

## Review on the Fundamental Approach to Giving Palliative Care Patients the Greatest Care

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### Abstract

The proportion of people suffering from advanced cancer or end-stage illnesses is rising as a result of population ageing, medical advancements, and improvements in public healthcare. These patients frequently go to an emergency room for help because of the load of symptoms they experience in the latter months of their lives. Acute care hospital-based services are frequently more effectively suited to managing the requirements of patients with severe chronic illnesses than treating acute clinical situations in industrialised nations. Medical practitioners who care for the palliative care (PC) population in hospitals face very substantial clinical issues as a result. To find the appropriate care model for these PC patients, the authors have created four critical questions (who, why, when, and how) to answer. The issues concern: (1) identifying individuals with serious chronic diseases; (2) managing the difficulty of these individuals unanticipated hospital admissions; (3) identifying PC patients among individuals with serious chronic diseases; and (4) determining the proper work of caring for this inpatient PC population. Acute care hospitals should plan the process of caring for these inpatients. Clinicians require the expertise, resources, and services to care for these PC patients.

**Keywords:** Palliative care; End-of-life care; Emergency department; Palliative care team; Palliative care unit

### Introduction

The World Health Organization believes that population ageing is growing quickly on a global scale. Most people may anticipate living into their 60s and beyond by 2050. As a result, chronic illnesses will cause more deaths than acute ones [1]. The effects on healthcare systems, their financial resources, and their human resources are significant [2].

These persons utilise acute care hospital-based services (emergency department, hospital ward, and intensive care unit) surprisingly often in the final year of life in many wealthy nations throughout the world [3-5]. For patients receiving palliative care (PC), the emergency department (ED) has developed beyond its core function to act as a point of entry to hospital services. According to several research, many unnecessary trips to the ED by PC patients may have been preventable. More than half of ED presentations by patients known to specialized PC services were found to be possibly preventable in a study [6]. These ED admissions were primarily brought on by uncontrolled symptoms as dyspnea, discomfort, constipation, nausea, and vomiting [6]. This may result in the usage of expensive hospital services to address chronic care requirements and a failure to adequately promote these people's preferences. In light of these serious problems, all healthcare systems should be compelled to develop specific activities for providing treatment for these patients.

### Chronic disease-focused discussion

The leading cause of hospitalization in patients over 65 is chronic heart failure (CHF). CHF patients exhibit significant symptom load equivalent to that of cancer, poor quality of life (QOL), and low survival rates. Because acute decompensation episodes occur often, patients frequently report to the emergency department (ED) for symptom control. Chronic obstructive pulmonary disease (COPD) patients have been found to have poorer dyspnea, functional status, and anxiety compared to lung cancer patients, but equal scores for severe pain and sadness. However, some studies found that patients with COPD compared to those with lung cancer received care that was more focused on prolonging life than palliating symptoms during the final six months of life, as well as less use of opiates and benzodiazepines in

outpatient settings, more frequent admissions to, and longer stays in, an intensive care unit (ICU) [7].

Among patients with chronic conditions, those with end-stage renal disease (ESRD) are most at risk for hospitalisation. According to a review of 769228 adult patients with ESRD, 70% of them visited an ED at least once between 2005 and 2011 [8]. According to the study, factors like female sex, younger age, black (as opposed to white) race, comorbidities, institutionalisation, Medicaid insurance (as opposed to Medicare alone), catheter or graft hemodialysis access (as opposed to fistula), tobacco use, and more recent ESRD diagnosis were all associated with higher rates of ED use. Additionally, the authors discovered that during the first ESRD year, sepsis, congestive heart failure, and hemodialysis access complications were the three most frequent admission diagnoses.

