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Nursing in Palliative Care

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Abstract

Palliative care is the best example of the art of nursing that looks at the circumstances and difficulties that cause suffering and affect the quality of life of patients. Palliative care iscomprehensive care aimed at providing the necessary health care to patients with incurable diseases. A palliative approach is a completely holistic approach to another person, one of whomis a health professional and the other a patient. Palliative care interventions are aimed primarilyat reducing suffering and pain which improves the quality of life of patients. The nurse is responsible for planning, conducting and evaluating health care with continuous assessment, educating patients and families, and collaborating with other members of the interdisciplinary team

Keywords: *Palliative Care, Patient, Nurse, Hospice*

Introduction

Palliative care is an important a part of the every-day work of most health care professionals, whether or not they work in the hospital or community setting [1]. The word 'palliative' originates from the Latin pallium, a cloak. In palliative care, symptoms are 'cloaked' with treatments whose primary aim is to promote comfort. The more modern definition within the Oxford mini-dictionary may prove easier to understand: reducing bad effects. But what's palliative care? The recognised World Health Organisation definition describes palliative care as 'the active total care of patients whose disease isn't responsive to curative treatment'. Palliative care is considered, in most definitions, to include the physical, psychological, social and spiritual aspects of care and is orientated to patients who have a non-curative condition. Palliative care shouldn't be confused with terminal care, as many patients have palliative care needs from the time of their diagnosis and need ongoing palliative care for many months or years. The aim of palliative care is to help patients and their families through the physical and emotional traumas of life-threatening illness and to support them in this journey. Palliative care isn't limited to cancer or perhaps to the terminal stages of illness; it can last for years, and may be applied to any life-threatening disease, though it's most frequently related to cancer. Palliative care isn't an alternative to other care, but could be a complementary and essential component of total patient care.

Nurses have particular concerns about telecare practices [2]. The first is that telecare will upset their relationship with patients. The second concern is that telecare will stop nurses noticing signs of trouble in time since they're no longer seeing their patients at home or within the clinic. The worst consequence would be that patients suffer needlessly.

Psychomotor Skills

Psychomotor skills are integral to nursing practice, and any deficiency in these skills among new graduates often ends up in criticism of nursing teaching programs [3]. Psychomotor skills enable nurses to perform effectively in action situations that need neuromuscular coordination. These skills are purposeful, complex, movement-oriented activities that involve an overt physical response. The term skill refers to the flexibility to hold out physical movements efficiently and effectively, with speed and accuracy. Therefore, psychomotor skill is over the capability to perform; it includes the ability to perform proficiently, smoothly, and consistently, under varying conditions and within appropriate limits. Psychomotor skill learning requires practice with feedback so as to refine the performance until the required outcome is achieved. Thus, clinical learning activities should

include plentiful opportunities for practice of psychomotor skills with knowledge of results to facilitate the skill-learning process.

However, psychomotor skill development involves over technical proficiency. While performing technical skills, nursing students and staff members must also perform caring behaviors, critical thinking, clinical reasoning, problem solving, and deciding. However, the flexibility to integrate all of those competencies directly usually isn't achieved until the technical skill component is so well developed that it now not requires the nurse's or nursing student's conscious attention for successful performance. It's only at now that the learner sees the full picture and is ready to focus on the patient as well because the technical skill performance.

Delivery of Care

Professional bodies have a profound effect on the work of the individual practitioner and influence work practices normally [4]. Although this influence is at its most intense for registered practitioners, those training for the professions must be fully conscious of the demands of their professional codes or rules of conduct. Because the codes and rules are produced by the registering bodies, infringement of the professional codes may end in deregistration of the practitioner, with consequent loss of status and earnings. The relationship of codes and rules of conduct to the law is considered, together with their significance for the expected professional behaviour of the practitioner.

Nurses may form the most important number of health care professionals within the delivery of care, but not all care is that the province of nursing. Increasingly, the vital input made by other health care professionals, both in hospital and within the community, may be a great a part of the treatment and rehabilitation of the client. Thus as codes and rules of conduct are important, so is that the smooth working of the multidisciplinary team in health care.

