Quality_of_Palliative.pdf

by

Submission date: 30-Apr-2023 07:52PM (UTC+0700)
Submission ID: 2079739180
File name: Quality_of_Palliative.pdf (481.33K)
Word count: 3155
Character count: 16272

ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/347939425

Quality of palliative care in intensive care unit "X" Hospital Indonesia

Article *in* Enfermería Clínica · December 2020
DOI: 10.1016/j.enfcli.2020.07.003

CITATIONS
0

READS
49

4 authors, including:

Ifa Hafifah
Universitas Lambung Mangkurat
15 PUBLICATIONS 13 CITATIONS
SEE PROFILE

Syamsul Arifin
96 PUBLICATIONS 120 CITATIONS
SEE PROFILE

Some of the authors of this publication are also working on these related projects:

KAJIAN EFEKTIVITAS PROGRAM SANITASI TOTAL BERBASIS MASYARAKAT BERDASARKAN KARAKTERISTIK LINGKUNGAN DAN EVALUASI PROGRAM DI KABUPATEN BANJAR Article HUBUNGAN GAYA KEPEMIMPINAN, MOTIVASI, STRES KERJA DENGAN KINERJA PERAWAT View project

All content following this page was uploaded by Syamsul Arifin on 02 January 2021.

The user has requested enhancement of the downloaded file.

Enferm Clin. 2020;30(S7):16–19

Enfermería Clínica

www.elsevier.es/enfermeriaclinica

Quality of palliative care in intensive care unit ''X'' Hospital Indonesia☆

Ifa Hafifah[a,*], Syamsul Arifin[b], Dhemes Alin[c], Isnawati[c]

[a] *Department of Critical Nursing, School of Nursing, Faculty of Medicine, Universitas Lambung Mangkurat, Indonesia*
[b] *Department of Public Health, School of Medical, Faculty of Medicine, Universitas Lambung Mangkurat, Indonesia*
[c] *School of Nursing, Faculty of Medicine, Universitas Lambung Mangkurat, Indonesia*

Received 12 May 2020; accepted 15 July 2020

KEYWORDS
Doctors;
Intensive room;
Nurse;
Palliative care

Abstract The high mortality in intensive care unit (ICU) requires health workers to be able to provide palliative care so that patients die in peace and help the patient's family face the grieving process. The implementation of palliative care must be organized and assessed for the quality of its implementation. The aim was to describe the quality of palliative care in ICU ''X'' Hospital. The research used Mixed Methods. The first was the quantitative with descriptive research. The sample was 38 nurses and 4 doctors to obtain data on the quality of palliative care with The Self-Report Questionnaire (0–10). The second of qualitative methods to deepen quantitative data with achieved data saturation in 5 nurses and 2 doctors. Retrieval of data from May to July 2019. The results were the quality of palliative care performed by nurses had a score of 6.68, for doctors were 5.19. The lowest score (5.29) was found in the emotional support, and organizational domain for ICU clinicians for nurses with the theme of the role of coworkers and the desire to act alone, for doctors the lowest score (3.93) was spiritual support for patients family with the theme of the absence of operational standards of spiritual support procedures and knowledge and experience of spiritual support. The conclusion is the quality of palliative care services performed by nurses has a score of 6.68 and for doctors was 5.19.
© 2020 Elsevier España, S.L.U. All rights reserved.

Introduction

Critical patients have dysfunction or failure of one or more organs so that their lives depend on sophisticated tools, monitoring and therapy. Studies have reported that one in five Americans who use Intensive Care Unit (ICU) services die.[1] The high mortality rate in the ICU requires health

☆ Peer-review under responsibility of the scientific committee of the International Nursing Research Conference of Udayana University. Full-text and the content of it is under responsibility of authors of the article.

* Corresponding author.
E-mail address: hafifah.ifa@ulm.ac.id (I. Hafifah).

https://doi.org/10.1016/j.enfcli.2020.07.003
1130-8621/© 2020 Elsevier España, S.L.U. All rights reserved.

workers to be able to provide palliative care, including near-death care so that patients can die in peace and help patients' families deal with the grieving process.

