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New and Updated Cochrane Systematic Reviews

New Reviews – May 2015

Palliative interventions for controlling vaginal bleeding in advanced cervical cancer

New Reviews – April 2015

Corticosteroids for the management of cancer-related pain in adults

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A selection of End of Life Care related topics:

Ethical considerations in effective pain management at the end of life

Overview of managing common non-pain symptoms in palliative care

Overview of comprehensive patient assessment in palliative care

Palliative care: The last hours and days of life

Palliative sedation
Journal Articles

Please click on the blue link at the end of the abstract (where available) to access the full text. You may need an OpenAthens username and password. To register for an OpenAthens account click here.

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Table of Contents

1. A communication training perspective on AND versus DNR directives.

2. A palliative environment: Caring for seriously ill hospitalized patients.

3. A patient’s last wish at end-of-life

4. A Scalable Web-Based Module for Improving Surgical and Medical Practitioner Knowledge and Attitudes about Palliative and End-of-Life Care.

5. A Survey of Bereaved Family Members To Assess Quality of Care on a Palliative Care Unit.

6. Acceptance and valued living as critical appraisal and coping strengths for caregivers dealing with terminal illness and bereavement.

7. Admissions of critically ill patients to the ED intensive care unit.

8. Advance care directives in residential aged care.


10. Benefits of Early Versus Delayed Palliative Care to Informal Family Caregivers of Patients With Advanced Cancer: Outcomes From the ENABLE III Randomized Controlled Trial.

11. Care of the human spirit and the role of dignity therapy: A systematic review of dignity therapy research Palliative Care, Spiritual Care and Chaplaincy: The current landscape Joshua Hauser

12. Description of a teaching method for research education for palliative care healthcare professionals.


14. Early Versus Delayed Initiation of Concurrent Palliative Oncology Care: Patient Outcomes in the ENABLE III Randomized Controlled Trial.


16. Effectiveness of multidisciplinary team conference on decision-making surrounding the application of continuous deep sedation for terminally ill cancer patients.

17. Effects of rehabilitation among patients with advances cancer: a systematic review.

19. Findings on Advance Care Plans among Cognitively Impaired Older Adults.


21. "It's Not that Easy"—Medical Students’ Fears and Barriers in End-of-Life Communication.

22. Lack of Documentation of Evidence-Based Prognostication in Cancer Patients by Inpatient Palliative Care Consultants.

23. Mindfulness-Based Supportive Therapy (MBST): Proposing a Palliative Psychotherapy From a Conceptual Perspective to Address Suffering in Palliative Care


25. Objective palliative prognostic score among patients with advanced cancer

26. Palliative Care Case Managers in Primary Care: A Descriptive Study of Referrals in Relation to Treatment Aims.

27. Palliative care health professionals’ experiences of caring for patients with advance care directives.

28. Patients’ preferences in palliative care: A systematic mixed studies review


30. Risk Factors Associated With Unplanned Hospital Readmissions in Adults With Cancer

31. The brain and breathlessness: Understanding and disseminating a palliative care approach.

32. The challenge to health professionals when carers resist truth telling at the end of life: a qualitative secondary analysis.

33. The communication experiences of patients with palliative care needs: A systematic review and meta-synthesis of qualitative findings.

34. The dignified approach to care: A pilot study using the patient dignity question as an intervention to enhance dignity and person-centred care for people with palliative care needs in the acute hospital setting Psychosocial

35. Tough conversations: Training medical students to lead family meetings

36. Verbalized desire for death or euthanasia in advanced cancer patients receiving palliative care.

1. **A communication training perspective on AND versus DNR directives.**

**Citation:** Palliative & Supportive Care, 01 April 2015, vol./is. 13/2(385-387), 14789515

**Author(s):** Levin, Tomer T, Coyle, Nessa

**Language:** English

**Abstract:** BACKGROUND: From a communication perspective, the term "do not resuscitate" (DNR) is
challenging to use in end-of-life discussions because it omits the goals of care. An alternative, "Allow Natural Death" (AND), has been proposed as a better way of framing this palliative care discussion. CASE: We present a case where a nurse unsuccessfully discusses end-of-life goals of care using the term DNR. Subsequently, with the aid of a communication trainer, he is coached to successfully use the term "AND" to facilitate this discussion and advance his goal of palliative care communication and planning. DISCUSSION: We contrast the advantages and disadvantages of the term AND from the communication training perspective and suggest that AND-framing language replace DNR as a better way to facilitate meaningful end-of-life communication. One well-designed, randomized, controlled simulation study supports this practice. We also consider the communication implications of "natural" versus "unnatural" death.

**Publication type:** journal article  
**Source:** CINAHL

2. A palliative environment: Caring for seriously ill hospitalized patients.  
**Citation:** Palliative & Supportive Care, 01 April 2015, vol./is. 13/2(201-209), 14789515  
**Author(s):** Timmermann, Connie, Uhrenfeldt, Lisbeth, Høybye, Mette Terp, Birkelund, Regner  
**Language:** English  
**Abstract:** OBJECTIVE: To explore how patients experience being in the hospital environment and the meaning they assign to the environment during serious illness. METHOD: A qualitative study design was applied, and the data analysis was inspired by Ricoeur's phenomenological-hermeneutic theory of interpretation. Data were collected through multiple qualitative interviews combined with observations at a teaching hospital in Denmark from May to September 2011. A total of 12 patients participated. RESULTS: The findings showed that the hospital environment has a strong impact on patients' emotions and well-being. They reported that aesthetic decorations and small cozy spots for conversation or relaxation created a sense of homeliness that reinforced a positive mood and personal strength. Furthermore, being surrounded by some of their personal items or undertaking familiar tasks, patients were able to maintain a better sense of self. Maintaining at least some kind of familiar daily rhythm was important for their sense of well-being and positive emotions. SIGNIFICANCE OF RESULTS: The results stress the importance of an aesthetically pleasing and homelike hospital environment as part of palliative care, since the aesthetic practice and a sense of homeliness strengthened patients' experiences of well-being, relief, and positive emotions while in a vulnerable situation. Such knowledge could encourage the development of new policies regarding appropriate care settings, which in turn could result in overall improved care during serious illness.  
**Publication type:** journal article  
**Source:** CINAHL

3. A patient's last wish at end-of-life  
**Citation:** Journal of the American Geriatrics Society, April 2015, vol./is. 63/(S239), 0002-8614 (April 2015)  
**Author(s):** Cimmino K., Pisano M.  
**Language:** English  
**Abstract:** Background: Patients who have transitioned to end-of-life (EOL) care are at an increased risk for polypharmacy as they face new symptoms requiring the initiation of palliative care medications. Routine continuation of maintenance medications may represent a major obstacle for family members and caregivers and impact the patient's quality of life. Case: MGD was a 96 year, 6 foot 2 inch, 125-pound male patient who was brought into the outpatient geriatric faculty practice by his devoted daughter, with whom he had been living all his life. The patient had no pain, but severe dysphagia. Both daughter and patient were fully aware that death was imminent, as the patient had lost 60 pounds in the past three to four months, due to a gastrointestinal cancer. The daughter asked if she could stop any of his medications, which she had been dutifully struggling to provide her bed-bound, anorectic father; at that point, the geriatrician called for a pharmacy consult, specifically to address the issue of unnecessary medications. The patient was taking ASA 81mg qd, finasteride 5mg qd, furosemide 20mg qd,
levothyroxine 25mcg qd, simvastatin 40mg qd, and terazosin 2mg qd. The pharmacist recommended discontinuing all maintenance medications except for levothyroxine, to the great relief of the daughter.

Discussion: According to the National Hospice and Palliative Care Organization, an estimated 1.5 to 1.6 million patients received hospice care, and two-third of these patients die at home. There is little evidence or guidance in reducing or discontinuing medications for chronic illnesses during EOL care. Indeed, evidence shows that family and caregivers feel inadequately prepared to manage medication administration. While it is understandable that the number of symptom relief medications will increase, patient comfort can be helped by reducing maintenance medications that have little to no short-term benefit.

