RESEARCH

EVALUATION OF THE PATIENT CONSULTATIONS FOR ADMISSION TO PALLIATIVE CARE: A DESCRIPTIVE STUDY

Turkish Journal of Geriatrics
DOI: 10.31086/tjgeri.2022.261
2022; 25(1): 42-48

■ Onur ÖZTÜRK[1]
■ Muhammet Ali ORUÇ[2]
■ Muhammed Emin GÖKTEPE[1]
■ Latife Merve YAĞLIOĞLU[1]
■ Muhammed OKUYUCU[3]

CORRESPONDANCE

[3] Muhammed OKUYUCU

Ondokuz Mayıs University, Internal Medicine, Samsun, Turkey

Phone: +905446391400
e-mail: muhammedokuyucu55@gmail.com

Received: Nov 19, 2021
Accepted: Feb 15, 2022

[1] Samsun Education and Research Hospital, Department of Family Medicine, Samsun, Turkey

[2] Ahi Evran University, Department of Family Medicine, Kırşehir, Turkey

[3] Ondokuz Mayıs University, Internal Medicine, Samsun, Turkey

Abstract

Introduction: It is essential to comply with palliative care philosophy during consultations for hospitalisation purposes between specific medical branches and specialised palliative care services (SPCS). We aimed to evaluate the patients who were admitted or consulted to the palliative care service with a palliative care approach.

Materials and Method: This descriptive study is based on retrospective review of data. The consultation requests delivered to the SPCS between December 1, 2019 and December 1, 2020 were evaluated through the hospital archive. The number of consultation requests delivered to the SPCS from other departments for hospitalisation purposes, demographic characteristics of patients, their acceptance and rejection rates, and reasons for which these decisions were made were examined.

Results: Of the total 394 consultation requests, 53.6% (n = 211) were for males. The acceptance rate was 40.9% (n = 161). The most common primary diagnosis category was gastrointestinal cancers (21.6%), the most common consulting branch was emergency department (44.6%), the most common reason for rejection (53.2%) was the patient's acute problems and the most common reason for acceptance was the need for nutritional support with a rate of 64.0%.

Conclusion: It has been determined that most of the consultations requests were not accepted. It is necessary to use SPCS more effectively.

Keywords: Consultation; Palliative Care; Patient Admission.

INTRODUCTION

A very few health centres, especially oncology centers, in the world have specialised palliative care services (SPCS) and accession to this health service is difficult, therefore the selection of patients for referral to the SPCS is of critical importance. Biopsychosocial approaches to increase the comfort of patients and their relatives should be presented on a medical basis. It is essential to comply with palliative care philosophy during consultations for hospitalisation purposes between specific medical branches and SPCS (1,2). In every respect, this approach contributes remarkably to patients, their relatives, hospital–staff, hospital resources, and the government.

Patients who are bedridden, do not have curative treatment, have difficulty in controlling physical and emotional symptoms, and need support from others are evaluated by the palliative care team. Hospitalization is provided for patients who are decided that inpatient care will be beneficial to the person or their family (3).

There is no consensus on who, when, on whom and how should palliative care be given. In this regard, approaches may vary according to the attending clinic (4). In our hospital, SPCS was managed by the family medicine clinic during the study period. Palliative care is an area where holistic care, one of the basic principles of family medicine, is applied effectively. With this holistic perspective, it requires a person-centered approach towards the individual, family and society, and these features form part of the core competencies of the family medicine discipline. Thus, family physicians have an important role in providing patients with access to SPCS (5,6).

The SPCS in our hospital has a capacity of 24 beds and provides services to approximately 4,000 adult patients registered to home healthcare services affiliated to the provincial health directorate, as well as adult patients who have not yet been registered with home healthcare services, but are receiving treatment in different clinics within the hospital. The requests for consultation are received from other branches in the hospital or directly from home healthcare services.

There are not enough studies in the literature on the suitability of consultations for SPCS, they also focused on the timing of the consultation. The aim of this study is to evaluate the patients who were admitted or consulted to the palliative care service with a palliative care approach.

MATERIALS AND METHOD

Study design and participants

This descriptive study is based on retrospective review of data. All of the consultation requests delivered to the SPCS of Samsun Education and Research Hospital between December 1, 2019 and December 1, 2020 is evaluated through the hospital archive. There is no data loss, all available data have been evaluated.

The number of consultation requests delivered to the SPCS from other departments for hospitalisation purposes, the demographic characteristics of patients, their acceptance and rejection rates, and the reasons for which these decisions were made were examined. Conditions such as urinary tract infections, acute upper/lower respiratory tract infections, acute coronary syndrome and stroke, that develop independent of the primary diagnosis were regarded as acute problems, and thus consultation for hospitalisation purposes were not accepted.