Palliative care is an approach that can improve the quality of life of patients and families by helping with life-threatening illnesses, through prevention and helping to alleviate suffering by early identification and assessment in an orderly manner, treating pain and other symptoms, physically psychosocial and spiritual.[2] Palliative care is given on the basis of the philosophy that every patient has the right to get the best care until the end of his life.[3] According to Nelson there are 7 main domains of palliative care and life termination care that are used to measure the quality of palliative care in the ICU, namely: (1) decision-making domains that focus on patients and families; (2) communication between the health team, patients and families; (3) continuity of care; (4) emotional support and practice for families and patients; (5) management of symptoms and treatment of comfort; (6) spiritual support for patients and families as well; (7) emotional and organizational support for clinicians in the ICU. Palliative care focuses on improving the quality of life and management of patient symptoms in life-threatening conditions.[4]

It is important to assess the quality of palliative care to identify aspects of care that have been performed or not. Quality assessment is central to conducting and supporting policy and strategy analysis from a room or hospital.[5] The absence of an assessment of the quality of palliative care in the ICU can cause a quality gap between knowledge and practice between clinicians. This quality gap is indicated by the persistent problems in handling symptoms, communication between clinicians, families and with clinical teams, and moral issues between doctors and nurses.[6–10]

Based on preliminary studies in ICU RS X with interview and observation methods, data obtained by health workers, especially nurses and doctors, have carried out palliative care but have not been well organized and until now there has been no assessment of the quality of the implementation of palliative care.

Method

This research method used Mixed Methods. The first was the quantitative method with descriptive research. This research variable is the quality of palliative nursing services performed by nurses and doctors in ICU Hospital X based on 7 domains. The sample was 38 nurses and 4 doctors to obtain data on the quality of palliative nursing with the purposive sampling technique. The instrument of quantitative research was The Self-Report Questionnaire with a score of 0–10 (getting closer to 0 indicating poor service quality and closer to 10 reflected excellent service quality).[11]

The second of method was the qualitative methods to deepen quantitative data with achieved data saturation in 5 nurses and 2 doctors. Retrieval of data was May until July 2019. The lowest domain of research results in nurses and doctors is followed by qualitative research. Qualitative research was carried out with interviews for 60 min and observation. Analysis of qualitative research data is a thematic analysis.[12]

Results

Table 1 give information about characteristics of nurse and doctor. The majority of the diploma level of education (71.05%) for nurses, Bachelor degree + profession (100%) for doctors, the length of work in the ICU majority of 1–5 years (39.47%) for nurses, (100%) for doctors, and all nurses and doctors (100%) have never attended palliative care training.

Quality of Palliative Care by nurses and doctors The ICU X Hospital is presented in Table 2. The results of the questionnaire showed that the quality of palliative care services performed by nurses had a score of 6.68 while the score for doctors was 5.19. The lowest score was obtained in the domain of emotional and organizational support for ICU clinicians with a score of 5.29 for nurses while for doctors the lowest score was on spiritual support for patients and families with a score of 3.93.

The theme derived from qualitative research with respondents from nurses was related to the emotional and organizational support domain for ICU clinicians, the role of coworkers (subthemes were nurses have each clinical authority guidelines; nurses does not interfere each joblist) and the desire to act alone (subthemes were nurses shy to ask with friend if cannot do action; punishment grade reduction if nurses cannot do intervention). The themes obtained from qualitative research with respondents from doctors was related to the domain of spiritual support for patients and families were the absence of standard operational procedures (SOP) of spiritual support (subthemes were absence of intervention palliative care guideline; and absence of assessment sheet for palliative patient), the absence of knowledge of spiritual support (subthemes were do not learn about palliative care in school; do not have palliative care in curriculum; do not attend conference of palliative care), and the absence of experience of spiritual support (subthemes were focus in curing disease; spiritual support is joblist for nurses).

Discussion

Table 2 shows that the quality of palliative care services performed by nurses in ICU RS X has a score of 6.68 while the score for doctors is 5.19. This shows that the application of palliative care in ICU RS X has been implemented. This is supported by the results of a study conducted by Alshaikh where nurses do not know the general concept of palliative care in relation to patients near death, but some of them already exist in their daily practice.[13]

The results of qualitative research from nurses were low emotional and organizational support for ICU clinicians. The themes were the role of coworkers and the desire to act alone. The role of coworkers have subthemes, they were nurses have each clinical authority guidelines and nurses does not interfere each joblist. The desire to act alone have subthemes, they were nurses shy to ask with friend if cannot do action, punishment grade reduction if nurses cannot do intervention.

This is supported by Espinosa et al., on the experience of nurses in the ICU in providing palliative care to adult patients who have terminal illness, there are three themes resulting from his research namely (1) obstacles in providing

Table 1 Characteristics of nurse and doctor respondents.

