondaries, with increasing breathlessness, fatigue and decreasing mobility. Concern about other metastases. Likely rapid decline

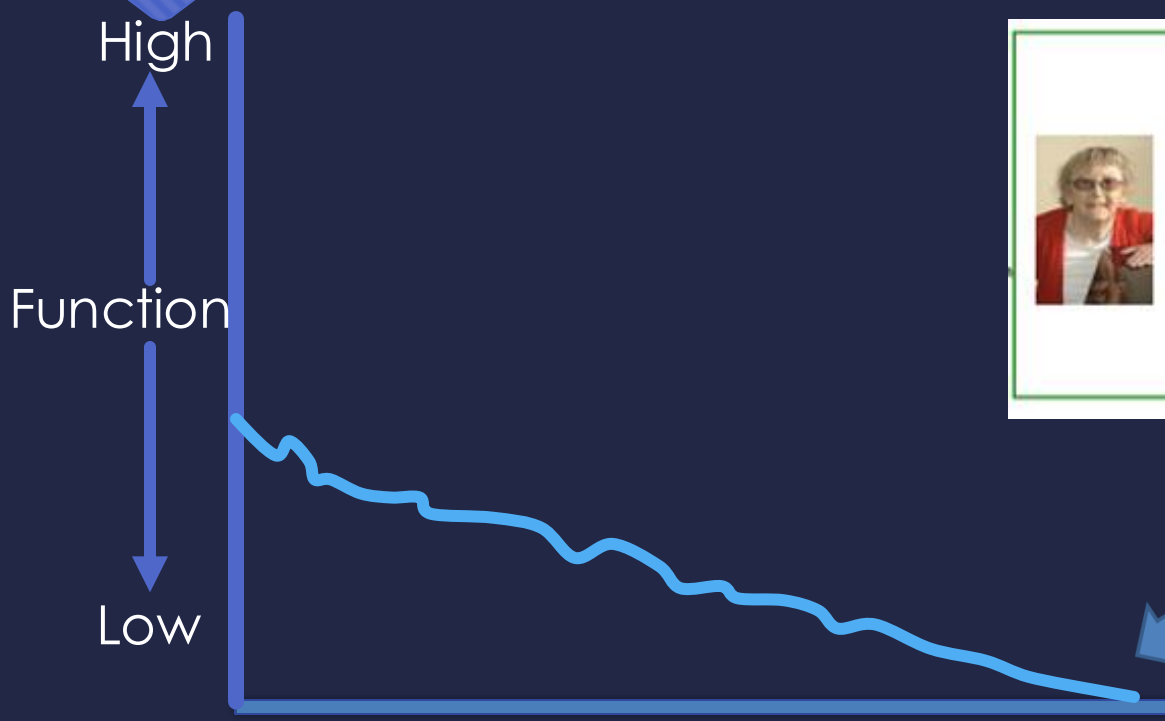
Organ System Failure Trajectory



2) Mr B – An 84 year old man with heart failure and increasing breathlessness who finds activity increasingly difficult. He had 2 recent crisis hospital admissions and is worried about further admissions and coping alone in future. Decreasing recovery and likely erratic decline

Uses Hospital more, Self-care more difficult → Time = 2-5 years

Frailty/Co-morbidity/Dementia trajectory



3) Mrs C – A 91 year old lady with COPD, heart failure, osteoarthritis, and increasing signs of dementia, who lives in a care home. Following a fall, she grows less active, eats less, becomes easily confused and has repeated infections. She appears to be 'skating on thin ice'. Difficult to predict but likely slow decline

Onset could be deficits in ADL, Speech, Ambulation → Time = Variable eg 6-8 years

The Rockwood Frailty Score[5] - measuring frailty in your patients using the clinical frailty scale

Robust, active and motivated, these people **exercise regularly** and are among the most fit members of their age group.

1 VERY FIT

Living **without active disease** but not as fit as those in the first category.

2 WELL

Living with disease symptoms that are **well controlled** and managed.

3 MANAGING WELL

While not dependent, these individuals **face challenges** that slow them down.

4 VULNERABLE

Living with **limited dependence** on others to perform activities of daily living.

5 MILDLY FRAIL

Help is needed for all activities of daily living (bathing, housework and getting around).

6 MODERATELY FRAIL

Completely dependent on others for personal care.

7 SEVERELY FRAIL

Completely dependent and approaching the end of life.

8 VERY SEVERELY FRAIL

Approaching the end of life, with a life expectancy of **less than six months**.

9 TERMINALLY ILL

Advanced care planning (ACP)

Advance care planning (ACP)

- ACP is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care.
- Person must have capacity at this point (ACP comes into effect when unable to make wishes known)

Advance care planning (ACP)

Other terms and forms used include:

- Anticipatory Care Planning (ACP)
- Treatment Escalation Plans (TEP)
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)
- Advanced Decision to Refuse Treatment (ADRT)

Advance decision (living will) - NHS (www.nhs.uk)

- Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)
- ***Only one of the above is legally binding – which one is it?***

Resuscitation Council UK

ReSPECT

Recommended Summary Plan for Emergency Care and Treatment

www.resus.org.uk/respect

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name

Date of birth

Address

NHS/CHI/Health and care number

Preferred name

Date completed

1. This plan belongs to:

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ Yes ☐ No

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me / **Quality of life and comfort matters most to me**

What I most value:

What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

Prioritise extending life — clinician signature

or

Balance extending life with comfort and valued outcomes — clinician signature

or

Prioritise comfort — clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

CPR attempts recommended Adult or child — clinician signature

For modified CPR **Child only, as detailed above** — clinician signature

CPR attempts **NOT** recommended Adult or child — clinician signature

www.respectprocess.org.uk

ReSPECT ReSPECT ReSPECT ReSPECT ReSPECT ReSPECT

Version 3.0 © Resuscitation Council UK

What matters most: the heart of ACP

Let's get talking.....

Why should we ask: 'What matters to me?'

.....about what matters to me

Relaxing

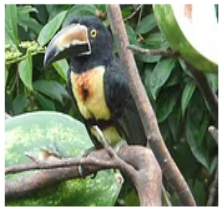
We all have different ideas about what is important to us. When our wishes are heard and respected, it means we can live better until the very end of life. Having meaningful conversations around what matters to us is essential throughout life. It can also make the difference between a peaceful, meaningful ending and a confusing, frightening one.

'What matters' conversations can also make the difference between family and friends feeli satisfied they did everything they could for their loved one, and the uncertainty and guilt of not knowing if they got it right.

Travel

Religion

What kind of things should we be learning about each other from these conversations?



