

Palliative care within the acute care setting



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Palliative Care during End-of-life: An Annotated Bibliography

Waldrop and Kirkendall (2009) surveyed employees from a 120-bed suburban nonprofit nursing home to explore how their staff recognized a dying patient and identified standards of care which would be put into place once palliative care has been initiated. Using a qualitative method to gather data, 42 employees were interviewed which included nurses, chaplains, social workers, nursing assistants, housekeepers, and administrators to provide multiple perspectives on the dying experience. The survey was done in the form of a 30-minute interview in a quiet location of the nursing home away from the nursing unit (Waldrop & Kirkensall, 2009). An affiliated research assistant or investigator whom has had training in conducting interviews and qualitative data analysis conducted it. They asked the employees open-ended and objective questions about frequency and standards of care for dying patients and their families. " All interviews were audio taped, transcribed by a professional transcriptionist, and labeled with a letter number combination (e. g., N[urse]-1). The transcripts were entered into Atlas ti software for data organization and management"(Waldrop & Kirkensall, 2009). The survey identified physical, behavioral, and social factors as the three main indicators of impending death. Physical indicators included altered breathing patterns (including apnea), anorexia, or increase in pain; behavioral indicators included mood changes and diminished activity level and social indicators sometimes included withdrawal from interaction with staff or family (Waldrop & Kirkendall, 2009). During the survey the staff explained that Comfort care is initiated when patients began to exhibit these signs. At this nursing home standard order sets were not used and comfort <https://assignbuster.com/palliative-care-within-the-acute-care-setting/>

care measures were described as being very patient individualized and holistic. Comfort care includes an interrelationship of symptom management, family care, interpersonal relationships, and interdisciplinary cooperation in which each member of the healthcare team participates in the care of the patient, according to their scope of practice (Waldrop & Kirkendall, 2009).

The survey revealed that health care employees deliver comfort care in different ways and it identified the need for more comparison studies in other nursing homes to explore standards of care in other facilities because this was just one study of one nursing home. By further comparing nursing homes which use different models of care comfort care standards and or improvements can be made. This survey was conducted in a nursing home setting but its results reflect on hospital end-of-life care. At the present time the standard of care for dying patients in a hospital setting consists of pre-printed order sets which are not individualized to the specific needs of the patient. This study promotes use of the holistic, individualized care approach to ensure a more satisfying and comforting dying experience.

Level of evidence: VI Single descriptive qualitative/physiologic study

Jarabek, B. R., Cha, S. S., Ruegg, S. R., Moynihan, T. J., & McDonald, F. S. (2008). Use of a palliative care order set to improve resident comfort with symptom management in palliative care. *Palliative Medicine*, 22, 343-349.

Jarabek, Cha, Ruegg, Moynihan, & McDonald, (2008) began a study within the Internal Medicine Residency Program at Mayo Clinic in Rochester, Minnesota hypothesized that standard palliative order sets within a hospital setting would enhance physician comfort with managing 4 aspects of end-of-
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life care: pain, secretions, agitation, and dyspnea. A 5-question, pre-intervention web-based survey regarding physician comfort in diverse aspects of palliative care was given to 144 internal medicine resident physicians before the release of the palliative order set, which would later be used within the hospital. Each question included a 5-item Likert response scale, ranging from 1, "very comfortable" to 5, "very uncomfortable" (Jarabek et al., 2008). Three months later an educational email was sent to all house staff and faculty addressing end-of life-care along with the initiation of the order set, which consisted of physical ailment provisions. Another 3 months was spent allowing staff to use and or work with the order sets at which point a post-intervention survey was performed. Results of the post-intervention survey were that 88% had utilized the palliative order sets and 63% stated that they felt increasingly comfortable with palliative care (Jarabek et al., 2008). There was an overall 10% increase in resident comfort regarding the 4 aspects of palliative care with the initiation of order sets, but no change in social or communication-related comfort (Jarabek et al., 2008). The survey concluded that palliative order sets can increase physician comfort in providing care to patients during end-of-life, but it also revealed that the order sets do not address the psychosocial needs of the patient when providing comfort care. Although physicians find comfort in having order sets as guidelines for end-of-life care, they are only guidelines and open communication needs to be initiated between the health care team and the patient to ensure all the comfort care needs of the patient and family are met in a holistic way so that they may have a peaceful dying experience.

Level of evidence:

Teno, J. M., Clarridge, B. R., Casey, V., Welch, L. C., Wetle, T., Shield, R., & Mor, V. (2004). Family perspectives on end-of-life care at the last place of care. *Journal of the American Medical Association*, 291(1), 88-93.

