

Quality Care in Palliative Care

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Abstract

Palliative care is defined as active and complete care for an individual with an advanced and incurable disease, his family and community. The emphasis of care is on preserving the quality of life, combating pain and other changes that the patient is facing. The patient's family has a key role to play in caring for the sick member. Patients who are in the terminal phase of the disease want to spend their last days in a familiar environment, their home, together with their loved ones. Often, due to the severity of the disease, patients must be placed in a palliative care facility. Patients receive comprehensive care thanks to a specially trained multidisciplinary team.

Keywords: Palliative Care, Patients, Doctors, Nurses, Family

Introduction

On the soapbox, telecare promised more efficient use of human resources and/or cost reduction in care [1]. It promised improved quality by helping patients engage in self-management. This might enhance efficiency, support the patients' own wish to be actively involved in their own care, and help keep them living at home instead of in an institution.

Professionals could become less active, which might leave efficient management of staff shortage, or they may become more active to prevent crises and induce security in patients. The normative threat was that implementing cold technology would make care devoid of human contact.

Questions

Accountability has been called the “third revolution” in medical care [2]. Health care providers are now often faced with new questions. For instance, what are the outcomes of palliative care that justify its continued institutional support? Or, what's the evidence for the utilization of a specific medical intervention for a specific patient? Fundamental to answering these questions are defining quality of care for seriously ill patients and determining how care is measured.

Quality care at the end of life is different than during the other period of time. Dying persons, their families, and health care providers are often faced with decisions that involve tradeoffs between length of life and quality of life. Reasonable persons may differ in such decisions. Thus, preferences and values are important to shaping treatment decisions in ways unlike other time periods. Outcomes assessment for the dying must take this into consideration.

The first response of staff to auditing the standard of care is, “Why?” A typical response is that their work cannot be measured. Yet, audits and ongoing quality monitoring through examining administrative data, reviewing medical records, and/or speaking with dying persons and families, results in important opportunities to enhance quality of care. Simply stated, “If you do not measure it, you will not improve it”.

The results of assessing the outcomes of palliative medicine can help create the needed attention to the problem of improving the standard of care. Such tension can create the attention among health care providers of opportunities to improve and enhance their current practice. Examining the outcomes may be critical to detecting early problems with new medications or other unintended consequences from medical interventions. Examining outcomes can guide organizational efforts to improve the quality of care. For instance, knowing that one in four persons now dies in a nursing home provides important information for the planning of new programs to fulfill the needs of the dying.

Delivery of Care

Professional bodies have a profound effect on the work of the individual practitioner and influence work practices normally [3]. Although this influence is at its most intense for registered practitioners, those training for the professions must be fully aware of the demands of their professional codes or rules of conduct. Because the codes and rules are produced by the registering bodies, infringement of the professional codes may end in deregistration of the practitioner, with consequent loss of status and earnings. The connection of codes and rules of conduct to the law is considered, together with their significance for the expected professional behavior of the practitioner.

Nurses may form the most important number of health care professionals within the delivery of care, but not all care is

that the province of nursing. Increasingly, the vital input made by other health care professionals, both in hospital and within the community, may be a great a part of the treatment and rehabilitation of the client. Thus as codes and rules of conduct are important, so is that the smooth working of the multidisciplinary team in health care.

Quality assurance and also the measurement of care-giving would seem difficult to quantify; much thought has been given to those over recent years, and systems are developed so as to quantify the great and bad aspects of practice. Although these issues impinge more on the moral than the legal side of supply, the widespread adoption of audit mechanisms and quality assurance methods makes their inclusion a subject of necessity.

Record-keeping, whether computerized or paper based, is, many would say, the bane of health care work. Despite this, record-keeping is extremely important and can't be neglected; legal proceedings may take a few years to come to court, memories fade, and every one which will be left is that the record made at the time of the incident. Records also provide smooth handover either from one professional to another or to facilitate communication among different groups of pros concerned with the care of 1 client. Records therefore form an integral a part of care delivery.

Even within the best-regulated world, things can and do get it wrong now and then. Health care delivery isn't any exception to the rule, and everyone three parties involved - the employer, the employee and therefore the client - may at some time have cause for complaint. As health care delivery presents a more and more commercial face, consumers are likely to feel an increasing freedom to complain about poor service, even as they'd in the other commercial service provision. An increasing trend on the part of complainants to resort to litigation if complaints cannot be handled promptly and

effectively makes effective complaints management a necessity.

