

Podiatry in end of life care: debridement, dying and decision making




Mark Povey - Clinical Lead Podiatrist, Kent Community Health NHS Foundation Trust

No conflicts of interest to declare...

.... but I am getting flashbacks!



Contents of this session

- Death of long-term Podiatry patients
 - Definition and context of end of life care (eolc)
 - Identifying people who are at the end of life
 - Podiatry in eolc: challenges, guidance, wound debridement
- 

My eolc journey:



#121 Creating a tool to support decision making at End of Life with podiatrist Mark Povey



Conversations About Advance Care Planning

3 Feb • 33 min • Finished ✓



In this episode it is my pleasure to talk with podiatrist Mark Povey. Mark and I first met when I was lead for EoLC at an NHS Trust and Mark presented an idea around decision making for podiatry patients towards the end of life. It's fascinating and a privilege to hear how this idea developed into a QI pr... [see more](#)

Death of long term Podiatry patients



Another one bites the dust?

Have you experienced the death of a long term patient this year?



Impact of the death of Podiatry patients

- There can be a deep emotional impact and Podiatrists may be ill-equipped to cope
- Cumulative effect as it is likely to occur throughout our careers
- Clinicians should be encouraged to be open about their feelings, to employ coping strategies, in order to prevent professional burnout

Robson, K. and Williams, C.M. (2017) Dealing with the death of a long term patient; what is the impact and how do Podiatrists cope? *Journal of Foot and Ankle Research*. 10.36.





End of life care: definition and context

End of life care

People are ‘approaching the end of life’ when they are likely to die *within the next 12 months*. This includes people with:

- advanced, progressive, incurable conditions
- general frailty and co-existing conditions that mean they are at increased risk of dying *within the next 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.

www.nice.org.uk/guidance/ng142/resources/end-of-life-care-for-adults-service-delivery-pdf-66141776457925

www.goldstandardsframework.org.uk/training-accreditation/free-resources-professionals/

