

References: Palliative Care

REF ID: 6174

QM: Quality Measures

Topic 5: Evaluation/Follow-up

New report card compares end-of-life care initiatives across the country.(2003). *Quality Letter for Healthcare Leaders*, 15(1), 10-11.

Journal Article

A report card from Last Acts and the Robert Wood Johnson Foundation takes a first look on a state-by-state basis at how end-of-life care and related issues are approached by healthcare organizations across the country.

REF ID: 6268

Level I: Systematic Reviews

Topic 6: Comprehensive

Ahmed, N., Bestall, J. C., Ahmedzai, S. H., Payne, S. A., Clark, D., & Noble, B. (2004). Systematic review of the problems and issues of accessing specialist palliative care by patients, carers and health and social care professionals. *Palliative Medicine*, 18(6), 525-542.

Objectives: To determine the problems and issues of accessing specialist palliative care by patients, informal carers and health and social care professionals involved in their care in primary and secondary care settings. Data sources: Eleven electronic databases (medical, health-related and social science) were searched from the beginning of 1997 to October 2003. *Palliative Medicine* (January 1997-October 2003) was also hand-searched. Study selection: Systematic search for studies, reports and policy papers written in English. Data extraction: Included papers were data-extracted and the quality of each included study was assessed using 10 questions on a 40-point scale. Results: The search resulted in 9921 hits. Two hundred and seven papers were directly concerned with symptoms or issues of access, referral or barriers and obstacles to receiving palliative care. Only 40 (19%) papers met the inclusion criteria. Several barriers to access and referral to palliative care were identified including lack of knowledge and education amongst health and social care professionals, and a lack of standardized referral criteria. Some groups of people failed to receive timely referrals e.g., those from minority ethnic communities, older people and patients with nonmalignant conditions as well as people that are socially excluded e.g., homeless people. Conclusions: There is a need to improve education and knowledge about specialist palliative care and hospice care amongst health and social care professionals, patients and carers. Standardized referral criteria need to be developed. Further work is also needed to assess the needs of those not currently accessing palliative care services. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 5464

Level V: Case report

Topic 4.3: Management-Medication

Allcock, N., McGarry, J., & Elkan, R. (2002). Management of pain in older people within the nursing home: A preliminary study. *Health and Social Care in the Community*, 10(6), 464-471.

Journal Article, Research, Tables/Charts

The provision of continuing care for older people has largely shifted from the hospital setting to the community, and nursing homes increasingly provide support for older people, many of whom exhibit multiple pathology and complex health and social care needs. However, the quality of pain management within this setting has been identified as an issue of concern. It has been estimated that approximately two-thirds of people aged 65 years and over experience chronic pain, and that the prevalence of chronic pain in nursing home residents is between 45% and 80%. However, there exist a number of barriers to the identification and management of chronic pain among older people resident in nursing homes, including sensory impairments in older people themselves and educational deficits among professionals. Such barriers need to be overcome if pain management is to be improved. The present study involved

administering a pre-piloted postal questionnaire to the managers of 121 nursing homes within a geographically defined area. Sixty-eight (56%) were completed and returned. The questionnaire broadly covered the following: prevalence of chronic pain and use of interventions; assessment and management strategies; education and training; and communication barriers. Overall, 37% of nursing home residents were identified as experiencing chronic non-malignant pain (pain lasting longer than 3 months not caused by cancer) and 2% were reported as experiencing chronic malignant pain (pain lasting for more than 3 months caused by cancer). Paracetamol was identified as the most 'often' used analgesia for both pain modalities. Sixty-nine per cent of nursing homes did not have a written policy regarding pain management and 75% did not use a standardised pain assessment tool. Forty-four per cent of nursing homes provided education or training sessions for qualified staff and 34% provided this for care assistants. Forty per cent of qualified staff and 85% of care assistants had no specialist knowledge regarding the management of pain in older people. The present study confirms the need for the development of effective pain management strategies underpinned by appropriate training and education in order to meet the particular needs of older people.

REF ID: 6303

Level V: Case report

Topic 3: Assessment

Allen, R. S., Haley, W. E., Small, B. J., & McMillan, S. C. (2002). Pain reports by older hospice cancer patients and family caregivers: The role of cognitive functioning. *Gerontologist, 42(4)*, 507-514.

Journal; Peer Reviewed Journal

Examined associations between pain, cognitive functioning, and gender among cancer patients and their family caregivers during in-home hospice care. 176 cancer patients (aged 37.79-95.62 yrs) receiving hospice care and their caregivers (aged 23.98-91.90 yrs) were assessed regarding cognitive functioning, functional status, independence in self-care, and care recipient pain intensity. Results show that care recipients with cognitive impairment reported more intense pain than did those with intact cognitive functioning. However, cognitive impairment among care recipients exerted no effects on the pain reported by family caregivers. Care recipient cognitive impairment was related to greater discrepancy in the pain reports of caregivers and care recipients. No gender differences in pain intensity report were observed. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6168

QM: Quality Measures

Topic 5: Evaluation/Follow-up

American Academy of Hospice and Palliative Medicine, Center to Advance Palliative Care, Hospice and Palliative Nurses Association, Last Acts, P., & National Hospice and Palliative Care Organization. (2004). National consensus project for quality palliative care: Clinical practice guidelines for quality palliative care, executive summary. *Journal of Palliative Medicine, 7(5)*, 611-627.

Consensus Development Conference. Guideline. Journal Article. Practice Guideline. Review

REF ID: 6181

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Arata, M. (2001). Changing pain management practice at franciscan woods. interview by samantha libby sodickson.[see comment]. *Journal of Palliative Medicine, 4(4)*, 575-580.

Interview

REF ID: 6172

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Aspinal, F., Addington-Hall, J., Hughes, R., & Higginson, I. J. (2003). Using satisfaction to measure the quality of palliative care: A review of the literature.[see comment]. *Journal of Advanced Nursing, 42(4)*, 324-339.

Journal Article. Review

BACKGROUND: The advent of clinical governance in British health policy has placed increased demands on health care providers and practitioners to ascertain the quality of their services. Traditional indicators of quality of health care, such as death or recovery rates, are not appropriate in palliative care. Thus, it is important to establish alternative approaches to measuring the quality of palliative care services and interventions. **AIMS:** Satisfaction levels have been used widely in palliative care to assess quality. A literature review was conducted which aimed to explore the strengths and weaknesses of using satisfaction as an indicator of the quality of palliative care services. It also aimed to provide a solid basis upon which further work could be built. **METHODS:** Five electronic databases were searched using key words and phrases and key authors. Hand searches were conducted of four journals that contributed significantly to the concept of satisfaction, and reference lists of reviewed papers were scrutinized. Relevant papers were reviewed, data were extracted and these data were thematically analysed. **FINDINGS:** There are a number of important unresolved issues in the literature with regard to using satisfaction as an indicator of the quality of palliative care services. First, few alternatives to satisfaction are available. Secondly, satisfaction is under-theorized and no widely accepted definition exists. Thirdly, there are methodological inconsistencies across studies. It is important to take into account these findings when planning and implementing change following service evaluation using satisfaction as a measure. **CONCLUSIONS:** Relying on findings of satisfaction surveys to determine clinical and policy amendments in palliative care may not result in improvements in overall quality of care. Using satisfaction as a method of assessing the quality of health care services is particularly problematic and requires further investigation in both practical and conceptual terms. [References: 59]

REF ID: 175

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Au, H., Mulder, K. E., & Fields, A. L. A. (2003). Systematic review of management of colorectal cancer in elderly patients. *Clinical Colorectal Cancer*, 3(3), 165-171.

Journal Article, Research, Systematic Review, Tables/Charts

This study is designed to clarify the benefits and risks of chemotherapy and radiation therapy in elderly patients with colorectal cancer through a systematic review of the literature. Searches of the Medline, Embase, and Cochrane Library databases; PDQ Cancer Information Summaries, American Society of Clinical Oncology Guidelines, Cancer Care Ontario Practice Guideline Initiative, Interprovincial Drug Strategies and Guidelines Group, and OncoLink Web sites; and manual searches of meeting proceedings and bibliographies were performed. Additional studies known to the authors were also identified. Randomized controlled trials, reviews, and guidelines evaluating the impact of age on overall survival and/or toxicity with adjuvant and palliative therapies for colorectal adenocarcinoma were selected. A preset study selection form was applied to all identified studies. All selected studies underwent a preset study appraisal. Analyses of the effect of age on overall survival benefits and/or toxicity of therapy were extracted. A qualitative synthesis and narrative review was undertaken. There is good evidence to support that patients = 80 years of age have similar overall survival benefits with adjuvant 5-fluorouracil (5-FU)-based chemotherapy for colon cancer and with palliative first-line monotherapy for metastatic colorectal cancer, as do younger patients. Data are limited with regard to toxicity of therapy in older patients in these settings. An increase in toxicity with bolus 5-FU chemotherapy regimens is evident. There is a paucity of data regarding adjuvant treatment of older patients with rectal cancer. More elderly patients need to be enrolled in clinical trials in order to fully evaluate the outcomes of colorectal cancer therapy in this population. Further studies are warranted.

REF ID: 6083

Level I: Systematic Reviews

Topic 4.1: Management-General

Au, H., Mulder, K. E., & Fields, A. L. A. (2003). Systematic review of management of colorectal cancer in elderly patients. *Clinical Colorectal Cancer*, 3(3), 165-171.

