



Care Beyond Cure



No. 11, JULY - SEPTEMBER 2006

A quarterly newsletter on Palliative Care issues by the Policy Advocacy Group of CMAI

Palliative Care: A meaningful way ahead for mission hospitals In-patient Service

Dear Friends,

In the previous issue of *Care Beyond Cure*, we gave some information regarding **Out-patient services** for Palliative Care centre. In this issue, we brief you about **In-patient services** which can function as a separate palliative care unit or integrated in an existing department.

Patients from curative to palliative care often face the hardest psychological transition in goals from 'life prolonging' to 'quality of life'. This process of transition is delicate and individualised. The transition needs to be facilitated by the skillfulness and gentleness of the referring team, and building up of trust towards the recipient team. In these situations, hospital-based in-patient palliative care unit serves as a good model. In hospitals where palliative care is integrated in the existing departments, comprehensive care of patients can



easily be achieved. It is easier for the staff in these settings to adopt palliative care approach without having a paradigm shift in care.

Hospital setting offers the advantage of allowing face-to-face communication between referring department and the referred department, thereby promoting interfac-

ing. Moreover, while promoting early interface and comprehensive care, patients are not deprived of options because of referring out of the original institution. It should be a fundamental understanding that different units within a hospital work as a team for the greatest benefit of the patient. The more collaborative the services, the greater will be the benefit it will bring to the patient.

Hospital-based in-patient palliative care units have been established in secondary, tertiary or specialised hospitals like cancer hospitals. The nature of the hospital can be acute, general or rehabilitative. Its direction can be a service-oriented hospital or a teaching-based hospital. This model has been very effective for a comprehensive care of the patients. Appropriate care can be given to the patient according to the need.

Dr Ronald Lalthanmawia
Guest Editor

Palliative Pearl

"I feel that the greatest reward for doing is the opportunity to do more"

- Dr Jonas Salk



In-patient palliative care unit within a general hospital

Different models of Palliative Care (PC) service play complementary roles in addressing different needs of patients and their families at different stages of their illnesses. Factors affecting the choice of models depend on care factors, local healthcare system factors, and the choices of patients and families.

According to studies conducted, home as the natural environment of the patient, is considered to be the preferred place for the last journey of many patients. Nevertheless, there are obvious limitations for the community/home-care model, despite its many advantages. Though the hospital-based in-patient palliative care model is a more expensive model compared to the community care model, it is considered necessary from three perspectives:

- In-patient palliative care unit provides rapid, intensive and continuous interventions for patients who are in severe distress; whether physical, psychological or spiritual.
- Hospitals provide medical care to the sickest patients in most countries therefore, an important place for patients to access palliative care.
- The integration of in-patient palliative care service within a secondary/tertiary hospital will significantly affect its philosophy, policy and care delivery towards terminally-ill patients.

Why Consider a hospital-based palliative care unit?

An in-patient palliative care unit can be either established as an independent hospice, or as a unit within a general hospital. Historically, many palliative care services came into existence as

independent hospices with distinct palliative care philosophy. However, recent experiences in many parts of the world have shown that palliative care service can be successfully established within general hospitals as in-patient units. So, are there any advantages of hospital-based PC units in contrast to the traditional free-standing hospice?

- Hospital-based in-patient PC unit can be part of the comprehensive care of cancer and other end-stage diseases.
- Hospital-based in-patient PC unit provides continuity of care within the same care setting. The environmental and psychological adjustment will be minimised for patients and their families.
- Hospital-based in-patient PC units encourage and facilitate mutual referral between curative services and palliative care services.
- The availability of excess number of beds within a general hospital will provide a back-up support for the palliative care unit.
- Sharing of a common pool of manpower in managerial and supporting staff. Other than providing skill, expertise and manpower; it also shares fixed costs.
- There is the possibility of rotating junior medical and nursing staff among different units, either as part of professional training or options in future career.
- Reduction of overall costs by sharing fixed cost or overhead.
- An in-patient PC unit has an important educational role for staff in other units.

Prerequisites for setting up a hospital-based palliative care unit

Check out if the hospital/hospice has:

- a top management, like hospital governing committee and hospital chief executive, to support the project. Seeking their support, by appropriate means and strategies, at opportune moment is of paramount importance
- palliative care concepts to convince the key influential personnel, e.g. head of other departments. Without the support from other units, the chance of success will be much reduced
- a close collaboration with hospital administrators. Patience is essential in communicating the care concept behind the design of the unit. (Negotiation with administrators can be a major stress for PC workers in such settings)
- suitable space available for the unit
- worked out plans to raise funds for both the set-up cost and recurrent expenditure
- a patient referral system in place
- a feasibility study done on space, money, sort of finance and staff, and had the priority examined.

What are the potential limitations of hospital-based palliative care units?

Hospital-based PC units will unavoidably face the issue of compliance to the culture, traditions, and style of the management of the whole institution. Besides, more specific issues need to be addressed such as direction of the service, philosophy of care, competing goals, and inflexible institutional regulations. It is important to anticipate the restrictions. It might help to reflect on some of these points:

- The priority of this PC unit within the general hospital
- Adequate autonomy in managing such unit
- Pressure to minimising length of stay within general hospital setting
- Unreal expectations from patients and families of adopting prolonging life measures, as in other units
- Pressure coming from other units and the reasons for such pressure
- separate salary scale and welfare benefits for PC staff
- competition from other units for funding
- adequate ward space to design a suitable environment to deliver the philosophy and standard of care?