Conclusion: As EOL approaches, patient’s last wishes must be respected, including timely changes to their medication regimen. Pharmacists are an essential asset to the geriatric inter-disciplinary team as they can provide extensive medication counseling and reassurance to the patient, family, and caregiver, that discontinuing most maintenance medications will not hasten death.

Publication type: Journal: Conference Abstract
Source: EMBASE

4. A Scalable Web-Based Module for Improving Surgical and Medical Practitioner Knowledge and Attitudes about Palliative and End-of-Life Care.

Citation: Journal of Palliative Medicine, 01 May 2015, vol./is. 18/5(415-420), 10966218
Author(s): Bergman, Jonathan, Lorenz, Karl A., Ballon-Landa, Eric, Kwan, Lorna, Lerman, Steven E., Saigal, Christopher S., Bennett, Carol J., Litwin, Mark S.
Language: English

Abstract: Background: We built a web-based, interactive, self-directed learning module about end-of-life care. Objective: The study objective was to develop an online module about end-of-life care targeted at surgeons, and to assess the effect of the module on attitudes towards and knowledge about end-of-life care. Methods: Informed by a panel of experts in supportive care and educational assessment, we developed an instrument that required approximately 15 minutes to complete. The module targets surgeons, but is applicable to other practitioners as well. We recruited general surgeons, surgical subspecialists, and medical practitioners and subspecialists from UCLA and the GLA-VA (N=114). We compared pre- and post-intervention scores for attitude and knowledge, then used ANOVA to compare the pre- and postmodule means for each level of the covariate. We performed bivariable analyses to assess the association of subject characteristic and change in score over time. We ran separate analyses to assess baseline and change scores based on the covariates we had selected a priori. Results: Subjects improved meaningfully in all five domains of attitude and in each of the six knowledge items. Individuals younger than 30 years of age had the greatest change in attitudes about addressing pain, addressing end-of-life goals, and being actively involved as death approached; they also had the most marked improvement in total knowledge score. Having a family member die of cancer within the last five years or a personal experience with palliative care or hospice were associated with higher change scores. Conclusions: A web-based education module improved surgical and medical provider attitudes and knowledge about end-of-life care.

Publication type: journal article
Source: CINAHL

5. A Survey of Bereaved Family Members To Assess Quality of Care on a Palliative Care Unit.

Citation: Journal of Palliative Medicine, 01 April 2015, vol./is. 18/4(358-365), 10966218
Author(s): Roza, Katherine A., Lee, Eric J., Meier, Diane E., Goldstein, Nathan E.
Language: English

Abstract: Background: More U.S. hospitals are adopting palliative care programs, prompting inquiry about the relationship of palliative care to patient and family satisfaction. This study compares the impact of palliative care units, palliative care consultation, and usual care on bereaved families' perceptions of care quality. Methods: Using the Bereaved Family Survey we conducted interviews with family members of patients who died at Mount Sinai Medical Center between March 2012 and March
2013. Results: Of 108 completed surveys, 31 were in the palliative care unit group, 28 in the consultation service group, and 49 in the usual care group. Family members of patients who died on the palliative care unit were more likely to report that their loved one's end-of-life medical care had been 'excellent' compared to family members of patients who received palliative care consultation or usual care (adjusted OR, 2.06; 95% CI, 1.17-3.61). Family members of palliative care unit patients also reported greater satisfaction with emotional support before the patient's death (adjusted OR, 1.71; 95% CI, 1.01-2.90). We found no significant differences between the consultation service and usual care. Conclusion: Family members of patients who died while receiving care in a dedicated palliative care unit report higher overall satisfaction and emotional support before death as compared to the consultation service or usual care.

Publication type: journal article
Source: CINAHL

6. Acceptance and valued living as critical appraisal and coping strengths for caregivers dealing with terminal illness and bereavement.

Citation: Palliative & Supportive Care, 01 April 2015, vol./is. 13/2(359-368), 14789515
Author(s): Davis, Esther L, Deane, Frank P, Lyons, Geoffrey C B
Language: English
Abstract: OBJECTIVE: Informal caregivers of palliative care patients play an essential role in the coordination of care for patients during their final phases of life. However, undertaking a caregiving role can have enduring psychological consequences for caregivers and interfere with functioning. Studies have investigated a variety of factors associated with individual differences in caregiver psychosocial outcomes, but little is known about their relative impact, and there is a need for guiding models to support research in this area. METHOD: A review of the literature was conducted on factors influencing the psychological distress and grief of caregivers. Drawing from acceptance and commitment therapy (ACT) and Stroebe and colleagues' integrative risk factor framework, we developed a process model to describe individual differences in caregiver psychological distress and grief. RESULTS: The model presents caregiver psychological distress and grief as functions of death attitudes and communication about death and dying, mediated by acceptance and valued living from an ACT perspective. An outline of the empirical and theoretical underpinnings for each component in the model is provided. Significant of results: The presented model is an inherently strengths-based model that is concordant with acceptance- and values- (ACT) based interventions to facilitate coping in caregivers.

Publication type: journal article
Source: CINAHL

7. Admissions of critically ill patients to the ED intensive care unit.

Citation: American Journal of Emergency Medicine, 01 April 2015, vol./is. 33/4(501-505), 07356757
Author(s): Aslaner, Mehmet Ali, Akkas, Meltem, Eroglu, Sercan, Aksu, Nalan M, Özmen, Mehmet Mahir
Language: English
Abstract: INTRODUCTION: Many emergency departments (EDs) have established units capable of providing critical care because of increasing need for critical care, called as ED intensive care unit (EDICU). However, prolonged critical care leads to crowding, resulting in poor quality of care and high mortality rates. We aimed to determine which type of critically ill patients play a main role for crowding in the EDICU, and how to manage these patients. METHOD: Patients aged older than 18 years who presented to the ED and presented for consultation to the ICU were eligible for inclusion in this study. Patients were classified into 4 priority groups by the Society of Critical Care Medicine. RESULT: Four hundred medical patients were enrolled in the study. Sixty-one patients were not admitted to hospital (15.2% of all patients) and were treated in the EDICU. These patients were older (mean age, 66.6 years) and had a higher percentage belonging to the priority 3 group (82.0%-unstable with reduced likelihood of recovery due to chronic illness) in comparison with other ICUs patients (mean age, 60.4 years and 11.9%, respectively) (P < .05). In priority 3 patients, the length of stay was median 120 hours, and also, length of
invasive mechanical ventilations duration was median 19 hours in the EDICU. CONCLUSIONS: Emergency department intensive care unit occupancy appears driven by categorized as "reduced benefit" patients, and these units tend to become alternative dumping grounds for palliative care services. Hospitals and health care administrators should take special care to develop policies for improving the management of these patients.