Journal Article, Research, Systematic Review, Tables/Charts

This study is designed to clarify the benefits and risks of chemotherapy and radiation therapy in elderly patients with colorectal cancer through a systematic review of the literature. Searches of the Medline, Embase, and Cochrane Library databases; PDQ Cancer Information Summaries, American Society of Clinical Oncology Guidelines, Cancer Care Ontario Practice Guideline Initiative, Interprovincial Drug Strategies and Guidelines Group, and OncoLink Web sites; and manual searches of meeting proceedings and bibliographies were performed. Additional studies known to the authors were also identified. Randomized controlled trials, reviews, and guidelines evaluating the impact of age on overall survival and/or toxicity with adjuvant and palliative therapies for colorectal adenocarcinoma were selected. A preset study selection form was applied to all identified studies. All selected studies underwent a preset study appraisal. Analyses of the effect of age on overall survival benefits and/or toxicity of therapy were extracted. A qualitative synthesis and narrative review was undertaken. There is good evidence to support that patients = 80 years of age have similar overall survival benefits with adjuvant 5-fluorouracil (5-FU)-based chemotherapy for colon cancer and with palliative first-line monotherapy for metastatic colorectal cancer, as do younger patients. Data are limited with regard to toxicity of therapy in older patients in these settings. An increase in toxicity with bolus 5-FU chemotherapy regimens is evident. There is a paucity of data regarding adjuvant treatment of older patients with rectal cancer. More elderly patients need to be enrolled in clinical trials in order to fully evaluate the outcomes of colorectal cancer therapy in this population. Further studies are warranted.

REF ID: 6085

Level I: Systematic Reviews

Topic 6: Comprehensive

Baggs, J. G. (2002). End-of-life care for older adults in ICUs. *Annual Review of Nursing Research*, 20, 181-229.

Journal Article, Research, Systematic Review, Tables/Charts

REF ID: 6130

Level I:

Topic 4.3: Management-Medication

Bain, K. T., Weschules, D. J., Knowlton, C. H., & Gallagher, R. (2003). Toward evidence-based prescribing at end of life: A comparative review of temazepam and zolpidem for the treatment of insomnia. *American Journal of Hospice & Palliative Care*, 20(5), 382-388.

Journal Article. Meta-Analysis

A comparative review of temazepam and zolpidem use in managing insomnia in the hospice patient was undertaken to determine whether treatment with temazepam is a more cost-effective approach for this patient population. A MEDLINE search was conducted to identify pertinent literature, including clinical trials and reviews that involved temazepam or zolpidem. Published data was used as background information and provided in the discussion. This retrospective analysis, conducted from June 2002 through November 2002, focused on the prescribing patterns of temazepam and zolpidem in our hospice practice setting. We examined the reasons for discontinuation of each agent, along with the frequency of therapeutic change from temazepam to zolpidem. The top 10 ICD-9 codes associated with each treatment modality were investigated to determine any prescribing patterns. A total of 4,752 participants were prescribed either temazepam or zolpidem during this six-month period. Of the 4,065 patients prescribed temazepam 9.9 percent had the agent discontinued, whereas, 13.0 percent of those taking zolpidem (n = 687) terminated therapy. Reasons for discontinuation included change in dose, incomplete efficacy, change in patient status, adverse drug reaction, cultural/social issues and "other." Analyses of prescribing patterns and the reasons for termination of each drug therapy were completed and compared with results found in the primary literature. Due to the limited financial resources available for hospice care, our goal is to provide the most clinically appropriate and cost-effective agents for hospice patients. With the lack of data pertaining to the hospice patient, physicians often are faced with challenges in deciding the most appropriate therapy. They may prefer one agent over another based on current medical opinion rather than sound clinical evidence. After review of the primary

literature and the prescribing patterns in our setting, there is currently no evidence in our patient population to support that zolpidem is superior to benzodiazepines for the treatment of insomnia.

REF ID: 6279

Level IV: Non-experimental study

Topic 3: Assessment

Bekelman, D. B., Black, Shore, A. D., Kasper, J. D., & Rabins, P. V. (2005). Hospice care in a cohort of elders with dementia and mild cognitive impairment. *Journal of Pain and Symptom Management*, 30(3), 208-214.

Journal Article, Research, Tables/Charts

The objectives of this study were to identify the characteristics associated with hospice enrollment, to determine whether enrollment in hospice was associated with less pain and psychiatric symptoms, and to assess caregiver satisfaction with care near death in a sample of patients with dementia and mild cognitive impairment (MCI). Participants included decedents with dementia or MCI and other medical illnesses whose deaths were expected (n = 81) during a 3-year prospective, longitudinal, community-based cohort study. A total of 29.6% (n = 24) of participants received hospice care prior to death. Participants in hospice experienced less pain compared to those not in hospice, but this did not reach statistical significance (41.7% vs. 62.5%, P = 0.085). They were 65% more likely to be free of psychiatric symptoms (including restlessness, sleep problems, agitation, nervousness, and aggression toward others) during their final illness prior to death (OR = 0.35; 95% CI 0.13-0.96). In this cohort of people with dementia and MCI who died, several markers of quality of care suggest that hospice care can be beneficial for patients with dementia or MCI. (C) 2005 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

REF ID: 6305

Level VI: Opinion

Topic 6: Comprehensive

Berger, A. (2001). Palliative care in long-term-care facilities: A comprehensive model. *Journal of the American Geriatrics Society*, 49(11), 1570-1571.

Journal; Peer Reviewed Journal

Comments on the study by D. J. Casarett et al (see record 2002-15679-009) on whether hospice has a role in nursing home care at the end of life. Their results suggest that hospices are able to identify needs for palliative care for a substantial proportion of nursing home residents who are referred to hospice, although nursing home residents may have fewer identifiable needs for care than do community-dwelling older people. The study clearly offers some preliminary data and helps the understanding that this topic is an important topic to address. However, the paper has limitations (e.g., no contact with nursing home residents, the number of nursing home residents was very small, etc.) which the current author addresses. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6187

Level V:

Topic 1: Risks

Berger, A., Pereira, D., Baker, K., O'Mara, A., & Bolle, J. (2002). A commentary: Social and cultural determinants of end-of-life care for elderly persons. *Gerontologist*, 42(SpecIssue3), 49-53.

Journal; Peer Reviewed Journal

Provides a survey of literature reviewing social and cultural determinants as they relate to the settings where elderly individuals in the US die. This paper outlines possible factors for choices of settings at the end of life: (1) sociodemographic characteristics of the patient, (2) characteristics of available support networks, (3) measures of functional characteristics and degree of dependence on support network, and (4) health system and institutional factors. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6298

Level II: Individual experimental study

Topic 3: Assessment

Bezjak, A., Adam, J., Barton, R., Panzarella, T., Laperriere, N., & Wong, C. S. et al. (2002). Symptom response after palliative radiotherapy for patients with brain metastases. *European Journal of Cancer*, 38(4), 487-496.

Clinical Trial. Journal Article. Randomized Controlled Trial

Whole brain radiotherapy (RT) is frequently used to palliate symptoms in patients with brain metastases, but the palliative benefit to patients has not been well documented. We conducted a longitudinal observational prospective study of patients receiving standard RT (20 Gray (Gy)/5 fractions) for symptomatic brain metastases. End-points were observer rating of neurological symptoms, patient-rated symptoms, performance status, neurological functional status, cognitive function and quality of life (QOL). Median survival for the 75 patients was 86 days (95% confidence interval (CI): 65-101 days). At 1 month, 19% of patients showed an improvement or resolution of presenting symptoms, 23% were stable and 55% had progressed or died. Patient-rated symptoms were increased at 1 month in comparison to baseline data. Only 4 patients had an improved performance status and 22 were stable. Many patients with brain metastases have a short life expectancy and may not benefit from even short duration radiation schedules. Further effort is needed to optimise patient selection and tailor treatment appropriately.

REF ID: 6110

Level I: Systematic Reviews

Topic 6: Comprehensive

Bookbinder, M., Rutledge, D. N., Donaldson, N. E., & Pravikoff, D. S. (2001). End-of-life care series. part I. principles. *Online Journal of Clinical Innovations*, 4(4), 1-30.

Journal Article, Research, Systematic Review, Tables/Charts

Care at the end of life has received increased attention over the last decade. There are several reasons for this, including the aging population, the emphasis on the individual's right to make decisions about health care, and apparent weaknesses in the American healthcare system. The curative medical model focuses on diagnosis and treatment rather than interventions to improve the quality of life of patients and families as seen in a palliative care model. This review describes end-of-life care principles, explores the meaning of "good dying" discusses the concepts of medical futility and ethical decision making in the midst of palliative caregiving, and examines quality of life issues in dying from both a conceptual and clinical perspective.

REF ID: 6286

Level IV: Non-experimental study

Topic 1: Risks; Topic 4.1: Management-General

Born, W., Greiner, K. A., Sylvia, E., Butler, J., & Ahluwalia, J. S. (2004). Knowledge, attitudes, and beliefs about end-of-life care among inner-city african americans and latinos. *Journal of Palliative Medicine*, 7(2), 247-256.