Wildlife

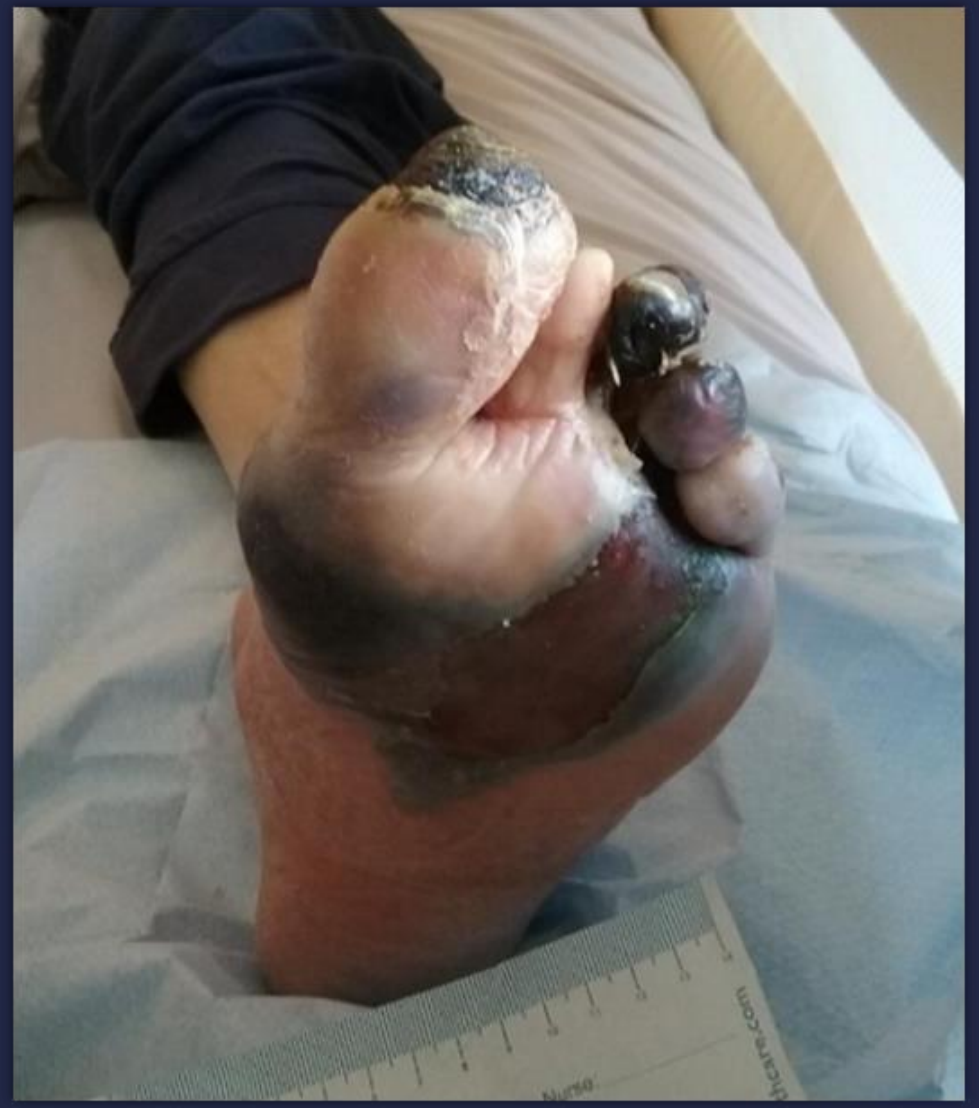
Unlike advance care planning (ACP) conversations, talking about what matters to you is more about overall wellbeing than medical matters – what will help you feel that life is enjoyable and worthwhile? These are normal everyday conversations. From such conversations we may learn unexpected things about each other like:

- What makes us happy, feel calm, content and peaceful?
- Our hopes? This could include finding a partner, career, travelling or an unusual interest.
- What would matter most if we had limited time, for example being with family.

www.whatmattersconversations.org


Have you made a will?

Podiatry in eolc




MIDSOMER
MURDERS

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When you have treated eolc patients, what challenges have you faced when treating foot ulcers or any other foot problems?

ⓘ Start presenting to display the poll results on this slide.

What challenges have you faced when treating foot ulcers or any foot problems, in eolc patients?

Expectations

Difficult conversations

Treatment decisions

Pain

Contractures

Deterioration

Challenges for Podiatry in eolc

- Historical role of Podiatry in eolc unrecognised?
- Lack of training at undergraduate & post-graduate level?
- Lack of guidance in eolc, especially regarding wound debridement

Between a rock and a hard place

Photo by Benjamin Behre on Unsplash

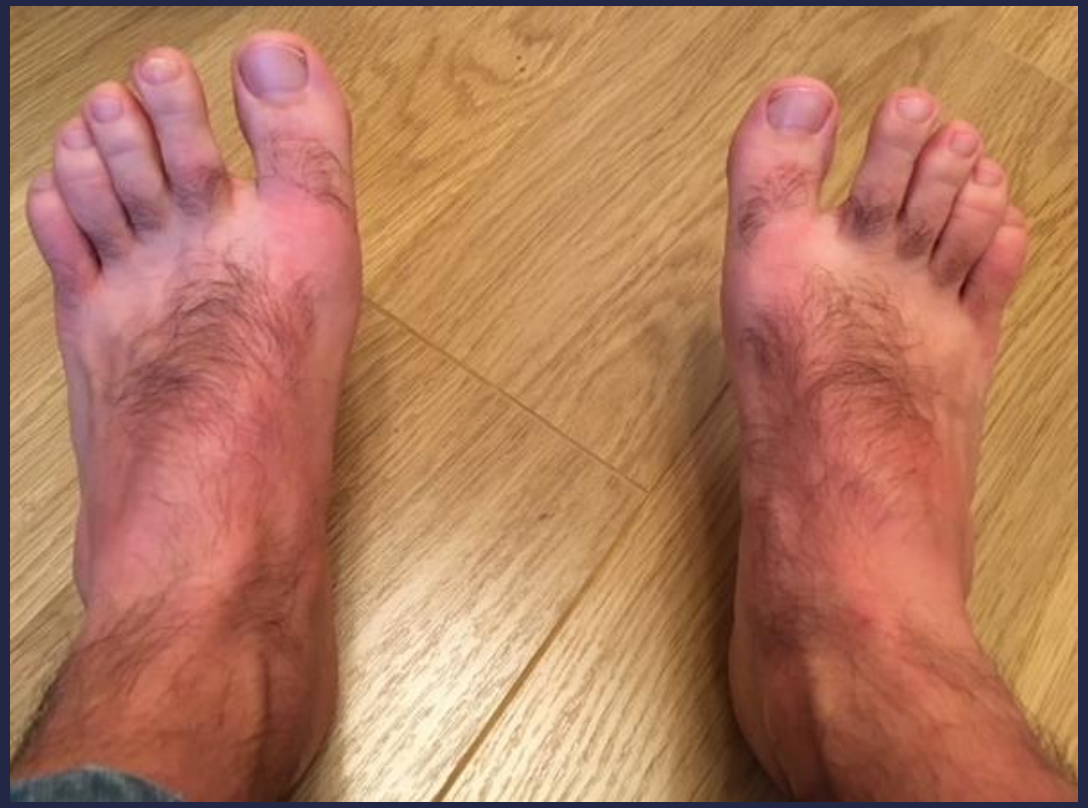
Podiatry in eolc key references

- Podiatrists have a unique role to play in delivering specialist wound management and high risk footcare, in order to improve quality of life (QoL) and enhance eolc in dying patients (Verdin & Rao 2016).
- There is a lack of clinical evidence-based guidance regarding palliative foot wound care but it is possible to provide clinical recommendations based upon principles of holistic and patient-centred eolc (Dunning 2016).
- Excellent wound care has a fundamental role to play in providing compassionate and holistic palliative care (Graves & Sun 2013) and it is essential that the management of the whole person and not just the foot disease or wound is considered (Dunning 2016).