Publication type: journal article
Source: CINAHL

8. Advance care directives in residential aged care.
Citation: Australian Family Physician, 01 April 2015, vol./is. 44/4(186-190), 03008495
Author(s): Leditshke, I Anne, Crispin, Therese, Bestic, Jill
Language: English
Abstract: BACKGROUND: Although most people have clear preferences with regard to end-of-life care, there is a disconnect between these preferences and what happens in practice. Advance care directives (ACDs) are a way of allowing people to plan ahead for any future loss in decision-making capacity, by allowing a systematic approach to decision making that respects the person's previously ex-pressed wishes. OBJECTIVE: This article reviews ACDs, considering, in particular, aspects of their use for patients in residential aged care. DISCUSSION: All people should be offered the opportunity to make an ACD as part of their routine care prior to any need for residential care. Once there is a need for residential care, advance care directives become even more important. Systems to ensure routine re-view of advance care directives and appropriate transfer of information between healthcare providers should be implemented by clinicians and residential aged care facilities.
Publication type: journal article
Source: CINAHL
Full text: Available ProQuest at Australian Family Physician

Citation: Nurse Prescribing, 01 April 2015, vol./is. 13/4(186-190), 14799189
Author(s): Hickson, Deirdre
Language: English
Abstract: Nausea and vomiting in specialist palliative care are common distressing and debilitating symptoms (Hamling, 2011). Prevalence in patients with advanced cancer is up to 70% and up to 50% in patients with non-malignant advanced disease, such as heart failure, chronic obstructive pulmonary disease and renal failure (Twycross and Back, 1998). Nausea and vomiting increase in prevalence as disease progresses (Keeley, 2009; Harris, 2010) and become more common as death approaches. The symptoms present as a result of many factors, which are most easily categorized as disease- or treatment-related. Pharmacological treatment of these distressing symptoms can produce undesirable extrapyramidal effects that mimic symptoms such as Parkinson's disease, depression and anxiety. Failing to recognize the causative agent of such symptoms could prolong a patient's suffering. Therefore, it is important that the nurse prescriber is aware of these side-effects when prescribing antiemetic drugs.
Publication type: journal article
Source: CINAHL
Full text: Available Nurse Prescribing at Nurse Prescribing

10. Benefits of Early Versus Delayed Palliative Care to Informal Family Caregivers of Patients With Advanced Cancer: Outcomes From the ENABLE III Randomized Controlled Trial.
Citation: Journal of Clinical Oncology, 01 May 2015, vol./is. 33/13(1446-1452), 0732183X
Author(s): Dionne-Odom, J Nicholas, Azuero, Andres, Lyons, Kathleen D, Hull, Jay G, Tosteson, Tor, Li, Zhigang, Li, Zhongze, Frost, Jennifer, Dragnev, Konstantin H, Akyar, Imatullah, Hegel, Mark T, Bakitas, Marie A
Language: English
Abstract: PURPOSE: To determine the effect of early versus delayed initiation of a palliative care intervention for family caregivers (CGs) of patients with advanced cancer. PATIENTS AND METHODS: Between October 2010 and March 2013, CGs of patients with advanced cancer were randomly assigned to receive three structured weekly telephone coaching sessions, monthly follow-up, and a bereavement call either early after enrollment or 3 months later. CGs of patients with advanced cancer were recruited from a National Cancer Institute cancer center, a Veterans Administration Medical Center, and two community outreach clinics. Outcomes were quality of life (QOL), depression, and burden (objective, stress, and demand). RESULTS: A total of 122 CGs (early, n = 61; delayed, n = 61) of 207 patients participated; average age was 60 years, and most were female (78.7%) and white (92.6%). Between-group differences in depression scores from enrollment to 3 months (before delayed group started intervention) favored the early group (mean difference, -3.4; SE, 1.5; d = -.32; P = .02). There were no differences in QOL (mean difference, -2; SE, 2.3; d = -.13; P = .39) or burden (objective: mean difference, 0.3; SE, .7; d = .09; P = .64; stress: mean difference, -.5; SE, .5; d = -.2; P = .29; demand: mean difference, 0; SE, .7; d = -.01; P = .97). In decedents' CGs, a terminal decline analysis indicated between-group differences favoring the early group for depression (mean difference, -3.8; SE, 1.5; d = -.39; P = .02) and stress burden (mean difference, -.11; SE, .4; d = -.44; P = .01) but not for QOL (mean difference, -4.9; SE, 2.6; d = -.3; P = .07), objective burden (mean difference, -.6; SE, .6; d = -.18; P = .27), or demand burden (mean difference, -.7; SE, .6; d = -.23; P = .22). CONCLUSION: Early-group CGs had lower depression scores at 3 months and lower depression and stress burden in the terminal decline analysis. Palliative care for CGs should be initiated as early as possible to maximize benefits.

Publication type: Journal: Review
Source: CINAHL
Full text: Available American Society of Clinical Oncology at Journal of Clinical Oncology

11. Care of the human spirit and the role of dignity therapy: A systematic review of dignity therapy research Palliative Care, Spiritual Care and Chaplaincy: The current landscape Joshua Hauser Citation: BMC Palliative Care, 2015, vol./is. 14/1, 1472-684X (2015)
Author(s): Fitchett G., Emanuel L., Handzo G., Boyken L., Wilkie D.J.
Language: English
Abstract: Background: Dignity Therapy (DT), an intervention for people facing serious illness, focuses on dignity conservation tasks such as settling relationships, sharing words of love, and preparing a legacy document for loved ones. Research on DT began more than a decade ago and has been conducted in 7 countries, but a systematic review of DT research has not been published. Methods: Using a PubMed search with key terms of 'dignity therapy', 'dignity psychotherapy', 'Chochinov', and 'dignity care', we found 29 articles on DT and retained 25 after full-text review. Results: Of these, 17 articles representing 12 quantitative studies establish that patients who receive DT report high satisfaction and benefits for themselves and their families, including increased sense of meaning and purpose. The effects of DT on physical or emotional symptoms, however, were inconsistent. Conclusions: Conclusions point to three areas for future research on DT, to determine: (1) whether the DT intervention exerts an impact at a spiritual level and/or as a life completion task; (2) how DT should be implemented in real world settings; and (3) if DT has an effect on the illness experience within the context of not only the patient, but also the family and community. Building on this body of DT research, investigators will need to continue to be sensitive as they involve participants in DT studies and innovations to facilitate the generation and delivery of legacy documents to participants near the end of life.
Publication type: Journal: Review
Source: EMBASE
Full text: Available National Library of Medicine at BMC Palliative Care

12. Description of a teaching method for research education for palliative care healthcare professionals.
OBJECTIVE: Despite the rapidly growing availability of palliative care services, there is still much to be done in order to better support clinicians who are starting research programs. Among the barriers identified in the literature, methodological issues and lack of research training programs are often reported. Our aim was to describe an educational research method for healthcare professionals working in palliative care and to report the result of a survey conducted among a three-year sample of students.

METHOD: The course was provided for a multidisciplinary group and was open to all healthcare professionals involved in palliative care. It took place over a single session during a full day. We used a 20-question e-survey to assess student outcomes (e.g., satisfaction, current status of their project).

RESULTS: We received answers from 83 of the 119 students (70%) who took the course. The majority were physicians (n = 62, 75%), followed by nurses (n = 17, 21%). During the class, students assessed the role of the teacher as an information provider (n = 51, 61%), role model (n = 36, 43%), and facilitator (n = 33, 40%), and considered all of these roles as suitable, with a score of 3.9-4.7 out of 5. Participants reported a high level of support from the teacher, with a mean score of 8.2 (SD, 1.7) out of 10, and good overall satisfaction with a mean score of 7.6 (1.8). Finally, 51 participants (77%) were able to start their research project after the class, 27 (41%) to complete it, and 8 (12%) to submit their research to a journal or conference.

SIGNIFICANCE OF RESULTS: Our results suggest that newer teaching methods such as roleplay, group work, and target acquisition are feasible and effective in a palliative research curriculum. Additional studies are needed to confirm the objective outputs of educational interventions, including research outputs.