Palliative Care and End-of-Life Care

Opportunities for the
NHS Ten Year Plan

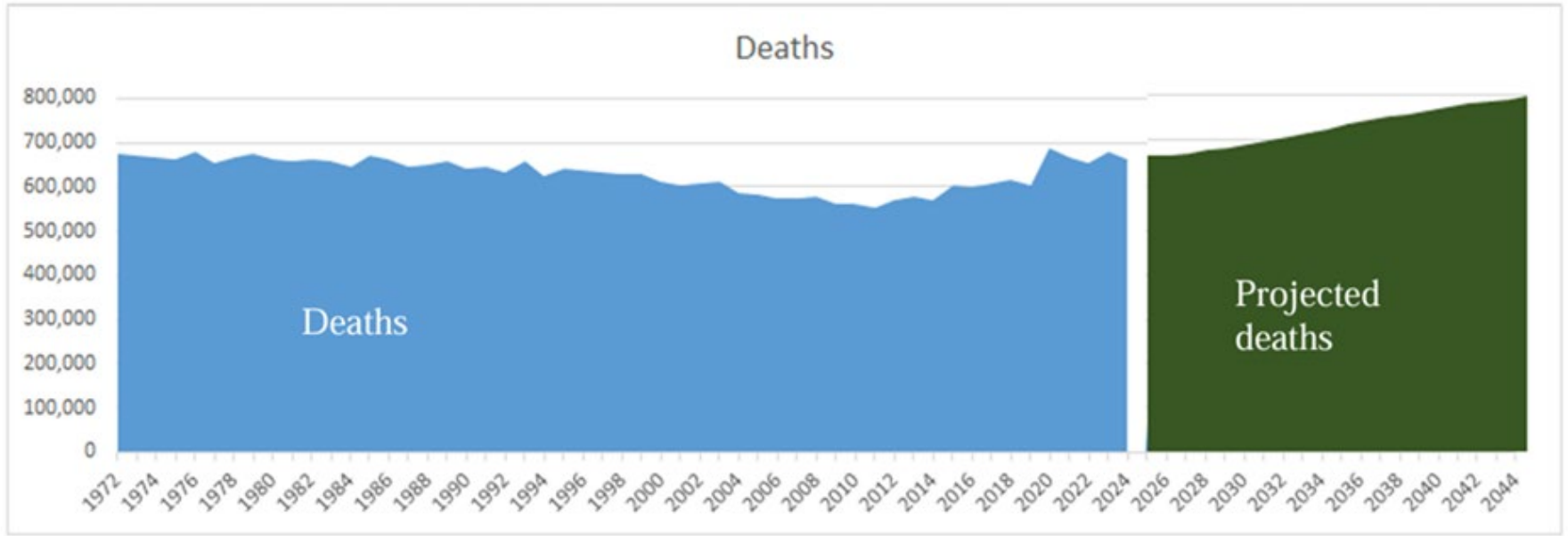
June 2025, Volume 2

Commission on Palliative
and End-of-Life Care

Growing need for palliative care

- more people are living longer with several long-term health conditions
- the number of people in England with two or more long-term conditions is projected to nearly double from 19.2 million in 2019 to 35.3 million by 2049
- managing symptoms, supporting decisions about treatment and care, and addressing physical, emotional, social and spiritual concerns.
- helping people live as well as possible, throughout the course of serious and often fluctuating illnesses and at the end of life.





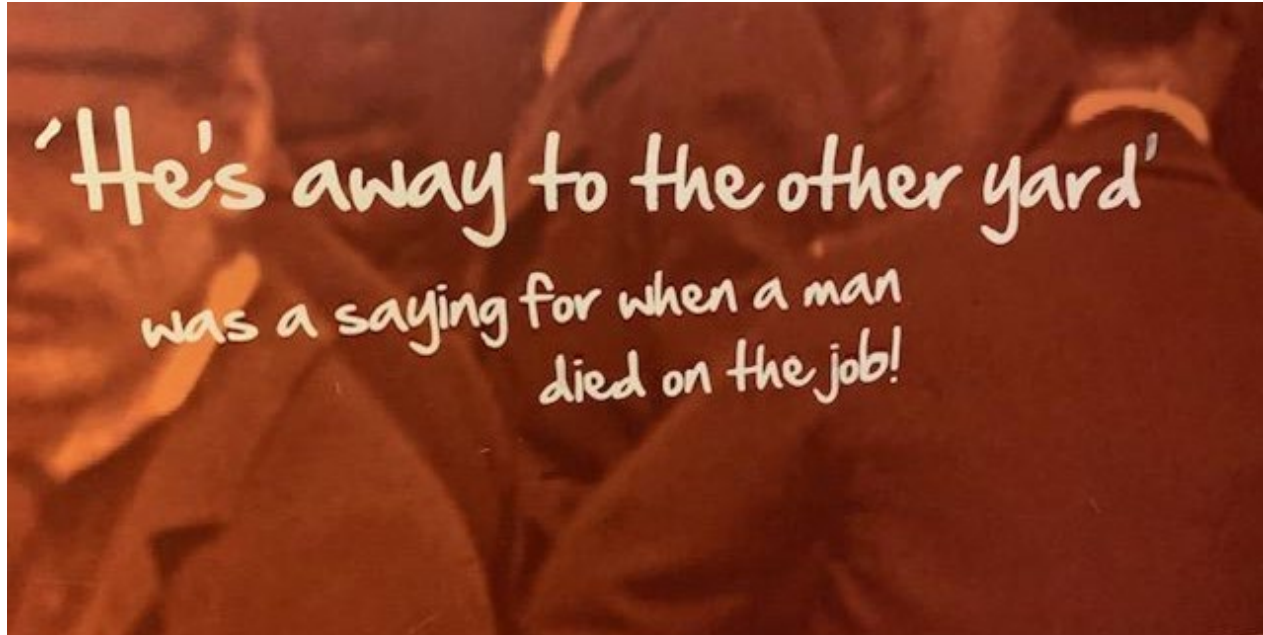
Deaths Projected deaths Figure 2: Annual deaths in the UK, actual and future projections 1973-2044 (2024 data not collated). Based on data from the Office for National Statistics (ONS) 53

Recommendation 4

- embed palliative care into undergraduate medical, nursing, and allied health curricula, alongside training modules for those already in practice.
- support professionals in delivering timely, compassionate, and coordinated care, improving outcomes for patients and families.
- ensuring more staff are equipped to communicate with skill and kind honesty.



Language matters





Dying for Beginners

WITH DR. KATHRYN MANNIX

www.youtube.com/watch?v=ayMhA1pRLeY

THE SUNDAY TIMES BESTSELLER
Kathryn Mannix

Bestselling author of *Listen*

'Illuminating and beautiful'
Cathy Rentzenbrink

**With
the
End
in
Mind**

'Extraordinary and profoundly moving'
New Statesman

How to Live and Die Well

'Impossible to read with dry eyes or an unaltered mind' *Sunday Times*



Identifying people who are
at the end of life

Identifying the end of life is near....



