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ORGANIZATION OF PALLIATIVE CARE AT HOME: SPECIFIC FEATURES AND MANAGEMENT

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Palliative care is usually provided by nurses within a multidisciplinary team, which includes physicians, nurses, psychologists, physical therapists, clinical pharmacists, occupational therapists, nutritionists and social workers. The aim of the study was to study the role of palliative medicine, its psychological and deontological aspects and the specific aspects of nursing process management in palliative medicine, the role of the nurse when organizing home-based care for palliative patients, the specific aspects of teamwork when providing patient care and the roles of all healthcare professionals in the team.

ОРГАНІЗАЦІЯ ПАЛІАТИВНОЇ ДОПОМОГИ ВДОМА: ОСОБЛИВОСТІ ТА УПРАВЛІННЯ

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Паліативну допомогу зазвичай надають медсестри, які працюють у мультидисциплінарній команді, до складу якої входять лікарі, медсестри, психологи, фізіотерапевти, клінічні фармацевти, ерготерапевти, дієтологи та соціальні працівники. Метою дослідження було вивчення ролі паліативної медицини, її психолого-деонтологічних аспектів та особливостей управління медсестринським процесом у паліативній медицині, ролі медсестри при організації догляду за паліативними хворими в домашніх умовах, особливостей командної роботи при наданні допомоги пацієнтам і ролі всіх медичних працівників у команді.

Introduction. The World Health Organization (WHO) defines palliative care as "an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual" [1–3].

The focus of palliative care as a branch of healthcare is on pain management, i.e. alleviation of pain and reducing the severity of the disease symptoms, as well as improving the quality of patient care, family care and health systems [4–6]. It is holistic, patient-oriented, comprehensive and multidimensional, involving not only the physical aspect, but also the psychological, social and spiritual aspects [7, 8].

Palliative care upholds life and views death as a normal process. The entire nursing process of care should aim to help the patients to live as active as possible life until the moment of their death, to provide the patients with a support system in order to help the caregivers and families to cope with the patient's disease and guide them through their grievous loss [4, 9–11].

Palliative care is usually provided by a multidisciplinary team, which includes physicians, nurses, psychologists, physical therapists, clinical pharmacists, occupational therapists, nutritionists and social workers [1, 8, 12]. In addition to that, pastoral care is also included according to the patient's religious beliefs. Other important components of palliative care include effective communication, planning and coordination of care. Palliative care can be provided in a number of different settings, such as a standalone service in a health center

or in a hospice, in the hospital, in one's community and in the home [6, 10, 13, 14].

The main part. The most effective method of working with palliative patients is working in a group, which includes team members of different levels, i.e. a physician, registered nurses, practical nurses/nursing aides, social workers, volunteers, relatives/neighbors acting as caregivers. The patient is viewed as a principal team member, around and involving whom the work is built. According to the wishes and needs of the patient, a priest/minister or other member of the clergy may be included in such a team.

There are a number of services and specialists who may help meet the physical, psychological, social and spiritual needs of patients with critical disease. These include general practitioners, visiting nurses, specialized hospital teams and various professionals of social care agencies.

There are also specialized teams (diagram) and palliative care services, which may help the patients and their relatives. There are two types of team-based care for palliative patients, with the following constituents: daily patient care and specialized palliative care.

Such teams, which are specifically designed to provide palliative care, are typically found in hospices, hospitals, certain outpatient clinics, and day care centers or ambulatory care facilities.

When a nurse is using teamwork successfully, they may reap a number of benefits for themselves, their colleagues, and their workplace:

- Greater satisfaction from work.
- Improved patient care.
- More effective processes.
- More robust professional connections.

Greater satisfaction from work: the opportunity to work well in a team with nursing colleagues may help reduce stress and increase happiness in the workplace. When there is an opportunity to trust others to work together towards a common goal, the nurse may enjoy a balanced workload and study the aspects of patient care, which they like the most.

Improved patient care: several nurses and other healthcare professionals may collaborate when treating patients, and working together ensures that they all deliver a consistent standard of care for each patient. This improves the patient's experience, supports responsibility and makes the process of treatment safer.

More effective processes. When several nurses work together as a team, they may effectively delegate tasks and determine the most efficient ways to achieve their goals. Teamwork skills save time by allowing nurses to care for more patients while providing high quality care.

More robust professional connections. Team thinking when working as a nurse provides an opportunity to learn more about the colleagues and strengthen professional networking. Communication with all healthcare professionals in the team may introduce the nurse to the mentorship opportunities, inspire more ambitious career goals and allow the nurse to share his/her experience in patient care.

By following this care process, the nurses are enabled to work in a team. This is important because this helps nurses learn from each other and see to it that they follow the rules established by public or private institutions.

Nurses who work together can also offer guidance if necessary; therefore, care will not be overlooked in all current tasks.

Teamwork in nursing has many benefits for both the patients and nurses. However, teamwork is not problem-free.

However, overcoming these difficulties strengthens the bond between the representatives of various professions, which is leading to improved patient outcomes over time.