Publication type: journal article
Source: CINAHL
Dionne-Odom, J Nicholas, Frost, Jennifer, Dragnev, Konstantin H, Hegel, Mark T, Azuero, Andres, Ahles, Tim A

Language: English

Abstract: PURPOSE: Randomized controlled trials have supported integrated oncology and palliative care (PC); however, optimal timing has not been evaluated. We investigated the effect of early versus delayed PC on quality of life (QOL), symptom impact, mood, 1-year survival, and resource use. PATIENTS AND METHODS: Between October 2010 and March 2013, 207 patients with advanced cancer at a National Cancer Institute cancer center, a Veterans Affairs Medical Center, and community outreach clinics were randomly assigned to receive an in-person PC consultation, structured PC telehealth nurse coaching sessions (once per week for six sessions), and monthly follow-up either early after enrollment or 3 months later. Outcomes were QOL, symptom impact, mood, 1-year survival, and resource use (hospital/-intensive care unit days, emergency room visits, chemotherapy in last 14 days, and death location). RESULTS: Overall patient-reported outcomes were not statistically significant after enrollment (QOL, P = .34; symptom impact, P = .09; mood, P = .33) or before death (QOL, P = .73; symptom impact, P = .30; mood, P = .82). Kaplan-Meier 1-year survival rates were 63% in the early group and 48% in the delayed group (difference, 15%; P = .038). Relative rates of early to delayed decedents' resource use were similar for hospital days (0.73; 95% CI, 0.41 to 1.27; P = .26), intensive care unit days (0.68; 95% CI, 0.23 to 2.02; P = .49), emergency room visits (0.73; 95% CI, 0.45 to 1.19; P = .21), chemotherapy in last 14 days (1.57; 95% CI, 0.37 to 6.7; P = .27), and home death (27 [54%] v 28 [47%]; P = .60). CONCLUSION: Early-entry participants’ patient-reported outcomes and resource use were not statistically different; however, their survival 1-year after enrollment was improved compared with those who began 3 months later. Understanding the complex mechanisms whereby PC may improve survival remains an important research priority.

Publication type: journal article
Source: CINAHL
Full text: Available American Society of Clinical Oncology at Journal of Clinical Oncology


Citation: Palliative & Supportive Care, 01 April 2015, vol./is. 13/2(285-293), 14789515

Author(s): Sakaguchi, Satoko, Okamura, Hitoshi

Language: English

Abstract: OBJECTIVE: Much of the cancer rehabilitation research that has been conducted has consisted of relatively early recovery-of-function rehabilitation, and little attention has been paid to the psychosocial aspects of palliative rehabilitation. The aim of the present preliminary study was to examine the "narratives" of elderly cancer patients that emerged as a result of a life review performed in association with collage activity and to assess the effectiveness of this intervention. METHOD: We conducted a collage activity based on a life review in two sessions. Some 11 cancer patients who were 65 years of age or older and receiving palliative care participated. Evaluations using the Functional Assessment of Chronic Illness Therapy-Spiritual (FACIT-Sp) Scale, the Hospital Anxiety and Depression Scale (HADS), and the Self-Efficacy Scale for Terminal Cancer (SESTC) were administered before and immediately after the intervention. RESULTS: The mean scores for the FACIT-Sp and affect regulation efficacy on the SESTC significantly increased, while the mean HADS score significantly decreased. Regarding the impressions after completion of the intervention, generally favorable evaluations were heard from families and medical staff members as well as from the subjects. SIGNIFICANCE OF RESULTS: A collage activity based on a life review may be effective for improving spiritual well-being, mitigating anxiety and depression, and improving self-efficacy. The collage itself was also useful in facilitating interactions with others, including family members, and the activity provided psychological support for families.

Publication type: journal article
16. Effectiveness of multidisciplinary team conference on decision-making surrounding the application of continuous deep sedation for terminally ill cancer patients.

Citation: Palliative & Supportive Care, 01 April 2015, vol./is. 13/2(157-164), 14789515
Author(s): Koike, Kazuhiko, Terui, Takeshi, Takahashi, Yujii, Hirayama, Yasuo, Mizukami, Naomi, Yamakage, Michiaki, Kato, Junji, Ishitani, Kunihiko
Language: English
Abstract: OBJECTIVE: Continuous deep sedation (CDS) is a way to reduce conscious experience of symptoms of severe suffering in terminally ill cancer patients. However, there is wide variation in the frequency of its reported. So we conducted a retrospective analysis to assess the prevalence and features of CDS in our palliative care unit (PCU). METHODS: We performed a systemic retrospective analysis of the medical and nursing records of all 1581 cancer patients who died at the PCU at Higashi Sapporo Hospital between April 2005 and August 2011. Continuous deep sedation can only be administered safely and appropriately when a multidisciplinary team is involved in the decision-making process. Prior to administration of CDS, a multidisciplinary team conference (MDTC) was held with respect to all the patients considered for CDS by an attending physician. The main outcome measures were the frequency and characteristics of CDS (patient background, all target symptoms, medications used for sedation, duration, family's satisfaction, and distress). We mailed anonymous questionnaires to bereaved families in August 2011. RESULTS: Of 1581 deceased patients, 22 (1.39%) had received CDS. Physical exhaustion 8 (36.4%), dyspnea 7 (31.8%), and pain 5 (22.7%) were the most frequently mentioned indications. Continuous deep sedation had a duration of less than 1 week in 17 (77.3%). Six patients (0.38%) did not meet the appropriate criteria for CDS according to the MDTC and so did not receive it. Although bereaved families were generally comfortable with the practice of CDS, some expressed a high level of emotional distress. SIGNIFICANCE OF RESULTS: Our results indicate that the prevalence of CDS will be decreased when it is carried out solely for appropriate indications. Continuity of teamwork, good coordination, exchange of information, and communication between the various care providers are essential. A lack of any of these may lead to inadequate assessment, information discrepancies, and unrest.
Publication type: journal article
Source: CINAHL

17. Effects of rehabilitation among patients with advanced cancer: a systematic review.

Citation: Acta Oncologica, 01 May 2015, vol./is. 54/5(618-628), 0284186X
Author(s): Salakari, Minna R. J., Surakka, Tiina, Nurminen, Raija, Pylkkänen, Liisa
Language: English
Abstract: Background. In parallel with the rising incidence of cancer and improved treatment, there is a continuous increase in the number of patients living with cancer as a chronic condition. Many cancer patients experience long-term disability and require continuous oncological treatment, care and support. The aim of this review is to evaluate the most recent data on the effects of rehabilitation among patients with advanced cancer. Material and methods. A systematic review was conducted according to Fink's model. Only randomized controlled trials (RCTs) published in 2009-2014 were included. Medline/PubMed and Cochrane databases were searched; five groups of keywords were used. The articles were evaluated for outcome and methodological quality. Results. Thirteen RCTs (1169 participants) were evaluated. Most studies were on the effects of physical exercise in patients with advanced cancer (N = 7). Physical exercise was associated with a significant improvement in general wellbeing and quality of life. Rehabilitation had positive effects on fatigue, general condition, mood, and coping with cancer. Conclusions. Rehabilitation is needed also among patients with advanced disease and in palliative care. Exercise improves physical performance and has positive effects on several other quality of life domains. More data and RCTs are needed, but current evidence gives an indication that rehabilitation is suitable and can be recommended for patients living with advanced cancer.
Source: CINAHL

**Citation:** Critical Care Medicine, 01 May 2015, vol./is. 43/5(1102-1111), 00903493

**Author(s):** Khandelwal, Nita, Kross, Erin K, Engelberg, Ruth A, Coe, Norma B, Long, Ann C, Curtis, J Randall

**Language:** English

**Abstract:** OBJECTIVE: We conducted a systematic review to answer three questions: 1) Do advance care planning and palliative care interventions lead to a reduction in ICU admissions for adult patients with life-limiting illnesses? 2) Do these interventions reduce ICU length of stay? and 3) Is it possible to provide estimates of the magnitude of these effects? DATA SOURCES: We searched MEDLINE, EMBASE, Cochrane Controlled Clinical Trials, and Cumulative Index to Nursing and Allied Health Literature databases from 1995 through March 2014. STUDY SELECTION: We included studies that reported controlled trials (randomized and nonrandomized) assessing the impact of advance care planning and both primary and specialty palliative care interventions on ICU admissions and ICU length of stay for critically ill adult patients. DATA EXTRACTION: Nine randomized controlled trials and 13 nonrandomized controlled trials were selected from 216 references. DATA SYNTHESIS: Nineteen of these studies were used to provide estimates of the magnitude of effect of palliative care interventions and advance care planning on ICU admission and length of stay. Three studies reporting on ICU admissions suggest that advance care planning interventions reduce the relative risk of ICU admission for patients at high risk of death by 37% (SD, 23%). For trials evaluating palliative care interventions in the ICU setting, we found a 26% (SD, 23%) relative risk reduction in length of stay with these interventions. CONCLUSIONS: Despite wide variation in study type and quality, patients who received advance care planning or palliative care interventions consistently showed a pattern toward decreased ICU admissions and reduced ICU length of stay. Although SDs are wide and study quality varied, the magnitude of the effect is possible to estimate and provides a basis for modeling impact on healthcare costs.