Journal Article, Research, Tables/Charts

OBJECTIVE: This project explored end-of-life care preferences and barriers among low-income, urban African Americans and Latino/Hispanic Americans (Latinos) to uncover factors that may influence hospice utilization. **METHODS:** Focus groups were conducted separately for African Americans (4 groups, n = 26) and Latinos (4 groups, n = 27). Transcripts were coded and analyzed using consensus and triangulation to identify primary themes. **RESULTS:** Four preference themes and four barriers were identified. Results were largely similar across the two groups. Both preferred having families provide care for loved ones but expressed desire to reduce caretaker burden. Groups emphasized spirituality as the primary means of coping and valued the holistic well-being of the patient and family. Barriers reported were closely tied to access to care. Participants reported low hospice utilization because of lack of awareness of hospice and the prohibitive cost of health care. Latinos were more likely to report language barriers, while African Americans were more likely to report mistrust of the system. **CONCLUSIONS:** African Americans and Latinos in this study were highly receptive to end-of-life care that would provide relief for patients and caregivers and emphasize spirituality and family consensus. Improving awareness of hospice services would likely increase utilization.

REF ID: 6277

Level V: Case report

Topic 3: Assessment

Brayne, S., Farnham, C., & Fenwick, P. (2006). Deathbed phenomena and their effect on a palliative care team: A pilot study. *American Journal of Hospice & Palliative Medicine*, 23(1), 17-24.

Journal Article, Research

Anecdotal evidence suggests that death may be heralded by deathbed phenomena (DBP) such as visions that comfort the dying and prepare them spiritually for death. Medical practitioners have been slow to recognize DBP, and there has been little research into the spiritual effect that DBP have on caregivers or on how these phenomena influence their work. A pilot study looking into the occurrence of DBP was conducted by the palliative care team at Camden Primary Care Trust. Interviews revealed that patients regularly report these phenomena as an important part of their dying process, and that DBP are far broader than the traditional image of an apparition at the end of the bed. Results of the interviews raise concerns about the lack of education or training to help palliative care teams recognize the wider implications of DBP and deal with difficult questions or situations associated with them. Many DBP may go unreported because of this. Results of this pilot study also suggest that DBP are not drug-induced, and that patients would rather talk to nurses than doctors about their experiences.

REF ID: 6278

Level V: Case report

Topic 4.6: Management-Other

Bruce, A., & Davies, B. (2005). Mindfulness in hospice care: Practicing meditation-in-action. *Qualitative Health Research*, 15(10), 1329-1344.

Journal Article, Research, Tables/Charts

In this interpretive study, the authors explore the experience of mindfulness among hospice caregivers who regularly practice mindfulness meditation at a Zen hospice. They explore meditative awareness constituted within themes of meditation-in-action, abiding in liminal spaces, seeing differently, and resting in groundlessness. By opening into nonconceptual, paradoxical, and uncertain dimensions of experience, hospice caregivers cultivate internal and external environments in which direct experience is increasingly held without judgment. This inquiry points to in-between spaces of human experience wherein mindfulness fosters openness and supports letting go, and creating spaces for whatever is happening in attending the living-and-dying process.

REF ID: 6304

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Buchanan, R. J., Choi, M., Wang, S., & Huang, C. (2002). Analyses of nursing home residents in hospice care using the minimum data set. *Palliative Medicine*, 16(6), 465-480.

Journal; Peer Reviewed Journal

Examined profiles of residents in hospice care at time of nursing home admission. 40,622 Minimum Data Set (MDS) admission assessments for nursing home residents in hospice care (aged <50-91+ yrs) were analyzed concerning pain, cognitive patterns, physical function, disease diagnoses, medications, nutrition, and specific treatments received. Results show that 81% of Ss had "do not resuscitate" orders and only 27% had a living will. 70%+ of Ss experienced pain, with almost half experiencing daily pain. As well, more than half of Ss in pain experienced moderate pain and approximately 33% experienced horrible or excruciating pain. About 57% of Ss had cancer, 21% had congestive heart failure, 20% had emphysema/chronic obstructive pulmonary disease, and 18% had depression. About half of Ss exhibited at least moderate impairment in cognitive function. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6121

Level VI: Opinion

Topic 4.3: Management-Medication; Topic 4.6: Management-Other

Cameron, K. (2005). Review: Chemotherapy plus supportive care improves survival and quality of life in advanced or metastatic gastrointestinal cancer more than supportive care alone.

Evidence-Based Nursing, 8(1), 18.

Journal Article, Abstract, Commentary, Tables/Charts

Are cancer treatments that include supportive care (SC) more effective than SC alone for improving length of survival and quality of life in patients with advanced or metastatic gastrointestinal (GI) cancer? METHODS Data sources: Medline (1966-2002), CINAHL (1982-2001), EMBASE/Excerpta Medico (1980-2002), Best Evidence (1991-2001), HealthSTAR (1975-2001), CancerLIT (1966-2001), Oncolink (1994-2001), PsycINFO (1967-2001), Science and Social Science Citation Indexes (1981-2001), Cochrane Library (Issue 2, 2001), Grey literature sources, current research and trials registers, the internet, reference lists of articles, experts in the field, and hand searches of Ann Oncol, Br J Cancer, Eur J Cancer, Support Care Cancer, and Cancer Rev. Study selection and assessment: randomised controlled trials (RCTs) in any language that compared chemotherapy, radiotherapy, or surgery with SC interventions for patients ≥ 18 years of age who were diagnosed with and treated for cancer of the stomach, GI/gastric cancer, or colorectal/colon cancer in any setting and assessed ≥ 1 of symptom control, pain relief, or quality of life (QOL). Individual study quality was assessed using the 5 point Jadad scale and the 7 point Rinck scale. Outcomes: included length of survival, QOL, symptom control, pain severity, pain relief, adverse effects, and disease progression. MAIN RESULTS 4 trials (n = 483) met the selection criteria; all compared chemotherapy plus SC with SC alone in patients with advanced/metastatic GI cancer. Definitions of SC varied; however, SC included analgesics in 4 trials, antibiotics in 2 trials, and psychological support in 1 trial. Jadad scores ranged from 2-3 out of 5, and Rinck scores ranged from 4.5-5.5 out of 7. Meta-analysis was not done because of heterogeneity among studies. Each of the 4 trials showed that patients who received chemotherapy plus SC survived longer than those who received SC alone (table). 2 of 3 trials that measured QOL showed a statistically significant difference for chemotherapy plus SC compared with SC alone ($p < 0.02$, $p < 0.05$). Chemotherapy plus SC improved symptom control in the absence of toxicity (1 trial, $p < 0.01$) and increased pain free survival more than SC alone (1 trial, $p = 0.003$). Adverse events were more frequent in the chemotherapy plus SC groups. All 4 trials found that patients who received chemotherapy plus SC had stable disease or longer median time to progression than those who received SC alone ($p < 0.005$). CONCLUSION Chemotherapy plus supportive care improves survival and quality of life and delays disease progression more than supportive care alone in patients with advanced or metastatic gastrointestinal cancer.

REF ID: 6084

Level I: Systematic Reviews

Topic 4.1: Management-General

Cartwright, J. C. (2002). Nursing homes and assisted living facilities as places for dying. *Annual Review of Nursing Research*, 20, 231-264.

Journal Article, Research, Systematic Review, Tables/Charts

REF ID: 6092

Level II: Individual experimental study

Topic 4.6: Management-Other

Casarett, D., Karlawish, J., Morales, K., Crowley, R., Mirsch, T., & Asch, D. A. (2005). Improving the use of hospice services in nursing homes: A randomized controlled trial. *JAMA: Journal of the American Medical Association*, 294(2), 211-217.

Journal Article, Clinical Trial, Research, Tables/Charts

CONTEXT: Hospice care may improve the quality of end-of-life care for nursing home residents, but hospice is underutilized by this population, at least in part because physicians are not aware of their patients' preferences. OBJECTIVE: To determine whether it is possible to increase hospice utilization and improve the quality of end-of-life care by identifying residents whose goals and preferences are consistent with hospice care. DESIGN, SETTING, AND PARTICIPANTS: Randomized controlled trial (December 2003-December 2004) of nursing home residents and their surrogate decision makers

(N=205) in 3 US nursing homes. INTERVENTION: A structured interview identified residents whose goals for care, treatment preferences, and palliative care needs made them appropriate for hospice care. These residents' physicians were notified and asked to authorize a hospice informational visit. MAIN OUTCOME MEASURES: The primary outcome measures were (1) hospice enrollment within 30 days of the intervention and (2) families' ratings of the quality of care for residents who died during the 6-month follow-up period. RESULTS: Of the 205 residents in the study sample, 107 were randomly assigned to receive the intervention, and 98 received usual care. Intervention residents were more likely than usual care residents to enroll in hospice within 30 days (21/107 [20%] vs 1/98 [1%]; $P < .001$ [Fisher exact test]) and to enroll in hospice during the follow-up period (27/207 [25%] vs 6/98 [6%]; $P < .001$). Intervention residents had fewer acute care admissions (mean: 0.28 vs 0.49; $P = .04$ [Wilcoxon rank sum test]) and spent fewer days in an acute care setting (mean: 1.2 vs 3.0; $P = .03$ [Wilcoxon rank sum test]). Families of intervention residents rated the resident's care more highly than did families of usual care residents (mean on a scale of 1-5: 4.1 vs 2.5; $P = .04$ [Wilcoxon rank sum test]). CONCLUSION: A simple communication intervention can increase rates of hospice referrals and families' ratings of end-of-life care and may also decrease utilization of acute care resources. PMID: 16014595 [PubMed - indexed for MEDLINE]

REF ID: 6086

Level I: Systematic Reviews

Topic 3: Assessment

Casarett, D. J., Hirschman, K. B., & Henry, M. R. (2001). Does hospice have a role in nursing home care at the end of life? *Journal of the American Geriatrics Society*, 49(11), 1493-1498.