Teno, clarridge, casey, welch, wetle, shield, mor (2004) evaluated 1578 adult patients with different, chronic illnesses end of life experiences by surveying the decedent's loved ones and determining whether their perspectives on quality end-of-life care were influenced by the environment where the patient spent their last 48 hours of life. A survey was devised from a conceptual model for patient-focused, family-centered medical care and the calculation of scores and psychometrics of the measures were taken from an online tool formulated by Brown University. Within 9 to 15 months from the time of death a close family member or informant whom was listed on the death certificate was surveyed and was asked about the quality of care their loved one received during their last 48 hours of life. Five different domains were used in the survey, including whether healthcare workers provided patient physical comfort and emotional support, supported collaborative decision-making with the physician, treated the patient with respect, attended to family needs, and provided coordinated care with other healthcare workers or facilities (Teno., et al. 2004).

Teno et al. (2004) concluded that 69% of the decedents site of death and last place to receive care was in a hospital or nursing home setting, 31% home, 36% without nursing service, 12% home nursing, and 52% home hospice. The survey showed that family perceptions of the quality of care

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were different according to where their loved one last received care. Families of patients who were in nursing homes or had home health had a higher rate of unmet needs for pain (Teno., et al. 2004). Over half of the families in hospital or nursing home settings reported unmet emotional needs. In addition, 70% of families receiving home health care reported inadequate emotional support in comparison to 35% in families who utilized home hospice care. Patient and family respect was also a concern to families and varied in different settings. Only 68% of nursing home residents' families felt they had been treated with respect and consideration compared to the 96% of families receiving hospice care (Teno et al., 2004). Survey participants felt that physical symptom management was adequately managed so it was comparably equal throughout all patient settings. Although families did not experience a difference in pain or dyspnea management in comparison to other nursing services families who used hospice services overall, 71% reported " excellent" care (Teno et al., 2004).

Kolcaba, K. Y., & Steiner, R. (2004). Efficacy of hand massage for enhancing the comfort of hospice patients. *Journal of Hospice and Palliative Nursing*, 6(2), 91-102.

Kolcaba, Dowd, Steiner, and Mitzel (2004) identified the need for comforting interventions for patients at end of life that are simple, easy to learn and administer, and require minimal effort on behalf of the patient. Bilateral hand massage is a good intervention because it is noninvasive, easy to do, does not take long, and relies on caring/healing touch(Kolcaba., et al. 2004). The purpose of their study was to determine empirically if a bilateral hand

massage provided to patients near end of life twice per week for 3 weeks was associated with higher levels of comfort and less symptom distress.

31 adult hospice patients from 2 hospice agencies participated in the study. Each patient was English-speaking and expected to remain alert and oriented for the duration of the trial, 13 months. “ Data collectors who were unknown to the patients called the homes of the patients, explained the study, and then scheduled an appointment for a research visit. Data was collected at the patients homes and at the hospice centers”(Kolcaba., et al. 2004). After informed consent, participants were randomly divided into the treatment group (with 16 patients) and the comparison group (with 15 patients). All participants were asked to complete a modified General Comfort Questionnaire (GCQ), tailored for end-of-life patients, once a week for 3 weeks. After completing the questionnaire each week, the treatment group then received the hand massage intervention twice a week for 3 weeks. The comparison group received the intervention once at the end of the study period.

The study concluded no significant difference between the treatment and comparison groups in regard to enhanced comfort or decreased symptom distress over time (Kolcaba et al., 2004). However, comfort did increase some in the treatment group even as the patient approached death. The study also revealed that the hand massage seemed to allow more time for therapeutic or face to face communication allowing the patients to talk about how they feel and their feelings on transitioning to death, and patients receiving the intervention reported it to be a personalized experience something they could engage in that feels good, and family members were

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appreciative of the care and attention their loved one was getting (Kolcaba et al., 2004). Because this intervention is easy to learn and requires minimal time for the caregiver to do and minimal effort for the patient it is an excellent intervention that can even be taught to the family. This study identifies interventions that can be used within the hospital setting and any other setting to enhance comfort during end-of-life. Nurses and family members can use this intervention to increase communication by using caring touch, which provide psychosocial care and therefore holistic comfort for the patient.

Bakitas, M., Lyons, K. D., Hegel, M. T., Balan, S., Brokaw, F. C., Seville, J., Hull, J. G., Li, Z., Tosteson, T. D., Byock, I. R., Ahles, T. A., (2009). Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer. *The Journal of the American Medical Association*. 302 (7): 741-749.