**Publication type:** journal article

**Source:** CINAHL

**Full text:** Available Critical care medicine at Critical Care Medicine

19. Findings on Advance Care Plans among Cognitively Impaired Older Adults.

**Citation:** Canadian Journal on Aging, 01 June 2015, vol./is. 34/2(165-175), 07149808

**Author(s):** Jeznach, Anna, Tuokko, Holly Anna, Garcia-Barrera, Mauricio A., Stajduhar, Kelli

**Language:** English

**Abstract:** Cognitively impaired and cognitively intact older adults seemingly differ regarding engagement in aspects of advance care plans (ACPs). Through informant reports in the Canadian Study on Health and Aging, we examined differences between deceased cognitively impaired and intact older adults in components of ACPs: (1) discussions/arrangements for end-of-life care; (2) creation of legal documents; and in ACP outcomes, (3) location of death; and (4) dying in accordance with wishes. Cognitively impaired older adults were more likely to have made arrangements for a substitute decision-maker (OR = 1.90) and to have created legal documents (OR = 2.64 for health care preferences, OR = 2.00 for naming a decision-maker). They were less likely to have discussed preferences for end-of-life care (OR = 0.62). These findings suggest that ACPs differ for cognitively impaired persons, indicating a need for further investigation. This is a step towards understanding this complex process in a particularly vulnerable population.

**Publication type:** journal article

**Source:** CINAHL

**Full text:** Available Critical care medicine at Critical Care Medicine

Abstract: Background: Intravenous lidocaine infusion has been clearly demonstrated as effective for pain in randomized controlled trials, but the belief that cardiac monitoring is required for safe administration is a barrier to access in the palliative care setting. There are also multiple infusion protocols reported in the literature. We have been administering lidocaine infusions for severe cancer pain at the BC Cancer Agency (BCCA) since 2003, without electrocardiographic (ECG) monitoring. Our simple protocol is for 5 mg/kg to be infused over 1 hour, with the option for subsequent doses to be increased if necessary, up to a maximum of 10 mg/kg. Our aim with this study is to share 11 years of our experience with this protocol.

Methods: This is a retrospective case series. Records of patients who received at least one lidocaine infusion for pain between 2003 and 2013 at the BCCA were reviewed. The primary end points were the documentation of clinical benefit and adverse effects.

Results: A total of 122 lidocaine infusions were administered in 51 individual patients. Twenty-five (49%) had a major response, 12 (23.5%) had a minor response, and 14 (27.5%) were considered nonresponders. Twenty-two (43.1%) patients were noted to have some adverse effect during at least one of the infusions, but only 1 (1.9%) patient had the infusion permanently discontinued. The most common side effects were drowsiness (30.7%), perioral numbness (13.4%), nausea (5.7%), and minor fluctuations of blood pressure (3.8%).

Conclusions: This case series demonstrates that our protocol of infusional lidocaine can be beneficial to patients with cancer with severe opioid-refractory pain, and can safely be administered with close observation and vital sign monitoring, without ECG monitoring. Lidocaine infusion is a useful option to consider when other pain treatments have not been successful. Although only approximately half of patients will respond well, there is little harm to be expected from a trial of lidocaine infusion and responders can be repeatedly treated. This treatment could be delivered in palliative care units, hospices, or even patients' homes, providing suitable nursing supervision can be provided.
22. Lack of Documentation of Evidence-Based Prognostication in Cancer Patients by Inpatient Palliative Care Consultants.

**Citation:** Journal of Palliative Medicine, 01 April 2015, vol./is. 18/4(382-385), 10966218

**Author(s):** Bruggeman, Andrew R., Heavey, Sean F., Ma, Joseph D., Revta, Carolyn, Roeland, Eric J.

**Language:** English

**Abstract:** Background: Prognostication plays a key role in palliative care (PC). It is critical for advance care planning, determining hospice eligibility, and communication. In contrast to subjective clinical prognostication, evidence-based prognostication (EBP) uses existing validated data to quantify prognosis; however, the extent to which PC providers use EBP is limited. Objective: The objective was to analyze documentation of EBP by PC providers in the absence of an inpatient consultation note template at a single academic medical center. Methods: We retrospectively evaluated prognostic documentation of inpatient PC consultations on oncology patients at a single academic hospital. Ratings of Eastern Cooperative Oncology Group (ECOG) Scale, Karnofsky Performance Scale (KPS), Palliative Performance Scale, and/or activities of daily living (ADLs) were considered documentation of functional status. PC-specific documentation of EBP included the Palliative Prognostic Index and/or Palliative Prognostic Score. Results: There were 412 inpatient PC consultations for oncology patients (2012-2013). Reasons for consultation included goals of care (n=108), symptom management (n=181), or both (n=123). In the absence of a note template, functional status was documented in 6% (n=24) of consultation notes, while no consultation notes contained EBP documentation of the Palliative Prognostic Index and Palliative Prognostic Score. Conclusion: This retrospective analysis conducted at a single academic medical center suggests poor documentation by PC providers of EBP in the absence of a consultation note template. Research and educational opportunities exist to evaluate barriers to EBP utilization and documentation by PC providers.

**Publication type:** journal article

**Source:** CINAHL

23. Mindfulness-Based Supportive Therapy (MBST): Proposing a Palliative Psychotherapy From a Conceptual Perspective to Address Suffering in Palliative Care.

**Citation:** American Journal of Hospice & Palliative Medicine, 01 March 2015, vol./is. 32/2(144-160), 10499091

**Author(s):** Beng, Tan Seng, Chin, Loh Ee, Guan, Ng Chong, Yee, Anne, Wu, Cathie, Jane, Lim Ee, Meng, Christopher Boey Chiong

**Language:** English

**Publication type:** journal article

**Source:** CINAHL


**Citation:** International Journal of Nursing Studies, 01 April 2015, vol./is. 52/4(794-803), 00207489

**Author(s):** Gallagher, Ann, Bousso, Regina Szylit, McCarthy, Joan, Kohlen, Helen, Andrews, Tom, Paganini, Maria Cristina, Abu-El-Noor, Nasser Ibrahim, Cox, Anna, Haas, Margit, Arber, Anne, Abu-El-Noor, Mysoon Khalil, Baliza, Michelle Freire, Padilha, Katia Grillo

