Palliative Care in the Hospital Setting

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In Brief

This article discusses the evidence-based implementation of a palliative care consultative service in a community hospital in Northern California. The process of implementing and promoting hospital-based palliative care services involved years of planning and hard work. Barriers are discussed, and a strategic plan for successful growth and integration with hospice services is presented.

The paradigm shift in end-of-life care has had a huge impact on hospitals in the United States. Palliative care in the hospital has evolved to describe a compassionate and comprehensive interdisciplinary approach to improving comfort and quality of life for people who are living with chronic debilitating disease. These services address the complex needs of seriously ill patients and their families and currently exist in over 80 percent of U.S. hospitals with over 300 beds.[1] With the philosophy of palliation being promoted through public policy, the legislative process, social networking, and hospital-specific policies, palliative care teams in the hospital setting have increased 138 percent over the last 10 years.[1] Still, "despite public opinion research showing that most Americans would prefer to be cared for at home if they were terminally ill, the majority of patients who confront life-limiting illness can expect to receive at least some of their care in acute-care hospitals, and half will die in the hospital."[2] This disparity between what patients say they want and what patients are likely to experience at end of life has created challenges in the acute-care setting.

Utilization Challenges

Palliative care focuses on relieving suffering and achieving the best quality of life for patients, families, and caregivers. In the hospital setting, palliative care involves:[3]

- Assessment and treatment of symptoms
- Support for decision making
- Assistance with patient and family goals
- Practical guidance for caregivers
- Mobilization of community resources
- Strategic care planning.

Palliative care is offered simultaneously with curative, life prolonging treatment, whereas "hospice care becomes appropriate when curative treatment options are no longer beneficial, when the burdens of these treatments exceeds the benefits, or when patients are entering the last weeks to months of life."[4]

Frequently, patients have continued to receive curative therapies despite a rapidly declining trajectory. End-of-life discussions have not occurred and patients have not been introduced to palliative approaches. Instead, patients populate emergency rooms and ICUs, and the impact on the U.S. healthcare system has been devastating.[5] "Despite the increasing availability of palliative care services in U.S. hospitals and the body of evidence showing the great distress to patients caused by symptoms of the illness, the burdens on family caregivers, and the overuse of costly, ineffective therapies during advanced chronic illness, the use of palliative care services by physicians for their patients remains low."[4]

The current economic crisis highlights the imperative to transform medical care in the United States. An opportunity to face this challenge exists, in part, by embracing national priorities and goals for end-of-life care.

According to the National Quality Forum, palliative care is one of the six top priorities for action to approach this challenge.[6] The National Consensus Project has identified eight domains and precepts for effective palliative care and the National Quality Forum has established 38 preferred practices associated with quality palliative care.[6,7] The Center to Advance Palliative Care operationalizes the National Quality Forum framework and fosters strategic planning and gap analysis, providing tools for the network of palliative care practitioners in the U.S.

Our Program

The Nursing Director of Oncology championed our palliative care program at Good Samaritan Hospital, with key support from the Social Service department and the Medical Director of Oncology. It took two years to design and launch our Palliative Care Program. A steering committee made up of physicians, social workers, and nurses initially monitored the program.

The palliative care team used business plans that reflect standards of care recommended by the Center to Advance Palliative Care and the Joint Commission. Business plans are based on performance elements, including organizational support, clinical practice, patient safety, patient satisfaction, physician satisfaction, and staff satisfaction.

Psychological principles of successful change management demonstrate that education and constructionist-based approaches promote success. In other words, change management involves addressing attitudes and behaviors by selling the importance of the change, role modeling by colleagues, reinforcement systems, and acquisition of the necessary skills to implement the change.[8]

When implementing our palliative care program, our team used "windows of opportunity" to promote and encourage palliative care, including:

- Skills labs
- Staff educational opportunities, such as brown bag lunches

Cancer care team at Good Samaritan Hospital.

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- Presentations at local hospitals
- Networking with colleagues at professional gatherings and retreats
- Participation on committees to promote integrative medicine and use of volunteers
- Publishing opportunities.

To help ensure the success of our palliative care program, we employed the following:

- Evidence-based practice guidelines, including clinical metrics
- Educational opportunities
- Distribution of books and pamphlets
- Communication via newsletters and staff meetings
- Quality improvement tools
- Physician engagement.