The patients were categorised into age groups as 18–64 years, 65–74 years (young old), 75–84 years (advanced old) and 85 years and older (very advanced old) (7).

Statistical Analysis

All data were evaluated using the SPSS version 20.0 software package. Descriptive statistics consisted of number, mean, standard deviation, and percentage. Chi-Square test was used to determine the relationship between the groups. The level of statistical significance was set to a p-value of less than 0.05.

Ethical Considerations

Approval was granted by the local non-interventional clinical research ethics committee with a protocol number GOKA/ 2020/ 7/ 11.

RESULTS

Of the total 394 consultation requests, 53.6% (n = 211) were for males and 46.4% (n = 183) were for females. The mean age was 72.3 ± 13.5 years. The acceptance rate was 40.9% (n = 161). The acceptance rate in females (49.2%) was statistically higher than in males (33.6%) (p = 0.002).

The most common primary diagnosis category was gastrointestinal cancers (21.6%) (Table 1). The most common consulting branch was emergency department (44.6%), there was no relationship between consultation branch categories and SPCS admission (p = 0,357) (Table 2). When these branch categories were reduced to two as hospital services and home health services, no relationship was found between them (p= 0.451). The most common reason for rejection (53.2%) was the patient's acute problems and the most common reason for acceptance was the need for nutritional support with a rate of 64.0% (Table 3). The number of consultation requests was the highest in October (14.0%, n = 55) (Figure 1). The female gender was predominant after the age of 75 (p <0.001) (Figure 2). The result of the consultation was also not found to be related to the month (p = 0.330).

DISCUSSION

This study provides important data in terms of evaluating the appropriateness of consultations to SPCS and emphasizing the importance of integration

Table 1. Primary diagnoses categories of patients consulted

Primary diagnoses categories	n	%
Gastrointestinal cancers	85	21.6
Respiratory cancers	73	18.5
Other cancer diagnoses	67	17.0
Cerebrovascular accident	59	15.0
Alzheimer's disease and dementia	57	14.5
Other non-cancer diagnoses	53	13.5
Total	394	100

Table 2. Branch categories that make consultations according to admission status

Branch categories	Acceptance		Rejection		Total		P value
	n	%	n	%	n	%	
Emergency department	63	35.8	113	64.2	176	100	0,357
Intensive care units	63	48.8	66	51,2	129	100	
Internal clinics	23	38.3	37	61.7	60	100	
Surgical clinics	8	36.4	14	63.6	22	100	
Home healthcare services	4	57.1	3	42.9	7	100	
Total	161	100	233	100			

Table 3. Reasons for rejection and acceptance of consultations

Rejection	**n**	**%**
Presence of acute illnesses	124	53.2
Lack of spare beds	59	25.3
COVID-19 rule out	13	5.6
Treatment rejection	10	4.3
Other	27	11.6
Total	233	100
Acceptance	**n**	**%**
Nutritional support	103	64.0
Wound care	20	12.4
Pain control	19	11.8
Respiratory palliation	13	8.1
Other	6	3.7
Total	161	100

with home health services. While the importance of referring patients and the time of their referral to SPCS in the early stages is frequently mentioned in the literature, it is intended to draw attention to the unwarranted consultations received by the SPCS by considering the subject from a different perspective.

Similar to the studies conducted in Belgium, Canada and Australia, most of our patients had been diagnosed with cancer (8-10). Although pain palliation has been reported as the main reason for consultation in the literature (11-13), our study reports nutritional support as the main reason. The prominence of pain palliation in the literature may be due to the fact that SPCSs are generally found in oncology hospitals however our hospital is a multidisciplinary organization. Another study conducted in our country also reported nutritional support as the main reason (14).

Figure 1. Distribution of consultations by months

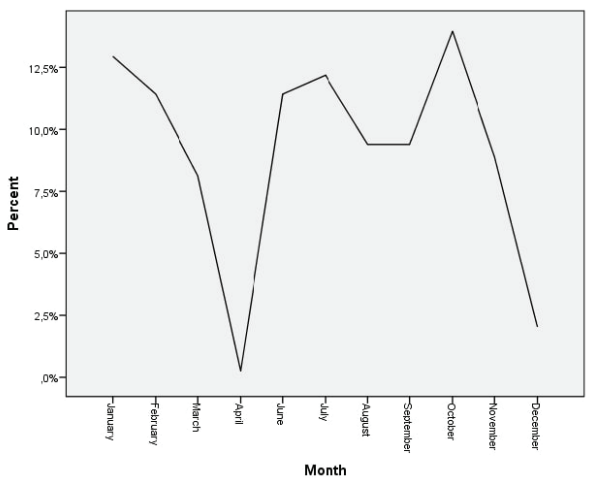
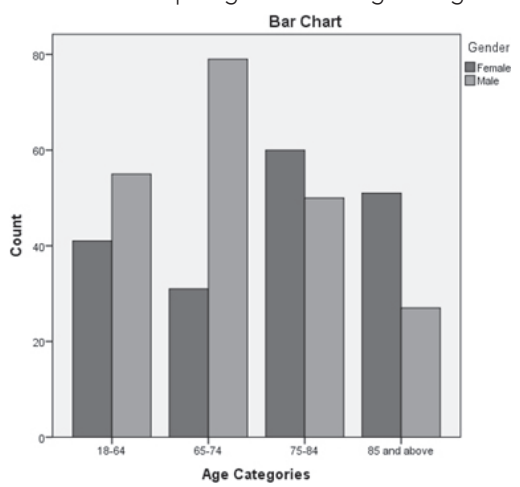