**Language:** English

**Abstract:** Background: Intensive care units (ICUs) focus on treatment for those who are critically ill and interventions to prolong life. Ethical issues arise when decisions have to be made regarding the withdrawal and withholding of life-sustaining treatment and the shift to comfort and palliative care. These issues are particularly challenging for nurses when there are varying degrees of uncertainty regarding prognosis. Little is known about nurses’ end-of-life (EoL) decision-making practice across cultures. Objectives: To understand nurses’ EoL decision-making practices in ICUs in different cultural
contexts. Design: We collected and analysed qualitative data using Grounded Theory. Settings: Interviews were conducted with experienced ICU nurses in university or hospital premises in five countries: Brazil, England, Germany, Ireland and Palestine. Participants: Semi-structured interviews were conducted with 51 nurses (10 in Brazil, 9 in England, 10 in Germany, 10 in Ireland and 12 nurses in Palestine). They were purposefully and theoretically selected to include nurses having a variety of characteristics and experiences concerning end-of-life (EoL) decision-making. Methods: The study used grounded theory to inform data collection and analysis. Interviews were facilitated by using key questions. The comparative analysis of the data within and across data generated by the different research teams enabled researchers to develop a deeper understanding of EoL decision-making practices in the ICU. Ethical approval was granted in each of the participating countries and voluntary informed consent obtained from each participant. Results: The core category that emerged was ‘negotiated reorienting’. Whilst nurses do not make the ‘ultimate’ EoL decisions, they engage in two core practices: consensus seeking (involving coaxing, information cuing and voice enabling); and emotional holding (creating time-space and comfort giving). Conclusions: There was consensus regarding the core concept and core practices employed by nurses in the ICUs in the five countries. However, there were some discernible differences regarding the power dynamics in nurse–doctor relationships, particularly in relation to the cultural perspectives on death and dying and in the development of palliative care. The research suggests the need for culturally sensitive ethics education and bereavement support in different cultural contexts.

Publication type: journal article
Source: CINAHL

25. Objective palliative prognostic score among patients with advanced cancer.
Citation: Journal of Pain & Symptom Management, 01 April 2015, vol./is. 49/4(690-696), 08853924
Author(s): Chen, Yen-Ting, Ho, Chih-Te, Hsu, Hua-Shai, Huang, Po-Tsung, Lin, Chin-Yu, Liu, Chiu-Shong, Li, Tsai-Chung, Lin, Cheng-Chieh, Lin, Wen-Yuan
Language: English
Abstract: CONTEXT: The accurate prediction of survival is one of the key factors in the decision-making process for patients with advanced illnesses. OBJECTIVES: This study aimed to develop a short-term prognostic prediction method that included such objective factors as medical history, vital signs, and blood tests for use with patients with advanced cancer. METHODS: Medical records gathered at the admission of patients with advanced cancer to the hospice palliative care unit at a tertiary hospital in Taiwan were reviewed retrospectively. The records included demographics, history of cancer treatments, performance status, vital signs, and biological parameters, Multivariate logistic regression analyses and receiver operating characteristic curves were used for model development. RESULTS: The Objective Palliative Prognostic Score was determined by using six objective predictors identified by multivariate logistic regression analysis. The predictors include heart rate >120/min, white blood cells >11,000/mm(3), platelets <130,000/mm(3), serum creatinine level >1.3 mg/dL, serum potassium level >5 mg/dL, and no history of chemotherapy. The area under the receiver operating characteristic curve used to predict seven-day survival was 82.0% (95% confidence interval 75.2%-88.8%). If any three predictors of the six were reached, death within seven days was predicted with 68.8% sensitivity, 86.0% specificity, 55.9% positive predictive value, and 91.4% negative predictive value. CONCLUSION: The Objective Palliative Prognostic Score consists of six objective predictors for the estimation of seven-day survival among patients with advanced cancer and showed a relatively high accuracy, specificity, and negative predictive value. Objective signs, such as vital signs and blood test results, may help clinicians make decisions at the end of life.
Publication type: journal article
Source: CINAHL

26. Palliative Care Case Managers in Primary Care: A Descriptive Study of Referrals in Relation to Treatment Aims.
Citation: Journal of Palliative Medicine, 01 April 2015, vol./is. 18/4(324-331), 10966218
Author(s): van der Plas, Annicka G. M., Onwuteaka-Philipsen, Bregje D., Francke, Anneke L., Jansen, Wim J. J., Vissers, Kris C., Deliens, Luc
Language: English
Abstract: Background: Three important elements of the World Health Organization (WHO) definition of palliative care are: 1) it includes patients who may have cure or life prolongation as treatment aims besides palliative care; 2) it is not exclusively for cancer patients; and 3) it includes attention to the medical, psychological, social, and spiritual needs of the patients and their families. Case managers (nurses with expertise in palliative care) may assist generalist primary care providers in delivery of good palliative care. Objectives: This study investigates the referral of patients to case managers in primary care with regard to the three elements mentioned: diagnosis, treatment aims, and needs as reflected in reasons given for referral. Methods: In this cross-sectional survey in primary care among case managers and referrers to case management, case managers completed questionnaires for 687 patients; referrers completed 448 (65%). Results: Most patients referred have a combination of treatment aims (69%). Life expectancy and functional status of patients are lower for those with a treatment aim of palliation. Almost all (96%) of those referred are cancer patients. A need for psychosocial support is frequently given as a reason for referral (66%) regardless of treatment aim. Conclusions: Referrals to case managers reflect two of three elements of the WHO definition. Mainly, patients are referred for support complementary to medical care, and relatively early in their disease trajectory. However, most of those referred are cancer patients. Thus, to fully reflect the definition, broadening the scope to reach other patient groups is important.
Publication type: journal article
Source: CINAHL

27. Palliative care health professionals' experiences of caring for patients with advance care directives.
Citation: Australian Health Review, 01 March 2015, vol./is. 39/2(154-159), 01565788
Author(s): Johnson, Claire E., Singer, Rachel, Masso, Malcolm, Sellars, Marcus, Silvester, William
Language: English
Abstract: Objective. To explore the health professionals' (HPs) perceptions and experiences of advance care directives (ACDs) and advance care planning in Australian palliative care services. Methods. A nationwide survey of 105 palliative care services was conducted, with two HPs from each service invited to participate. A qualitative analysis of open responses about advance care planning was undertaken. Results. Sixty questionnaires were returned with open responses. Most responders were nurses (75%), aged ≥40 years (80%) and with a mean of 12 years palliative care experience. Data were grouped into four key themes: (1) the ACD; (2) the process of developing ACDs; (3) the process of using ACDs; and (4) the consequences of having ACDs. Participants were positive about advance care planning, commenting that ongoing communication about end-of-life care ensures mutual understanding between patients, family and HPs. Provision of care was considered easier and more efficient with an ACD in place. ACDs were perceived to reduce distrust and conflict between family, friends and HPs, and promote communication. Suboptimal documentation, clarity and explicitness limited the usefulness of ACDs when they were available. Conclusions. Advance care planning benefits HPs, patients and their family. To maximise these benefits, ACDs need to be clear, comprehensive, medically relevant and transportable documents. What is known about the topic? Ideally, advance care planning encompasses the identification and documentation of a person's preferences for future medical treatments and care in preparation for an occasion when the person cannot express their values and wishes. The uptake and practice of advance care planning is inconsistent, and the extent to which it is used by health professionals and patients is variable. Many people are cared for at the end of life in specialist palliative care services, but the intersection between palliative care and advance care planning remains under researched. What does this paper adds? ACDs facilitate communication and advance care planning; help establish trust between health professionals, patients and their families; and make multiple aspects of care easier for HPs. Processes surrounding ACDs, particularly inadequate documentation, limit adherence
and application. What are the implications for practitioners? Clear communication is necessary for effective ACD development and application. The presence of an ACD makes communication and advance care planning easier, and improves trust between HPs, patients and their family. To be useful, ACDs must be clear, comprehensive, medically relevant, transportable documents.