Bakitas, Lyons, Hegel, Balan, Brokaw, Seville, hull, Li, Tosteson, Byock, Ahles, (2009) using project ENABLE combined with a nurse-led intervention with ongoing assessment, coaching, symptom management, crisis prevention, and timely referral to palliative care and hospices hypothesize that patients newly diagnosed with advanced cancer if exposed to this intervention right away would become informed, active participants in their care, and would experience an improved quality of life, mood, and have better symptom relief. " The study protocol and data and safety monitoring board plan were approved by the institutional review boards of the Norris Cotton Cancer Center and Dartmouth College in Lebanon, New Hampshire, and the Veterans Administration (VA) medical center in White River Junction, Vermont. All patient and caregiver participants signed a document <https://assignbuster.com/palliative-care-within-the-acute-care-setting/>

confirming their informed consent.”(Bakitas., et al (2009). Participants completed baseline questionnaires when they were enrolled and then completed a follow-up one month later. Using a stratified randomization scheme patients and their caregivers were randomly assigned to the interventions or usual care group. One of 2 advanced practice nurses with palliative care experience conducted 4 structured educational problem solving sessions first one lasting 41 minutes and sessions 2 through 4 approx 30 minutes each and at least monthly telephone follow-up sessions until the participant died or the study ended (Bakitas., et al. 2009) The advanced practice nurse began all contacts with an initial assessment by administering the Distress Thermometer, an 11-point rating scale recommended by the National Comprehensive Cancer Network guidelines. It identifies sources of distress in the 5 areas of practical problems physical problems, family problems, spiritual, emotional problems or religious concerns. If distress intensity was higher than 3, the advanced practice nurses then identifies the sources of distress and checks to see if the participant would like to problem/solve to take care of their issue. The nurse then covers the assigned module for that session. The participants’ clinical teams are responsible for all medical decisions and inpatient care management, however the advanced practice nurse was readily available by telephone for the participants and they could also facilitate ancillary resources. The participants also were able to participate in group shared medical appointments (SMAs), which are led by certified palliative care physicians. The usual care participants were allowed to use all oncology and supportive services without restriction. Follow-up questionnaires were mailed every 3 months until the patient died or study completion in December 31, 2007.

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Quality of Life was measured with a 46-item tool called the Functional Assessment of Chronic Illness Therapy for Palliative Care. It measures the participants' physical, social, emotional, and functional well being along with the concerns of a person whom has a life-threatening illness. Of 1222 screened, 681 were eligible and were approached and 322 were enrolled (47% participation rate). There were a total of 134 participants in the usual care group and 145 participants in the intervention group. " ' A systematic review of specialized palliative care identified 22 trials (16 from the United States) between 1984-2007 with a median sample size of 204, half exclusively with cancer patients. " " There was lack of evidence due to contamination, adherence, and recruitment etc. The trial addressed these issues and contributed to the increasing evidence that palliative care may improve quality of life and mood at the end of life." In our study, intervention participants' higher quality of life and lower depressed mood may be attributed to improved psychosocial and emotional well being." Mood is a determinant of the experience of quality of life and suffering despite a mounting burden of physical symptoms"(Bakitas., et al. 2009). " However, while patients in the intervention group had improvement in these outcomes, we conservatively planned our original target trial enrollment of 400 based on a significance level of . 01.' Statistical inferences based on this stringent critical value would lead to the conclusion that there were no statistically significant differences between groups in quality of life or mood"(Bakitas., et al. 2009). The study concluded that compared with participants receiving usual oncology care those receiving a nurse-led, palliative care-focused interventions that takes care of the patient holistically provided at the same time with oncology care had higher scores for quality

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of life and mood, but did not have improvements in symptom intensity scores or reduced days in the hospital (Bakitas., et al. 2009).

Level of evidence-

Summary

The research presented reveals while palliative care order sets provide a helpful guideline or tool which reassures health care providers in giving consistent good quality care, patients care needs should be assessed and individualized orders and interventions should be implemented to ensure a peaceful and comforting dying experience. Hospice care settings have been shown to provide excellent holistic care for dying patients and they have also been shown to show compassion to the family as well. The comfort interventions from these facilities can be modified for application in the hospital for use in the acute care setting. Holistic comfort care interventions include hand massage, music therapy, or the utilization of a visual analog scale” the faces” to measure comfort. These are some of the ways hospitals can utilize the findings from this research into daily practice to ensure quality holistic patient comfort is achieved and ultimately a peaceful death.