Palliative Care

Palliative care provides healthcare and emotional support to those living with a serious illness and their families throughout the course of the illness and often the patient's life [4]. Palliative care may be a style of patient-centered long-term care that prioritizes the quality of life of the patient. It's not limited to older adults. Palliative care is designed to treat the whole person, not just their medical concerns. It combines coordinated care management with psychological support for patients and their families as they navigate life with serious illness. Psychological support includes help with stress or depression. Both are critical quality-of-life concerns that are often overlooked in traditional care. Other features of a good palliative care program include around-the-clock access to a clinician, care that's coordinated across multiple specialties and care that's aligned with the priorities of the patient including end-of-life preferences.

Five percent of the foremost ill patients living with multiple chronic conditions and functional limitations account for 60 percent of the overall cost of healthcare within the US. Eighty-nine percent of this population will live for over a year. Palliative care not only enables a better quality of life for people living with illness and their families, but it's value-based care which will substantially lower healthcare costs. This savings is only when care is delivered within the home setting. It's possible to require care of three people in their home for the same cost as keeping one person in a very long-term care residence. When care is coordinated across the continuum, it's more efficient and reduces redundancies, medical error, unnecessary care, length of hospital stays, hospitalizations, emergency department visits, overall healthcare utilization, patient depression and pain, and conflicting care and medications.

Overtreatment and over testing raise healthcare costs for insurers and also for the patient and their families. In the US, overtreatment results in each household paying thousands of dollars out of pocket for unnecessary care every year. Not all families can bear the brunt of the prices without compromising on other important spending like food, education, and their own healthcare. This drives an increase within the social determinants that lead to poor health, which eventually costs the healthcare system more within the long run. It should be noted that out-of-pocket costs impact lower-income households more strongly than medium- and upper-income households, thus perpetuating a cycle of poverty.

Practice

The experimental practices showed that care at a distance is usually more intense than otherwise because contact between patients and carers becomes more frequent [1]. Professionals often initiated the frequent contact particularly when monitoring symptoms. Patients contacted one another more frequently further so as to exchange practical knowledge.

There is much to mention in favor of care at a distance that intensifies contact between patients: it implies interesting roles for people with chronic diseases without making them so dependent on professional care that they need to remain at home to get the care they require. This sort of care also takes seriously the requirement for social contact and also the hazards of loneliness, particularly in old age. Befriended patients are great 'low-threshold' carers for his or her peers, and their friendship and shared needs provide reciprocal relations and continuity in care as well as advice for standard of living problems, advice that professional carers don't always provide. The investment required would be for equipment and organization of patients, demanding a rather more coaching and initiating role for professional carers. The potential of patients to become each others' carers may result in interesting new social roles, like becoming professional carers trained in using their experiential knowledge.

Professionals

There are situations where more intense professional care may well be legitimate, like within the practice of palliative care for the oncology patients [1]. The telecare system fits the case of patients that suffer in silence rather than turning to the doctor for timely treatment. It also fits the aims of this practice: patients don't seem to be trained to become self-managers but need instead to return to terms with their changed prospects in life and their imminent death. The professionals make sure of symptoms or side effects. The participants achieved the goals of this practice without criticism, bar solving the problem of who cares for the administration of the system or the research.

For the COPD (Chronic Obstructive Pulmonary Disease) and heart failure patients, this was different. It seems that intensified professional control could keep patients out of the hospital, at least for a while. Yet there have been worries, too: about the desirability of professional surveillance, the sense and feasibility of daily measurements, the relation between telecare and other styles of self-care and therefore the reduced responsibility of the patients. Increased control by professionals would give patients no other opportunities to develop their practical knowledge, whereas their condition demands that they are doing this anyway. Tele care devices cannot take disease away. They are doing not cook or carry people from one place to another. For people with COPD or heart failure, it's never a choice to 'leave it all to the professionals' or to their devices.

To place 'care for symptoms' within the foreground, as happened within the monitoring practices, runs the risk of framing just one version of problems because the most relevant, and this might frustrate the capacity for self care that patients must engage in anyway. The daily battles with salt free diet and reduced fluid intake melted into the background within the version of the difficulty defined by the monitoring

devices, even when it absolutely was still central to patients. For the COPD patients, crises were also relevant, and that they found it particularly hard to choose when to travel to the doctor or take medication. Yet their daily worries were about the way to keep moving and do meaningful things when short of breath. These problems have a large impact on daily life, although they will fall outside narrow medical definitions of treatment.

The rules and codes of conduct are an important guide for all health care professionals and will also shape the behavior and thinking of these in training to qualify for the professions [3]. Unqualified staff doesn't seem to be bound by the codes but should be encouraged by their supervisors to take care of the standards set by the statutory bodies governing the professionals. For trainee members, many of the professions have developed modified student codes as a suggestion. Properly speaking, the rules and codes of conduct are codes of ethics that are developed by the individual registering bodies but provide guidelines for the law to judge the conduct expected of professionals under the legal duty of care.