Quality assurance and therefore the measurement of care-giving would appear difficult to quantify; much thought has been given to those over recent years, and systems are developed so as to quantify the great and bad aspects of practice. Although these issues impinge more on the moral than the legal side of health care delivery, the widespread adoption of audit mechanisms and quality assurance methods makes their inclusion a subject of necessity.

Record-keeping, whether computerized or paper based, is, many would say, the bane of health care work. Despite this, record-keeping is extremely important and can't be neglected; legal proceedings may take many years to come to court, memories fade, and every one which will be left is that the record made at the time of the incident. Records also allow smooth handover either from one professional to a different or to facilitate communication among different groups of professionals concerned with the care of 1 client. Records therefore form an integral a part of care delivery.

Even within the best-regulated world, things can and do get it wrong occasionally. Health care delivery is not any exception to the rule, and everyone three parties involved - the employer, the employee and also the client - may at some times have cause for complaint. As health care delivery presents a more and more commercial face, consumers are likely to feel an increasing freedom to complain about poor service, even as they'd in the other commercial service provision. An increasing trend on a part of complainants to resort to litigation if complaints cannot be controlled promptly and effectively makes effective complaints management a necessity.

Palliative Care

Palliative care provides healthcare and emotional support to those living with a serious illness and their families throughout the course of the illness and sometimes the patient's life [5]. Palliative care could be a variety of patient-centered long-term care that prioritizes the standard of lifetime of the patient. It's not limited to older adults. Palliative care is meant to treat the full person, not just their medical concerns. It combines coordinated care management with psychological support for patients and their families as they navigate life with serious illness. Psychological support includes help with stress or depression. Both are critical quality-of-life concerns that are often overlooked in traditional care. Other features of a good palliative care program include around-the-clock access to a clinician, care that's coordinated across multiple specialties, and care that's aligned with the priorities of the patient—including end-of-life preferences.

Five percent of the foremost ill patients living with multiple chronic conditions and functional limitations account for 60 percent of the full cost of healthcare within the US. Eighty-nine percent of this population will live for more than a year. Palliative care not only enables a much better quality of life for people living with illness and their families, but it's value-based care that may substantially lower healthcare costs. This savings is best when care is delivered within the home setting. It's possible to require care of three people in their home for the identical cost as keeping

one person in a very long-term care residence. When care is coordinated across the continuum, it's more efficient and reduces redundancies, medical error, unnecessary care, length of hospital stays, hospitalizations, emergency department visits, overall healthcare utilization, patient depression and pain, and conflicting care and medications.

Overtreatment and over testing raise healthcare costs for insurers and also for the patient and their families. In the US, overtreatment results in each household paying thousands of dollars out of pocket for unnecessary care annually. Not all families can bear the brunt of the costs without compromising on other important spending like food, education, and their own healthcare. This drives a rise within the social determinants that result in poor health, which eventually costs the healthcare system more within the long term. It should be noted that out-of-pocket costs impact lower-income households more strongly than medium- and upper-income households, thus perpetuating a cycle of poverty.

Devices

Three devices were involved here, the primary of which was a monitor for heart condition patients [2]. Patients weigh themselves and measure their blood pressure daily. The devices transmit the measurement figures to a server where they're coded for deviations and made them available to nurses in an exceedingly call center. Patients can keep track of their own measurements on their TV. Centre nurses monitor the daily figures; a sudden gain in weight may point to fluid retention that will, if neglected, be lethal to heart condition patients. Low blood pressure may point to medication problems. The call centre nurses follow informed deviations and discuss treatment options with the nurse within the hospital who is responsible for the patient.

The second device monitors patients by asking them questions daily. The ‘white box’ installed within the heart failure or COPD (chronic obstructive pulmonary disease) patient's home. The white box, a health buddy, asks patients to look at their bodies for symptoms, because it did within the palliative care practice. In contrast to the palliative care practice, however, the white box also provides education and advice on good ways of living with heart failure or COPD. Specialist nurses within the hospital (in the case of cardiopathy and diabetes), in homecare (in the case of COPD) or assistants generally practices (in the case of diabetes) keep a watch on the answers that patients give and are warned by alarm signals if intervention is required.