When individual teams are surrounded by encouragement and support on the part of management and colleagues, this often leads to employees feeling more happy.

Teamwork is defined as communication, coordination and joint efforts. Teamwork should be focused on the patient and common goals to achieve measurable outcomes.

Teamwork in Nursing means "communication, coordination and joint efforts". This definition of teamwork should be focused on the patient and common goals.

For successful collaboration in the team, one needs an understanding that each team member has their own tasks and knows how to work together to achieve common goals.

Many patients have their unique issues, and the objective of medical teams is to provide first-class patient care through communication and collaboration.

Team-based medical care means provision of health services to individuals, families and/or their communities by at least two health care providers who work collaboratively with patients and caregivers

to the extent that it is preferred by each patient, to reach common goals and in various conditions to achieve coordinated high quality care. Making use of segregation of responsibilities with accountability between team members in health systems creates great benefits. However, in a real-life setting, shared responsibilities without a quality teamwork may lead to immediate risks for patients. For example, poor communication between health professionals, patients and caregivers is a frequent cause of patients' litigation against healthcare providers. Medical errors, "mishaps" and other unfavorable events may occur due to inadequate communication between team members even in a well-coordinated team. Moreover, the absence of targeted team care may also lead to unnecessary losses. In this manner, identification of best practices may help avoid some of these risks and may help control the costs.

Nurses of the department assist patients in meeting their basic physiological needs (food, fluids, movement and bowel and bladder functions) and during painful conditions (vomiting, choking, coughing, pain, etc.), and monitor the health status of patients.

If a decision was made to continue palliative care in a hospice setting, in order to ensure a quality nursing care in the hospice, all patient observations are documented by the nurse in an in-patient nursing record.

The following documents are kept in the hospice when providing palliative care:

• the card of patient's preferences (issued at the time of patient's admission);

• nursing assessment of changes in patient's health status (daily for the first three days and further if the patient's condition deteriorates; the last record is made on the day of discharge);

• nursing process sheet, which specifies the nursing diagnosis and the goals (short-term and long-term) (Evaluation: 1. all goals have been met; 2. short-term goals have been met, long-term goals could not be met; 3. no goals have been met; 4. new problem has emerged);

• plan of implementation and evaluation of the results achieved;

• patient diary (daily for the first three days and further if the patient's condition deteriorates; the last record is made on the day of discharge).

The implementation and documenting of nursing process is monitored by the nursing supervisor/nursing coordinator, as ordered by the medical director of the hospital.

All nursing interventions performed as part of patient care are documented in the anti-decubitus sheet.

As part of their daily routine, the nurses assess the severity of the patient's condition, obtain decubitus risk score on the Waterlow Pressure Sore Risk Assessment Tool and monitor changes in the patient's body position at least every 2 hours.

In collaboration with nursing aides, the general ward nurse monitors the bedclothes and underwear of the patients, helps with hygienic patient care (washing, brushing teeth and oral cavity cleaning, cutting nails/hair and shaving) and monitors the quality of its implementation. Patients should be bathed at least once every 10 days.

Modern skin care products are used to prevent pressure ulcers and to protect the patient's skin, such as cleansing foam, tonic liquid, protective cream, gloves for wiping and washing, skin care protector and hygienic chest cover for feeding the patient). Other modalities used include anti-decubitus sheets and single use napkins soaked in different fluids (e.g. for dressing change).

Pain control is an important aspect of palliative care, since pain syndrome abruptly reduces the patient's quality of life and deteriorates their psychoemotional status. In this case, the nurse adheres to the following rules and principles:

• analgesics are used by physician's order only; however, in some countries the decision to administer analgesics is within the nurse's scope of practice;

• analgesic administration should be scheduled, prior to emergence of pain syndrome;

• when taking analgesics, the patient should drink plenty of fluid and take food rich in plant fibers;

• the nurse should keep the patient monitoring card for a patient with pain syndrome.

Spiritual support for hospice patients can be provided by ministers of appropriate religious denominations. Whenever possible, it is preferable for such ministers to have special training in working with hospice patients. An in-house or visiting hospice chaplain is frequently preferred.

The main signs of the final stage of the disease include progressive deterioration of the patient's condition, impaired consciousness and disorientation, apathy, drowsiness, and loss of appetite and willingness

to take food. The most frequent symptoms of terminal stage of the disease include the following:

- noisy and humid breathing, tachypnea;
- urinary tract disorders;
- enhancement of pain syndrome;
- restlessness and increased motor activity;
- cough, dyspnea;
- nausea and vomiting;
- excessive sweating;
- muscle twitching and clonic seizures;
- disorientation and confusion.

Based on the patient's clinical presentation, it is important to identify the beginning of extinction of vital functions, to plan adequate therapy, to provide stage-appropriate care and inform the family about the anticipated soon demise of the patient.

When studying symptom frequencies in palliative patients, we have reviewed medical records of the patients who died within the last three months during home-based palliative care provided by the specialists of our healthcare facility.