Gold Standards Framework – Proactive Identification Guidance Tool (GSF-PIG)

"End of life care is everyone's business" Prof. Keri Thomas - Founder of GSF

Why is it important to identify that people are nearing the end of their life?

- Leads to improved planning and coordinated care
- Predicting needs rather than predicting death, so timely care can be provided
- Proactive care in line with personal preferences

The aim of GSF....

*to enable a 'gold standard' of care
for all people in their last years of life,
supporting them to live well until they die.*



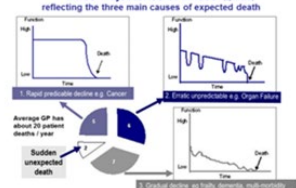
The National GSF Centre's guidance for clinicians to support earlier identification of patients nearing the end of life, leading to improved proactive person-centred care.

GSF PIG 7th Edition June 2022 Kerli Thomas, Max Watson (HUK), Julie Armstrong Wilson and the GSF team
For details see <http://www.goldstandardsframework.org.uk/PIG>, <https://www.gsfinternational.org.uk/PIG-tool>

Proactive Identification Guidance – Identifying patients' decline earlier, enabling more proactive care.

This updated 7th edition of the GSF Proactive Identification Guidance or PIG (previously known as the GSF Prognostic Indicator Guidance), aims to enable the earlier identification of people who may need additional supportive care as they near the end of their life (see GMC and NICE definition of end of life care), to include final year of life as well as final days. This includes people with any condition, in any setting, given by any care provider (not just those needing specialist palliative care), following any trajectory of decline for expected deaths (see below). Additional contributing factors when considering prediction of likely needs include underlying co-morbidities, current mental health and social care provision etc.

Three Trajectories of Illness reflecting the three main causes of expected death



Why is it important to identify patients early?

Earlier identification of people who may be in their final stage of life leads to more proactive person-centred care as recommended in the NHS Long Term Plan (2019) and NICE guidance (2021). Earlier recognition of decline leads to earlier anticipation of likely needs, better planning, fewer crisis hospital admissions and care tailored to peoples' wishes, with better outcomes enabling more people to live and die where they choose. Once identified, people are included on a register and where available the locality/electronic register, triggering specific active supportive care, as used in all GSF programmes and in GSF Cross boundary care sites.



The 3 key steps of GSF – Early proactive identification of patients is the crucial first step of GSF, used by many thousands of doctors and nurses in the community and hospitals.

For more information on GSF, how it is used in practice to help identify patients early, assess needs and wishes through advance care planning discussions and plan care tailored to patient choices

For information on the development of the GSF PIG, its use in practice, evidence base, applications and when referring it, please refer to <http://www.goldstandardsframework.org.uk/PIG>, <https://www.gsfinternational.org.uk/PIG-tool> or contact info@gsfcentre.co.uk

Definition of End of Life Care General Medical Council

GMC - <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors-treatment-and-care-towards-the-end-of-life>

NHS - <https://www.nhs.uk/conditions/end-of-life-care/what-it-involves-and-when-it-starts/>

The GMC definition of End of Life Care, used by the NHS, NICE and others is "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.'

NICE Guidance in End of Life care 2021 Identification

<https://www.nice.org.uk/guidance/ta313/chapter/Quality-statement-1-Identification>

"Statement 1: Adults who are likely to be approaching the end of their life are identified using locally developed systems."

NICE Service Delivery systems <https://www.nice.org.uk/guidance/ta313>

Services should develop systems to identify adults who are likely to be approaching the end of their life e.g., using tools such as GSF proactive identification guidance (PIG).

SARS COVID 19 infections can cause rapid decline, emphasising the importance of early advance care planning and screening.

Contributing factors include age, multi-morbidity, BAME and social status, etc. Pulse oximetry SpO2 of 92% or under triggers immediate treatment - more information see NHS guidance or [https://www.thelancet.com/journal/S0140-6736\(20\)31539-7](https://www.thelancet.com/journal/S0140-6736(20)31539-7)

GSF Proactive Identification Guidance Flow-chart

Proactive Identification Guidance – GSF PIG Flow-chart



STEP 1: The Surrogate Question

For patients with advanced disease or progressive life limiting conditions, would you be surprised if the patient were to die in the next year, months, weeks, days?

The answer to this question should be an intuitive one, pulling together a range of clinical, social and other factors that give a whole picture of deterioration. If you would not be surprised, then what measures might be taken to improve the patient's quality of life now and in preparation for possible further decline?

