

Palliative care is a multidisciplinary approach to specialized medical and nursing care for people with life-limiting illnesses.

It focuses on providing relief from the symptoms, pain, physical stress, and mental stress at any stage of illness.

The goal is to improve the quality of life for both the person and their family

Palliative care is provided by a team of physicians, nurses, physiotherapists, occupational therapists and other health professionals who work together with the primary care physician and referred specialists and other hospital or hospice staff to provide additional support.

It is appropriate at any age and at any stage in a serious illness and can be provided as the main goal of care or along with curative treatment.

Although it is an important part of end-of-life care, it is not limited to that stage.

Palliative care can be provided across multiple settings including in hospitals, at home, as part of community palliative care programs, and in skilled nursing facilities.

Interdisciplinary palliative care teams work with people and their families to clarify goals of care and provide symptom management, psychosocial, and spiritual support.

Physicians sometimes use the term palliative care in a sense meaning palliative therapies without curative intent, when no cure can be expected (as often happens in late-stage cancers).

Medications and treatments are said to have a palliative effect if they relieve symptoms without having a curative effect on the underlying disease or cause.

This can include treating nausea related to chemotherapy or something as simple as morphine to treat the pain of broken leg or ibuprofen to treat pain related to an influenza infection.

Medical Uses

Palliative care is given to people who have any serious illness and who have physical, psychological, social, or spiritual distress as a result of the treatment they are seeking or receiving.

Palliative care increases comfort by lessening pain, controlling symptoms, and lessening stress for the patient and family, and should not be delayed when it is indicated.

Palliative care is not reserved for people in end-of-life care and can improve quality of life, decrease depressive symptoms, and increase survival time.

If palliative care is indicated for a person in an emergency department, then that care should begin in the

emergency department immediately and with referral to additional palliative care services.

Emergency care physicians often are the first medical professionals to open the discussion about palliative care and hospice services with people needing care and their families.

In some cases, medical specialty professional organizations recommend that sick people and physicians respond to an illness only with palliative care and not with a therapy directed at the disease.

The following items are indications named by the American Society of Clinical Oncology as characteristics of a person who should receive palliative

care but not any cancer-directed therapy:

People who have a limited ability to care for themselves

People who received no benefit from prior evidence-based treatments

People who are ineligible to participate in any appropriate clinical trial and the physician sees no strong evidence that treatment would be effective

The term "palliative care" is increasingly used with regard to diseases other than cancer such as chronic, progressive pulmonary disorders, renal disease, chronic heart failure, HIV/AIDS and progressive neurological conditions.

In addition, the rapidly growing field of pediatric palliative care has clearly shown the need for services geared specifically for children with serious illness.

While palliative care may seem to offer a broad range of services, the goals of palliative treatment are concrete: relief from suffering, treatment of pain and other distressing symptoms, psychological and spiritual care, a support system to help the individual live as actively as possible and a support system to sustain and rehabilitate the individual's family.

In the United States, a distinction should be made between palliative care and hospice care.

Hospice services and palliative care programs share similar goals of providing symptom relief and pain management.

Palliative care services can be appropriate for anyone with a serious, complex illness, whether they are expected to recover fully, to live with chronic illness for an extended time, or to experience disease progression.

Hospice care focuses on five topics: communication, collaboration, compassionate caring, comfort, and cultural (spiritual) care.

The end of life treatment in hospice differs from that in hospitals because the medical and support staff are

specialized in treating only the terminally ill.

This specialization allows for the staff to handle the legal and ethical matters surrounding death more thoroughly and efficiently with survivors of the patient.

Hospice is a type of care involving palliation without curative intent.

Usually, it is used for people with no further options for curing their disease or in people who have decided not to pursue further options that are arduous, likely to cause more symptoms, and not likely to succeed.

Hospice care under the Medicare Hospice Benefit requires that two physicians certify that a person has

less than six months to live if the disease follows its usual course.

This does not mean, though, that if a person is still living after six months in hospice he or she will be discharged from the service.

The biggest difference between hospice and palliative care is the type of illness people have, where they are in their illness especially related to prognosis, and their goals/wishes regarding curative treatment.

Comfort care in hospitals

Comfort care can require meticulous techniques to alleviate the distress caused by severe health troubles near the end of life.

Doctors, nurses, nurses aides, social workers, chaplains, and other hospital support staff work systematically together to carry out the end of life care and comfort in the hospital setting.

Hospitals are able to accommodate the demand for acute medical attention as well as education and supportive therapies for the families of their loved ones.

Within hospital settings, there is an increasing shortage of board-certified palliative care specialists.

Assessment of symptoms

A method for the assessment of symptoms in people admitted to palliative care is the Edmonton

Symptoms Assessment Scale (ESAS), in which there are eight visual analog scales (VAS) of 0 to 10, indicating the levels of pain, activity, nausea, depression, anxiety, drowsiness, appetite and sensation of well-being, sometimes with the addition of shortness of breath.

End-of-life care

Medications used in palliative care are used differently from standard medications, based on established practices with varying degrees of evidence.