Journal Article, Research, Systematic Review, Tables/Charts

OBJECTIVES: To assess the possible benefits and challenges of hospice involvement in nursing home care by comparing the survival and needs for palliative care of hospice patients in long-term care facilities with those living in the community. DESIGN: Retrospective review of computerized clinical care records. SETTING: A metropolitan nonprofit hospice. PARTICIPANTS: The records of 1,692 patients were searched, and 1,142 patients age 65 and older were identified. Of these, 167 lived in nursing homes and 975 lived in the community. MEASUREMENTS: Patient characteristics, needs for palliative care, and survival. RESULTS: At the time of enrollment, nursing home residents were more likely to have a Do Not Resuscitate order (90% vs 73%; $P < .001$) and a durable power of attorney for health care (22% vs 10%; $P < .001$) than were those living in the community. Nursing home residents also had different admitting diagnoses, most notably a lower prevalence of cancer (44% vs 74%; $P < .032$). Several needs for palliative care were less common among nursing home residents, including constipation (1% vs 5%; $P = .02$), pain (25% vs 41%; $P < .001$), and anticipatory grief (1% vs 9%; $P < .001$). Overall, nursing home residents had fewer needs for care (median 0, range 0-3 vs median 1, range 0-5; rank sum test $P < .001$). Nursing home residents had a significantly shorter survival (median 11 vs 19 days; log rank test of survivor functions $P < .001$) and were less likely to withdraw from hospice voluntarily (8% vs 14%; $P = .03$). However, there was no difference in the likelihood of becoming ineligible during hospice enrollment (6% for both groups). CONCLUSIONS: These results suggest that hospices identify needs for palliative care in a substantial proportion of nursing home residents who are referred to hospice, although nursing home residents may have fewer identifiable needs for care than do community-dwelling older people. However, the finding that nursing home residents' survival is shorter may be of concern to hospices that are considering partnerships with nursing homes. An increased emphasis on hospice care in nursing homes should be accompanied by targeted educational efforts to encourage early referral.

REF ID: 6191

Level II: Individual experimental study

Topic 4.2: Management-Behavior Therapy

Chan, E. K. H., O'Neill, I., McKenzie, M., Love, A., & Kissane, D. W. (2004). What works for therapists conducting family meetings: Treatment integrity in family-focused grief therapy during palliative care and bereavement. *Journal of Pain and Symptom Management*, 27(6), 502-522.

Journal; Peer Reviewed Journal

The purpose of this study was to evaluate the treatment integrity of Family-Focused Grief Therapy (FFGT), a preventive intervention designed for families at high risk of poor functioning during palliative care and bereavement. From the 81 families participating in a randomized controlled trial (53 assigned to therapy), 28 were, randomly selected for this study of treatment fidelity using the FFGT integrity measure. A total of 109 family sessions were appraised. This represented a review of 62 % of treated families, 38 % of total therapy sessions, and 87% of the 15 participating therapists. Weighted mean percentage occurrences of therapist behaviors permitted trends in therapy application to be observed. Inter-rater reliability using the FFGT integrity measure was satisfactory, with 88% overall agreement. Eighty-six percent of therapists adhered faithfully to core elements of the model. Therapist competence was evidenced by a strong therapeutic alliance (94 %), affirmation of family strengths in over 90%, and focus on agreed themes in 76% of sessions. Therapists averaged 10 grief-related questions per session, 7 on communication-related issues during assessment, 7 on conflict late in therapy, and 4 on cohesiveness across the course of therapy. Consistent application of FFGT, with attention to its four key themes of family communication, cohesiveness, conflict resolution, and shared grief has been demonstrated. The model is generalizable when applied by family therapists. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6091

Level IV: Non-experimental study

Topic 3: Assessment

Chong, K., Olson, E. M., Banc, T. E., Cohen, S., AndersonMalico, R., & Penrod, J. D. (2004). Types and rate of implementation of palliative care team recommendations for care of hospitalized veterans. *Journal of Palliative Medicine*, 7(6), 784-790.

Journal Article, Research, Tables/Charts

BACKGROUND: Hospital-based interdisciplinary palliative care teams (PCTs) are increasingly being established to meet the growing demand for high quality care for patients with life-limiting illnesses in which the goal is comfort rather than cure. Two recent studies suggest that PCTs teams are highly effective in influencing care of patients within large academic medical centers. The current study examines whether the previously demonstrated success of palliative care teams within subspecialty academic health centers could be replicated in an urban Veterans Affairs medical center (VAMC). **OBJECTIVE:** To describe the characteristics of patients referred to, recommendations made by, and implementation rate of an interdisciplinary PCT in an urban VAMC. **DESIGN:** Retrospective, observational study. **SETTING/SUBJECTS:** One hundred patients referred by inpatient doctor to the PCT between October 1999 and March 2002 in a 214-bed VA hospital in the New York City area. **MEASUREMENTS:** Patient demographics, prevalence of five types of recommendations by the PCT and implementation rate by primary physician: (1) advance directives; (2) discharge planning; (3) pain management; (4) symptom management of dyspnea, delirium, constipation, nausea, anxiety, and depression; and (5) consultation orders for other services. **RESULTS:** The average number of recommendations per patient was 2.84 and 84.2% were implemented. The most frequent recommendations concerned discharge plans. The reasons recommendations were not implemented included: (1) patient or family refusal noted in the medical record, (2) the patient's clinical status changed, including patient death, and (3) the attending physician chose a different dose, medication, or route of administration than was recommended. **CONCLUSIONS:** Overall, most recommendations were implemented by the referring physicians. This finding is consistent with several prior studies demonstrating that PCTs in acute care can and do influence processes of care for hospitalized patients. Well-designed observational studies and randomized controlled trials of specific palliative care interventions and their effect on patient, family, and health care system outcomes are needed.

REF ID: 6138

Level II: Individual experimental study

Topic 4.3: Management-Medication

Coluzzi, P. H., Schwartzberg, L., Conroy, J. D., Charapata, S., Gay, M., & Busch, M. A. et al.

(2001). Breakthrough cancer pain: A randomized trial comparing oral transmucosal fentanyl citrate (OTFC) and morphine sulfate immediate release (MSIR). *Pain*, 91(1-2), 123-130.

Clinical Trial. Journal Article. Randomized Controlled Trial

Oral transmucosal fentanyl citrate (OTFC); Actiq) is a drug delivery formulation used for management of breakthrough cancer pain. Previous studies with open-label comparisons indicated OTFC was more effective than patients' usual opioid for breakthrough pain. The objective of this study was to compare OTFC and morphine sulfate immediate release (MSIR) for management of breakthrough pain in patients receiving a fixed scheduled opioid regimen. This double-blind, double-dummy, randomized, multiple crossover study was conducted at 19 US university- and community-based hospitals and clinics and comprised 134 adult ambulatory cancer patients. Patients were receiving a fixed scheduled opioid regimen equivalent to 60-1000 mg/day oral morphine or 50-300 microg/h transdermal fentanyl, were using a 'successful' MSIR dose (15-60 mg) as defined by entry criteria, and were experiencing 1-4 episodes of breakthrough pain per day. In open-label fashion, OTFC was titrated such that a single unit (200-1600 microg) provided adequate pain relief with acceptable side effects. Successfully titrated patients entered the double-blind phase of the study and received ten prenumbered sets of randomized capsules and oral transmucosal units. Five sets were the successful OTFC dose paired with placebo capsules, and five sets were placebo OTFC paired with capsules containing the successful MSIR dose. Patients took one set of study medication for each episode of target breakthrough pain. Pain intensity (PI), pain relief (PR) and global performance of medication (GP) scores were recorded. Pain intensity differences (PID) were calculated and 15-min PID was the primary efficacy variable. Adverse events were recorded. Sixty-nine percent of patients (93/134) found a successful dose of OTFC. OTFC yielded outcomes (PI, PID, and PR) at all time points that were significantly better than MSIR. GP also favored OTFC and more patients opted to continue with OTFC than MSIR following the study. Somnolence, nausea, constipation, and dizziness were the most common drug-associated side effects. In conclusion, OTFC was more effective than MSIR in treating breakthrough cancer pain.

REF ID: 5982

Level I: Systematic Reviews

Topic 3: Assessment

Coventry, P. A., Grande, G. E., Richards, D. A., & Todd, C. J. (2005). Prediction of appropriate timing of palliative care for older adults with non-malignant life-threatening disease: A systematic review. *Age and Ageing*, 34(3), 218-227.

Journal Article, Research, Systematic Review, Tables/Charts

BACKGROUND: most people in contemporary western society die of the chronic diseases of old age. Whilst palliative care is appropriate for elderly patients with chronic, non-malignant disease, few of these patients access such care compared with cancer patients. Objective referral criteria based on accurate estimation of survival may facilitate more timely referral of non-cancer patients most appropriate for specialist palliative care. **OBJECTIVE:** to identify tools and predictor variables that might aid clinicians estimate survival and assess palliative status in non-cancer patients aged 65 years and older. **METHODS:** systematic review and quality assessment using criteria modified from the literature. **RESULTS:** 11 studies that evaluated prognoses in hospitalised and community-based older adults with non-malignant disease were identified. Key generic predictors of survival were increased dependency of activities of daily living, presence of comorbidities, poor nutritional status and weight loss, and abnormal vital signs and laboratory values. Disease-specific predictors of survival were identified for dementia, chronic obstructive pulmonary disorder and congestive heart failure. No study evaluated the relationship between survival and palliative status. **CONCLUSION:** prognostic models that attempt to estimate survival of < or = 6 months in non-cancer patients have generally poor discrimination, reflecting the unpredictable nature of most non-malignant disease. However, a number of generic and disease-specific predictor variables were identified that may help clinicians identify older, non-cancer patients with poor prognoses and palliative care needs. Simple, well-validated prognostic models that provide clinicians with objective measures of palliative status in non-cancer

patients are needed. Additionally, research that evaluates the effect of general and specialist palliative care on psychosocial outcomes in non-cancer patients and their carers is needed.