The third device is that the webcam employed by COPD patients related to a homecare institute. Here, patients have weekly webcam contact with nurses. additionally, a touch screen gives patients access to a web site offering entertainment and news on neighbourhood activities. A central Service Centre provides online bingo and other entertainment. The local homecare organization is responsible for care. Email and internet is available to advanced users. One homecare organization used both the webcam and therefore the white box for COPD patients.

Hospice

Hospice is a type of palliative care for people who have six months or less to live [6]. It's provided to both the patient and family and includes attention to the physical, psychological, spiritual, and emotional needs of the dying. It's provided in many settings: home, nursing home, assisted living facility, or inpatient hospital. Although the U.S. Medicare Hospice Benefit affords terminally ill patients six months of hospice care, most patients use hospice care for fewer than 24 days. One reason why patients and families aren't using hospice for the total extent of their eligible benefits is because physicians must refer them to hospice and most providers have difficulty communicating about hospice or difficulty determining the simplest time to refer to hospice care. When physicians are uncomfortable navigating end-of-life discussions and have a less positive attitude toward hospice, the result's more aggressive care and higher end-of-life spending.

Nationally, individuals with advanced disease are referred to hospice very late in their illness journey, and most patients die receiving aggressive treatments. Providers also refer too late to hospice because the course of disease is unpredictable in chronic illness, and chronic illness has not previously received palliative care support. As an example, providers have difficulty predicting death for people living with dementia, and an absence awareness of palliative care keeps them from addressing the subject with patient/family members. Similarly, patients on hemodialysis have less predictive illness trajectories and providers who are less willing to speak about the prognostic outcomes of their patients leading to very low hospice use, averaging six days.

In the absence of a health-literate delivery system, patient and family may receive conflicting messages from different specialty teams (e.g., between palliative care and oncology or between primary physician and palliative care. Decision support is therefore not available to patient/family who then must choose from their specialty teams and

sometimes between the team and their primary care physician. With multiple healthcare providers involved in chronic illness care, clinical information about referral to hospice could also be miscommunicated among members of the healthcare team.

For good reason, there's an absence of hospice health literacy, with a misconception that hospice is just for care immediately before death. This results from a lack of trust, discomfort in talking about death (among providers/patients/family), and preference and reliance on religious beliefs over medical advice. For instance, among Latinos on hemodialysis, barriers to hospice care include family reluctance to possess advance care planning discussions. However, when both patient and caregiver understand that the disease is incurable, they're more likely to prefer hospice.

Today, the principles of hospice are applied to a broader population (including those with chronic illness) through palliative care, with the goal of reaching these patients much earlier in their illness or disease process. Palliative care permits patients to receive curative, life-prolonging treatment simultaneously with receiving care that enhances quality of life. It's holistic care that treats the whole person, not merely the disease. It involves both curative treatment by physicians, nurses, and other healthcare providers and also emotional, psychological, and spiritual care by a team of specialists including social workers, psychologists, and chaplains. While early literature in palliative care looked exclusively at end-of-life care, patients are now receiving the comforts of palliative care as they suffer chronic, not necessarily terminal, illnesses, making family caregivers even more central and critical to the caregiving process.

End of Life

Family members may communicate care providers to assist them understand what to expect when their loved one is dying [7]. Patients who are very near the end of life display a series of signs that predict the closeness of their deaths. one in every of the primary signs may be a decrease in engagement with one's surroundings and in communication. Because the body is preparing to die, the patient decreases his/her oral intake. this is often the foremost difficult change for members of the family, as they'll become concerned that their loved one is suffering and starving. Often, it's enough to clarify to them that this can be a part of the normal dying process. Most of the time, patients don't report being hungry or thirsty, although they will complain of a dry mouth. in this case, effective mouth care with moistened sponges and a lip balm is sufficient.