Cirrhosis of the liver can cause complications that are potentially fatal. Ascites, gastrointestinal bleeding, hepatorenal syndrome, hepatic encephalopathy, and sepsis are among the symptoms that are often seen in individuals with decompensated cirrhosis. The emergency department (ED) provides the first chance to quickly diagnose these problems and begin effective treatment. Numerous studies have shown that persons with Parkinson's disease have a high prevalence of falls injuries, which lead to numerous ED visits, longer ED stays, and a high rate of admission [9]. To find the baseline independent factors predicting likelihood of ED and hospital usage, data from a cross-

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national sample of senior home care recipients (60 years) were used in a secondary analysis. The scientists discovered that the risk rises if a person develops a long number of distinct illness diagnoses, clinical issues, and challenging therapies. The presence of serious illnesses (renal failure, COPD/emphysema, cancer), infections (pneumonia, urinary tract infection), skin issues (stasis ulcers, wound care), recent deterioration (unintentional weight loss, a major deterioration in status in the last 90 days, unscheduled physician visits, falls), and close monitoring for complex treatments are included on this list (daily nurse monitoring, IV infusion, intravenous medications).

Why were people with serious chronic diseases admitted to hospitals for acute care? The majority of chronic illness patients endure severe or deteriorating symptoms in their final months of life, which forces them to seek treatment in acute care facilities. These individuals are seen in the emergency department (ED) and get prompt treatment to manage their symptoms. Patients are occasionally brought into the ED due to the anxiety of family members who are close to the EOL. Between 40% and 80% of patients with advanced cancer or other chronic conditions attend the emergency department during their last months of life in wealthy nations [3,10]. Barbera et al. noted that the most frequent causes of ED visits among cancer patients in their final 6 months and 2 weeks of life were pain (mostly abdominal), dyspnea, pneumonia, exhaustion, and pleural effusion [10]. The authors also discovered that inability to cope was highly prevalent and that lung cancer was the major malignancy for which people were diagnosed the most frequently.

To determine the variables impacting ED visits by all persons who died from cancer in England in a year, a population-based cohort research was conducted recently. The researchers discovered that patients with more coexisting conditions, those who were younger, men, members of Asian and Black ethnic minorities, and those from lower socioeconomic position were more likely to make many ED visits in the final month of life. Additionally, they found a link between the presence of the disease and the number of ED visits; in particular, patients with head and neck cancer are more likely to experience problems that might damage their airways. Furthermore, because dyspnea is a particularly challenging symptom for patients and their families to manage and because people with lung cancer are more likely to make frequent ED visits.

Pain has historically been the sign of major chronic illnesses that has received the most attention from researchers. However, a growing body of research suggests that pain is just one of many unpleasant sensations. Depression, anxiety, confusion/delirium, exhaustion, shortness of breath, insomnia/sleep problems, nausea/vomiting, constipation, diarrhoea, and appetite loss/anorexia are some other conditions that are usually present in these people.

In end-stage patients with cancer, heart disease, COPD, renal illness, and acquired immunodeficiency syndrome (AIDS), Solano et al. examined the frequency of symptoms [10]. They noted that three symptoms-pain, weariness, and shortness of breath-are particularly prevalent and frequent, with prevalence rates frequently exceeding 50% in all the disorders under investigation. However, these individuals also frequently have anorexia and sleeplessness.

According to Moens et al., advanced cancer and non-oncological illnesses (heart failure, COPD, renal disease, multiple sclerosis, motor neuron disease, Parkinson's disease, dementia, and AIDS) all have significant rates of pain, exhaustion, anorexia, dyspnea, and anxiety [11]. The authors also compare and characterise the frequency of PC-

related issues among these individuals, demonstrating that there are patterns in the frequency of issues among them.

Patient-reported symptoms are typically multifaceted in character, can have a negative effect on a patient's quality of life (QOL), performance status, and load on carers. Clinical practice requires an understanding of symptom severity and presence. In order to effectively manage these end-stage illnesses, routine thorough symptom evaluation using validated tools is strongly advised. One of the most qualifying features of PC is symptom management, which is based on patient reports rather than clinician-based assessments. One of the first symptom scores in PC was the Edmonton Symptom Assessment System (ESAS), which was created by Bruera et al. [12]. It has since been validated by numerous studies, translated into more than 20 languages, and used to manage symptom assessment in a number of centres around the world.

The use of validated instruments, such as the ESAS, can enhance the use of mofunce ESe, Ccssede

Similar to this, there have been an enormous number of clinical trials comparing concurrent curative therapy and PC to normal care alone in outpatient and inpatient settings, offering solid justification for the incorporation of PC throughout the course of significant chronic diseases.

