

Primary palliative care: Implementation on an inpatient oncology unit

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History of Palliative Care in the US

- **1963:** Dame Cicely Saunders introduced concept of hospice to the US at Yale University (National Hospice and Palliative Care Organization [NHPCO], 2015).
- **1967:** She then established the first modern hospice in London (NHPCO, 2015).
- **1974:** First hospice established in the US (NHPCO, 2015).
- The concept of palliative care was developed *from* hospice care and has changed significantly over time.



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Defining Palliative Care

Former WHO definition (1986)

“The active total care of patients whose *disease is not responsive to curative treatment*. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best possible quality of life for patients and their families” (Gilbert, 1996).

Current WHO definition (2002)

“Palliative care is an approach that *improves the quality of life of patients and their families facing the problem associated with life-threatening illness*, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (World Health Organization [WHO], 2015).



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Domains of Palliative Care

- Defined in the Clinical Practice Guidelines for Quality Palliative Care (National Consensus Project, 2013):
 - structures and processes of care;
 - physical aspects of care;
 - psychological and psychiatric aspects of care;
 - social aspects of care;
 - spiritual, religious, and existential aspects of care;
 - cultural aspects of care;
 - care of the imminently dying patient; and
 - ethical and legal aspects of care.

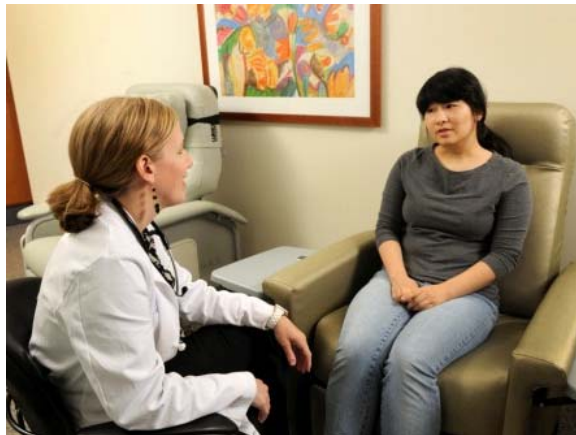


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Primary Palliative Care



(Winship Cancer Institute, 2015, retrieved from <https://winshipcancer.emory.edu/patient-care/index.html>)



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Primary Palliative Care

- Primary palliative care:
 - Defined as “the basic skills and competencies required of all physicians and other health care professionals” (von Guten, 2002).
- Secondary palliative care:
 - Defined as “the specialist clinicians and organizations that provide consultation and specialty care” (von Guten, 2002).
- Tertiary palliative care:
 - Defined as “the academic medical centers where specialist knowledge for the most complex cases is practiced, researched, and taught” (von Guten, 2002).



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Health Resources And Services Administration Grant

(HRSA) Nurse Education, Practice, Quality and Retention Program – Interprofessional Collaborative Practice

Overview:

- Teams of advanced practice nurses and collaborating physicians will lead in the adoption, implementation, and maintenance of **interprofessional collaborative practice primary palliative care** (IPCP-PPC) in 6 major service units of EUH.
- The units include: Hospital Medicine, **Hematology/Leukemia**, Medicine, Neurology, Surgical Critical Care (3 separate units), and Cardiology/Heart Failure.

Health Resources And Services Administration Grant

Rationale:

- PPC implementation in these six units provides an ideal way to strengthen and expand IPCP on units whose main clinical focus is **curative**.
- The needs for symptom management of patients in EUH (or any hospital) will always exceed the capacity of tertiary palliative care provided by subspecialists.
- Therefore, to address the larger patient need, **all first line providers** must be able to provide quality primary palliative care.

Goals of Project

Empower advanced care nurses and nursing staff to:

- Improve patients and family's understanding of diagnosis, prognosis, and goals of care
- Early advanced care planning
- Symptom (pain) management
- Improve documentation of above



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Plan for Implementation

Focus on newly diagnosed patients:

- Identify surrogate decision maker upon admission
- Family meeting within the first week of hospitalization
- Advanced directives within 1st week of hospitalization
- Orientation packet (patient)
- Chaplain consultation (if patient amenable)



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Behavior Change is a Process

Triumphs

- Increased documentation with APP provider presence
- Palliative care sessions for RN and NT staff
- Palliative care champion

Barriers

- Time
- Bias and perception of palliative care concept by providers



Effective communication is an essential skill
for all oncology providers!

(Winship Cancer Institute, 2015, retrieved from
<http://www.emoryhealthcare.org/bone-marrow-transplant/>)

Effective Communication

SPIKES	Six Step Protocol to Communicate Effectively
Setting	1. Getting started. Set the stage.
Perception	2. What does the patient know?
Invitation	3. How much does the patient want to know?
Knowledge	4. Share the information.
Emotion	5. Respond to feelings.
Subsequent	6. Plan next steps and follow up.

(Bailea, Buckman, Lenzia, Globera, Bealea & Kudelkab, 2000)



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Setting the stage

- Plan! Assist the providers with planning the meeting.
- A lot adequate time. Advocate for adequate time.
- Create a private and welcoming environment. Advocate for no interruptions.
- Determine who else the patient would like present, family, friends, or other members of the interdisciplinary team.

(Bailea et al., 2000)



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Perception

- Assess what the patient already knows or believes.
- Start the conversation by asking what the patient knows.
- Bring any information about the patient's perception to the provider prior to a scheduled family meeting.
- Ask open ended questions.

(Bailea et al., 2000)

Invitation

- Assess what the patient wants to know?
- Consider important social factors, how race, ethnicity, culture, religion, and educational status may affect the patient's ability to understand and cope.
- Advanced preparation.
- Ethical handling of information.

(Bailea et al., 2000)

Knowledge

- Share the information in a sensitive, but straightforward manner.
- Start by letting the patient and family that the healthcare team will be sharing bad news.
- Use simple language that is easy to understand.
- Pause frequently, using silence to assess understanding.
- Avoid the phrase “I’m sorry”.

(Bailea et al., 2000)



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Emotion

- Acknowledge the emotions of the patient and family.
- Listen attentively and observe for body language.
- Let them know their responses are normal.
- Allow time for expression of emotions.

(Bailea et al., 2000)



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Subsequent

- Establish a plan for next steps. Introduce resources.
- Reassure patient by letting them know the team is available.
- Revisit and provide additional information when there is a lack of understanding.

(Bailea et al., 2000)



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Center for National Cancer Control Education Programs

Language barrier

- Assess for language understanding and the language the patient prefers to have information delivered.
- Use a translator. Do not use family members.
- Prep the translator and make sure they feel comfortable delivering the content.

(The Education in Palliative and End-of-life Care for Oncology [EPEC-O] Curriculum, 2015)



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Questions

- Thank you for your time!
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