Aims of palliative wound care

- Stabilisation of a non-healing wound
- Avoidance of hospital admission/surgical intervention
- Wound improvement
- Wound healing/closure

Wound debridement in eolc



- The DECIDE tool encapsulates the key questions that clinicians need to consider, before conducting sharp wound debridement in eolc patients…

DECIDE: wound debridement clinical decision-making tool

D – Desired outcome

E – Everyone in agreement?

C – Clinically justified?

I – Interests (Best)

D – Detrimental?

E – Every time

DECIDE - wound debridement clinical decision-making tool

Case studies

Case study one

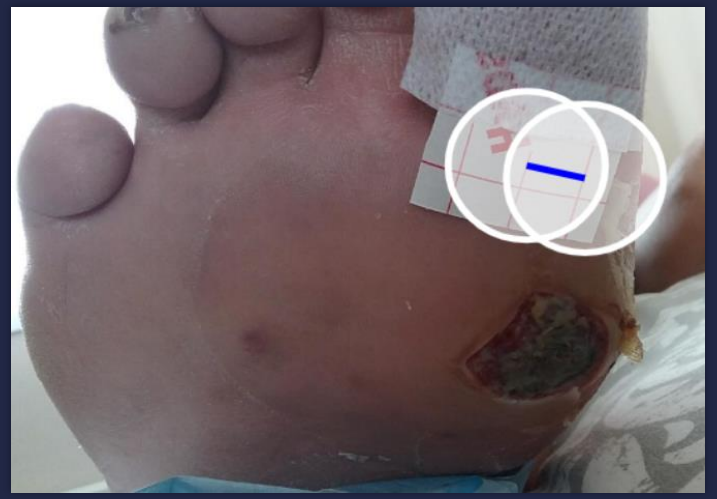
- Male aged 68 - Medical history:

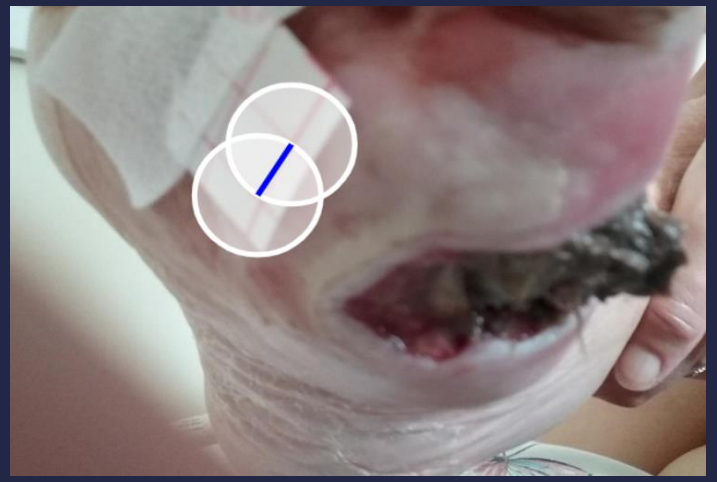
2021 Iron deficiency anaemia
2020 On gold standards palliative care framework
2020 Not for attempted CPR
2020 End of life care pathway (bedbound)
2020 Hepatic encephalopathy
2020 Stricture of oesophagus
2020 Atrial fibrillation
2019 Alcoholic cirrhosis of liver

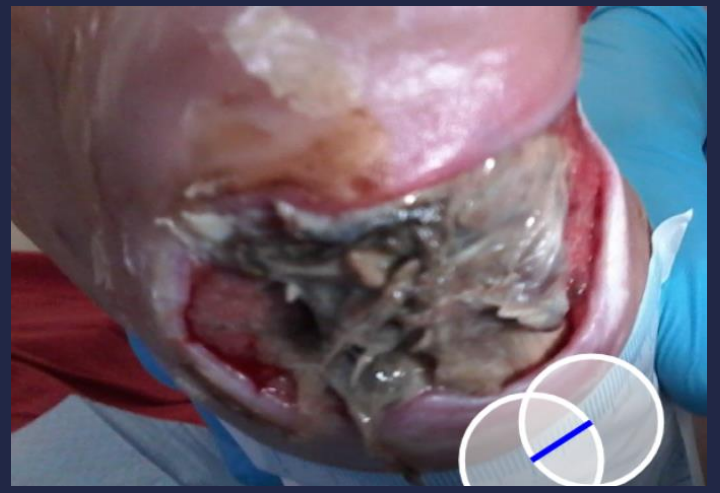
Case study one – right foot

- Bedbound end of life care (eolc) patient, living at home and under the care of community nurses
- Developed deteriorating right foot pressure ulcer (1st MTPJ) with increased exudate, malodour and suspected osteomyelitis
- Warm well perfused foot with biphasic pulses and moderate sensory neuropathy
- Using the DECIDE tool, consider your rationale for debriding or not debriding this wound