REF ID: 6288

Level IV: Non-experimental study

Topic 3: Assessment

Covinsky, K. E., Eng, C., Lui, L., Sands, L. P., & Yaffe, K. (2003). The last 2 years of life: Functional trajectories of frail older people. *Journal of the American Geriatrics Society, 51(4), 492-498.*

Journal Article, Research, Tables/Charts

OBJECTIVES: To characterize the functional trajectories during the last 2 years of life of patients with progressive frailty, with and without cognitive impairment, and to assess whether it was possible to identify discrete functional indicators that signal the end of life. **DESIGN:** A retrospective analysis of functional trajectories during the last 24 months of life. **SETTING:** Twelve demonstration sites of the Program of All-inclusive Care for the Elderly (PACE). PACE cares for frail older people who meet criteria for nursing home placement, with the goal of keeping the patient at home. **PARTICIPANTS:** Nine hundred seventeen patients who died while enrolled in PACE. **MEASURES:** At PACE entry and every 3 months thereafter, data were collected about the degree of dependence (none, partial, or full) in bathing, eating, and walking and the degree of incontinence (none, bladder, or bowel). Cognitive impairment was defined as six or more errors on the Short Portable Mental Status Questionnaire. To describe the end-of-life trajectories of patients, data were analyzed from observational windows of time, beginning with the patients' dates of death and extending backward in time to 24 months before death. Each analytical window was 3 months in duration. For each of the functional measures, the probability of functional deterioration in the last 2 years of life in patients with (64%) and without (36%) cognitive impairment was also compared. **RESULTS:** The mean age at death was 84; 69% of patients were women. For patients with and without cognitive impairment, a prolonged, steady increase in the rates of functional dependence that were evident at least 1 year before death, rather than sudden increases in functional dependence shortly before death, characterized the functional trajectories. It was not possible for any of the four measures to detect a time point before death at which there was an abrupt decline in function likely to signal impending death. For each measure, patients with cognitive impairment declined earlier, were more likely than patients without cognitive impairment to have the maximal level of dependence in the 0- to 3-month window before death (e.g., 56% vs 30% for mobility, $P < .001$), and were more likely to decline in the 2 years before death (e.g., 56% vs 36% for mobility, $P < .001$). **CONCLUSION:** Patients with advanced frailty, with or without cognitive impairment, have an end-of-life functional course marked by slowly progressive functional deterioration, with only a slight acceleration in the trajectory of functional loss as death approaches. Patients with cognitive impairment have particularly high rates of functional impairment at the time of death. These results suggest that end-of-life care systems that are targeted toward patients with functional trajectories clearly suggesting impending death (such as the Medicare hospice benefit) are poorly suited to older people dying with progressive frailty.

REF ID: 6223

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Critchley, P., Plach, N., Grantham, M., Marshall, D., Taniguchi, A., & Latimer, E. et al. (2001). Efficacy of haloperidol in the treatment of nausea and vomiting in the palliative patient: A systematic review. *Journal of Pain and Symptom Management, 22(2), 631-634.*

Journal; Peer Reviewed Journal

Examines clinicians' frequent practice of prescribing haloperidol as an antiemetic and antinauseant in terminal patients. Authors note that nausea and vomiting are common in patients with terminal illness, even in the absence of treatment with chemotherapy or radiotherapy. Studies report that 50-62% of patients with terminal malignant disease suffer from nausea and vomiting at some point during their illness. Of 80 articles identified in the literature, 6 met the inclusion criteria, which included data

published in any country, in any language, on humans of any age with cancer or a terminal or palliative condition, experiencing nausea or vomiting not induced by chemotherapy or radiotherapy. Four of the 6 were case series and 2 were case reports. No controlled studies were found. Three of the studies in the review provided enough information on baseline symptoms, interventions, outcome measures, and evaluation tools to suggest that haloperidol may be effective in patients diagnosed with a variety of different cancers. Results of this systematic review show the paucity of well-designed and clearly reported studies evaluating the treatment of nausea and vomiting in palliative patients. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6284

Level VI: Opinion

Topic 4.6: Management-Other

Crow, S., & Banks, D. (2004). Guided imagery: A tool to guide the way for the nursing home patient. *Advances in Mind-Body Medicine, 20(4), 4-7.*

Journal Article, Research

Nursing-home patients often ask "Why me? Why am I still here?" They often feel helpless and abandoned. A guided-visualization intervention called "The Waiting Room" was used for 35 patients who expressed these feelings. This visualization could be a tool in helping nursing-home patients find peace.

REF ID: 6124

Level I:

Topic 6: Comprehensive

de Kort, S. J., Willemse, P. H., Habraken, J. M., de Haes, H. C., Willems, D. L., & Richel, D. J. (2006). Quality of life versus prolongation of life in patients treated with chemotherapy in advanced colorectal cancer: A review of randomized controlled clinical trials. *European Journal of Cancer, 42(7), 835-845.*

Journal Article. Meta-Analysis. Review

Oncologists disagree if chemotherapy in advanced cancer can improve quality of life (QoL), to prolong duration of life, or both. The objective of this study was to clarify the main treatment intention of palliative chemotherapy (PCT): the prolongation of life (PoL); or QoL. Randomized controlled clinical trials of PCT in advanced colorectal cancer that included HRQoL assessment were selected from PubMed and reviewed. Authors' conclusions were based on both PoL- and QoL-related outcomes. However, if PoL and QoL outcomes of the experimental arm were opposite, which was the case in 13 out of 28 trials, the authors generally based their conclusion on PoL outcomes. Authors' conclusions focused mainly on PoL-related outcomes, while QoL-related outcomes were of overriding importance in only 1/28 case. QoL can therefore not be considered as the main outcome of PCT. The review shows that in the context of chemotherapy in advanced colorectal cancer, 'palliative' refers to a life-prolonging intention, whereas within palliative care it refers to an improvement in QoL. [References: 39]

REF ID: 6285

Level V: Case report

Topic 4.6: Management-Other

Dean, R. A. K. (2003). Transforming the moment: Humor and laughter in palliative care., 281. Doctoral Dissertation, Research

The purpose of the research was to develop an extensive description of when and how humor and laughter are present in palliative care; to determine what functions are served by humor and laughter; and to identify circumstances where humor and laughter may be observed or experienced by patients, families, or staff as inappropriate or offensive. Data were collected through participant observation, informal interviews with patients and families, and semi-structured interviews with members of the healthcare team. Fieldwork involved over 200 hours spent accompanying six nurses for all of their daily activities on a 30 bed inpatient palliative care unit. Informal interviews occurred in the context of interactions with patients and families over the course of the fieldwork. Data analysis revealed that humor and laughter were pervasive and important in the research setting. An overall attitude of good

humor pervaded the environment. Within that atmosphere, humor took varied expressions, ranging in form and intensity. Gentle humor in the form of understated subtleties was pervasive. Witticisms and wordplay were common among the staff, as were playfulness, teasing, and jokes. Uproarious hilarity sometimes erupted in response to unexpected and spontaneous events or the high jinks of staff. Occasionally there was dark humor which poked fun at death and serious situations. Sometimes there was the more biting humor of sarcasm and putdowns. Humor served a variety of functions which were identified in three overarching themes; building relationships, contending with circumstances, and expressing sensibility. Humor between patients, families, and staff most commonly served to build therapeutic relationships, relieve tension, and protect dignity and a sense of worth. Amongst staff, humor was particularly significant in maintaining collegial relationships, dealing with stressful situations, and maintaining a sense of perspective. Several factors influenced whether or not humor arose. Humor was affected by individual differences in personality characteristics and experience, differing circumstances, ethnicity, gender, and degree of stress. Participants expressed difficulty in identifying strategies for when and how to introduce humor. Many indicated that they were not sure how it was that they discerned whether or not to use humor but felt that it was an intuitive knowing or a felt sense of what was appropriate. Further probing uncovered techniques for assessment including identification of cues and indications of receptivity. Findings established the significance of humor and laughter as therapeutic phenomena in care of the dying. (Abstract shortened by UMI.)

REF ID: 6282

Level V: Case report

Topic 4.6: Management-Other

Dean, R. A. K., & Gregory, D. M. (2005). More than trivial: Strategies for using humor in palliative care. *Cancer Nursing*, 28(4), 292-300.

Journal Article, Research, Tables/Charts

Humor and laughter are ubiquitous in human interactions. Terminal illness, however, is often accompanied by circumstances of anxiety, fear, and sadness. Hospice/palliative care emphasizes quality of life and the importance of human relationships. In this context, humor finds its place in authentic person-to-person connectedness. This article presents findings from a clinical ethnography that investigated the phenomena of humor and laughter in an inpatient palliative care unit. As a participant observer, the lead author accompanied 6 nurses throughout their day-to-day activities, twice weekly over 12 weeks. In addition to more than 200 hours of fieldwork, informal conversations were held with patients and families and semistructured interviews were conducted with nurses (n = 11), physicians (n = 2), a social worker (n = 1), and a physiotherapist (n = 1). Humor was pervasive, varied in the setting, and occurred across a range of intensities. Both clients and team members used humor to build relationships, contend with circumstances, and express sensibilities. Humor was affected by differences in people, differing circumstances, ethnicity, gender, and degree of stress. Participants relied on intuition as well as a constellation of other factors in discerning whether or not to use humor. Techniques for assessment included identification of cues such as expression in the eyes and timing as indications of receptivity. Combined with caring and sensitivity, humor is a powerful therapeutic asset in hospice/palliative care. It must neither be taken for granted nor considered trivial.