The first research investigating how transitions to a PC strategy were thought to be handled in acute hospital settings in the UK was conducted. The authors discovered that the reality of practice in these contexts was very different from a systematic approach to PC transitions. Based on these findings, the UK policy guideline advised improving early identification of patients in their final year of life, which would assist decrease hospitalizations and make it easier for patients to obtain supportive and PC services. In order to possibly decrease unnecessary hospitalizations and ED visits, new models of care that better manage ED presentations of patients with significant chronic illnesses have been proposed. According to one model, ED staff members should be familiar with fundamental palliative care techniques and be able to use them on a regular basis to successfully manage these patients, even in a busy ED. Similar to this, increasing the amount of primary PC provided by oncologists might improve the provision of early and simultaneous PC in cancer patients. The focus of the UK initiatives is on enhancing EOL care provided by primary care teams, hospital professionals, and social care agencies because there are an increasing number of people who might benefit. In this approach, treating professionals who are involved in the everyday care of patients with severe chronic diseases can incorporate PC ideas and practices into any healthcare environment. However, this model's drawback is that the majority of hospital HCPs often do not receive enough training on PC, communication, and pain management, especially when it comes to EOL care for terminally ill patients. It is true that discussing PC and EOL treatment with the patient and the emergency physician might be difficult (or caregivers). Additionally, a lot of doctors report having faced difficult moral decisions while dealing with refractory symptoms and stopping life-prolonging medications for patients who were dying [15].

For the past 20 years, specialised hospital-based PC programmes have been created, with a focus on the formation of multidisciplinary PC teams, in order to better treat patients with advanced cancer or end-stage illnesses. With the assistance of additional HCPs (dietician, respiratory therapist, physical therapist, and pharmacist), social workers, case managers, spiritual counsellors, and volunteers, these PC teams are made up of doctors, nurses, and psychologists. Each team member possesses the professional credentials, education, and expertise necessary to provide the best patient- and family-centered care.

The acute palliative care unit (APCU) has served as a novel paradigm of care for treating the PC population (mostly advanced cancer patients) in the hospital environment over the past ten years. The APCU's main goals are to quickly and effectively manage physical symptoms with high scores and to offer intense psychological care in cases of acute distress. When compared to hospice facilities, the APCU has a shorter duration of stay (10-15 days) and a lower death rate (40-50%). The APCU varies from hospice in that it provides fewer medical treatments, a longer length of time (between one and six months), and often near-death care, with a mortality rate close to 95%.

## Limitations

To deliver EOL treatment to acute PC patients outside the ICU, doctors require doable tools and approaches. Our analysis suggests the

SST as a useful tool for this goal, together with a specific hospital unit for acute PC patients, to help the ED staff identify patients for referral to the PC team. It is outside the scope of this study to advocate for a disease-centered or practical, all-inclusive approach to EOL care.

## Discussion

Research on the training of non-PC doctors is crucial, and the primary care and emergency department personnel should be the key HCP groups targeted for increased PC training. The delivery of PC in daily practice may be improved, in particular, through continuing medical education and current information on pain and symptom management in EOL care. The education of clinicians about the ideal times to disclose the patients prognosis and the change from active therapy to PC should also be addressed.

## Conclusion

Due to population ageing, advancements in medicine, and improvements in public healthcare, there are an increasing number of people who suffer from major chronic diseases. As the need for acute hospital-based treatments rises, this transformation in industrialised nations creates significant organisational issues (especially ED). In order to effectively manage the few healthcare resources and allocate HCPs, it is necessary to assess the current features and trends of these patients' utilisation of acute care hospitals. Every acute care hospital should reconsider the real effort involved in managing the shift from curative therapies to PC for inpatients with major chronic conditions.

PC should be made accessible depending on the patients' clinical requirements (primarily, psychological, social, and spiritual support) and difficulties (primarily, the existence and severity of symptoms), not on their diagnosis or prognosis.

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## Conflict of Interest

The authors declare no conflict of interest.

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