Case study one – right foot

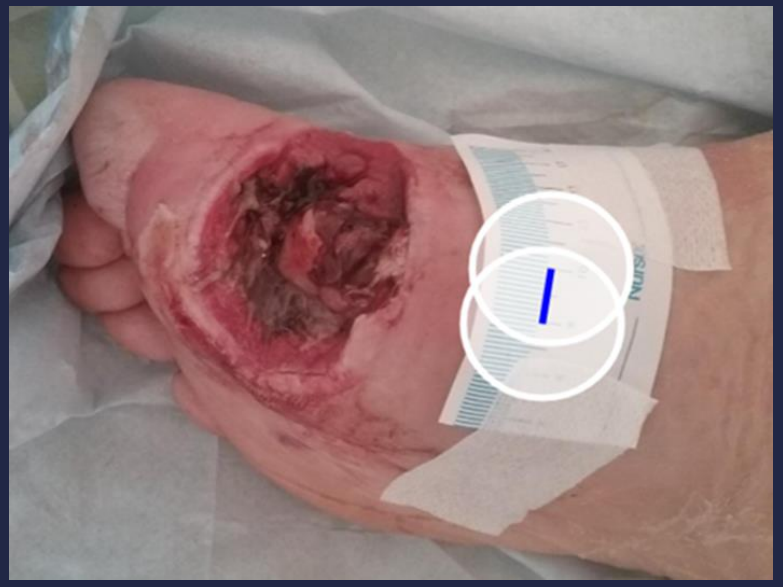


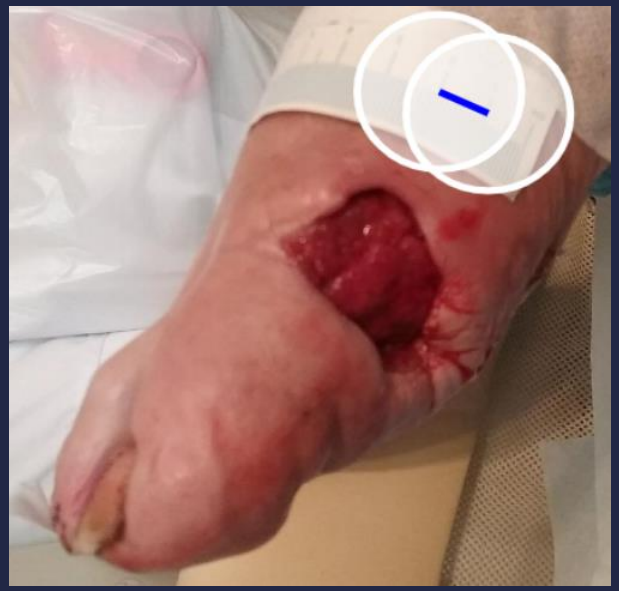


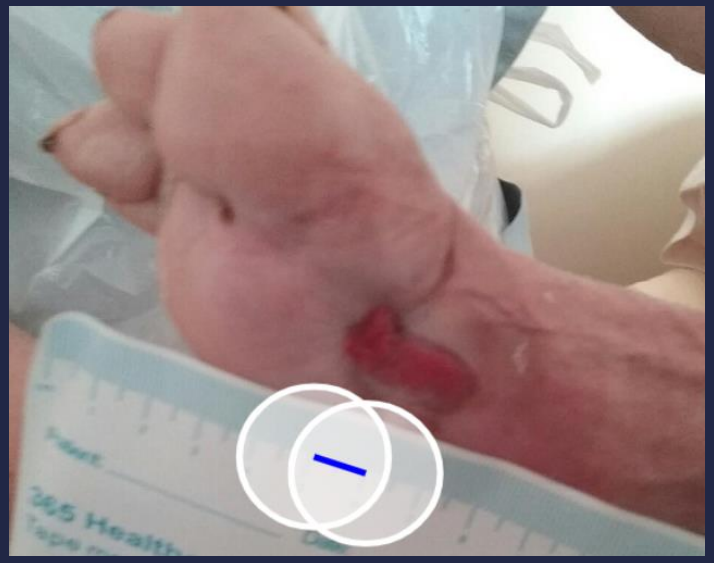


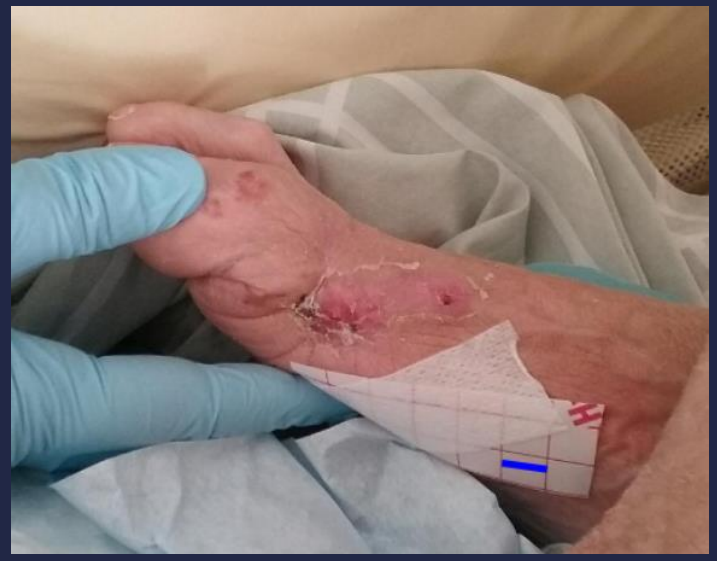

Desired outcome:
What will it achieve?
Everyone in agreement?
Discuss risks & benefits, gain Consent
Clinically justified?
Interests
In the patient's best interests?
Detrimental?
To the patient, foot or wound
Every time:
Question your rationale
Debridement of foot wounds in eolc

