Incidence of inpatient mortality in the palliative medicine unit at tertiary care hospital in Saudi Arabia

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ABSTRACT
After one year of the official opening of the hospital as a tertiary care facility mainly managing cancer patients in the Eastern province in Saudi Arabia in 2006, a palliative care service has been established as a section under medical oncology department to serve patients at King Fahad Specialist Hospital in Dammam, Saudi Arabia.

Introduction:
After one year of the official opening of the hospital as a tertiary care facility mainly managing cancer patients in the Eastern province in Saudi Arabia in 2006, a palliative care service has been established as a section under medical oncology department to serve patients at King Fahad Specialist Hospital in Dammam, Saudi Arabia.

The palliative care team was consisted of one associate consultant, with a medical oncology background, and it provided an inpatient consultation service. Services has been expanded, to include a palliative inpatient service, under the umbrella of medical oncology.

Gradually and as a response to the incremental increase of the number of the oncology patients and subsequently the palliative cases the need of extra man power was obvious. Hiring new staff members in the palliative service was mandatory. Acceptance of more patients under the care of the palliative team was very appreciated by the oncology team, hospital administration and the patient’s families as well.

After few years, the palliative medicine has been separated from the medical oncology department and became a separate department reporting to the oncology center director directly.

During the year 2015, the palliative team consisted of two consultants, six assistant consultants, in addition to two nursing coordinators.

The team has been expanded again to include a social worker, a spiritual advisor, and a clinical dietician.

During the year of 2015;

Acceptance of patients under palliative care done through either ways; inpatients referrals of appropriate patients, with limited survival expectation, and inappropriateness of further disease modifying treatments, after conducting a family meeting to discuss goals of care, and further management plans to focus on comfort only.

Code status is also discussed in those meetings.

In our hospital, as policy states, code status (DNR) is considered a pure medical decision, taken unilaterally, two consultants should sign in the DNR form, one of them should be the MRP, in addition to one assistant consultant, without input from patients or families, although, by convention, they need to be informed.

The family meeting is documented in a special form, which is signed by all concerned parties, whom attended the meeting, and is kept as part of the patient’s medical record.

The other way for referral under palliative care is the outpatient referrals with the same requirements as the previous one.

The palliative care team accepted 204 patients from the inpatient referral to be cared for in the inpatient palliative unit. In addition, 56 patients from the outpatient clinic referral in the year 2015. The palliative inpatient unit consists of 10 (+5) beds of specialized palliative care, with specialty trained nursing staff.

Because we believe that most patients wish to die at home, our team tries hard to keep our terminally ill patients at the comfort of their homes, with the support of the social services and home health care services provided by the hospital in a certain capture radius around the hospital.
We managed to keep 155 patients out of a total of 260 (about 60%), at their homes, to enjoy their last days among loved ones in their own familiar comfortable place.

Some of those patients lived in far places away from the hospital, occasionally not even reachable by car, and their wish was to go home to die there. We succeeded to send some of them to their place of origin, with intensive education and adequate supply of comfort supplies and medications.

When patients living far away are in need for hospitalization, we have communicated with treating physicians at local hospital to discuss management and occasional need for transfer to our hospital.

In spite of these challenges, we are facing every day to keep our terminally ill patients comfortable at their homes for maximum number of their valued days, with help of our social services provided and the support of the home health care team, we managed to keep about 60% of them at their home, allow them to die comfortably in their preferred place, and give them a chance to enjoy last few days of life with their beloved families and friends without the need of be inside the hospital for these valuable times.

Patients who was living in far places that cannot be reached with a car easily, and their only wish to die there in their places, we also managed to send them to their original places even if there was no facility for palliative care service, or home health care there.

In some occasions access for needed medications was not available as well, so we provided them the medications supply they needed for long period of time, specially opioids, and we kept our contact with them through the phone call. Refill of the medications they needed have been done and any one of the patients relatives who can come to our hospital collected them from the outpatient pharmacy.

In spite of all of that, still good number of the palliative patients were still in need for hospitalization, so local hospital could carry the rule of medical admission if needed with the same view of the comfort care and no major undesired interferences.

Treating physicians in local hospitals referred to us the difficult symptoms which needed specialized palliative physician and in most of the cases it was successfully managed in order to keep the patients comfortable in places near to their families and friends.

Summary:

According to Holloway et al, palliative care, known by the general community as “comfort care” focuses in psychological and spiritual needs of the patient and support for the dying patient and the patient’s family, with limitation of invasive or aggressive interventions(1)

Admission to hospital for terminally ill patients and continuation of admission in palliative unit are not necessarily indicated medically. Palliative patients can be well taken care of at home, which is usually a patient goal. A lot of challenges faced to achieve this goal, lack of adequate social and community support was the main reason to keep the palliative care patients in the hospital.

Although the lack of hospices was the next challenge,

most hospice care is provided at home — with a family member typically serving as the primary caregiver(2)

With adequate education, easy communication, and access to medication and needed equipments unnecessary hospitalizations could be waived or at least postponed for few days, that could help terminally ill patients to remain where they wanted to be.

So the benefits of palliative care team was not only to the patients and their relatives in order to keep them comfortable at home as long as they can, but also to the hospital administration to decrease the burden on the hospital facilities, by decreasing the unnecessary admissions number, and long stay in the hospital.

The way to achieve that is to provide the medications and equipments they needed at home along with the reassurance and psychosocial support they and their families needed.

The family’s insight into the patient’s condition should be considered sensitively.

Relatives of patients dying in the community should be given contact telephone numbers so that they have easy access to health care facility whenever needed, that makes them reassured and more comfortable(3)

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