This includes proactive planning of care and treatments and offering advance care planning and DNACPR discussions as early as possible.

STEP 2: General indicators of decline and increasing needs

- General physical decline, increasing dependence and need for support
- Repeated unplanned hospital admissions or acute crises at home
- Advanced disease - unstable, deteriorating, complex symptom burden
- Presence of significant multi-morbidities
- Decreasing activity – functional performance status declining (e.g., Barthel or Karnofsky Performance score, Rockwood) limited self-care, in bed or chair 50% of day and increasing dependence in activities of daily living
- Increasing response to treatments, decreasing reversibility
- Patient choice for no further active treatment, focus on quality of life
- Progressive weight loss (>10%) in past six months
- Sentinel Events e.g., serious fall, carer distress, bereavement, transfer to nursing home, etc
- Serum albumin <25g/l
- Considered eligible for DS1500 payment

STEP 3: Specific indicators related to single/multiple organ failure

1. CANCER

Deteriorating performance status and functional ability due to metastatic cancer, multi-morbidities or not amenable to treatment – if spending more than 50% of time in bed/dying down, prognosis estimated in months

Persistent symptoms despite optimal palliative oncology. More specific prognostic predictors for cancer are available, e.g., PPS, iPOS, ECG.

2. ORGAN FAILURE

HEART DISEASE

- Advanced heart failure - CHF NYHA Stage 3 or 4 with symptoms despite optimal HF therapy – shortness of breath at rest/on minimal exertion
- Repeated admissions with heart failure – 3 admissions in 6 months or a single admission aged over 75 (50% 1yr mortality)
- Heart failure patients with reduced ejection fraction (HFrEF) have a poorer prognosis than those with preserved ejection fraction (HFpEF)
- Severe unretractable coronary artery or peripheral vascular disease
- Difficult ongoing symptoms despite optimally tolerated therapy
- Unpredictability but other indicators include age, low EF, ischaemic heart disease/arrhythmias multi-morbidities including diabetes, obesity depression, hyponatraemia, high BP, declining renal function, anaemia

See NICE Guidance <https://www.nice.org.uk/topics/heart-failure-chronic>

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

- Severe disease (e.g., FEV1 <30% predicted), persistent symptoms e.g., breathlessness despite optimal therapy, causing distress
- Recurrent hospital admissions (at least 3 in last year due to COPD)
- Hypoxaemia/frequent long term oxygen therapy criteria (PaO2<7.3kPa)
- Too unwell for surgery or pulmonary rehabilitation
- MRC grade 4/5 – shortness of breath after 100 metres on level surface
- Required UTU/NIV during admission or ventilation contraindicated
- Other factors e.g., right heart failure, anaemia, cachexia, >6 weeks steroids in preceding 6 months, despite specialist review/treatment optimisation, requires palliative medication for breathlessness.

KIDNEY DISEASE

- Stage 4/5 Chronic Kidney Disease (CKD) deteriorating eGFR<30ml/min
- Repeated unplanned admissions (more than 3/year)
- Patients with poor tolerance of dialysis with change of modality
- Patients choosing the 'no dialysis' option (conservative management), dialysis withdrawal or not opting for dialysis if transplant has failed
- Difficult physical or psychological symptoms that have not responded to specific treatments
- Symptomatic Renal Failure in patients who have chosen not to dialyse or complicating other life limiting conditions – nausea and vomiting, anorexia, pruritus, reduced functional status, intractable fluid overload

LIVER DISEASE

- Advanced cirrhosis - see the Child-Turcotte-Pugh (CTP) score for chronic liver disease and cirrhosis mortality - See CTP calculator <https://www.hepatitis.uw.edu/page/clinical-calculator/ctp>
- Hepatocellular carcinoma
- Liver transplant is considered potentially difficult or not amenable to treatment of underlying condition
- Other adverse factors including malnutrition, bacterial infection, raised INR, hyponatraemia

GENERAL NEUROLOGICAL DISEASES

- Progressive deterioration in physical and/or cognitive function despite optimal therapy
- No longer able to communicate basic needs
- Symptoms which are complex and too difficult to control
- Increased hospital admissions not returning to previous baseline
- Swallowing problems (dysphagia) leading to recurrent aspiration pneumonia, sepsis, breathlessness or respiratory failure
- Speech problems: increasing difficulty in communication and progressive dysphasia
- Mobility problems and falls increasing
- Reduced independence, needs ADL help, similar to frailty below
- Deteriorating cognition/psychiatric signs (depression, anxiety, hallucinations, psychosis)