The study enrolled a total of 93 patients with various terminal disease.

The most frequent symptoms of terminal-phase disease, which we have observed during the study, included the following:

- respiratory disorders;
- pain syndrome;
- dyspeptic disorders;
- neurological disorders;
- cognitive impairment.

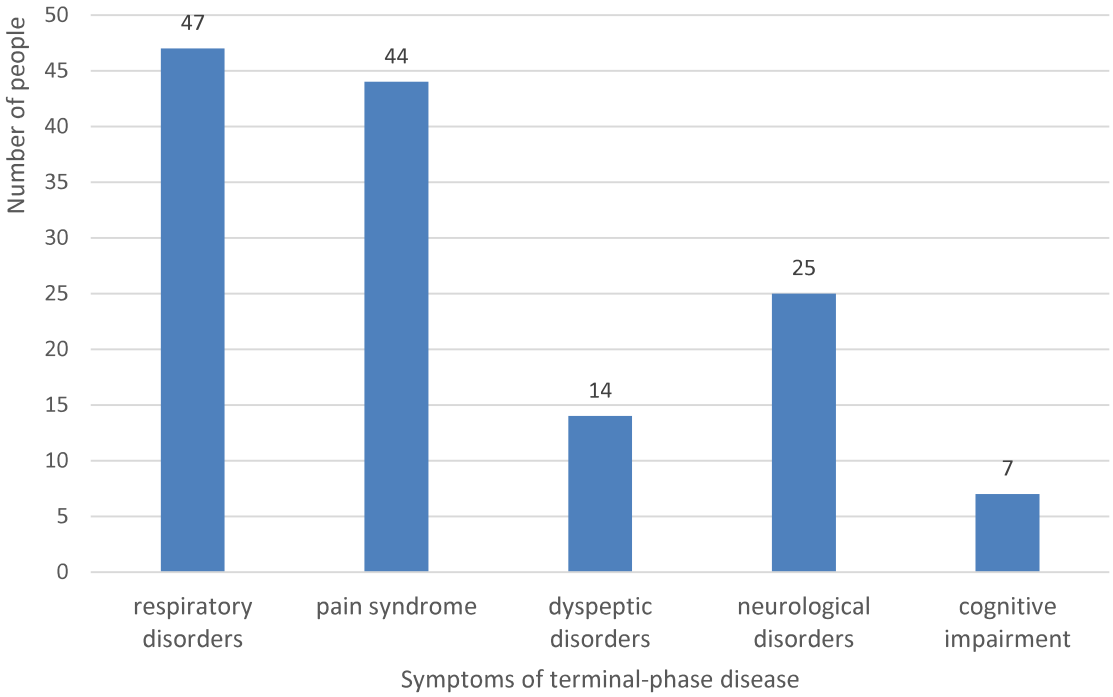

Diagram. **A study and analysis of symptom frequency in patients with terminal disease who were provided with home-based palliative care by the specialists of our healthcare facility.**

Based on the results obtained in the study, we can assert that the most frequent syndromes in terminal patients provided with home-based palliative care included respiratory disorders (50.5 %) and pain syndrome (47.3 %); somewhat less frequent findings included dyspeptic disorders (15.1 %) and neurological disorders (26,9 %); and substantially less frequent cognitive impairment (7.5 %). In general, as demonstrated by the results of the study, the incidence of these severe disorders is high; moreover, these disturbances are combined in many patients, which greatly aggravates their condition and calls for a full-scale palliative care.

The treatment and care for patients in this stage of the disease mainly include provision of rest and maximal possible comfort, adequate pain control, use of sedatives and elimination of distressful symptoms, where the nurse's role is of primary importance.

Conclusions. 1. A study of specific aspects and deontological accents of palliative care shows that pal-

liative care should be properly adjusted to the physical, emotional, social and spiritual needs of the patient and their family.

2. The main methods and principles of work with palliative patients in the home include the following: the ability to communicate effectively with the patients and their families; the ability to explain complex information, since the patients often need clarity regarding disease progression, drugs and care plan.

3. When organizing care for palliative patients, the roles of each member in a multidisciplinary group/team of specialists are defined in a group meeting; the group/team approves a new plan of patient management, resolves conflicts between the nurses and decides on specific topics to be covered during the classes for nurses.

4. Specific aspects of symptoms have been identified in palliative patients: chronic pain syndrome, trophic fractures, tumor necrosis; perifocal inflammation with microbial contamination, formation of ulcers and decay cavities; arterial and venous thrombosis due to compression, changes in respiratory pattern or dyspnea, nausea or vomiting, and agitation. All of the above abnormalities require symptomatic treatment.

5. The most frequent symptoms and syndromes in terminal palliative patients who are recipients of palliative care in the home include the following: respiratory distress (50.5 %) and pain syndrome (47.3 %); somewhat less frequent disorders include dyspeptic disorders (15.1 %) and neurological disorders (26.9 %); cognitive impairment is substantially less frequent (7.5 %).

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