As the dying process continues, the patient will become progressively somnolent, with fewer and shorter awake periods. Sometimes the patient may become confused or restless. The clarity of hearing and vision is additionally often seen to decrease. Members of the family sometimes ask if their loved one continues to be able to hear them. Hearing is that the last one amongst the five senses to be lost, and family members should be invited to continue talking to their loved one.

As oral intake decreases and metabolic changes continue, urine output will decrease and therefore the urine are going to be more concentrated. When very near death, patients may develop urinary and bowel incontinence. Other physical changes include alterations in temperature and blood pressure, increased perspiration, and skin changes, like mottling or a pale, yellowish pallor. Breathing changes also occur, including increased, decreased, or irregular respirations, yet as periods of apnea. Because the patient is becoming weaker and more somnolent, s/he is not any longer able to clear the throat or cough. Secretions begin to pool within the throat directly above the vocal cords. As air is passing by these secretions, the sound produced could also be loud and rattling, often referred to as “death rattle.” members of the family who never have witnessed somebody dying may become concerned and wonder if the patient is “drowning.” very often, comparing the death rattle to snoring can comfort them; like snoring, this sound could also be disturbing to the person hearing it, but isn't uncomfortable to the person producing it. Measures to decrease the death rattle include simply repositioning the head or the use of anticholinergic medications. Deep suction isn't recommended, because it is uncomfortable and might result in bleeding.

Additionally, of great importance are nursing interventions, like daily bathing, good mouth care, and application of artificial tears and lubricating ointment to the eyes, also as comfortable positioning within the bed with pillows placed under the calves or other areas of support. Members of the family could also be instructed within these nursing interventions and participate in the care of their loved one. This often is very meaningful and comforting to both the patient and members of the family.

Call Centre

The importance of meeting patients within the same space isn't questioned by the caretakers involved in telecare, but they'll delegate actual meetings to

particular professionals while others take care of the telecare [2]. This happened, for example, when a center linked up with specialist heart condition teams in hospitals. The hospital nurses met patients in their offices, whereas the call centre nurses used the telecare device and also the phone. The requirement of meeting the patient was uncontested. Or was it?

The nurse directed the eyes of the patient to watch the relevant clinical signs for heart failure. But she did over that. She invited the patient to speak about standard of living to focus the 'clinical eye' and interpret the signs for his or her relevance. In telling their stories, patients gave the nurse relevant information about their condition without being tuned in to it. Symptoms are retold in stories about everyday practices. Do patients get dead set the shops, whether or not they say their ankles are okay?

Interestingly, being unable to see patients also revealed the advantages of not seeing patients. Here, telecare disconnects daily life from useful information.

Telecare practices where nurses didn't see patients, however, also challenged this 'rock bottom of clinical knowledge'. Nurses thought of styles of care that failed to need meetings with patients within the same space. At the same time, the monitoring system changed what problems were relevant to look at out for. It reduced the prospect of spotting relevant signs in any situation, but it increased the frequency of monitoring specific symptoms. Only the monitored figures started deviating did the nurse retrieve older and broader norms to interpret the deviations.

Patients

The intent to revive total control over their lives and increasing that control to end the life at the time pre-determined by the patient is one big controversial and debatable topic in modern medical science [8]. The explanations may differ why the terminally ill patients may decide that why wait for death to embrace them once they can embrace the death at their own preferential times. The legal and ethical system doesn't endorse this ideology because their understanding is that the modern palliative medicine can overcome the patients' fears of loss of control over their terminal symptoms by effective and aggressive palliation. Still a very few states respect persons' decisions to end their lives at their own free will and practice euthanasia and/or physician assisted suicide. This very small percentage of worldwide community practicing the debatable palliative concept may represent the analogous very small percent of terminal patients who if given the chance, will decisively complete their wishes for death despite aggressive palliative support.