PARKINSONS DISEASE including the above, and more specifically -

- Drug treatment less effective or increasingly complex drug regime, less well controlled with increasing "off" periods
- Dyskinesias, mobility problems and falls

MOTOR NEURONE DISEASE including the above, and specifically -

- Episodes of aspiration pneumonia
- Low vital capacity (below 70% predicted), or initiation of NIV

STROKE

- Predicting the prognosis after acute stroke can be challenging, yet 1.20 die within 72 hours. Care should include symptomatic control and not to impose burdensome restrictions
- Persistent paralysis after stroke with significant loss of function, medical complications, lack of improvement or ongoing disability
- Persistent vegetative, minimal conscious state or dense paralysis
- Cognitive impairment/Post-stroke dementia
- FRAILTY, DEMENTIA and MULTI-MORBIDITIES
- For older people with complexity and multiple comorbidities, with frequent fluctuations in health needs and deterioration
- Electronic Frailty Index (0.24 or more) or Rockwood Score/ CFS 7 or above
- Comprehensive Geriatric Assessment (CGA) includes cumulative multiple morbidities, weakness, weight loss, fatigue, advancing frailty e.g., male over 85, health problems, reduced activity and need to stay at home, needs regular help, uses stick/walker regularly

DEMENTIA

- Identification of moderate/severe stage dementia using a validated tool or Comprehensive Geriatric Assessment (CGA) of frailty, Clinical Frailty Scale (CFS), Functional Assessment Staging, Electronic Frailty Index (EFI) or Rockwood scale, identifying decline in dementia or frailty, Triggers to consider that indicate that someone is entering a later stage are:
- Unable to recognise family members or consistently unable to have meaningful conversations
- Completely dependent on others for care or unable to do ADL
- Recurrent episodes of delirium
- Aspiration pneumonia
- Urinary and faecal incontinence, and Barthel score <3

Plus: Weight loss, urinary tract Infection, skin failure or stage 3 or 4 pressures ulcers, recurrent fever, reduced oral intake

MULTI-MORBIDITIES

- Increasingly relevant in ageing population needing complex care
- 2 or more long term conditions including physical, mental, learning disability, frailty, sensory impairment, alcohol misuse
- Consider multi-morbidity approach if have frailty, physical + mental conditions, not managing ADL or treatments, using multiple services, frequent falls or crisis admissions
- See NICE Guidance - <https://www.nice.org.uk/guidance/ng56>
- BGS - <https://www.bgs.org.uk/topics/multimorbidity>

GSF-PIG tool

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

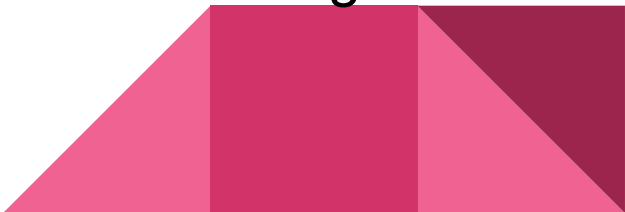
- **Step 1 - The Surprise Question:**

“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 come to mind?



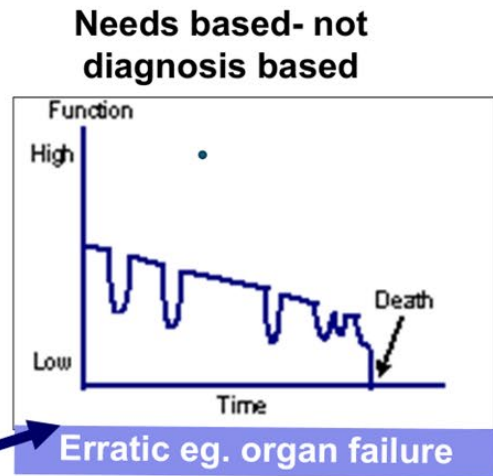
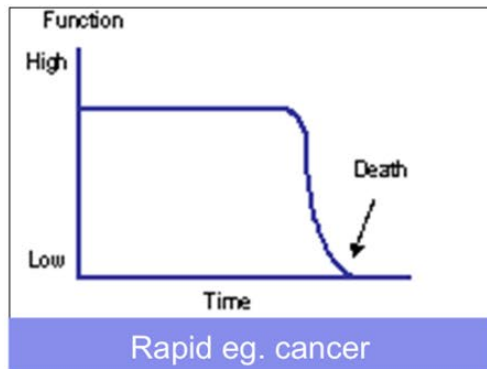
Step 2 – General indicators of declining health