Level of education	Total (person)	Percentage (%)
Diploma of nursing	27 (Nurse)	71.05
Bachelor degree + profession	11 (Nurse)	28.95 (Nurse)
	4 (Doctor)	100 (Doctor)
Duration of work at the ICU		
<1 year	11 (Nurse)	28.95
1–5 years	15 (Nurse)	39.47 (Nurse)
	4 (Doctor)	100 (Doctor)
5–10 years	7 (Nurse)	18.42
>10 years	5 (Nurse)	13.16
Have attended palliative care		
No	38 (Nurse)	100 (Nurse)
	4 (Doctor)	100 (Doctor)

Table 2 Quality of palliative care by nurses and doctors in intensive room X Hospital.

Domain	Average nurse score (n = 38)	Average doctor score (n = 4)
Communication within the team and with patients and their families	7.4	6.18
decision making based on patient and family	7.04	5.37
Sustainability of care	7.14	6.17
Practical and emotional support for patients and families	6.72	5.15
Management of symptoms and treatment of comfort	7.17	5.33
spiritual support for patients and families	6.01	3.93
Emotional and organizational support for ICU clinicians	5.29	4.24
Total	6.68	5.19

optimal care, lack of involvement in treatment plan, the difference between medical and nursing practice models, the perception that care is futile and the lack of experience and education of nurses, (2) internal conflicts was internal conflicts between nurse's feelings or desires, (3) coping, positive and adaptive coping strategies are needed by nurses in dealing with terminal patients and their families, namely by building trust with family, empathy, being humorous, discussing with the health team about terminal care, and do not avoid treating terminal patients.[14]

Gelinas et al, in their research on stressors experienced by nurses in the provision of palliative care at the end of the patient's life in the ICU room concluded that various causes of stress experienced by nurses in providing near-death care in the ICU room were grouped into three categories were organization (lack of palliative care approach), professional (lack of competence in palliative care or end of life, difficulty communicating with family and working with medical teams), and emotional (value conflicts, lack of emotional support, also when dealing with patient and family suffering patient).[15]

The results of the average domain score of emotional and organizational support for clinicians in the ICU obtained 5.29 results for nurses and 4.24 for doctors. This shows the lack of optimal emotional and organizational support for ICU staff. The results of the questionnaire also showed that there was no education and training in palliative care for ICU RS X staff. The previous research results also showed that the lowest score they gave was in the domain related to emotional and organizational support for nurses and doctors in the ICU mainly related to the provision of education for ICU clinicians.[13] The lack of results in this domain is related to the implementation of palliative education in general, both in the academic and clinical settings which are still not optimal. In India, 16.0% of nurses do not have palliative care in their educational curriculum.[16] Studies conducted in Qatar found that 36 (31.3%) oncology nurses received formal education in palliative care.[17]

The results of qualitative research from doctor were spiritual support for patients and families. The themes were absence of SOP of spiritual support, absence of knowledge of spiritual support, and absence of experience of spiritual support. Absence of SOP of spiritual support have subthemes, they were absence of intervention palliative care guideline and absence of assessment sheet for palliative patient. Absence of knowledge of spiritual support have subthemes, they were do not learn about palliative care in school, do not have palliative care in curriculum, and do not attend conference of palliative care. Absence of experience of spiritual support has subthemes, they were focus in curing disease, and spiritual support is joblist for nurses.

The results that there were no SOP for palliative care. Doctor and nurse also mentioned the need for SOP for the implementation of palliative care so that they could have guidance in their implementation. The same thing was

revealed in previous studies that the need for SOP. The absence of nurses and doctors participating in palliative care training shows that support for the development of nurse's and doctor's knowledge is not optimal at work. Whereas in the provision of professional nursing care nurses need knowledge that can be obtained from activities such as training. This is supported by the results of research by McIlfatrick et al., who say education and training are very important to improve the quality of palliative care and end of life care for patients.[18] The same thing was expressed by Friedenberg et al., who stated that the need for training for the provision of optimal end-of-life care in the ICU.[19]

The results of observation found that doctor and nurse have asked the family to pray for patients, but it has not been optimal because health workers have not monitored whether the act of spiritual guidance to patients has been done. This is because in the room, there are no SOP for spiritual support, and for doctors experiencing difficulties due to lack of experience and knowledge in these actions. These results are consistent with Clark's research which states that the health care team at the ICU has traditionally emphasized stabilizing a patient's vital signs and relieving physiological symptoms, but rarely paying attention to the psychological and spiritual needs of the patient. Like Ruland and Moore's theory which states that one of the standard criteria for a peaceful death is freedom or the minimum sense of client suffering.[20]

Conflict of interest

The authors declare no conflict of interest.