Our palliative care staff consists of social services, chaplaincy, the attending physician, hospice physicians for consultation, an advanced practice nurse, and any other hospital team members who are involved in the patient's care, including physical therapy, speech therapy, occupational therapy, and/or physician specialists, such as neurologists, cardiologists, and pulmonologists. Currently, we have two dedicated beds on the Oncology Unit for palliative patients, which are largely used for patients nearing end of life. However, our palliative care staff consults with patients throughout the cancer program and hospital. Future plans include an expansion of the palliative care program.

Our palliative care team regularly updates and alters patient treatment plans based on patient progress or decline. Our team also collects and analyzes data to ensure that our goals are met and to promote performance improvement. Program analyses are presented quarterly to the Cancer Care Committee. In fact, our Cancer Care Committee has been one vehicle to systematically initiate change and promote palliative care services.

Because the Committee's scope is large, our palliative care team also uses other venues to promote communication and stimulate referrals. For example, regular rounding and case management screening are essential vehicles to help identify patients who may be candidates for palliative care. Triggers include chronic conditions associated with comorbidities, long lengths of stay in the ICU, frequent readmissions, and patients in decline and who would benefit from an end-of-life discussion or transition to hospice services. These triggers generate palliative care intervention by requesting a consultation.

Now that our palliative care program is up and running, our team uses family meetings, staff conferences, newsletters, and telephone conversations to provide program updates. While we have made significant progress in the four years since implementation of our palliative care program, our team has experienced challenges, including:

- Recruiting clinical champions
- Working with steering committees and task forces, which often takes time and patience in the complex hospital administrative environment
- Facing competing or conflicting hospital priorities
- Adapting to changing regulatory functions and policies.

Still our team remains committed to the goal at Good Samaritan Hospital: to provide optimal and compassionate care and reduce readmissions and long lengths of stay by promoting palliative treatment and hospice utilization at end of life. Our vision is to provide a palliative care unit where optimal palliative care can be delivered by a dedicated team.

Barriers to Palliative Care

For community cancer centers looking to implement or strengthen their palliative care programs, we offer this advice on overcoming barriers and obstacles.

One barrier to building a successful palliative care program is a lack of randomized trials that substantiate the benefit of palliative care. However, one recent article in the *New England Journal of Medicine* (N=151) concluded that patients with metastatic non-small-cell lung cancer who received early palliative care had longer survival, improved quality of life, and less depression than patients receiving standard care.[9]

A second barrier to effective use of palliative care is the lack of physician knowledge. Physicians tend to perceive palliative care as what we do when all else fails rather than as a valuable adjunctive service for the chronically ill patient requiring advanced illness management.[4,10] Consequently, physician education is a large part of palliative promotion.

A lack of advanced directive education and utilization or family interference with allowing the advanced directive to be upheld can also hamper effective palliative care.[11] At Good Samaritan Hospital, our social workers facilitate healthcare directive clarification. These issues may prove to be rather complex when family psychosocial dynamics

ILLUSTRATIONS/ISTOCKPHOTO

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are chaotic or conservatorship is involved. Family meetings and care coordination between the physician, social worker, palliative care nurse, and case manager help to focus on goals of care and create a patient-centered care plan to prevent unwanted intubation, ventilation, or cardiac resuscitation at end of life. Code status clarification can also assist the team to direct end-of-life and hospice transition.

Other barriers to palliative care include extended lengths of stay in ICUs, frequent readmissions, and unresolved ethical dilemmas.

Prescription for Success

Successful palliative care programs have many factors in common, including:[12]

- Goals that are in alignment with the philosophy of the healthcare system
- Effective leaders
- Clear staff roles and service descriptions
- Interdisciplinary team engagement and expertise
- Informal visibility and communication
- Involvement in educational activities
- Metric management.

Palliative care is most effective when introduced at the time of diagnosis of a life-limiting disease or when there is a prognosis of less than one year.[13] Promoting palliative care and educating physicians thus becomes essential to the success of inpatient palliative programs.

"The most prevalent model of palliative care service delivery in acute care hospitals is the consultation service, which provides symptom management, family guidance for complex patients, and support to patients and families having to make challenging care decisions.[14] The palliative care team identifies complex seriously ill patients who will most benefit from the interdisciplinary approach.

It is neither feasible nor desirable that all seriously ill patients receive specialty management. Therefore, there is a need to improve basic palliative care admission screening and assessment skills among clinicians caring for seriously ill patients. Key recommendations include:[14]

- Combining evidence-based assessment with treatment algorithms
- Developing quality improvement initiatives
- Offering provider and patient education to help understand and embrace palliative services.