**Publication type:** journal article  
**Source:** CINAHL  
**Full text:** Available *Australian health review : a publication of the Australian Hospital Association* at *Australian Health Review*

### 28. Patients’ preferences in palliative care: A systematic mixed studies review.

**Citation:** Palliative Medicine, 01 May 2015, vol./is. 29/5(399-419), 02692163  
**Author(s):** Sandsdalen, Tuva, Hov, Reidun, Høye, Sevald, Rystedt, Ingrid, Wilde-Larsson, Bodil  
**Language:** English  
**Publication type:** journal article  
**Source:** CINAHL  
**Full text:** Available *Palliative medicine* at *Palliative Medicine*


**Citation:** Journal of Palliative Medicine, 01 April 2015, vol./is. 18/4(332-337), 10966218  
**Author(s):** Perez, Giselle K., Haime, Vivian, Jackson, Vicki, Chittenden, Eva, Mehta, Darshan H., Park, Elyse R.  
**Language:** English  
**Abstract:** Background: Palliative care clinicians (PCCs) are susceptible to burnout, as they regularly witness immense patient and family suffering; however, little is known about their specific challenges and training needs to enhance their long-term sustainability. Objective: The purpose of this qualitative study was to explore common stressors, coping strategies, and training needs among PCCs in efforts to inform the development of a targeted Resiliency Program. Methods: Utilizing a semistructured interview guide, we conducted a series of in-depth interviews with 15 PCCs at the Massachusetts General Hospital. Results: Content analysis highlighted three main areas of stressors: (1) systematic challenges related to managing large, emotionally demanding caseloads within time constraints; (2) patient factors, such as addressing patients' mutable needs, managing family dynamics, and meeting patient and family demands and expectations; and (3) personal challenges of delineating emotional and professional boundaries. Engaging in healthy behaviors and hobbies and seeking emotional support from colleagues and friends were among the most common methods of coping with stressors. In terms of programmatic topics, PCCs desired training in mind-body skills (e.g., breathing, yoga, meditation), health education about the effects of stress, and cognitive strategies to help reduce ruminative thoughts and negative self-talk. A majority of clinicians stressed the need for brief strategies that could be readily integrated in the workplace. Conclusions: These results suggest that an intervention aimed to enhance PCC sustainability should focus on utilizing a skill-building approach to stress reduction that imparts strategies that can be readily utilized during work hours.  
**Publication type:** journal article  
**Source:** CINAHL

### 30. Risk Factors Associated With Unplanned Hospital Readmissions in Adults With Cancer.

**Citation:** Oncology Nursing Forum, 01 May 2015, vol./is. 42/3(0-), 0190535X  
**Author(s):** Granda-Cameron, Clara, Behta, Maryam, Hovinga, Mary, Rundio, Al, Mintzer, David  
**Language:** English  
**Abstract:** Purpose/Objectives: To identify risk factors associated with 30-day unplanned hospital readmissions in adults with cancer. Design: Case-control study. Setting: A teaching hospital in an urban center in the Mid-Atlantic region of the United States. Sample: 302 adults with solid tumors: 87
readmitted within 30 days (cases) and 215 not readmitted (controls). Methods: The Conceptual Model of Re-Hospitalization was used as a theoretic framework. Univariate logistic regression and multivariate logistic regression were conducted to identify risk factors for hospital readmission. Main Research Variables: Risk factors included patient, clinical, hospitalization, and discharge-planning characteristics. Findings: From November 2011 to November 2012, 29% of patients were readmitted within 30 days after discharge, and a higher percentage of those readmissions occurred within the first week of discharge. Several predictors for hospital readmission were identified in the univariate logistic analysis, but the most relevant in the final multivariate logistic model were moderate to high risk for falls and advanced stage disease (metastatic). Conclusions: Hospital readmission is an indicator of quality care. Learning about risk factors allows opportunities to prevent hospital readmission by identifying those at high risk and implementing optimal discharge-planning systems and early referrals to palliative care. Implications for Nursing: Oncology nurses are best positioned to develop strategic plans aimed at improving discharge planning and transitions of care that will decrease unplanned hospital readmissions.

**Publication type:** journal article

**Source:** CINAHL

### 31. The brain and breathlessness: Understanding and disseminating a palliative care approach.

**Citation:** Palliative Medicine, 01 May 2015, vol./is. 29/5(396-398), 02692163

**Author(s):** Booth, Sara, Chin, Chloe, Spathis, Anna

**Language:** English

**Publication type:** journal article

**Source:** CINAHL

**Full text:** Available Palliative medicine at Palliative Medicine

### 32. The challenge to health professionals when carers resist truth telling at the end of life: a qualitative secondary analysis.

**Citation:** Journal of Clinical Nursing, 01 April 2015, vol./is. 24/7/8(927-936), 09621067

**Author(s):** Noble, Helen, Price, Jayne E, Porter, Sam

**Language:** English

**Abstract:** Aims and objectives To draw out the similar complexities faced by staff around truth-telling in a children’s and adult population and to interrogate the dilemmas faced by staff when informal carers act to block truth-telling. Background Policy encourages normalisation of death, but carers may act to protect or prevent the patient from being told the truth. Little is known about the impact on staff. Design Secondary analysis of data using a supra-analysis design to identify commonality of experiences. Methods Secondary 'supra-analysis' was used to transcend the focus of two primary studies in the UK, which examined staff perspectives in a palliative children’s and a palliative adult setting, respectively. The analysis examined new theoretical questions relating to the commonality of issues independently derived in each primary study. Both primary studies used focus groups. Existing empirical data were analysed thematically and compared across the studies. Results Staff reported a hiding of the truth by carers and sustained use of activities aimed at prolonging life. Carers frequently ignored the advance of end of life, and divergence between staff and carer approaches to truth-telling challenged professionals. Not being truthful with patients had a deleterious effect on staff, causing anger and feelings of incompetence. Conclusions Both children’s and adult specialist palliative care staff found themselves caught in a dilemma, subject to policies that promoted openness in planning for death and informal carers who often prevented them from being truthful with patients about terminal prognosis. This dilemma had adverse psychological effects upon many staff. Relevance to clinical practice There remains a powerful death-denying culture in many societies, and carers of dying patients may prevent staff from being truthful with their patients. The current situation is not ideal, and open discussion of this problem is the essential first step in finding a solution.

**Publication type:** journal article

**Source:** CINAHL
33. The communication experiences of patients with palliative care needs: A systematic review and meta-synthesis of qualitative findings.

**Citation:** Palliative & Supportive Care, 01 April 2015, vol./is. 13/2(369-383), 14789515

**Author(s):** Murray, Craig D, McDonald, Claire, Atkin, Heather

**Language:** English

**Abstract:** **OBJECTIVE:** Optimal communication is essential in ensuring that the palliative care needs of patients are met. This continues to be an area of concern for healthcare providers. The goal of our present review was to gain a deeper understanding of the communication experiences of patients with palliative care needs that have been identified within the qualitative literature. **METHOD:** A systematic search for qualitative research papers was undertaken in February of 2012. Five databases (ASSIA, CINAHL, MEDLINE, PsychArticles, and PsychINFO) were searched using the search terms ["palliative care" OR "terminal care" OR "end of life care"] AND ["experience" OR "perspective" OR "qualitative" OR "interview"] AND ["patients" OR "clients" OR "service-user"]. Meta-synthesis was conducted on the data within the found papers. **RESULTS:** A line-of-argument synthesis of 15 studies yielded four overarching themes: talking-facilitating and inhibiting factors; the importance of humanitarian qualities within communication encounters; perceptions of autonomy within communication experiences; and individual differences in preferences for honesty within interactions. **SIGNIFICANCE OF RESULTS:** Our findings are discussed in relation to existing literature and offer a deeper insight into the communication experiences of this clinical population. A number of clinical implications are offered for the healthcare professionals who are providing support to patients with palliative care needs.