Case study one – right foot









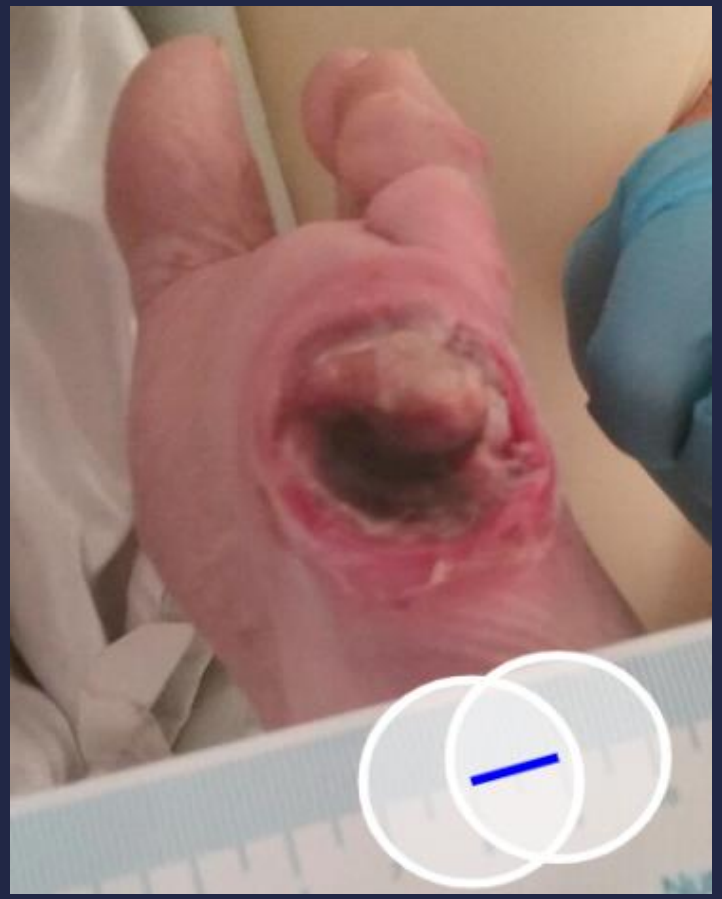
Case study one – left foot

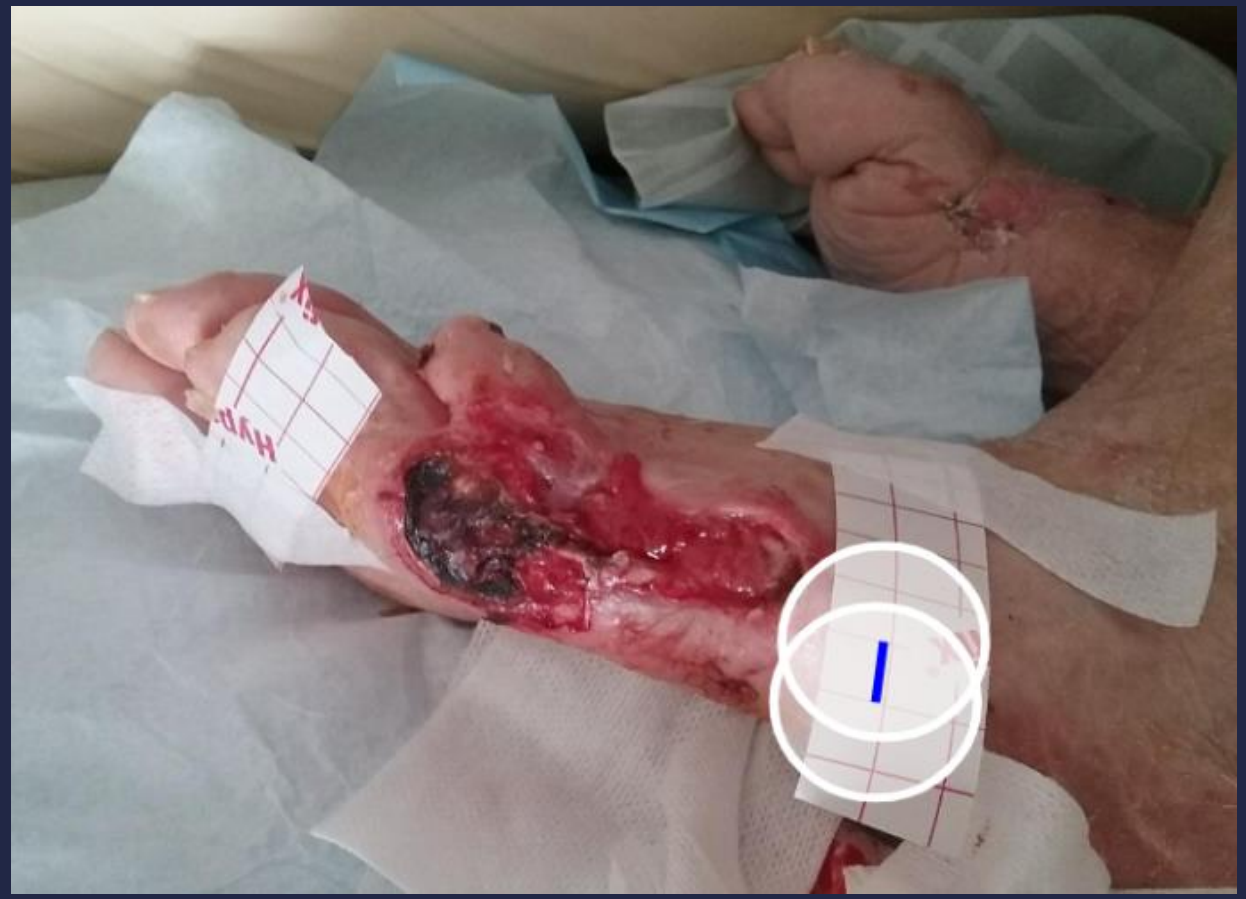
- Bedbound eolc patient now in final weeks of life
- General decline in health
- Developed deteriorating pressure ulcers to his left heel and lateral 5th MTPJ (despite the use of Prevalon boots and a Toto mattress)
- Deterioration of leg contracture
- Warm well perfused foot with monophasic pulses and moderate sensory neuropathy

- Using the DECIDE tool, consider your rationale for debriding or not debriding this wound

