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Integrated palliative care within a general hospital

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Abstract The goal of the project was to integrate essential elements of palliative care into the regular duties of an internal ward located in a general hospital serving a rural area. To achieve this goal, the medical and nursing staff was moderately expanded, which was made possible by a grant from the Deutsche Krebshilfe, and training and supervision were instituted. Patients with malignant diseases in advanced and terminal phases were enrolled in the project and evaluated using a specifically designed documentation system. On average, 8.5 (18%) of the 46 beds on the ward were occupied by patients being cared for as part of the project at any one time. Effective re-

lief of pain, nausea and respiratory distress were documented. For those dying in the hospital, a single room and the presence of family members were possible in the majority of cases. A high impact on the team became apparent through an anonymous questionnaire given during supervision. The project shows that it is possible to integrate palliative care into the work of a regular internal medical ward, with positive consequences for the patients and the team.

Key words General hospital in rural area · Advantages of integrated palliative care · Staff motivation

Introduction

In November 1985, the newly built community hospital in Günzburg started to serve a rural population of approximately 80,000 inhabitants. The hospital is equipped with 265 beds, 110 of which are assigned to internal medicine. Since one of the two heads of the department of internal medicine had specialist qualifications in haematology and medical oncology, a relatively high proportion of patients cared for on his wards had malignant diseases. Consequently, these patients also sought help from our hospital in the terminal phase of their disease, frequently up to their death. The care of the terminally ill posed a heavy professional and emotional burden on the medical and nursing staff, who felt that they had too little time, skill and personal strength to provide the care that was apparently needed. To overcome these problems, the concept of “integrated palliative care” was developed and proposed with an application for support to the Deutsche Krebshilfe, who provided a grant for the years 1995 through 1998. This re-

port summarises our experience in the first 3 years of the project.

The concept of the “integrated palliative care” project

It did not appear feasible to establish a separate palliative ward or a hospice for our rural area. Instead, it seemed it could be possible to integrate essential elements of palliative care into the regular duties of patient care on a general medical ward if the following requirements could be met:

- Oncological and palliative competence
- A moderate increase in manpower
- Regular education and training of the staff
- Regular supervision

The grant from the Deutsche Krebshilfe made it possible to implement the concept on two internal medicine wards. These wards comprise 46 beds, mostly in two-bedded rooms. Patients with all medical diagnoses are admitted to the wards, with a predominance of gastroenterological, haematological and oncological dis-

eases. The medical staff establishment of three and one half positions was increased by one half-position, and the nursing staff of 19 by 2 additional positions. This expanded manpower allowed all members of the team to spend additional time in providing palliative care to the tumour patients who were in the terminal phase of illness. The concept stresses the participation of all team members in the palliative care project.

The patients treated under this project are distributed on the wards as beds are available. During the final phases, and in certain instances also for longer periods of time, a two-bedded room is reserved for a patient and close members of his or her family, who are then allowed and encouraged to stay with the patient day and night if possible.

Education and training are provided in the form of regular teaching sessions for the staff. In addition, two physicians and five nurses belonging to the team have taken part in palliative care courses offered by the Mildred Scheel House in Cologne. There is regular supervision every 2 weeks by an external supervisor / psychologist for the two nursing teams.

Patient admission and documentation

All patients with progressive malignant diseases who seek help for symptom control and who are not eligible for tumour-oriented therapy are enrolled in the project. To evaluate the efficiency of the project, a documentation system was developed comprising the following items:

- Admission sheet, containing basic data, cause of admission, diagnosis, previous treatments, stage of the disease, evaluation of actual symptoms
- Flow sheet for daily evaluation of symptoms, to be completed during the daily visits, containing the following information: duration and grade of pain, grade of nausea and vomiting, respiratory function and mental state, on a visual analogue scale; type and dose of analgesics and co-analgesics (when changed)
- Final evaluation sheet at time of death or discharge from the hospital

Patient data

Table 1 gives statistical data on the patients included in the project. The number of admissions increased through the years: 161 in 1995, 185 in 1996, 233 in 1997. About two thirds of the patients were admitted only once, while 24% had three or more stays in the hospital under the project. The average duration per admission was 17 days, with a wide range from 1 to 91 days. A list