- 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, fall, transfer to Nursing home
- 

Step 3 - Specific clinical indicators related to certain conditions

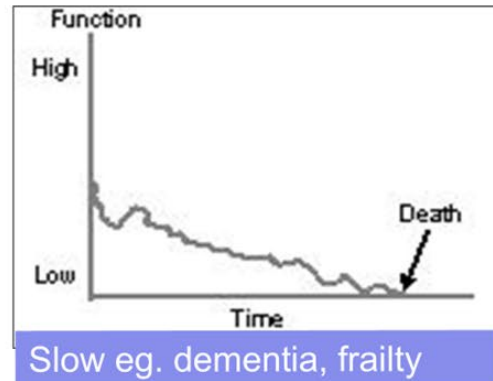
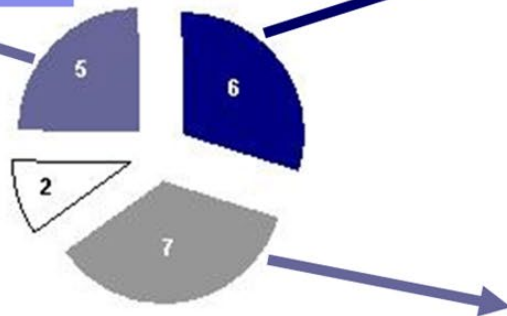
Different ways of dying

Rapid, erratic and slow dying trajectories

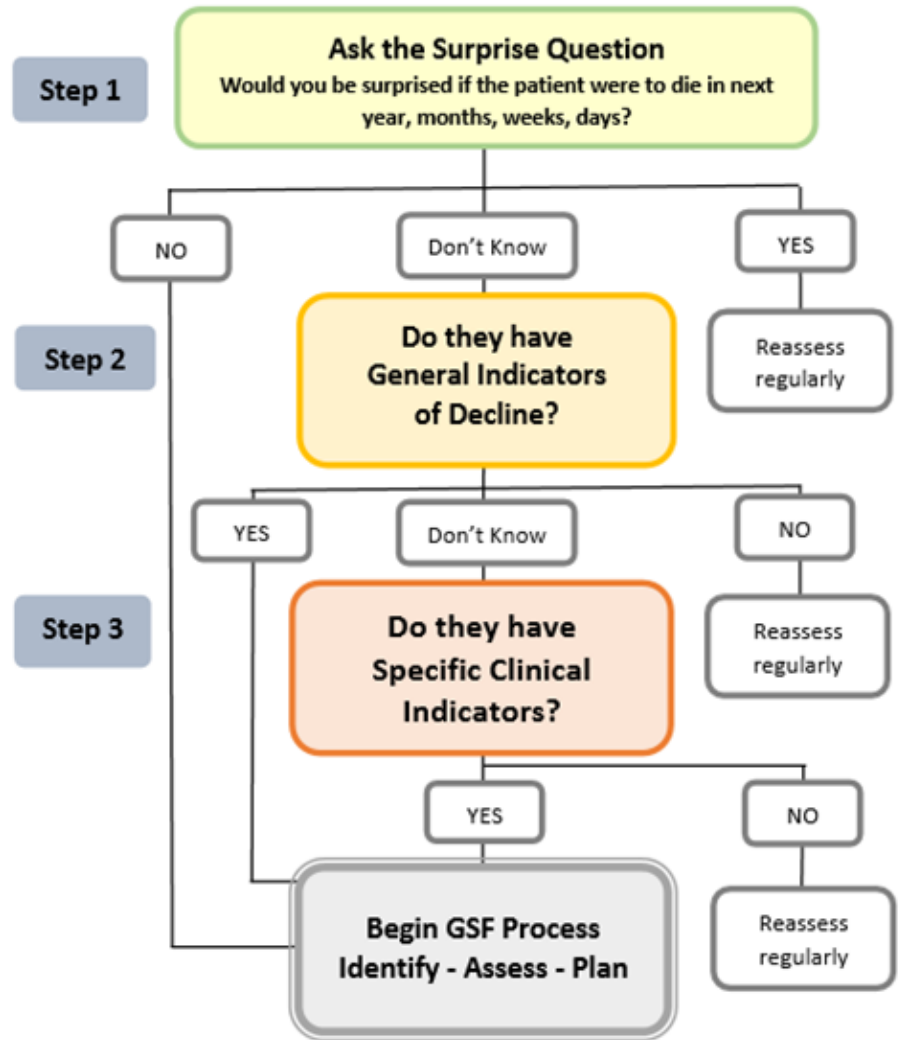


GP has about
20 deaths / year

Sudden
death /
Other



If your patient might be eol, then so what?