Toto mattress

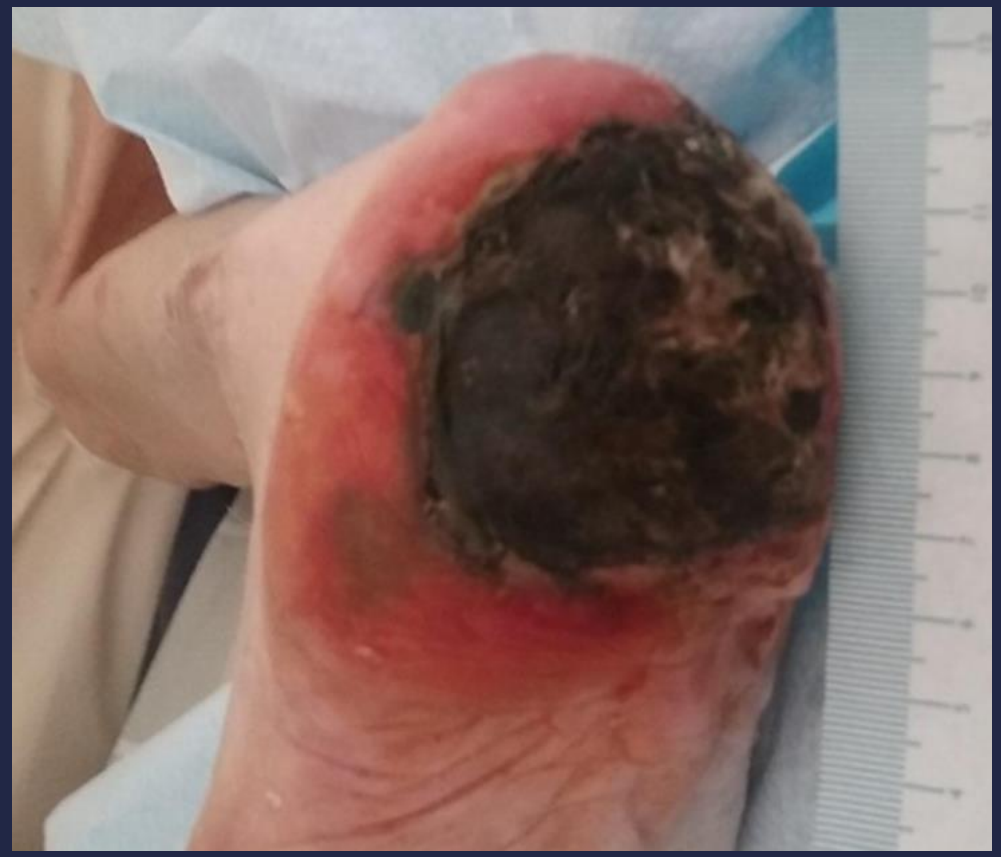
Case study one - left foot

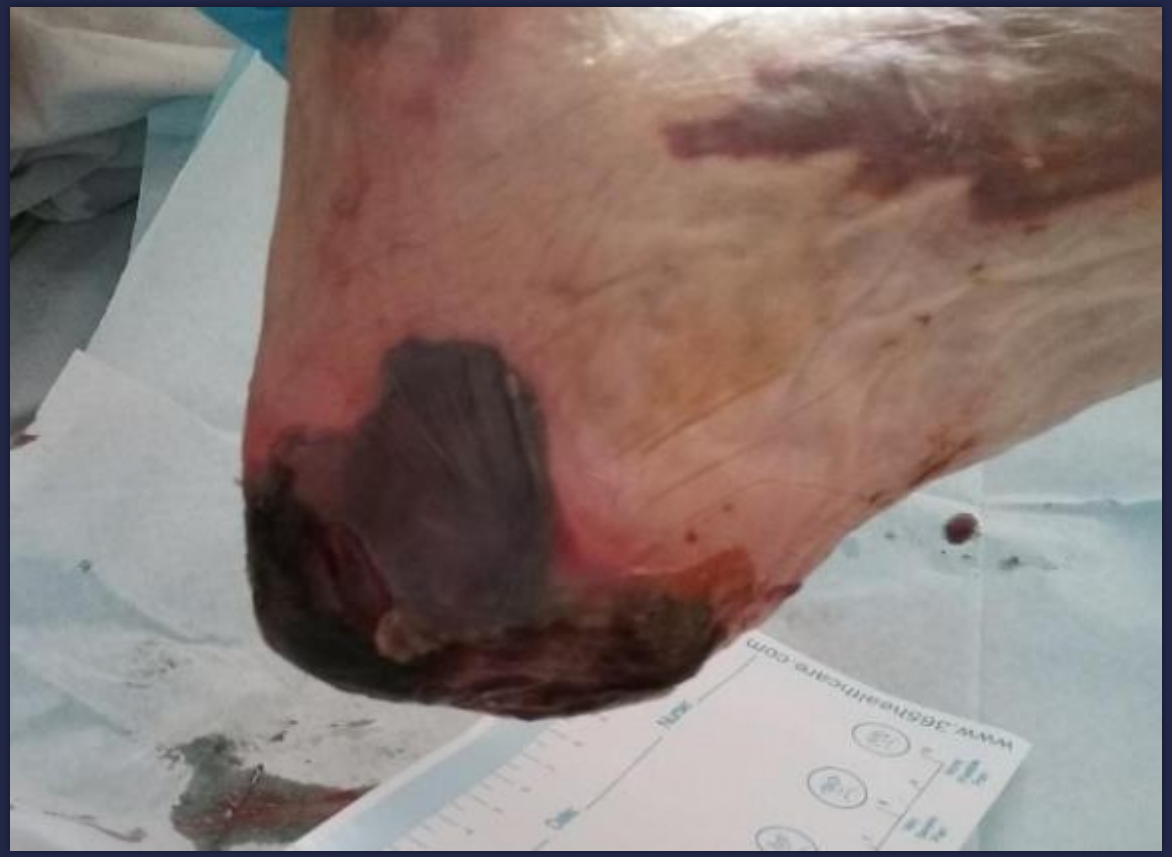





Desired outcome:
What will it achieve?
Everyone in agreement?
Discuss risks & benefits, gain Consent
Clinically justified?
Interests
In the patient's best interests?
Detrimental?
To the patient, foot or wound
Every time:
Question your rationale
Debridement of foot wounds in eolc

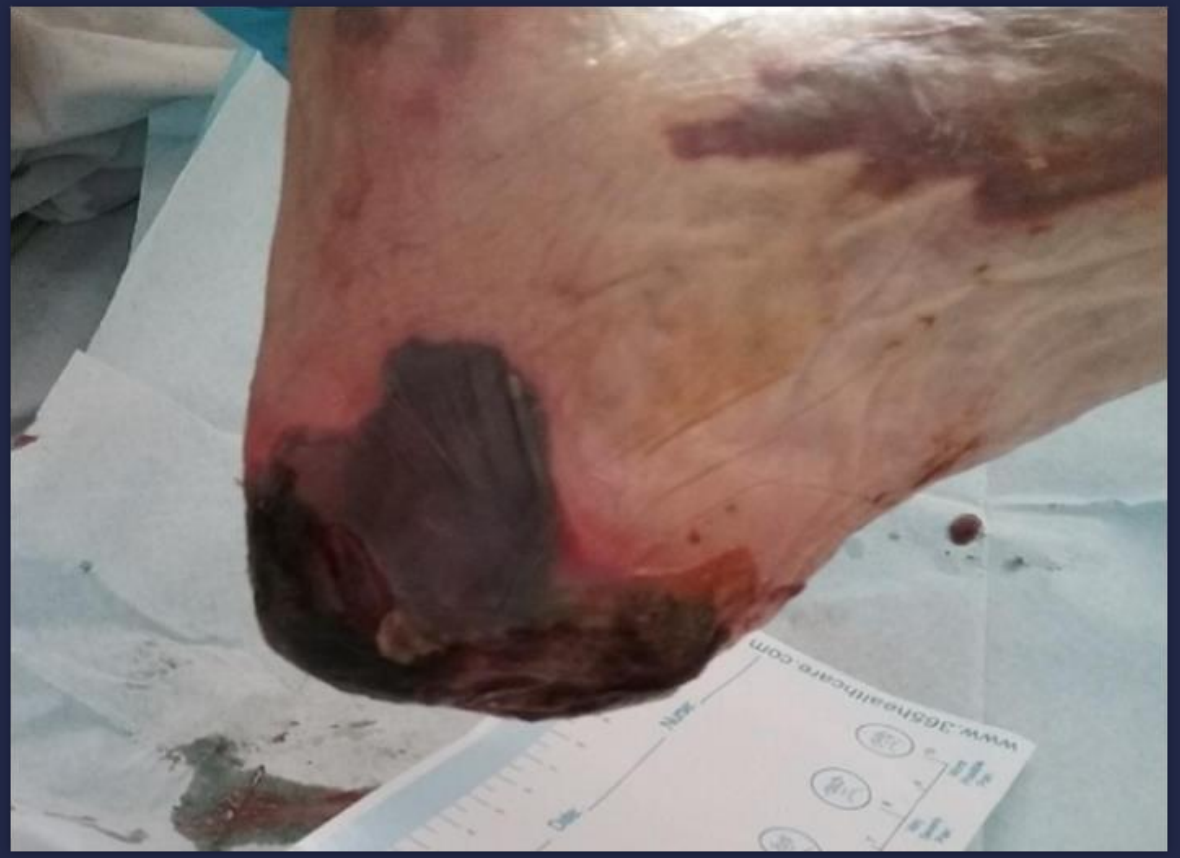
Case study one - left heel





Skin breakdown in the final days/weeks of life

- The dying foot in the dying patient
- Skin organ failure – butterfly necrosis?