Routes of administration may differ from acute or chronic care, as many people in palliative care lose the ability to swallow.

A common alternative route of administration is subcutaneous, as it is less traumatic and less difficult to maintain than intravenous medications.

Other routes of administration include sublingual, intramuscular and transdermal.

Medications are often managed at home by family or nursing support.

Dealing with distress

For many, knowing that the end of life is approaching induces various forms of emotional and psychological distress.

The key to effective palliative care is to provide a safe way for the individual to address their distresses.

Dealing with total suffering involves a broad range of concerns, starting with treating physical symptoms such as pain, nausea, and breathlessness with various medications.

Usually, the sick person's concerns are pain, fears about the future, loss of independence, worries about their family and feeling like a burden.

The interdisciplinary team also often includes a licensed mental health professional, a licensed social worker, or a counselor, as well as spiritual support such as a chaplain, who can play roles in helping people and their families cope.

There are five principal methods for addressing patient anxiety in palliative care settings.

They are: counseling, visualization, cognitive methods, drug therapy and relaxation therapy. Palliative pets can play a role in this last category.

Total pain

To take care of a patient's pain that is at the End of Life, one has to understand that it is of the utmost importance to take care of the Total Body Pain.

This Total Body Pain is the sum of all of the physical, psychosocial, and spiritual pain they can be enduring at this stressful time.

When someone is at the end of their life and they are seeking comfort care, the majority of the time they are in excruciating pain.

This pain can be a physical manifestation to where their body is beginning to fight back on itself causing a multitude of physical symptoms.

The pain can be in a psychosocial manifestation and can be dealt with by the medical team having open communication about how to cope with and prepare for death.

The last aspect of pain that is included in Total Body Pain is the spiritual pain manifestation; if patients spiritual needs are met, then

studies show that they will be more likely to get hospice care.

Physical pain

The Physical pain can be managed in a way that uses adequate pain medications as long as they will not put the patient at further risk for developing or increasing medical diagnoses such as heart problems or difficulty breathing.

Patients at the end of life can exhibit many physical symptoms that can cause extreme pain such as dyspnea (or difficulty breathing), Coughing, Xerostomia (Dry Mouth), Nausea and Vomiting, Constipation, Fever, Delirium, Excessive Oral and Pharyngeal Secretions ("Death Rattle") and many more painful

symptoms can be seen in that they are hoping to get some pain relief from.

Psychosocial pain

Once the immediate physical pain has been dealt with, it is important to remember to be a compassionate and empathetic caregiver that is there to listen and be there for their patients.

Being able to identify the distressing factors in their life other than the pain can help them be more comfortable.

Spiritual pain

When a patient is at the end of life, Chaplain services are one of the best

services available for meeting this spiritual need.

Children's palliative care

Palliative care for children and young people is an active and total approach to care, from the point of diagnosis, throughout the child's life, death and beyond.

It embraces physical, emotional, social and spiritual elements and focuses on the enhancement of quality of life for the child or young person, and support for the whole family.

It includes the management of distressing symptoms, provision of short breaks, end of life care and bereavement support.

Palliative care can be introduced at any point throughout a child's life; it is completely individual.

Some children may require palliative care from birth, others only as their condition deteriorates.

Families may also vary as to whether they wish to pursue treatments aimed to cure or significantly prolong life.

In practice, palliative care should be offered from diagnosis of a life-limiting condition or recognition that curative treatment for a life-threatening condition is not an option; however, each situation is different and care should be tailored to the child.

Terminology

Life-limiting/life-shortening conditions are those for which there is no reasonable hope of cure and from which children or young people will die.

Some of these conditions cause progressive deterioration rendering the child increasingly dependent on parents and carers.

Life-threatening conditions are those for which curative treatment may be feasible but can fail, such as cancer.

Children in long-term remission or following successful curative treatment are not included.

Costs and funding

Families of persons who get a referral to palliative care during a hospitalization incur fewer costs than people with similar conditions who do not get a palliative care referral.

Palliative care services in the US are paid by philanthropy, fee-for-service mechanisms, or from direct hospital support.

Certification and training for services

In most countries, hospice care and palliative care is provided by an interdisciplinary team consisting of physicians, pharmacists, registered nurses, nursing assistants, social workers, hospice chaplains,

physiotherapists, occupational therapists, complementary therapists, volunteers, and, most importantly, the family.

Caregivers, both family and volunteers, are crucial to the palliative care system.

Caregivers and people being treated often form lasting friendships over the course of care.

In the United States, hospice and palliative care represent two different aspects of care with a similar philosophy, but with different payment systems and location of services.

Palliative care services are most often provided in acute care hospitals

organized around an interdisciplinary consultation service, with or without an acute inpatient palliative care unit.

Palliative care may also be provided in the dying person's home as a "bridge" program between traditional US home care services and hospice care or provided in long-term care facilities.

Physicians practicing palliative care do not always receive support from the people they are treating, family members, healthcare professionals or their social peers.