In addition, data indicate that the use of checklists and communication tools can help facilitate and improve palliative care.[14] Patient satisfaction surveys and physician satisfaction surveys are aids to assess and improve program impact. They reflect program strengths and weaknesses, as well as foster growth and improvement.

Standardized collection and analysis of data is essential for strategic planning, quality improvement, and demonstration of program impact. The Center to Advance Palliative Care provides consensus recommendations for consultative services to collect and evaluate data. Operational metrics, clinical metrics, customer metrics, and financial metrics are all utilized and reflect the domains of care. Symptom assessment and management, as well as patient-centered goals of care, and transition of care across care settings should also be tracked. Portable advanced care directives, such as the POLST (Physician Order for Life Sustaining Treatment), should be promoted and employed. Metrics may be systematically used for internal programmatic strategizing and growth. For example, at Good Samaritan Hospital, we submit data annually to the Center to Advance Palliative Care registry for program analysis and comprehensive national data collection.

Transitioning to Hospice

Ideally, patients transition to hospice services from palliative care in a smooth fashion. Hospice liaison nurses interface with palliative care nurses, case managers and social workers at team and department meetings regularly. Hospices provide feedback about patients we have referred on a quarterly basis to promote closure and continuity of care.

At Good Samaritan Hospital, we are currently forging a relationship with hospices to promote inpatient hospice care for patients with intractable pain or needs that preclude the patient being managed at home. These patients would essentially be "boarding" in our hospital under the auspices of hospice. Not only does this type of partnership forge closer relationships between the hospital and hospice, it paves the way for improved patient-centered care.

It has been demonstrated that a dedicated palliative care unit with dedicated palliative care staff is most effective in assessing end-of-life patients and identifying those that would benefit by hospice services. This model best promotes symptom management, interdisciplinary care, and focus on patients who need counseling and guidance at end of life. A dedicated team with a clear focus is therefore the best model to deliver effective services with a smooth transition.

Spiritual Care

It is well documented that spiritual support and guidance can promote tranquility, reduce anxiety, and help individuals to cope with chronic illness. At Good Samaritan Hospital, chaplaincy services are available by request to patients throughout the hospital. Patients and families are encouraged to consult their spiritual leader for advice and comfort. Religious leaders may visit inpatients and occasionally speak with physicians or members of the palliative care

palliative care admission screening and assessment skills seriously ill patients.

team. When religious laws impact delivery of care, respectful compliance is incorporated into the patient care plan (e.g., Jehovah's Witnesses declining blood transfusions).

Annual memorial services and individual spiritual guidance have been well received by our patients and their family members. The impetus of a "Death with Dignity" project in our emergency department led to the creation of a "No One Dies Alone" caring companion program in November 2009 via palliative care services. The NODA program is based on a model from Sacred Heart Medical Center in Eugene, Oregon, and has been well utilized and busy.[15] Trained volunteers from the Good Samaritan Auxiliary vigil with inpatients in the last 72 hours of life when no family is present or respite is required. A coordinator is notified and caring companions are scheduled to sit at the bedside for spiritual guidance.

In a similar fashion to how we have implemented palliative care services at our hospital, we are introducing integrative medicine modalities to our patients, including our oncology patients. Guided imagery, music therapy, pet therapy, humor therapy, and massage therapy are complementary modalities being incorporated in our "Healing Arts" program. We are beginning to introduce Reiki as well.

Ethical Considerations

Effective bioethics committees can promote better utilization of resources and positively impact healthcare decision making. This complex challenge involves an appreciation of cultural norms that impact healthcare delivery, as well as promotion of a philosophy of healthcare that is respectful but promotes healthcare goals. In concert with key stakeholders and leaders in the community, our palliative care team has been building a strong and effective program with a view toward excellence utilizing best practices and evidence-based guidelines.

Death with dignity is recognized by healthcare professionals all over the world as one of the most fundamental of human rights. The introduction of palliative care into healthcare is a relatively recent phenomenon. These services have focused primarily on elderly patients dying from cancer. However, patients who die from cardiac, renal, or respiratory failure comprise a large proportion of palliative patients. Proactive strategies to utilize diverse approaches consistent with cultural norms and values, as well as expansion of the scope of services are indicated.[16] Patients with a terminal illness deserve our compassionate guidance and care to embrace this transition from a physical, emotional, and spiritual perspective. As healthcare providers, we are obligated to embrace their need to talk and to play an active, informed part in their care at the end of life, a most intimate and poignant time.

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