REF ID: 6289

Level V: Case report

Topic 4.6: Management-Other

Demmer, C., & Sauer, J. (2002). Assessing complementary therapy services in a hospice program. *American Journal of Hospice and Palliative Care*, 19(5), 306-314.

Journal Article, Research, Tables/Charts

Increasing numbers of people have been supplementing their health care needs with complementary therapies. Complementary therapies have been used to promote health and treat patients with a variety of ailments. Types of complementary therapies used with terminally ill patients have included massage, therapeutic touch, Reiki, art and music therapy, aromatherapy, and hypnotherapy. The purpose of this study was to survey primary caregivers (PCGs) regarding their perceptions and satisfaction with a

hospice complementary therapy program. Perhaps this study's most interesting finding is that patients who received complementary therapies were generally more satisfied with overall hospice services.

REF ID: 6272

Level V: Case report

Topic 4.6: Management-Other

DePalma, J. A. (2003). Evidence-based management of end-of-life pain. *Home Health Care Management & Practice, 16(1), 58-60.*

Evidence-based practice is the current buzzword in health care; it refers to basing practice decisions on the best available evidence. When advising clinicians to adopt an evidence base for their practice, I encourage searching for systematic reviews or meta-analyses in literature or already established evidence-based guidelines available online. Searching, accessing, and evaluating such sources of evidence are skills that need to be developed to successfully incorporate an evidence base into practice. A search of literature for end-of-life or chronic pain management revealed three sources that are worth sharing within the context of using existing syntheses. The first is a systematic review article about the use of hydromorphone for acute and chronic pain. The second is a combination of narrative and statistical review about palliative care teams and their impact on patients and their caregivers. The third is a meta-analysis on the effects of psychoeducational interventions with cancer pain. Each of these articles includes summary tables of the research studies included in that particular synthesis. These tables are extremely helpful for anyone who may be looking for a particular type of study to refer to or replicate in their setting. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 5455

Level I: Systematic Reviews

Topic 4.2: Management-Behavior Therapy

Devine, E. C. (2003). Meta-analysis of the effect of psychoeducational interventions on pain in adults with cancer. *Oncology Nursing Forum, 30(1), 75-89.*

Journal Article, Research, Systematic Review, Tables/Charts

PURPOSE/OBJECTIVES: To determine the effect of psychoeducational interventions on pain in adults with cancer. **DATA SOURCES:** 25 intervention studies published from 1978-2001. **DATA**

SYNTHESIS: When analyzed across all studies, a statistically significant, beneficial effect on pain was found. However, threats to validity were present in some studies. The most serious of these involved a lack of random assignment to treatment condition and a floor effect on pain. When limited to the studies with the best methodologic quality, the effect on pain continued to be statistically significant. Effect on pain by type of treatment was examined and found to be somewhat variable and limited by the small number of studies testing each type of treatment. **CONCLUSIONS:** Methodologic quality was variable. Reasonably strong evidence exists for relaxation-based cognitive-behavioral interventions, education about analgesic usage, and supportive counseling. Minimal data were available about the relative effectiveness of different types of psychoeducational interventions because few studies included within-study contrasts of different experimental interventions and usual care was not well documented.

IMPLICATIONS FOR NURSING: Psychoeducational interventions are not a substitute for analgesics, but they may serve as adjuvant therapy. Assessment and clinical judgment are critical. The intervention must be acceptable to patients and not too burdensome for patients in pain to use.

REF ID: 6294

Level VI: Opinion

Topic 6: Comprehensive

Dobratz, M. C. (2002). Voices from among the dying: Protecting a vulnerable population... 35th annual communicating nursing research Conference/16th annual WIN assembly, "health disparities: Meeting the challenge," held april 18-20, 2002, palm springs, california. *Communicating Nursing Research, 35, 266.*

Journal Article, Abstract, Research

REF ID: 6301

Level V: Case report

Topic 1: Risks

Dobratz, M. C. (2003). Issues and dilemmas in conducting research with vulnerable home hospice participants. *Journal of Nursing Scholarship*, 35(4), 371-376.

Journal; Peer Reviewed Journal

Purpose: To describe issues and dilemmas related to nonparticipation, attrition, and needs for assistance in research with vulnerable home hospice participants. Design and Methods: Retrospective analysis, with descriptive statistics of the frequency of issues and dilemmas that occurred in a research study with a vulnerable population. Findings: From a group of 113 potential participants, 16 (14.1%) people who gave initial consent were unable to participate or were lost to the study (subset I) for the following reasons: unable to give informed consent, cognitive disturbance, and physical distress. Of the 97 participants who completed testing, 28 (28.8%) required assistance (subset II) because of poor vision, physical weakness, and other physical impairments. Conclusions: Loss of potential participants limited this study and hampered effect size. Research with home hospice patients required careful assessment for symptoms that precluded informed consent. Issues with cognition indicated need for a tool to assess mental acuity. Although several participants required assistance, those who completed testing expressed gratitude at being able to contribute information that they believed would benefit others. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 5547

Level V: Case report

Topic 4.3: Management-Medication; Topic 3: Assessment

Duggleby, W. (2002). The language of pain at the end of life. *Pain Management Nursing*, 3(4), 154-160.

Journal Article

The effective management of pain at the end of life relies on the accurate assessment of pain. Language is the mechanism through which pain is assessed using self-report pain tools. The purpose of this study was to explore how elderly hospice patients describe their pain and to compare their descriptions with three commonly used pain assessment tools (i.e., McGill Pain Questionnaire, Memorial Pain Assessment Card, and the Visual Analogue Scale). Eleven elderly hospice patients with cancer were interviewed in their homes using open-ended unstructured questions. Data were analyzed line by line to identify descriptors of pain. These descriptors were then compared to standardized language used in the three pain assessment tools. In describing their pain, participants used many words, emphasized their pain by repeating those words, and used similes to describe their pain. The participants used approximately 30% of the standardized language found in three commonly used self-report instruments. These findings suggest that in conjunction with self-report instruments, the patient's own verbal descriptions should be used in the assessment of pain. Copyright 2002 by the American Society of Pain Management Nurses

REF ID: 6167

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Earle, C. C., Neville, B. A., Landrum, M. B., Souza, J. M., Weeks, J. C., & Block, S. D. et al. (2005). Evaluating claims-based indicators of the intensity of end-of-life cancer care. *International Journal for Quality in Health Care*, 17(6), 505-509.

Journal Article

OBJECTIVE: To evaluate measures that could use existing administrative data to assess the intensity of end-of-life cancer care. METHODS: Benchmarking standards and statistical variation were evaluated using Medicare claims of 48,906 patients who died from cancer from 1991 through 1996 in 11 regions of the United States. We assessed accuracy by comparing administrative data to 150 medical records in one hospital and affiliated cancer treatment center. RESULTS: Systems not providing overly aggressive care near the end of life would be ones in which less than 10% of patients receive chemotherapy in the last 14 days of life, less than 2% start a new chemotherapy regimen in the last 30 days of life, less than 4% have multiple hospitalizations or emergency room visits or are admitted to the intensive care unit

(ICU) in the last month of life, and less than 17% die in an acute care institution. At least 55% of patients would receive hospice services before death from cancer, and less than 8% of those would be admitted to hospice within only 3 days of death. All measures were found to have accuracy ranging from 85 to 97% and 2- to 5-fold adjusted variability between the 5th and 95th percentiles of performance. CONCLUSIONS: The usefulness of these measures will depend on whether the concept of intensity of care near death can be further validated as an acceptable and important quality issue among patients, their families, health care providers, and other stakeholders in oncology.

REF ID: 6276

Level V: Case report

Topic 6: Comprehensive

Ellison, N. M., & Radecke, M. W. (2005). An undergraduate course on palliative medicine and end-of-life issues. *Journal of Palliative Medicine*, 8(2), 354-362.

Journal Article, Research, Tables/Charts

BACKGROUND: The concept and development of this course were the joint efforts of the directors of the Susquehanna University Office of the Chaplain and the Geisinger Health System Palliative and Supportive Medicine Program (PMP). Both individuals perceived a need for increased awareness of students for issues related to advancing age and terminal illness. **OBJECTIVES:** Our objectives in formulating and presenting this course were to demystify aging, illness and death; increase awareness and tolerance for cultural and religious differences; enhance empathy and teach compassion; provide communication skills that could be used in many difficult situations; and provide a caring and mutually beneficial relationship for the elderly and students in our community. **DESIGN:** The one semester course consisted of 28 one-hour forty-five minute classes and a separate service-learning project. One half of the lectures, presented by the Susquehanna University chaplain (M.R.), predominantly involved religious and spiritual issues. The other 14 were organized by the PMP and were presented primarily by health care professionals. A required service-learning project was the creation of a "personal legacy." **SETTINGS/SUBJECTS:** The PMP group comprised 7 physicians, 3 nurses, 1 chaplain, and 2 individuals participating in volunteer community activities for the elderly and infirm. All volunteered their time for this endeavor. Each had autonomy concerning his class content and format. Eighteen students (2 seniors, 6 juniors, 7 sophomores and 3 freshmen) registered for and completed the course. **MEASUREMENTS:** In the final week, students were asked to evaluate the course with predominantly open-ended questions. They were informed that they would not be graded on their responses, and complete candor was encouraged. A less detailed evaluation of the overall experience by the course instructors was also solicited. These various comments are reviewed and discussed. **RESULTS AND CONCLUSIONS:** Overall, student and faculty comments about the course were quite positive. Every student believed that it was a very worthwhile course, but 4 of 18 would not sign up for it again and would not recommend it to a friend. We used the comments from the student and faculty participants to change the curriculum and presentation style for future courses.