Care of the client at the end of life demands the abilities of an outsized number of professional groups, many of whom work both on a curative yet as a palliative basis. Multidisciplinary team therapy professionals may include hospital-based radiologists and radiographers who specialize in the treatment of cancer and also the control of distressing symptoms using X-rays (radiotherapy) and radio-isotopes. Doctors and nurses who specialize in pain control and palliative care may additionally work with the client and family additionally to the core team. Caring for the client's spiritual needs is additionally of vital importance to overall well-being, and spiritual guidance and support can be by a priest of the client's choosing.

Program

In establishing a palliative medicine program, a physician trained in palliative medicine is important to the viability of the program [5]. Doing so will bring a unique skill set necessary to provide comprehensive care to patients with advanced disease. These are: 1) communication, 2) symptom control, 3) management of complication, 4) care of the dying, 5) psychosocial care, and 6) coordination of care. It's been shown that integrating palliative medicine has actually improved the care of the terminally ill in acute care settings.

The presence of a palliative medicine program can have several advantages to both patient care and therefore the institution. They are: 1) providing clinical services in terms of symptom control, psychosocial care and discharge planning, 2) supporting other specialties within the institution in sharing the complex management of people with advanced illness, 3) allowing a system where the institution's goals will be accomplished. The presence of specialist palliative care teams does improve outcomes for cancer patients. A scientific literature review that included five randomized controlled trials showed that patients and caregivers that were taken care of by palliative medicine specialists had improved symptom control, better satisfaction scores by patients and caregivers, decreased length of stay in hospital with a corresponding decrease in overall cost. Additionally, patients were more likely to die in an exceedingly place of their choice.

Patients

The intent to restore total control over their lives and extending that control to end the life at the time pre-determined by the patient is one big controversial and debatable topic in modern medical science [6]. The explanations may differ why the terminally ill patients may decide that why watch for death to embrace them after they can embrace the death at their own preferential times. The legal and ethical system doesn't endorse this ideology because their understanding is that the modern palliative medicine can

overcome the patients' fears of loss of control over their terminal symptoms by effective and aggressive palliation. Still a very few states respect persons' decisions to end their lives at their own free will and practice euthanasia and/or physician assisted suicide. This very small percentage of worldwide community practicing the debatable palliative concept may represent the analogous very small percent of terminal patients who if given the chance, will decisively complete their wishes for death despite aggressive palliative support.

Let us attempt to understand this debate with a clinical scenario. At the time of diagnosis of their terminal disease, the patients decide to end their lives due to their poor understanding of the disease and its terminal symptoms and therefore the failure of medical care teams to pursue timely efficacious discussions about their diseases. Because the disease evolves, the patient understands their diseases and therefore the supportive care offered and rendered by the palliative care teams; and at this point of time, they will decide that this could be the proper time to require the final flight at their own leisure because they feel that it should be the correct thing to try and do. However, eventually, the patient despite attempting to sell their thought for dying at their chosen time finishes up losing their full competence or control on their mental status; and is left at the mercy of their family or surrogate decision maker to choose for what they need been asking all the time: timely death. Additionally, while the surrogate decision making endorses the withdrawing and withholding the life-sustaining treatments as terminal palliative management protocols, however, rather than the pre-determined times by the patients' choices, now the death is occurring when the surrogates and medical teams supported their understanding and perception of the progressive terminal disease decides to let go the patient.

Hospice Care

Homes for the dying or, as they were soon to be called, hospices, were established in Ireland and France within the

nineteenth century [7]. However, it was not until 1967 that the first modern hospice, Saint Christopher's Hospice, was founded in London. There, Dr. Cicely Saunders, a former nurse and social worker who had earned a medical degree, helped establish the underlying philosophy of hospice and palliative medicine. She emphasized clinical excellence in pain and symptom management; care of the entire person, including physical, emotional, social, and spiritual needs; and also the need for research during this newly developing field of medicine. Interdisciplinary team care became the norm, because it became clear that no one physician, nurse, social worker, or chaplain could address all the wants of the terminally ill person. Further, although the main target of care was clearly on the dying individual, the requirements of the family were also addressed.

Eligibility criteria for hospice enrollment through the MHB (Medicare Hospice Benefit) require that patients waive traditional Medicare coverage for curative and life-prolonging care associated with the terminal diagnosis and be certified by their physician and also the hospice medical director as having a life expectancy of 6 months or less if the disease runs its usual course. Recertification periods within the MHB provide reexamination of hospice eligibility. If the hospice medical director believes that the patient incorporates a life expectancy of ≤ 6 months if the disease runs its usual course, the patient could also be recertified as eligible for the MHB whether or not the patient has already been receiving the benefit for six months or longer.