Podiatry in eolc: challenges,
guidance, wound debridement

Challenges faced by Podiatrists in eolc

Expectations

Difficult
conversations

Complex
decisions

Pain

Contractures

Deterioration

GMC guidance

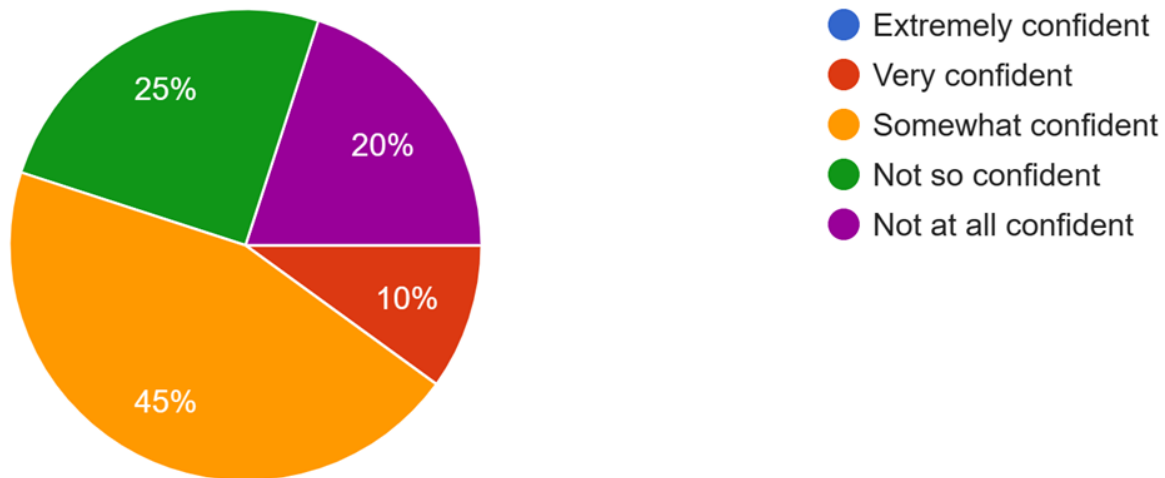
“Patients coming to the end of their lives need high quality care and treatment. Providing this care is likely to involve making difficult and emotionally challenging decisions”.

www.gmc-uk.org/professional-standards/the-professional-standards/treatment-and-care-towards-the-end-of-life