REF ID: 6176

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Emmett, M. K. (2002). End-of-life care: Population-based quality measures. *West Virginia Medical Journal*, 98(3), 108-109.

Journal Article

REF ID: 6166

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Ethunandan, M., Rennie, A., Hoffman, G., Morey, P. J., & Brennan, P. A. (2005). Quality of dying in head and neck cancer patients: A retrospective analysis of potential indicators of care. *Oral Surgery Oral Medicine Oral Pathology Oral Radiology & Endodontics*, 100(2), 147-152.

Journal Article

OBJECTIVE: The objective of this study was to evaluate the quality of the dying experience in a cohort

of head and neck cancer patients by a retrospective analysis of potential indicators of care. **STUDY DESIGN:** The study design included retrospective case note analysis of previously evaluated factors considered important in the care of terminally ill patients and validated indicators of care obtainable from administrative data. The documented factors were analyzed to indicate specific elements of the quality of death and dying experience. **RESULTS:** Pain was a common symptom (84%) and was managed successfully in all patients, with 93% receiving opioids. Management of other symptoms, except neuropsychological problems, were satisfactory. Sixty-three percent of patients died in hospital and only 22% had a relative present at the time of death. Resuscitation status was documented in only 65% of the notes, though none were admitted to the intensive care unit or underwent resuscitation. Fifty-three percent of patients were admitted as an emergency in the last month of life and bleeding was the most common cause of admission. **CONCLUSION:** Valuable information can be obtained from a focused retrospective analysis. The indicators evaluated suggest that biomedical aspects of care are being recognized and addressed, although there is room for improvement. Psychosocial and spiritual aspects of care were not documented and must be taken into account to assess the "complete quality of dying" experience.

REF ID: 6195

Level I: Systematic Reviews

Topic 6: Comprehensive

Evans, R., Stone, D., & Elwyn, G. (2003). Organizing palliative care for rural populations: A systematic review of the evidence. *Family Practice, 20(3), 304-310.*

Journal; Peer Reviewed Journal

Conducted a systematic literature review of studies that have examined the organization of rural palliative care and the views of professionals in rural areas. Six electronic databases were searched for published studies between 1991 and 2001. Articles had to match against 1) MeSH or keyword terms relating to palliative, terminal or end of life care; and 2) MeSH or keyword terms relating to rural. Twenty-six studies were identified. Most studies were questionnaire surveys and reports; a few were qualitative studies. No randomized controlled studies or cohort studies were identified. Education and strategic issues were dominant research questions. The qualitative studies had methodological strengths and elicited important views from nurses, carers and families. General practitioners were unrepresented. The role of primary care emerged as an important theme, yet primary care professionals reported difficulties in obtaining education and training. Problems in symptom control, management of emotional issues such as bereavement counselling, and hospice services were also reported. Families were reported as having problems in accessing information. Developments in information technology such as telemedicine were seen as possible solutions to some of the problems. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 5534

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Feldt, K. S. (2004). The complexity of managing pain for frail elders.[comment]. *Journal of the American Geriatrics Society, 52(5), 840-841.*

Comment. Editorial

REF ID: 6144

Level I: Systematic Reviews

Topic 4.6: Management-Other

Fellowes, D., Barnes, K., & Wilkinson, S. (2004). Aromatherapy and massage for symptom relief in patients with cancer. *Cochrane Database of Systematic Reviews, (2), 002287.*

Journal Article. Review

BACKGROUND: Aromatherapy massage is a commonly used complementary therapy, and is employed in cancer and palliative care largely to improve quality of life and reduce psychological distress. **OBJECTIVES:** To investigate whether aromatherapy and/or massage decreases psychological morbidity, lessens symptom distress and/or improves the quality of life in patients with a diagnosis of

cancer. SEARCH STRATEGY: We searched CENTRAL (Cochrane Library Issue 1 2002), MEDLINE (1966 to May week 3 2002), CINAHL (1982 to April 2002), British Nursing Index (1994 to April 2002), EMBASE (1980 to Week 25 2002), AMED (1985 to April 2002), PsycINFO (1887 to April week 4 2002), SIGLE (1980 to March 2002), CancerLit (1975 to April 2002) and Dissertation Abstracts International (1861 to March 2002). Reference lists of relevant articles were searched for additional studies. SELECTION CRITERIA: We sought randomised controlled trials; controlled before and after studies; and interrupted time series studies of aromatherapy and/or massage for patients with cancer, that measured changes in patient-reported levels of physical or psychological distress or quality of life using reliable and valid tools. DATA COLLECTION AND ANALYSIS: Two reviewers independently assessed trials for inclusion in the review, assessed study quality and extracted data. Study authors were contacted where information was unclear. MAIN RESULTS: The search strategy retrieved 1322 references. Ten reports met the inclusion criteria and these represented eight RCTs (357 patients). The most consistently found effect of massage or aromatherapy massage was on anxiety. Four trials (207 patients) measuring anxiety detected a reduction post intervention, with benefits of 19-32% reported. Contradictory evidence exists as to any additional benefit on anxiety conferred by the addition of aromatherapy. The evidence for the impact of massage/aromatherapy on depression was variable. Of the three trials (120 patients) that assessed depression in cancer patients, only one found any significant differences in this symptom. Three studies (117 patients) found a reduction in pain following intervention, and two (71 patients) found a reduction in nausea. Although several of the trials measured changes in other symptoms such as fatigue, anger, hostility, communication and digestive problems, none of these assessments was replicated. REVIEWERS' CONCLUSIONS: Massage and aromatherapy massage confer short term benefits on psychological wellbeing, with the effect on anxiety supported by limited evidence. Effects on physical symptoms may also occur. Evidence is mixed as to whether aromatherapy enhances the effects of massage. Replication, longer follow up, and larger trials are need to accrue the necessary evidence. [References: 83]

REF ID: 6089

Level IV: Non-experimental study

Topic 4.3: Management-Medication

Fisher, K., Stiles, C., & Hagen, N. A. (2004). Characterization of the elderly pharmacodynamic profile of oral methadone for cancer-related breakthrough pain: A pilot study. *Journal of Pain and Symptom Management*, 28(6), 619-625.

Journal Article, Research, Tables/Charts

Methadone is effective for chronic cancer pain, but its early pharmacodynamic profile and effectiveness for breakthrough pain remain uncertain. This was an open-label, non-randomized, crossover study comparing the use of oral methadone for breakthrough pain with patients' usual opioid. Study variables included pain intensity (pretreatment and at 10-minute intervals post treatment), treatment-related side effects, and treatment satisfaction. In 37 discrete episodes of breakthrough pain, onset of analgesic effect of a titrated dose of oral methadone was rapid for all patients; 3 of 6 study patients experienced an onset of relief by 10 minutes post-ingestion. The adverse effect profile of oral methadone was not different from patients' usual 'rescue' opioid, and patients were moderately to completely satisfied with oral methadone as a breakthrough pain medication. These observations suggest that oral methadone can have a rapid onset of analgesic action and may have a legitimate role in the management of cancer-related breakthrough pain.

REF ID: 6270

Level V:

Topic 4.6: Management-Other

Flannelly, K. J., Weaver, A. J., & Costa, K. G. (2004). A systematic review of religion and spirituality in three palliative care journals, 1990-1999. *Journal of Palliative Care*, 20(1), 50-56.

Religious community and spiritual practice are important in the lives of a substantial number of people in the United States. Religion is a fundamental coping mechanism for many people when dealing with grave illness. Research in the U.S and Great Britain on people grieving the death of a family member or

close friend found a strong association between their psychological health and their ability to find meaning in their loss through religious beliefs. Other studies have also found religious beliefs to be of considerable help in dealing with grief. Studies of patients and physicians in several specialties in the U.S. and the U.K. have consistently found that both patients and physicians favour incorporating religion/spirituality into medical practices. In light of the reported interest of both patients and physicians in the role of religion and spirituality, and its importance as a patient coping mechanism, one might expect to find a fair number of articles that discuss the importance of religion and spirituality in health care in the hospice and palliative care literature, especially in recent years. The purpose of this study was, therefore, to assess the degree to which articles, published during the past decade in the three palliative care journals, discussed and examined religion and spirituality. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6216

Level I: Systematic Reviews

Topic 3: Assessment

Glare, P., Virik, K., Jones, M., Hudson, M., Eychmuller, S., & Simes, J. et al. (2003). A systematic review of physicians' survival predictions in terminally ill cancer patients. *BMJ: British Medical Journal*, 327(7408), 195-197.