**Publication type:** journal article

**Source:** CINAHL

34. The dignified approach to care: A pilot study using the patient dignity question as an intervention to enhance dignity and person-centred care for people with palliative care needs in the acute hospital setting

**Citation:** BMC Palliative Care, April 2015, vol./is. 14/1, 1472-684X (09 Apr 2015)

**Author(s):** Johnston B., Pringle J., Gaffney M., Narayanasamy M., McGuire M., Buchanan D.

**Language:** English

**Abstract:** Background: Providing person-centred, dignity-conserving care for hospitalised patients is central to many healthcare policies and essential to the provision of effective palliative care. The Patient Dignity Question (PDQ) "What do I need to know about you as a person to take the best care of you that I can?" was designed from empirical research on patients' perceptions of their dignity at end of life to help healthcare professionals (HCPs) understand the patient as a person. **Methods:** This mixed method pilot study was designed to inform a larger multisite study in the future. It tests the hypothesis that the PDQ intervention could be used to enhance a more person-centred climate for people with palliative care needs in the acute hospital setting, and provide evidence regarding its acceptability. **Outcome measures** pre and post intervention Person-centred Climate Questionnaire - patient version (PCQ-P), and the Consultation and Relational Empathy (CARE) measure; PDQ feedback questionnaires were used for all participants post intervention, in addition to qualitative interviews. Results: 30 patients, 17 HCPs, and 4 family members participated. Results showed a positive correlation between higher PCQ-P scores and higher CARE scores, indicating that the PDQ can make improvements to a person-centred environment and levels of empathy perceived by patients. Individual results from the PCQ-P and the CARE indicated overall improvements in the majority of fields. The PDQ supported disclosure of information previously unknown to HCPs, has implications for improving person-centred care. Positive results from PDQ feedback questionnaires were received from all participants. Qualitative findings indicated patients' appreciation of staff (Attributes and attitudes), that patients wanted staff to have awareness of them (Know me as a person), take the time to talk, and work flexibly, to allow for patient individuality (Time and place). **Conclusion:** The PDQ has potential to improve patients' perceptions of care, and HCP attitudes. Furthermore, it was well received by participants. The PDQ could be incorporated into clinical
practice for the care of palliative care patients in the acute setting to the benefit of personalized and dignified care. Further research using the PDQ across wider geographical areas, and more diverse settings, would be beneficial.

35. Tough conversations: Training medical students to lead family meetings

Citation: Journal of the American Geriatrics Society, April 2015, vol./is. 63/(S6), 0002-8614 (April 2015)

Author(s): Hagiwara Y., Ross J., Reilly A., Lee S., Sanchez-Reilly S.

Language: English

Abstract: Background: Family Meetings (FMs) are valuable interventions which promote communication between the health care team and the seriously ill patient and family. However, few educational interventions have been developed to teach FM communication skills. We developed an innovative curriculum to address this gap. Methods: 4th-year medical students during 2011-2013 (n=674) completed the course on conducting a FM. This included didactic information and opportunities for students to role play the tasks of leading a FM. To assess the effectiveness of this training, students completed a FM Objective Structured Clinical Exam (OSCE). Students watched a video of a team meeting where the case of a terminally ill patient dying in the intensive care unit was discussed. Subsequently, each student was asked to assume the role of the physician leading a complex FM (standardized family members). Tasks included discussion of prognosis, establishment of goals of care and demonstration of conflict resolution skills when family members “disagreed.” Direct one-to-one feedback from both standardized family members and faculty observer was given immediately after each encounter. Students were evaluated in 15 domains on a 1-5 point Likert scale. Group debriefings with faculty were held after the OSCE experience. Results: Preceptor feedback comments revealed four themes in which many students required improvement; 1) Discussing prognosis, 2) Explaining palliative care/hospice, 3) Avoiding medical jargon, 4) Discussing cultural/religious preferences. Evaluation total mean score was 28.2 (Min 15, Max 63; SD 7.57), and identified student’s need to; 1) Ask more about the degree of knowledge family members want, 2) Ask religious beliefs, 3) Assess family member’s level of education (p<0.001).

Qualitative analysis of group debriefings suggested that student perception of the OSCE experience was positive overall. Students found the case to be realistic and immediate feedback to be helpful. Many students commented on their lack of experience giving bad news or with conflict resolution. Conclusions: Conducting a FM is an advanced skill. More extensive training would be required for students to achieve the targeted level in all domains. This study shows that it is possible to develop training and assessment in relation to conducting a FM.

36. Verbalized desire for death or euthanasia in advanced cancer patients receiving palliative care.

Citation: Palliative & Supportive Care, 01 April 2015, vol./is. 13/2(295-303), 14789515

Author(s): Güell, Ernest, Ramos, Adelaida, Zertuche, Tania, Pascual, Antonio

Language: English

Abstract: OBJECTIVE: We aimed to address the prevalence of desire-to-die statements (DDSs) among terminally ill cancer patients in an acute palliative care unit. We also intended to compare the underlying differences between those patients who make desire-to-die comments (DDCs) and those who make desire-for-euthanasia comments (EUCs). METHOD: We conducted a one-year cross-sectional prospective study in all patients receiving palliative care who had made a DDC or EUC. At inclusion, we evaluated symptom intensity, anxiety and depression, and conducted a semistructured interview regarding the reasons for these comments. RESULTS: Of the 701 patients attended to during the study period, 69 (9.8%; IC 95% 7.7-12.3) made a DDS: 51 (7.3%) a DDC, and 18 (2.5%) an EUC. Using Edmonton Symptom
Assessment Scale (ESAS) DDC group showed higher percentage of moderate-severe symptoms (ESAS > 4) for well-being (91 vs. 25%; p = 0.001), depression (67 vs. 25%; p = 0.055), and anxiety (52 vs. 13%; p = 0.060) than EUC group. EUC patients also considered themselves less spiritual (44 vs. 84%; p = 0.034). The single most common reason for a DDS was pain or physical suffering, though most of the reasons given were nonphysical. SIGNIFICANCE OF RESULTS: Almost 10% of the population receiving specific oncological palliative care made a DDC (7.3%) or EUC (2.5%). The worst well-being score was lower in the EUC group. The reasons for both a DDC and EUC were mainly nonphysical. We find that emotional and spiritual issues should be identified and effectively addressed when responding to a DDS in terminally ill cancer patients.

Publication type: journal article
Source: CINAHL
School of Economics and Political Science. It shows that people with cancer are far more likely to access palliative care than those with other conditions, despite 70% of deaths being attributable to other conditions. The report suggests that over 100,000 people each year are denied access to palliative care around the UK, and that people’s background and level of deprivation can influence the standard of care they receive, as well as the dignity and respect afforded to them. Further, the report notes that the majority of hospitals do not provide specialist palliative care 24/7.

**New guide to help prepare people on what to expect when someone they know is dying**

Thursday 26th March 2015

A new guide which prepares people on what to expect when someone is dying has today been published by the National Council for Palliative Care. ‘What to expect when someone important to you is dying’ aims to demystify the dying process so that people better understand the changes that can happen to their loved ones in the last days of life. Shaped by people who have experienced the death of someone they were close to, and with support from NHS England, Marie Curie, Sue Ryder and Hospice UK, the guide is intended to make the last hours and days of someone’s life less distressing for all concerned, including friends, family members and carers.

**New Books**

A selection of new books on an End of Life Care related topic available from Healthcare Library. To search the library catalogue visit [www.swims.nhs.uk](http://www.swims.nhs.uk)

**Pain – a textbook for health professionals**
Edited by H van Griensven, J Strong, and A M Unruh
Churchill Livingstone, Elsevier 2014
ISBN: 978-0-7020-3478-7
Barcode: T026914
Shelfmark: WL800 GRI

**Pain Management in Practice**
Shelagh Wright
Sage Publications Ltd 2015
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To book a search please complete and return the attached form.
Alternatively the Clinical Librarian service can bring the library service to you, by attending department meetings, and searching for evidence on site. See leaflet here for further information.

For further details on either service contact the library on ext. 4433, (01722) 429054, library.office@salisbury.nhs.uk.

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This bulletin was produced by Helen Clemow, Librarian, Salisbury NHS Foundation Trust Healthcare Library. If you have any comments to make about this bulletin please contact helen.clemow@salisbury.nhs.uk.