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Debridement of foot wounds in eolc

Case study two

- Male aged 78 - Medical history:

2022 Pressure ulcer
2021 EHCP (Emergency health care plan) agreed
2021 Treatment escalation plan

2021 Not for attempted CPR
2020 Dementia
2020 Type 2 Diabetes

2020 Vitamin B12 deficiency

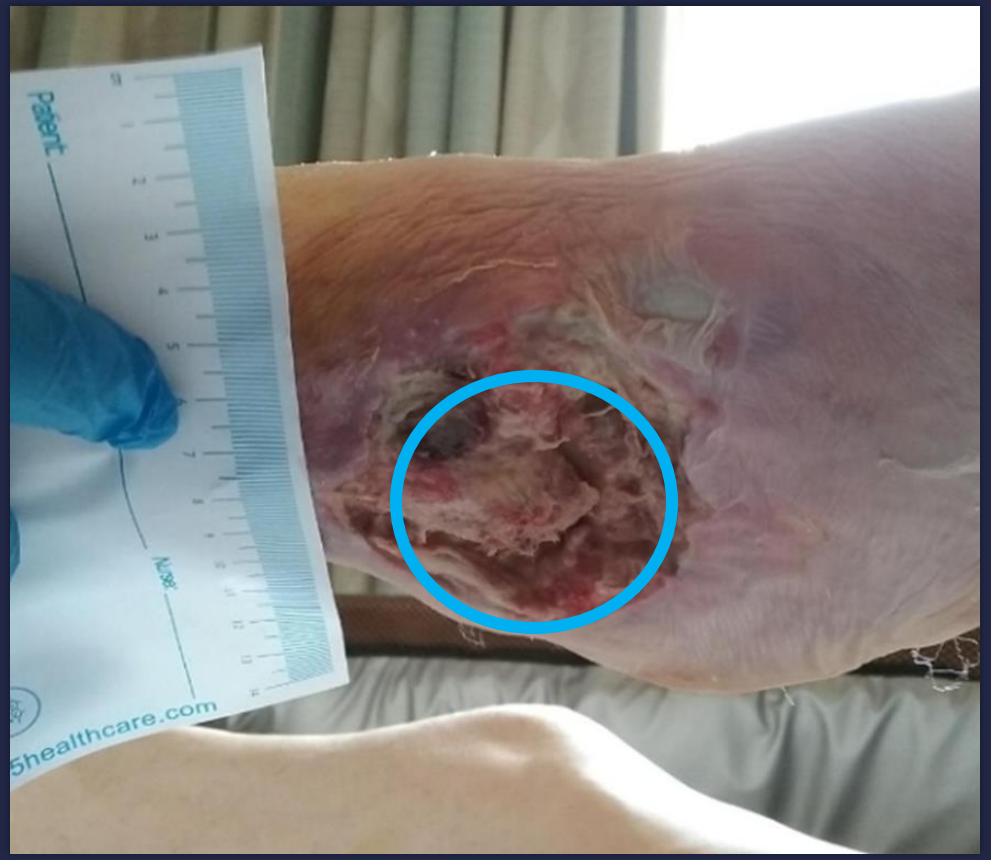
2020 On end of life care register

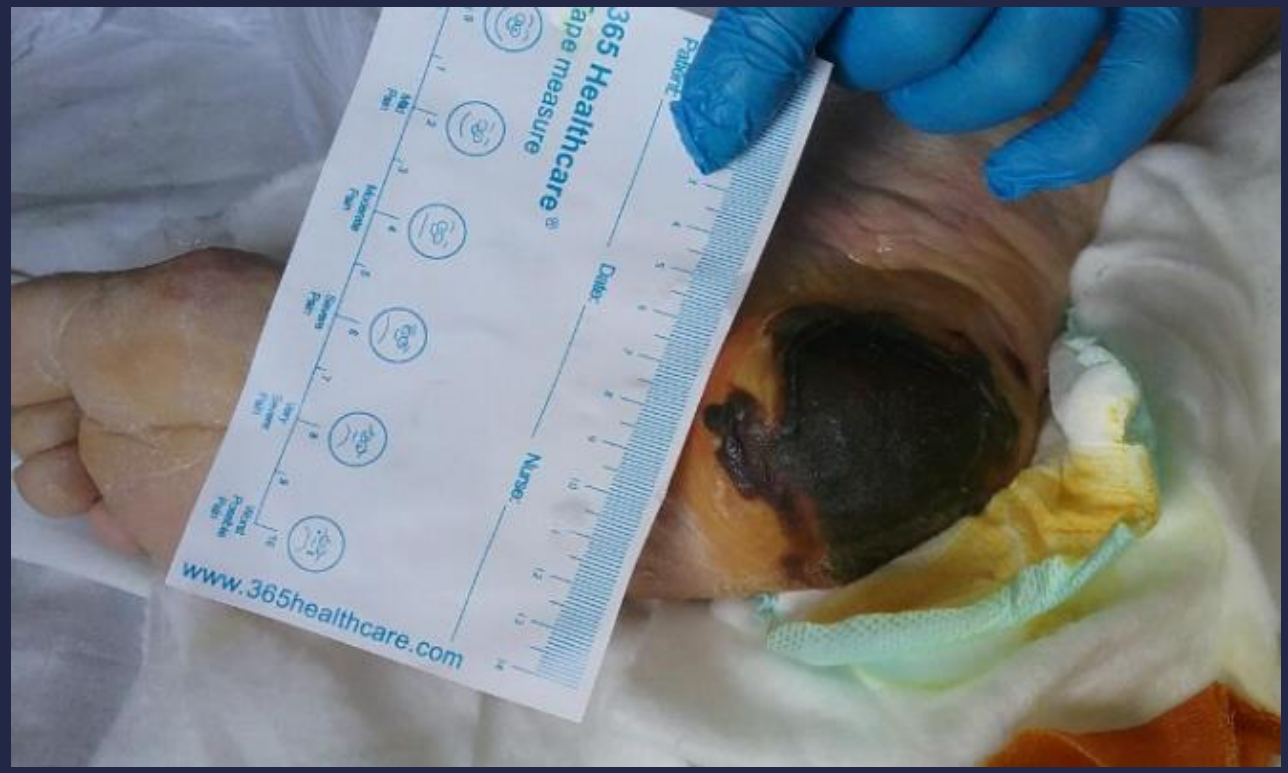
Case study two

- Lack of mental capacity, no NOK, minimal communication
- Exposed Fibular (lateral malleolus), partial dislocation of ankle and ungradeable PU to heel

- Using the DECIDE tool, explain your rationale for debriding or not debriding this wound