References

1. Angus DC, Barnato AE, Linde-Zwirble WT, Weissfeld LA, Watson S, Rickert T, et al. Use of intensive care at the end of life in the United States: An epidemiologic study. Crit Care Med. 2004;32:638-43.
2. WHO. Definition of Palliative Care [Internet]. Geneva: World Health Organization. 2010. Available from: http://www.who.Int/cancer/palliative/definition/en.
3. Kemenkes. Keputusan Menteri Kesehatan Indonesia Nomor 812/Menkes/SK/VII/2007 Tentang Kebijakan Perawatan Paliatif. Jakarta: Kementerian Kesehatan Republik Indonesia; 2007.
4. Nelson JE, Angus DC, Weissfeld LA, Puntillo KA, Danis M, Deal D, et al. End-of-life care for the critically ill: A national intensive care unit survey. Crit Care Med. 2006;34:2547-53.
5. Royal College Of Nursing (RCN). Measuring Of Quality. 2012.
6. Gelinas C. Management of pain in cardiac surgery ICU patients: Have we improved over time? Intensive and Crit Care Nurs. 2007;23:298-303.
7. Poncet MC, Toullic P, Papazian L, Kentish-Barnes N, Timsit JF, Pochard F, et al. Burnout Syndrome in Critical Care Nursing Staff. Am J Respir Crit Care Med. 2007;175:698-704.
8. Nelson JE, Mercado AF, Camhi SL, Tandon N, Wallenstein S, August GI, et al. Communication About Chronic Critical Illness. Arch Intern Med. 2007;167:2509-15.
9. Siegel MD, Hayes E, Vanderwerker LC, Loseth DB, Prigerson HG. Psychiatric illness in the next of kin of patients who die in the intensive care unit. Crit Care Med. 2008;36:1722-8.
10. Azoulay E, Timsit JF, Abizanda R, Sprung CL, Soares M, Rusinova K, et al. Prevalence and Factors of Intensive Care Unit Conflicts The Conflicus Study. Am J Respir Crit Care Med. 2009;180:853-60.
11. Suryaty SS, Setiyarini S. Kualitas Perawatan Paliatif Pasien Kritis di ICU RSUP DR. Sardjito Yogyakarta. ETD. Gajah Mada. 2013.
12. Boyatzis RE. Transforming Qualitative Information. London: Sage; 1998.
13. Alshaikh Z, Alkhodari M, Sormunen T, Hillerås P. Nurses Knowledge About Palliative Care In An Intensive Care Unit In Saudi Arabia. Middle East Journal Of Nursing. 2015;9:7-13.
14. Espinosa L, Young A, Symes L, Haile B, Walsh T. ICU Nurses' Experiences in Providing Terminal Care. Crit Care Nurs Q. 2010;33:273-81.
15. Gelinas C, Fillion L, Robitaille MA, Truchon M. Stressors Experienced by Nurses Providing End Of Life Palliative Care In The Intensive Care Unit. Can J Nurs Res. 2012;44:18-39.
16. David A, Benerjee S. Effectiveness of Palliative Care Information Booklet In Enhancing Nurse's Knowledge. Indian J Palliat Care. 2010;16:164-7.
17. Al-Kindi SG, Zeinah GF, Hassan AA. Palliative Care Knowledge and Attitudes Among Oncology Nurses in Qatar. Am J Hosp Palliat Care. 2014;31:469-74.
18. McIlfatrick S, Mawhinney A, Gilmour F. Assessing the educational needs of palliative care link nurses. Int J Palliat Nurs. 2010;16:555-9.
19. Friedenberg AS, Levy MM, Ross S, Evans LE. Barriers to End-of-Life Care in the Intensive Care Unit: Perceptions Vary by Level of Training. Discipline, and Institution. J Palliat Med. 2011;15:404-11.
20. Ruland CM, Moore SM. Theory Construction Based on Standards of Care: A Proposed Theory of the Peaceful End of Life. Nurs Outlook. 1998;46:169-75.

View publication stats

Quality_of_Palliative.pdf

ORIGINALITY REPORT

14%	13%	12%	5%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

#	Source	Type	%
1	knepublishing.com	Internet Source	3%
2	"Palliative Care for Chronic Cancer Patients in the Community", Springer Science and Business Media LLC, 2021	Publication	3%
3	Submitted to Universitas Indonesia	Student Paper	2%
4	repository.politeknikmfh.ac.id	Internet Source	2%
5	careersdocbox.com	Internet Source	2%
6	journals.sagepub.com	Internet Source	2%

Exclude quotes	On	Exclude matches	< 2%
Exclude bibliography	On		