Development of a Palliative Care Team in an Oncology Department : The PWH Experience

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With a background of good palliative care support already available in Shatin area, why is there a need to establish a palliative care team in an Oncology Department in PWH? This is because a major portion of patients seen in the Dept of Clinical Oncology in PWH needs palliative care support and staff education on palliative care is required. In 1999, a working party on palliative care was set up. The Party consisted of the COS, two medical officers with palliative care training (diploma holder), two oncologists, DOM and two nurse specialists. After some preparation work, a Proposal was put forward for consultation among the staff of the Dept. The first meeting on Palliative Care Team took place in April,2000 and the Team was formally established in May, 2000.

The aims of the Team are : (1) To provide a more comprehensive and integrated palliative care service to cancer patients in PWH before their discharge or transfer; (2) To supplement the palliative care services not yet provided by palliative care/hospice units in NTE region; (3) To provide information and education about palliative care to the staff, medical students, and the general public; (4) To provide consultation services about palliative chemotherapy and radiotherapy for other departments in PWH, as well as for other hospitals and palliative units within its catchment area; (5) To cooperate with other oncology centers and specialties (surgeons, physicians and para-medical staff) for developing common treatment policies and guidelines, for conducting research/audit/studies, and for better use of resources.

The proposed structure of the Team is multidisciplinary and ideally should include doctors (in-charge doctors, doctors with training or interest in palliative care , and anaesthetists), nurses (frontline nurses, nurse specialists equipped with palliative care knowledge), physiotherapist, occupational therapist, staff involved in making prosthesis

and orthosis, MSW, clinical psychologist and/or psychiatrist, chaplain, volunteers and patient's family. In the team, the opinion of each member is respected in the formulation of treatment plan, and final decision is based on conclusion of team discussion. A coordinator is to be assigned in team meetings and service provision, e.g. a doctor or a nurse specialist. The team will hold regular meetings on cases seen and advises given and audit the health outcome. In complicated cases, the team members will consult senior staff in the Dept and other specialists as needed. The progress of the team will be reported to the COS regularly.

The proposed phases of development of the team are as follows. In Phase I (intra-departmental services), the following are provided: (1) production of formal assessment tools and guidelines; (2) provision of inpatient consultation services for difficult cases or patients with significant symptoms unrelieved after admission; (3) provision of OPD consultation for old cases with symptoms and problems difficult to manage. After discussion with frontline staff, pain control for inpatients was identified as the priority task in the first team meeting. Inpatient pain control perfomance standard was set: pain should be controlled to a bearable extent and all patients could have a fair sleep not severely disturbed by pain at night. In fact, PAIN is recorded as the fifth vital sign on the nursing chart. A Symptom Assessment Chart, a Pain Assessment Chart were designed and had been in use. Other job priorities were also identified: other forms should be designed for data collection, as well as education materials to staff and information pamphlets to patients/families; outpatient clinic for difficult symptom cases should be organized.

In Phase II development, inter-departmental (inside PWH) services would be provided. Consultation services to other departments in PWH concerning palliative care matters as well as participation in combined clinics with other specialties in order to formulate more comprehensive treatment plans, e.g. pain Clinic at present run by anaesthetists would be provided. In Phase III development. inter-hospital services would be provided. It is envisaged the team would cooperate with other hospice units to provide a more comprehensive palliative care service and to cooperate with palliative care teams in other oncology centers in order to develop common treatment recommendations and to work for joint project.

Potential difficulties and problems are to be expected . The team works in an oncology center which provides heavy acute medicine with curative aggressive

treatments and subsequent complications. The ward situation is thus very stressful and is not conducive to palliative care services. Not enough facilities and manpower can be provided. In fact, there is always a competition for manpower, time and bed between the acute and the palliative care teams. However, opportunities are also seen in such a setting. Being in an acute hospital provides access to many subspecialties and investigational facilities as well as research personnel. Intimate integration of interventional treatments (RT, chemotherapy) and supportive care can be facilitated. Cooperation with anaesthetists to provide better pain services is foreseen. Besides, education about palliative care for doctors, nursing staff, para-medical staff and medical students could be provided.

At present, the team is run by two Medical Officers (not dedicated) and two nurse specialists (not dedicated) with support from other medical and nursing staff. Since its establishment one year ago, it has seen 30+ cases in ward and 10+ cases in OPD. A Pain Chart has been incorporated for patients with complaint of pain and some Assessment Forms were produced. Some teaching sessions on pain control have been provided to staff. Meetings with other palliative care units in Shatin area have been organized to facilitate cooperation. An audit on pain control by RT in bone metastases as well as an audit on palliative care workload were produced.