Table 1 Statistical data for the patients cared for under the project during 1995–1997

No. of patients	357
No. of admissions	559
Patients with 1 admission	246 (69%)
Patients with 2 admissions	67 (19%)
Patients with 3 or more admissions	44 (12%)
Duration of stay (days) – mean (range)	16.7 (1–91) days
Duration of stay in hospital	
< 1 week	120 (21%)
1–2 weeks	181 (32%)
2–3 weeks	122 (22%)
> 3 weeks	136 (24%)
Patients per day averaged on a monthly basis	
Mean	8.5
Minimum	3.0
Maximum	12.8
Patients previously treated in our hospital	210 (59%)

Table 2 Most frequent diagnoses of the patients cared for in the course of the project

Carcinoma	No. of patients	%
Colorectal	57	16%
Breast	54	15%
Bronchial	50	14%
Pancreatic	18	5%
Gastric	17	5%
Ovary	14	4%
Other	147	41%

Table 3 Outcome of the admissions and data on those dying in the hospital

Outcome of admissions	(<i>n</i> = 559)	100%
Death in the hospital	189	34%
Discharge with further contact	188	34%
Discharge without further contact	182	32%
Outcome for patients	(<i>n</i> = 357)	100%
Death in the hospital	189	53%
In single room	147 (78%)	
In presence of family	109 (58%)	

of the most frequent diagnoses is given in Table 2, and the mode of discharge in Table 3. One third of the hospital stays ended in death, one third ended with discharge with a date for readmission or control in the outpatient clinic, and one third with discharge without follow-up. A number of patients were readmitted for the final phase; overall, 189 of the 357 patients, i.e. 53%, died in our hospital. A single room could be provided in 78% of these cases, and the family was present in 58%. When averaged on a monthly basis, the number of patients per day in the project varied widely, indicating the variable demand for this type of support.

The majority of patients had been treated in our hospital during earlier phases of their malignant disease.

Symptom control

The symptoms presented on admission are given in Table 4. The change in symptoms was evaluated according to WHO criteria on a scale of 0–4. Table 5, shows the intensity of symptoms on admission and at the final evaluation, indicating satisfactory improvement of pain and nausea and moderate success with respiratory problems. On admission, 46% of the patients had no regular therapy for pain; at discharge, 28% did not need pain medication. The percentage of patients treated with opioids (WHO step III) rose from 21% at admission to 53% at the final evaluation (Table 6). A high proportion, 84%, of those who died in the hospital needed parenteral opioids during their final days (Table 7).

Table 4 Symptoms on admission to the project (multiple entries possible)

Symptom	Admissions	%
Weakness	414	74%
Pain	341	61%
Dyspnoea	261	47%
Nausea	196	35%
Cachexia	170	30%
Problems of nursing	103	18%
Obstipation	59	11%
Anxiety	45	8%
Psychosocial problems	27	5%

Table 5 Change of symptoms from time of admission to the final evaluation, as judged by the attending physician on a scale of 0–4

Symptom	Score on admission	Score on discharge	Difference
Pain frequency	1.8	0.3	–83%
Pain intensity	1.5	0.3	–80%
Nausea	1.1	0.3	–73%
Respiratory distress	1.6	1.1	–31%

Table 6 Distribution of pain medication stages according to WHO for all admissions ($n = 559$) at the first evaluation on admission and at the final evaluation

	On admission	Final evaluation
WHO 0	260 (46%)	159 (28%)
WHO I	99 (18%)	60 (11%)
WHO II	83 (15%)	45 (8%)
WHO III	117 (21%)	295 (53%)

Impact on the team

Within the context of the supervision, 12 members of the nursing team responded anonymously to a questionnaire about the impact of the project on the team. The 19 statements listed (Table 8) could be rated from 1 (great impact) to 5 (minimal impact). One member of the group was apparently unsatisfied (rating 3.8). The other 11 members gave very good to good ratings, the individual average for the 19 questions ranging from 1.3 to 2.2, with a median of 1.8.