Figure 2. Relationship of gender with age categories



The efforts towards providing curative medical therapies are futile during the transition to end-of-life period (15). Palliative care should definitely focus on needs and not on prognosis. When focusing on chronic complaints, more primary and secondary gains can be obtained in palliative care (4). It has been shown that considering consultation to SPCS for eligible patients without any delay increases patient and family satisfaction and consequently reduces health expenditures (16-18).

Several studies report that consultation requests to SPCS are most commonly received from oncology units (19,20). Consultation requests received from home healthcare services, which should be coordinated with SPCS, are also important. This integration also provides cost-effectiveness (14). Regardless of whether the patients are bedridden at home or elsewhere, patients in need of palliative care should be referred to SPCS for the assessment of their complaints rather than to an emergency room or a specific specialist. Brumley et al. reported that palliative care in the home setting reduces the number of admissions to the emergency department (21). However, the consultation requests to our department were most frequently received from the emergency medicine units. Considering our results, it is understood that home healthcare services lag behind in consultation requests.

Looking at the issue of consultation from another perspective, it should be considered how this service can be evaluated in the most efficient way in health institutions which offer SPCS facilities. It is not a rational practice to direct bedridden patients with chronic conditions or those with poor life expectancy to SPCS when they approach the hospital with any complaint. According to the 'National Clinical Program for Palliative Care' prepared by the 'Health Service Executive' in Ireland, the patient must have an advanced, progressive, life-limiting condition along with a lack of symptom control, end-of-life planning, or existing or expected complexities with respect to other physical, psychosocial or spiritual needs that may not be mitigated reasonably (22). Similarly, criteria of referral to SPCSs prepared by the 'Midland Cancer Network' in New Zealand focuses on the refractory complaints of these patients (23).

Despite the perceived need for early referral of patients to SPCS (24) and that the majority being referred or being able to be referred to SPCS in the terminal period still remains a global problem, the fact that less than half of the consultation requests delivered to our service were accepted suggests that the palliative care philosophy has not been well understood. In addition, some branches may be reluctant to spare time for patients with low life expectancy, and this increases the number of unnecessary consultations.

Strengths and Limitations

Our service is the most comprehensive SPCS in the region in terms of its geographical location, and accepts patients from many cities. This has paved the way for the circulation of patients and consultation requests for different patient populations which may have strengthened the present study, however if multicenter and longer-term studies are carried out in the future, awareness about the consultation problem may appear more. Besides, the coincidence of our study period with the COVID-19 pandemic has restricted the admission of new patients and caused uneven patient circulation but this limitation does not hinder the evaluation of unwarranted consultation requests which is the main subject of this study.

CONCLUSION

It has been determined that most of the consultations requests were not accepted. The most common diagnosis is gastrointestinal cancers, consultation requests are usually received from hospital

services, the most common reason for rejection is the patient's acute problems, and the most common reason for admission is nutritional support. It is necessary to use SPCS more effectively.

Conflict of interests: The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding: The authors declared no fundings.