Case study two






Desired outcome:
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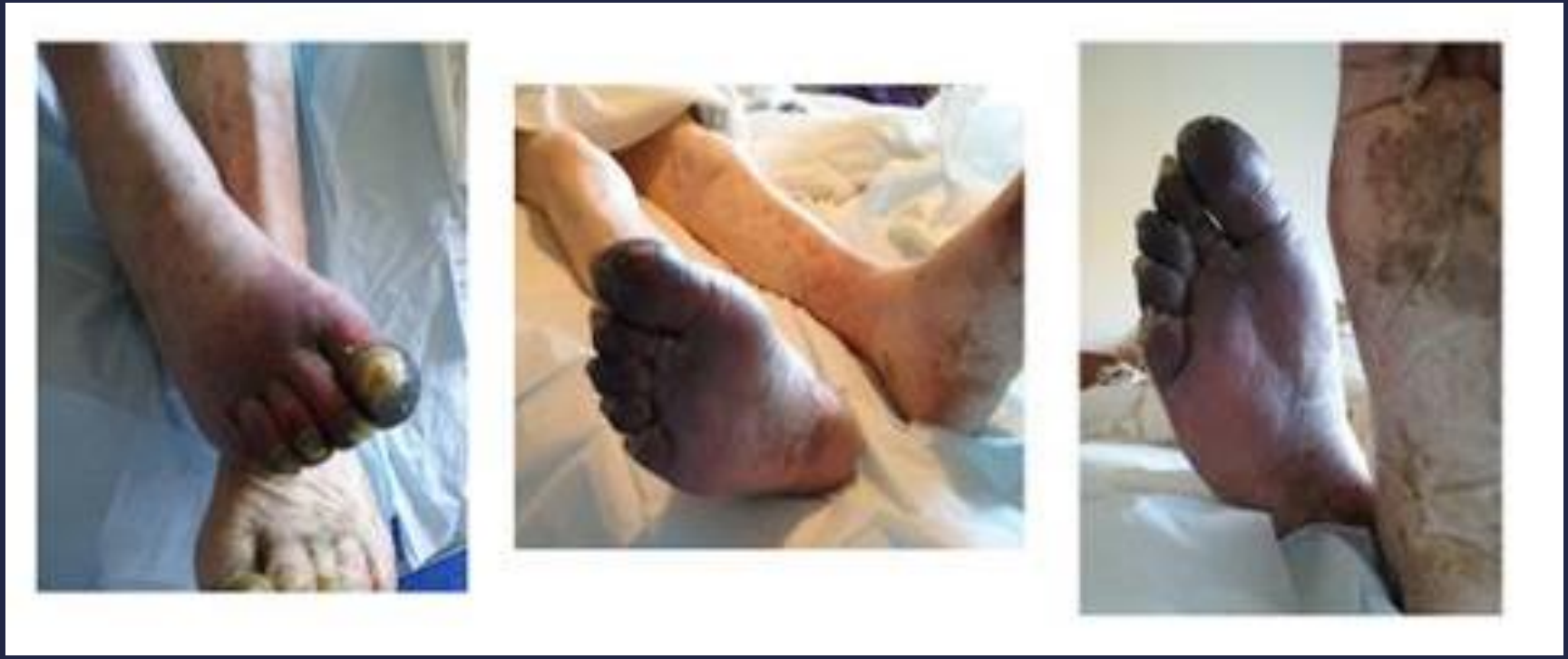
To the patient, foot or wound
Every time:
Question your rationale
Debridement of foot wounds in eolc

Case study three

- Leukaemia palliative care patient with acute limb ischaemia



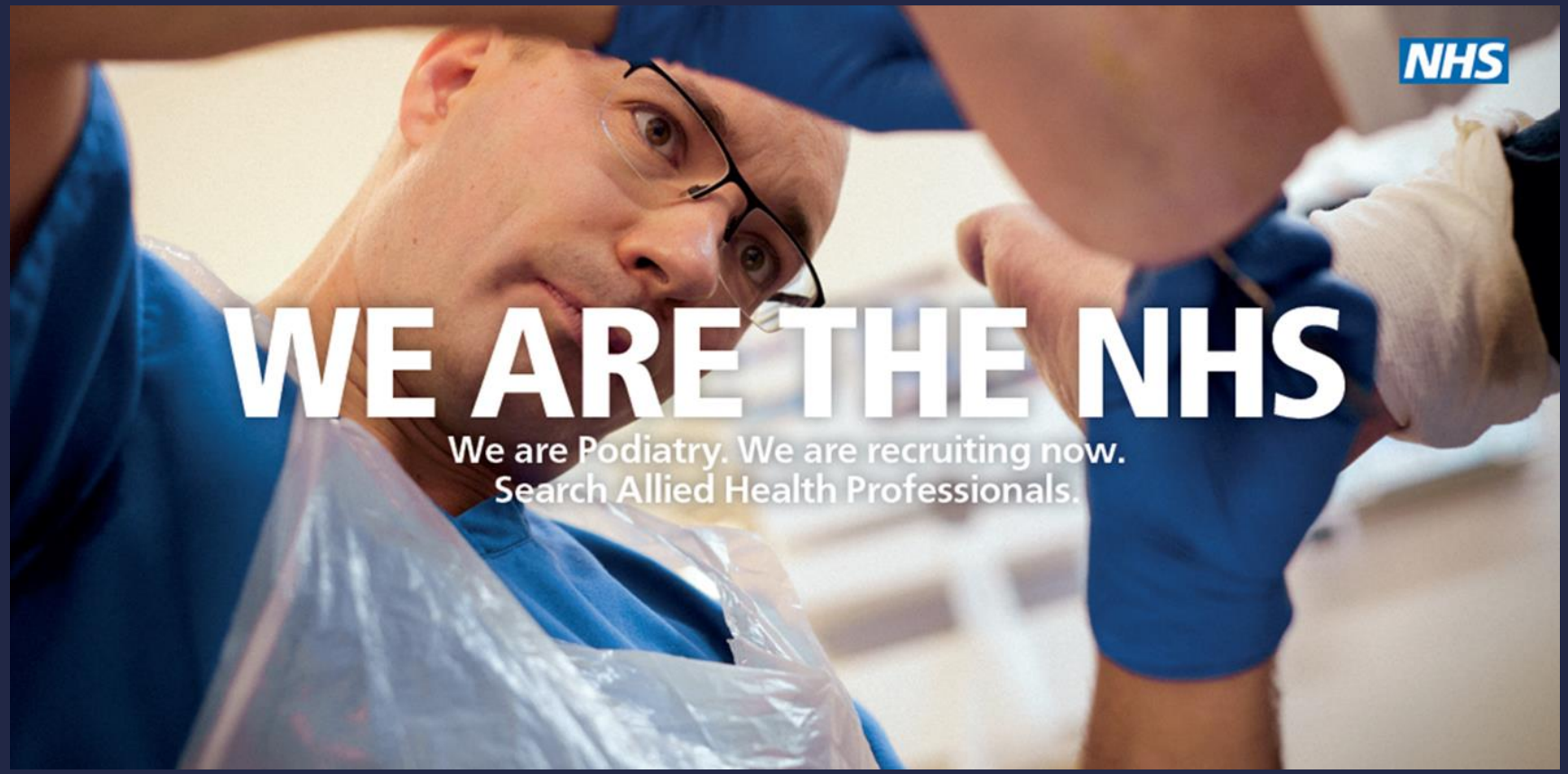
Conclusion

- Identify patients who maybe eol and act on signs of deterioration: timely conversations and referrals
- Eolc training for Podiatrists can be beneficial by increasing confidence in decision-making regarding wound care
- A need for mandatory training, undergraduate and/or postgraduate training?

Conclusion

- Please use the DECIDE tool with your eolc patients
- Back to the future: communication, individual holistic care planning & shared care/decision-making: these are complex cases!
- You have a unique and privileged role to play!

Thank you for listening and taking part!
Any comments or questions?



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