Discussion

The data of our project document that essential elements of palliative care can be effectively provided within the framework of a regular medical ward when the requirements listed are met. Of course, there are deficits compared with a typical hospice with its homely atmosphere, the help of volunteers, the possibility of

Table 7 Distribution of pain medication stages according to WHO at final evaluation for patients dying in the hospital ($n = 189$)

WHO 0	10 (5%)
WHO I	4 (2%)
WHO II	2 (1%)
WHO III enteral	14 (8%)
WHO III parenteral	159 (84%)

Table 8 Questionnaire on the impact of the project on team members. Each item could be rated from 1 (high impact) to 5 (low impact)

Personal attitude

- Improved my attitude to patients' problems
- Improved my professional skills
- Helped to ease my personal attitude toward my personal finiteness
- Helped to cope with private problems
- Stimulated my handling of personal conflicts

Team approach

- Improved my ability to communicate within the team
- Improved my willingness for cooperation
- Helped to overcome difficulties within the team
- Increased my sensibility for quality of care
- Increased my openness for innovation
- Improved our team spirit

Care of patients

- Improved my ability to communicate with the patients
- Sensitised to the "melody" of communication with patients and family
- Improved my understanding of the fears and anxieties of the patient
- Increased my feeling of being helpful to the patient
- Improved my ability to communicate with patients' relatives

music, special diets and other services. On the other hand, our project has met with appreciation and support not only from the ward staff but also from relevant groups in the hospital. The department of physical therapy was highly motivated to work with these patients. The hospital chaplains were committed to assisting our patients with their spiritual needs and met regularly with the medical and nursing staff to discuss their problems.

Certain advantages of our project became apparent:

1. Flexibility. The demand for supportive inpatient care in our area is variable because of the "law of small numbers." Since these patients are integrated into the regular ward, beds are provided as needed. The number of patients in the project on any day, averaged on a monthly basis, ranged from 3.0 to 12.8. We can also be flexible in the selection of patients. There is no need for restrictive admission criteria. All patients with advanced malignant diseases who are in need of inpatient treatment of their symptoms are admitted. Some patients who improve during symptomatic therapy may then want to have a new chance of specific therapy. If feasible, chemotherapy can be offered on the same ward. There were 12% of patients who were shifted from palliative to specific therapy at some point in the project.
2. Continuity. Most patients in the project have been treated at our hospital during previous phases of their disease. Therefore, they are familiar with the hospital and with the staff. There is no need to choose a specific institution for the terminal illness, which relieves patients and family of the psychological stress of such a decision.
3. Staff motivation. The impact of the project on the staff was manifold. First, the increased manpower enabled them to care for the terminally ill and dying patients in such a way that feelings of inadequacy could be overcome and they could take satisfaction in the difficult task. Since these patients are only a fraction of all the patients on the ward, the emotional burden on the staff is alleviated. On the other hand, caring for the palliative patients, the special

in-service training and the supervision inspired the team to improve their standards for all their patients. This resulted in the development of nursing standards for all patients and an improved documentation system encompassing medical and nursing information. The interactions within the team improved markedly, as documented in the evaluation by questionnaire, and a high level of stability resulted.

Palliative care is regarded more as an attitude than a fixed structure. The Canadian Palliative Care Association defined it as follows in 1995 [2]: "Palliative care is a philosophy of care, in the combination of active and passionate therapies intended to comfort and support individuals and families living with a life-threatening illness." The place of hospice care within the health care system is discussed by Clark [3]: "Hospice care, though often counter-posed to the mainstream provision, does not exist in isolation from it. The place of hospice within overall patterns of health care delivery is therefore crucial." In the United Kingdom, the integration of palliative care into hospital structures was promoted by its development as a subspecialty and its recognition by the political institutions as an integral part of hospital services, as reported by Field at the 2nd Meeting of the German Society for Palliative Care in Berlin in 1998. Consequently, mobile multidisciplinary teams for palliative care were instituted in general hospitals, the first at St. Thomas's Hospital [1]. By 1996, more than 200 such teams were active [5].

In the Introduction to the *Oxford Textbook of Palliative Care*, the editors state: "Tomorrow, the principles of palliative medicine should be the norm worldwide" [4]. Our experience of integrating palliative care into the regular service of a general ward may be considered useful for hospitals serving a rural area where a separate palliative care unit or a hospice may not be feasible. Thus, integrated palliative care could represent a step towards the acceptance of palliative medicine as the norm in these conditions.

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