3. How confident are you in deciding when to debride foot ulcers in eolc patients?

20 responses

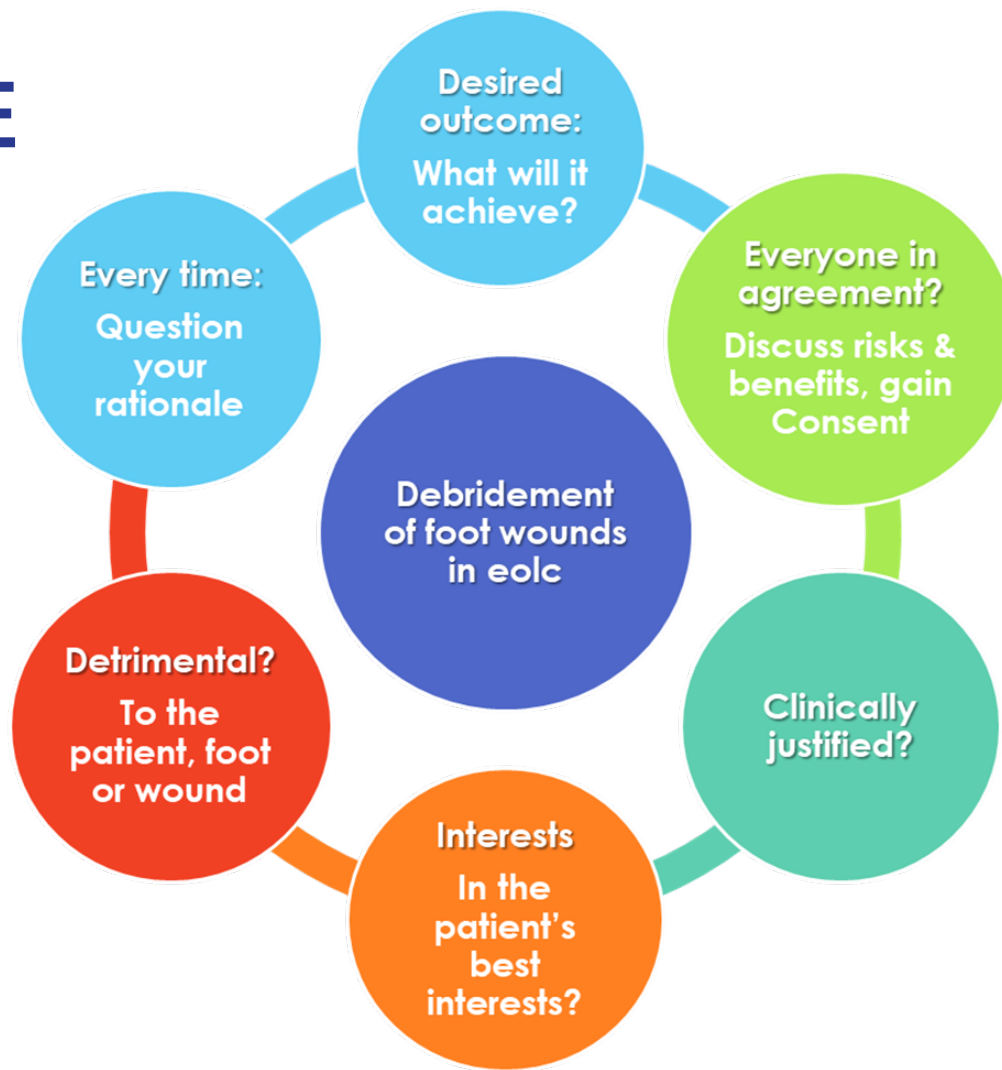


“To debride or not debride?” that is the question

- Is it appropriate to sharp debride a wound in a dying patient?
- Is it right to deny debridement of a wound as a useful treatment option in a dying patient?
- **Introducing the DECIDE tool....**



DECIDE







Skin breakdown in the final weeks or days of life

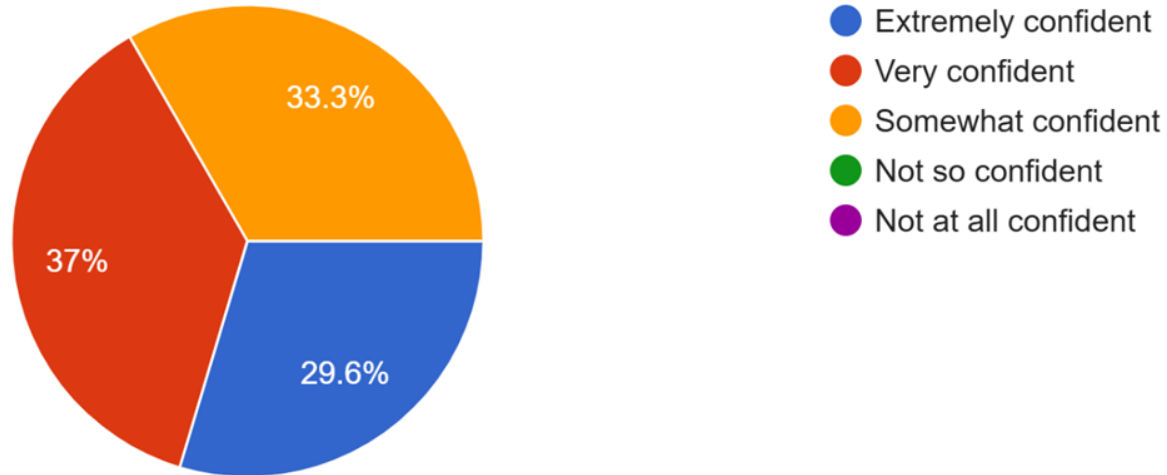


- The dying foot in the dying patient
- Skin organ failure – butterfly necrosis?



5. Having learnt about the DECIDE tool, how confident do you now feel about deciding when to debride foot ulcers in eolc patients?

27 responses



Conclusion

- A need for more training in eolc?
- Consider using the DECIDE tool with your eolc patients
- Eolc is complex - requires individual holistic care planning, kind honest communication and shared care/decision-making
- You have a privileged and unique role to play!



*“Palliative care needs to be given the priority it deserves.
Dying is inevitable but pain and distress need not be”*

Professor Mike Richards
Chair of Commission

Palliative Care and End-of-Life Care

Opportunities for the
NHS Ten Year Plan

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and End-of-Life Care

Thank you for listening!

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