The goal of hospice care is to relieve suffering and improve the patient's and family's quality of everyday life. To realize those goals, hospice care has come to be defined as holistic, patient-, and family-centered instead of disease-centered. Hospice provides a team composed of these trained to care for problems in a holistic manner: physician, nurse, social worker, chaplain, bereavement counselor, nursing assistant, and volunteer. The hospice team meets weekly, under the direction

of the hospice medical director, to review the care plans of all patients. The hospice program is charged with providing medications for the relief of physical distress, durable medical equipment, supplies, a multidisciplinary team to produce care, and bereavement support before and after the patient's death.

Palliative medicine has developed as a medical subspecialty within the US since the mid-1990s, bringing a "hospicelike" approach to patients with serious illnesses regardless of prognosis or their interest in pursuing life prolonging treatments. The goals of palliative care programs are just like those of the hospice: pain and symptom control; emotional, social, and spiritual support of patients and families; and facilitation of clear and compassionate communication regarding goals of care. Early involvement of palliative care has been shown to significantly improve symptom management, quality of life, mood, and, in one study, survival. Furthermore, palliative care has been shown to increase patient and family satisfaction and reduce costs by limiting the use of high-technology care.

End of Life

A death, whether sudden or expected, may bring with it an intensity of reaction and grief for which staff are quite unprepared [8]. Confidence in handling such situations obviously comes with experience, but all staff need training during this area to form them conscious of the policies and procedures, encourage sensitivity to ethnic and religious issues and familiarity with the processes of death certification, registration and reporting to the Coroner. Staff must be ready to offer sympathy and time, to pay attention to and support the relatives and guide them through the complexities of the legal process. Staff involved in dealing with death may have access to counseling facilities for themselves, and must be allowed to grieve.

The statements of policies and procedures should be clear, and may cover the medical, social, legal and administrative aspects

of dealing with death. They must be available on every ward. For instance, staff should remember of any decisions regarding the possible resuscitation of a patient, and know the way and where to record these decisions. They ought to know the way to reply if a patient requests to be sent home to die, and how to request domiciliary service provision for such a patient.

For patients who spend their last days in hospital, there should be unrestricted visiting all around the clock, including children, and families should be encouraged to assist deliver some of the necessary care. Visitors should have access to amenities, like refreshments, toilets and telephones, and in some cases even a bed. Spiritual counsel should be available for all religions, and interpreting facilities as required. Patients who are being readmitted to die should ideally be nursed on a familiar ward.

Relatives may wish to be present at death, and arrangements should be available to call them, and allow them to stay as long as they want. Staff should have skill in breaking bad news and be ready to spend time with the bereaved, if there's no other family support at hand. Religious rites must be accommodated.

Following a death there should be sensitive handling of the body, and any property, with due regard for ethnic and spiritual considerations, and arrangements for dignified removal from the ward to the mortuary. The bereaved may require counseling and ongoing support, which should be available for all ethnic and spiritual groups. They must be able to spend time, in privacy, with the deceased and be ready to speak to a doctor who is in a position to answer their questions. Requests for post mortem or organ donation must be made sensitively. Relatives need clear guidance on what to do next, particularly about death certification and funeral arrangements. If community support is probably going to be necessary, staff should be aware of how this might be

organized. There should be a system for informing the general practitioner, not just of the death but also of the bereaved, who might have aftercare.

For the bereaved that weren't present at the death, there should be arrangements for somebody who knew the patient to accompany them to the mortuary, and reasonable access to the mortuary all around the clock (although this could be difficult in areas where mortuaries are closed out of hours). The viewing room should be pleasant and dignified, and someone should be available to answer any questions the relatives might need to ask.

Many hospitals now have a bereavement officer, whose job it's to ensure the smooth arrangements following a death. Some issue a 'with sympathy' card to the relatives, which contain written instructions of immediate necessary procedures and points of contact. Some hospitals run small working groups on various aspects of dying or death, like death, sudden death or pain relief, and are ready to introduce improvements in good practice. They'll run liaison groups with general practitioners and produce information packs for his or her use. they will make sure that all medical and nursing staff have access to some terminal care training, or a minimum of gain an awareness of its importance.

Conclusion

Palliative care is an approach that improves the quality of life of patients and their families, including all those suffering from advanced and incurable diseases, preventing and alleviating their suffering through early identification, treatment of pain and other problems. With an interdisciplinary approach, palliative care covers the patient, the family and the community. Palliative care is led by a professional team consisting of doctors, nurses, psychiatrists, psychologists, social workers, physiotherapists, dieticians, and priest. Palliative care involves caring for a patient's needs

wherever they are cared for, whether at home or in an institution.

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