At the time of diagnosis of their terminal disease, the patients decide to end their lives because of their poor understanding of the disease and its terminal symptoms and also the failure of treatment teams to pursue timely efficacious discussions about their diseases. Because the disease evolves, the patient understands their diseases and also the supportive care offered and rendered by the palliative care teams; and at this point of time, they may decide that this could be the correct time to require the ultimate flight at their own leisure because they feel that it's going to be the proper thing to try and do. However, eventually, the patient despite attempting to sell their thought for dying at their chosen time finally ends up losing their full competence or control on their mental status; and are left at the mercy of their family or surrogate decision maker to choose for what they need been asking all the time: timely death. Additionally, while the surrogate decision making endorses the withdrawing and withholding the life-sustaining treatments as terminal palliative management protocols, however, rather than the pre-determined times by the patients' choices, now the death is occurring when the surrogates and medical teams based on their understanding and perception of the progressive terminal disease decides to let go the patient.

Refusal of Assistance

The moral discussion of providing nourishment or hydration has primarily addressed the refusal of someone who can assist [9]. However, there are limitations on the chance of assisting that arise not from any unwillingness to help, but from circumstances which may render impossible either the activities within which assisting consists or their successful outcomes. Examples of the primary impossibility include situations within which the needed food and water are unavailable, likewise as those within which the person in need cannot eat, drink, or swallow and other technologies for providing nourishment and hydration aren't accessible to care providers. An example of the second impossibility is that the futility of providing nutrition and hydration when nutrients and hydration cannot be absorbed by a debilitated or imminently dying person. In such cases, one cannot really assist the person in need, and once that's clear the effort to try and do so is irrational, and obviously not an ethical obligation.

A practically important and sometimes epistemically complex form of impossibility can emerge from a patient's refusal of assistance. In some of these cases, those seeking to assist can overcome this

rejection, perhaps by coaxing the person to eat or drink what's provided; but in other cases, the patient may well be confused or incapable of understanding persuasive efforts to the purpose that there's not a rational refusal of assistance but rather an uncontrollable incapacity to cooperate. In such cases— e.g., frail, elderly patient incapacitated by dementia—providing the help might prove impossible. Alternatives to feeding or helping the person to drink might rather be unavailable, or perhaps excluded for the identical reasons helping to feed the person is excluded—the person might systematically pull-out feeding tubes. Acquiescing within the futility of trying to overcome this resistance isn't refusing assistance but recognizing impossibility.

Moreover, honoring such a refusal of feeding on a part of a disabled patient who is deemed competent to create such decisions is sometimes also the recognition of the impossibility of assisting. One wishing to help may come to acknowledge that force-feeding a recalcitrant person has limited effectiveness and might well cause grave incidental harm. Of course, even when there's no impossibility present, the costs of helping, broadly understood, will be so high and also the prospects of success so dim that, one able to help might reasonably desist.

Furthermore, within the context of a medical facility, the strong presumption of healthcare favoring a competent patient's right to refuse actions on his or her person, whether or not these aren't narrowly medical, remains in place. Here the impossibility of providing assistance is based on reasonable human convention, not biology. But there's an impossibility: one cannot assist without violating this norm. That norm doesn't imply that those honoring it accept a patient's decision as morally correct. For it's not supported the concept that patients' desires establish what's morally right, but instead is established on a division of responsibility, and thus authority, for health-related decisions among the parties to them. In short, the serious refusal of a person to just accept food and drink, or more technologically based alternatives like tube-feeding appears generally, but not universally, to be a special case of the impossibility of rendering assistance.

Conclusion

Palliative care seeks to ensure the quality of life of palliative patients, the last stage of life in which every person strives for integration and reconciliation. The basic skill in palliative care is the control and alleviation of symptoms, especially pain, combining physical, social, psychological and spiritual forms of help in preserving the dignity of the patient and his integrity, but also the integrity of the family. An interdisciplinary approach, coordination and cooperation can slow down and alleviate the presence of symptoms and signs, especially pain whether the patient is at home or in an inpatient setting. Relieving symptoms, pain, suffering, preserving the quality of life and integrity of patients are fundamental features of palliative care that are needed but not always available.

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