Setting up of an inpatient palliative care unit/programme

System of referral & Intake of patients should be established.

Define care goals / care types of hospital-based palliative care unit.

The types of advanced patient being admitted in in-patient unit have to be defined. Does it include non-malignancy terminal illness, or patients with HIV infection? The goals of care can be better defined by different "Care types" with specific treatment goals, criteria of discharge and optimal length of stay.

Efficient use of beds is often an issue within hospital setting. Different care pathway can be implemented for different care types. As an example, four care types with different care goals are listed:

- Acute palliative care: for rapid symptom control and intensive psychological care. The length of stay should be short varying from a few days to a week, and aim at discharge after acute problems are relieved.
- Extended palliative care: for smouldering type of cancer, patient with extreme weakness or high dependency, patient who requires complex nursing, e.g. paresis resulting from spinal cord compression, brain tumor, patient with tracheostomy. The goals of care should be to provide support that could not be provided within community setting. Depend on resources of community, and the possibility of referring to other long-term care facilities, the length of stay is difficult to predict.



- Rehabilitation: patient who requires physical therapy, occupational therapy, or speech therapy. Depending on the potential of rehabilitation; the length of stay should tailor to the goals of rehabilitation. Experience showed that often 2-3 weeks are often required.
- Terminal care: Some patients or their families prefer to die within an in-patient setting. The goals of care

should be peaceful death and fulfilling last wish of patients and their families. The expected length of stay can be as short as a few days.

An optimal size of a unit should be decided for:

- deciding a team size for optimal operation, e.g. rotation of duty, on call coverage
- cost effectiveness. Too small a unit will be expensive
- training opportunities for professionals.

To decide optimal number of beds, the following factors should be considered:

- Proportion of different care types – the bed number is closely related to the pool of patients in the community. No matter how sufficient and efficient is the community care, the proportion of in-patient beds to support the needs will increase as the community pool increases.
- Number of referral patients per year
- Average length of stay
 - Percentage of occupancy
 - Proportion of death in in-patient unit/the rate of home death in local community or culture.

There is no ideal floor plan for ward design of an in-patient unit. In general, there are more restrictions for a hospital-based in-patient unit compared to a free-standing hospice. It depends on hospital policy, funding, availability of space and culture. Nevertheless, the following principles could act as a guideline in designing a PC ward:

the following principles could act as a guideline in designing a PC ward:

- Space to promote privacy of patient
- Space to promote patient choice e.g. permissive personal habits like smoking
- Space to enhance family communication, facilitating them to stay
- Space to have leisure
- Space to have tranquility

- Space serving multidisciplinary purpose, e.g. on-site rehabilitation, conducting groups, etc
- Space or management dangerous drugs like opioids
- Space to manage dying phase, and rituals after death
- Space to accommodate rituals of different religious beliefs
- Space for infection control
- Space for suicide precaution
- Space for staff to express emotions in private

Facilities for in-patient care include:

- Easy accessibility incorporated in design or lift facilities

- Toilet and shower facilities – take into consideration transport of frail patients, especially those with cachexia or prone to fracture; spacious to accommodate chairs, trolleys, other special bathing devices
- Fall-prevention aspect – foot lighting, low-set beds, bars and rods in the bathroom, non-slipping floors etc.
- Medical equipment - oxygen, suction, syringe driver, resuscitation trolley (depends on unit policy), kit for emergency e.g. massive bleeding.

Team structure:

The team structure is similar to that of free-standing hospice, but in general, there might be restrictions due to rules of institution. There will be a proportion of “mobile” staff, who may be accountable to their own departments. The key principles will be a team approach, with clear clinical leadership, regular communicating meetings, and ways to bring consensus.

*Excerpted from "Getting Started: Guidelines & Suggestions for those considering starting a hospice/palliative care services" (IAHPC publication).
www.hospicecare.com*

Forum News

Fellowship in Palliative Medicine

Four students, Dr Ambareesha Mairpadi, Dr Shibumon Koshy, Dr Sunita Madan and Dr Sudhakar Nayak have successfully completed Fellowship in Palliative Medicine 2005 – 2006.

The next batch of students of 2006 (January) will appear for examination in December 2006.

Thirteen more students joined the programme for 2006 – 2007. They are Dr Abhijit Kanti Dam, Dr Victoria Seb, Dr Deshpande Muralidhar, Dr Santosh Lionel Thomas, Dr Geeta Samson Pawar, Dr Shanti Matilda, Dr Kiran Kumar, Dr CM Hyderali, Dr Aparna Amin, Dr Mohammed Hussain Saif, Dr Rana Jagdeep Singh, Dr Cecil Ajay Harrison and Dr Manju Ninan.

Workshop on Palliative Care

✦ St Stephen's Hospital, New Delhi organised an in-house training on Palliative Care for the staff.

✦ *CanSupport* in association with WHO organised 'Workshop on Setting Minimum Standards for Home Care' in Delhi from September 23 – 24, 2006. There were thirty-seven participants at the workshop.

Errata

Dr Matthew Varghese is the Director of St Stephen's Hospital till September 30, 2006. In our last issue of CBC, No.10, April - June issue on page 1, it was mentioned that he is the former Director of St Stephens. The error is regretted.

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Printed at: Creative Lab

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