REFERENCES

1. Kabalak AA, Öztürk H, Çağil H. Yaşam Sonu Bakım Organizasyonu; Palyatif Bakım. Yoğun Bakım Dergisi. 2013; 11(2): 56-70. (in Turkish)
2. Schlick CJR, Bentrem DJ. Timing of Palliative Care: When to Call for a Palliative Care Consult . J Surg Oncol. 2019; 120 (1): 30-4. (PMID: 31102469).
3. Şenel G. Palyatif Bakım Kavramı ve Palyatif Bakıma Kabul Kriterleri. Turkiye Klinikleri J Anest Reanim-Special Topics 2017;10(1):1-6. (in Turkish)
4. Göktepe ME, Öztürk O, Ünal M. Palliative care approach to oncological patient- main points. Arch Cancer Sci Ther. 2020; 4: 015–6. (DOI: 10.29328/journal.acst.1001015).
5. Kahraman N, Yağlıoğlu LM, Doğru Balakbabalar AP, Öztürk O. Unusual palliative medicine intervention: smoking cessation. BMJ Support Palliat Care. 2020; bmjspcare-2020-002804. (PMID: 33268474).
6. Rotar Pavlič D, Aarendonk D, Wens J, Simões JAR, Lynch M, Murray S. Palliative care in primary care: European Forum for Primary Care position paper. Prim Health Care Res Dev. 2019; 20(e133): 1–6. (PMID: 31530333).
7. Tümerdem Y. Gerçek yaş. Turkish Journal of Geriatrics 2006; 9(3): 195-6. (in Turkish)
8. Vanbutsele G, Deliens L, Cocquyt V, Cohen J, Pardon K, Chambaere K. Use and timing of referral to specialized palliative care services for people with cancer: A mortality follow-back study among treating physicians in Belgium. PLoS One. 2019; 14(1): e0210056. (PMID: 30653508).
9. Burge F, Johnston G, Lawson B, Dewar R, Cummings I. Population-based trends in referral of the elderly to a comprehensive palliative care programme. Palliat Med. 2002; 255–7. (PMID: 12047004).
10. Hunt RW, Fazekas B, Luke C, Priest KR, Roder DM. The coverage of cancer patients by designated palliative services: a population-based study. Palliat Med. 2002; 403-10. (PMID: 12380658).
11. Sasahara T, Watakabe A, Aruga E, et al. Assessment of reasons for referral and activities of hospital palliative care teams using a standard format: a multicenter 1000 case description. J Pain Symptom Manage. 2014; 47(3): 579-87.e6. (PMID: 23972575).
12. Sasahara T, Miyashita M, Umeda M, et al. Multiple evaluation of a hospital-based palliative care consultation team in a university hospital: activities, patient outcome, and referring staff's view. Palliat Support Care. 2010; 8(1): 49-57. (PMID: 20163760).
13. Morita T, Fujimoto K, Tei Y. Palliative care team: the first year audit in Japan. J Pain Symptom Manage. 2005; 29(5): 458-65. PMID: (15904748).
14. Benli AR, Sunay D. A Model of Collaboration Between Palliative Care Unit and Home Health Care Services: Karabük. Ankara Med J. 2017; 17(3): 143-50. (DOI: 10.17098/amj.339333).
15. Richmond C. Dame Cicely Saunders: BMJ. 2005; 331(7510): 238.
16. McDarby M, Carpenter BD. Barriers and facilitators to effective inpatient palliative care consultations: a qualitative analysis of interviews with palliative care and non-palliative care providers. Am J Hosp Palliat Care. 2019; 36(3): 191-9. (PMID: 30103619).
17. Parker SM, Remington R, Nannini A, Cifuentes M. Patient outcomes and satisfaction with care following palliative care consultation. J Hosp Pall Med. 2013; 15(4): 225-32. (DOI: 10.1097/NJH.0b013e318279f4ce).
18. Scibetta C, Kerr K, Mcguire J, Rabow MW. The costs of waiting: implications of the timing of palliative care consultation among a cohort of decedents at a comprehensive cancer center. J Palliat Med. 2016; 19(1): 69-75. (PMID: 26618636).
19. Wentlandt K, Krzyzanowska MK, Swami N, Rodin GM, Le LW, Zimmermann C. Referral practices of oncologists to specialized palliative care. J Clin Oncol. 2012; 30(35): 4380-6. (PMID: 23109708).
20. van der Stap L, de Nijs EJM, Oomes M, et al. The self-perceived palliative care barriers and educational needs of clinicians working in hospital prima-

ry care teams and referral patterns: lessons learned from a single-center survey and cohort study. Ann Palliat Med. 2021; 10(3): 2620-37. (PMID: 33474950).

21. Brumley R, Enguidanos S, Jamison P, et al. Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. J Am Geriatr Soc. 2007; 55(7): 993-1000. (PMID: 17608870).
22. NCPPC Eligibility Criteria SPCS V2.0 June 2016. Available from: https://www.hse.ie/eng/about/who/cspd/ncps/palliative-care/resources/referring/ Accessed: February 05, 2021.
23. Midland Palliative Care Workgroup. Referral Criteria for Adult Palliative Care Services in Midland Region. Available from: https://baynav.bopdhb.govt.nz/media/1302/referral-criteria_specialist-palliative-care_midlands_final_sept_2014_-2.pdf Accessed: February 05, 2021
24. Pini S, Hackett J, Taylor S, et al. Patient and professional experiences of palliative care referral discussions from cancer services: A qualitative interview study. Eur J Cancer Care (Engl). 2021; 30(1): e13340. (PMID: 33051957).