Journal; Peer Reviewed Journal

Reviewed the accuracy of physicians' clinical predictions of survival in terminally ill cancer patients. Studies were included in this analysis if a physician's temporal clinical prediction of survival (CPS) and the actual survival (AS) for terminally ill cancer patients were available for statistical analysis. Study quality was assessed by using a critical appraisal tool produced by the local health authority. 17 published studies were identified; 12 met the inclusion criteria and 8 were evaluable, providing 1,563 individual prediction-survival dyads. CPS was generally overoptimistic; it was correct to within 1 week in 25% of cases and overestimated survival by at least 4 weeks in 27% of cases. The longer the CPS the greater the variability in AS. Although agreement between CPS and AS was poor, the two were highly significantly associated after log transformation. Although clinicians consistently overestimate survival, their predictions are highly correlated with actual survival; the predictions have discriminatory ability even if they are miscalibrated. Clinicians caring for patients with terminal cancer need to be aware of their tendency to overestimate survival, as it may affect patients' prospects for achieving a good death. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6297

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Gloth FM, I. I. I., Scheve, A. A., Stober, C. V., Chow, S., & Prosser, J. (2001). The functional pain scale: Reliability, validity, and responsiveness in an elderly population. *Journal of the American Medical Directors Association*, 2(3), 110-114.

Journal Article, Equations & Formulas, Research, Tables/Charts

Objectives: Because of difficulty experienced in assessing pain in frail older patients and the lack of pain assessment tools with standardization in the elderly, the Functional Pain Scale (FPS), an instrument incorporating both subjective and objective components to assess pain, was developed and evaluated. Design, setting, participants, and measures: One hundred subjects more than 65 years old participated in the validity, reliability, and responsiveness (the clinical sensitivity of the instrument to change) testing of the Functional Pain Scale. Subjects were recruited from a geriatrics inpatient setting, a geriatrics outpatient setting, and a local hospice (residing in their homes). Ninety-four of the subjects completed all phases of testing. Reliability was tested using a test-retest format and a correlation matrix. Criterion-related validity was established as compared with the Visual Analog Scale (VAS), the Present Pain Intensity (PPI), the McGill Short Form Questionnaire (MPQ-SF), and the Numeric Pain Scale (NPS) instruments. Responsiveness for the FPS, the VAS, the PPI, the MPQ-SF, and the NPS instruments was determined using five previously described techniques: effect size, standardized response means, relative efficiency, direct comparison of t test scores, and direct comparison of P values. A cumulative

index was developed to rank each scale. Cumulative responsiveness index scores were based on individual scale performance for each separate responsiveness test. The lowest score in the cumulative responsiveness index indicated the most responsive scale. Results: Interrater reliability for instruments tested exceeded 0.95 for all instruments tested. Validity testing showed high correlations as well ($r = 0.62$, $r = 0.85$, $r = 0.80$, $r = 0.90$ for the VAS, the PPI, the MPQ-SF, and the NPS respectively). Responsiveness evaluated overall by the responsiveness index was best for the Functional Pain Scale (7) followed by the Visual Analog Scale (12), the Present Pain Intensity (13), the McGill Pain Questionnaire-Short Form (19), and the Numerical Pain Questionnaire (24). Conclusions: The Functional Pain Scale was determined to be reliable, valid, and responsive. The responsiveness of the Functional Pain Scale was superior to the other instruments tested. The Functional Pain Scale is an acceptable instrument for assessing pain in older adults and may reflect changes in pain better than other instruments tested. Further testing in other populations is warranted.

REF ID: 6265

Level I: Systematic Reviews

Topic 1: Risks

Gomes, B., & Higginson, I. J. (2006). Factors influencing death at home in terminally ill patients with cancer: Systematic review. *BMJ: British Medical Journal*, 332(7540), 1-7.

Objectives: To determine the relative influence of different factors on place of death in patients with cancer. Data sources: Four electronic databases-Medline (1966-2004), PsycINFO (1972-2004), CINAHL (1982-2004), and ASSIA (1987-2004); previous contacts with key experts; hand search of six relevant journals. Review methods: We generated a conceptual model, against which studies were analysed. Included studies had original data on risk factors for place of death among patients, > 80% of whom had cancer. Strength of evidence was assigned according to the quantity and quality of studies and consistency of findings. Odds ratios for home death were plotted for factors with high strength evidence. Results: 58 studies were included, with over 1.5 million patients from 13 countries. There was high strength evidence for the effect of 17 factors on place of death, of which six were strongly associated with home death: patients' low functional status (odds ratios range 2.29-11.1), their preferences (2.19-8.38), home care (1.37-5.1) and its intensity (1.06-8.65), living with relatives (1.78-7.85), and extended family support (2.28-5.47). The risk factors covered all groups of the model: related to illness, the individual, and the environment (healthcare input and social support), the latter found to be the most important. Conclusions: The network of factors that influence where patients with cancer die is complicated. Future policies and clinical practice should focus on ways of empowering families and public education, as well as intensifying home care, risk assessment, and training practitioners in end of life care. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6291

Level V: Case report

Topic 1: Risks

Goodridge, D., & Marr, H. (2002). Factors associated with falls in an inpatient palliative care unit: An exploratory study. *International Journal of Palliative Nursing*, 8(11), 548-556.

Journal Article, Research, Tables/Charts

In one inpatient palliative care unit falls were identified as a frequent and distressing, yet potentially avoidable, concern. The unit had the highest rate of falls in this long-term care setting, exceeding even that of dementia care units. No literature could be identified that examined falls in the palliative care population. The objective of the exploratory study was to examine factors associated with falls through retrospective archival data collection. Detailed information was collected on all 177 falls that occurred in the unit in 1999. Data were also gathered on patients who had not fallen for comparison. Analysis was conducted comparing risk factors of those patients who fell once and those who fell multiple times. It was found that advanced age, longer length of stay and a previous history of falls might be risk factors for future falls. Patients who fell multiple times had less symptom distress than patients who fell once.

REF ID: 6131

Level I:

Topic 6: Comprehensive

Goodwin, D. M., Higginson, I. J., Edwards, A. G., Finlay, I. G., Cook, A. M., & Hood, K. et al. (2002). An evaluation of systematic reviews of palliative care services. *Journal of Palliative Care*, 18(2), 77-83.

Journal Article. Meta-Analysis

This review aimed to identify and appraise all systematic reviews of palliative care services, to examine their findings in relation to methods used, and to explore whether further methods such as meta-analysis and meta-regression may be worthwhile. Ten databases were searched and augmented by hand searching specific journals, contacting authors, and examining the reference lists of all papers retrieved. Five systematic reviews met the inclusion criteria, and the update electronic search identified a further systematic review which found similar studies. A total of 39 studies were identified by the five systematic reviews. Of the 39 studies, 15 were RCTS, and 12 of those were North American. In comparison, the majority of U.K. studies were retrospective. Each review concluded similarly that there was a lack of good quality evidence on which to base conclusions. The more recent reviews were more rigorous, but none used a quantitative analysis. Despite the difficulties in combining heterogeneous interventions and outcomes in meta-analysis or meta-regression, such techniques may be valuable. More high quality evidence is needed to compare the relative merits of the differences in models of palliative care services, so that countries can learn from other appropriate systems of care at end of life.

REF ID: 5454

Level I: Systematic Reviews; QM: Quality Measures

Topic 3: Assessment ;Topic 5: Evaluation/Follow-up

Gordon, D. B., Pellino, T. A., Miaskowski, C., McNeill, J. A., Paice, J. A., & Laferriere, D. et al. (2002). A 10-year review of quality improvement monitoring in pain management: Recommendations for standardized outcome measures. *Pain Management Nursing*, 3(4), 116-130.

Journal Article, Research, Systematic Review, Tables/Charts

Quality measurement in health care is complex and in a constant state of evolution. Different approaches are necessary depending on the purpose of the measurement (e.g., accountability, research, improvement). Recent changes in health care accreditation standards are driving increased attention to measurement of the quality of pain management for improvement purposes. The purpose of this article is to determine what indicators are being used for pain quality improvement, compare results across studies, and provide specific recommendations to simplify and standardize future measurement of quality for hospital-based pain management initiatives. Pain management quality improvement monitoring experience and data from 1992 to 2001 were analyzed from 20 studies performed at eight large hospitals in the United States. Hospitals included: the University of Wisconsin Hospital and Clinics, Madison; Texas Medical Center, Houston; McAllen Medical Center, McAllen, TX; San Francisco General Hospital, San Francisco; Rush-Presbyterian-St. Luke's Medical Center and Northwestern Memorial Hospital, Chicago, IL; Memorial Sloan Kettering Cancer Center, New York; and Kaiser Sunnyside Medical Center of Kaiser Permanente Northwest, Clackamas, OR. Analyses of data led to consensus on six quality indicators for hospital-based pain management. These indicators include: the intensity of pain is documented with a numeric or descriptive rating scale; pain intensity is documented at frequent intervals; pain is treated by a route other than intramuscular; pain is treated with regularly administered analgesics, and when possible, a multimodal approach is used; pain is prevented and controlled to a degree that facilitates function and quality of life; and patients are adequately informed and knowledgeable about pain management. Although there are no perfect measures of quality, longitudinal data support the validity of a core set of indicators that could be used to obtain benchmark data for quality improvement in pain management in the hospital setting. Copyright 2002 by the American Society of Pain Management Nurses

REF ID: 5728

Level II: Individual experimental study

Topic 1: Risks

Grande, G. E., Farquhar, M. C., Barclay, S. I. G., & Todd, C. J. (2004). Caregiver bereavement

outcome: Relationship with hospice at home, satisfaction with care, and home death. *Journal of Palliative Care*, 20(2), 69-77.

Journal Article, Clinical Trial, Research, Tables/Charts

This study used a randomized controlled trial design to investigate the impact of hospice at home (HAH) on caregiver bereavement outcome. Secondary analyses considered the association between bereavement, place of death, and carers' assessment of support. Ninety-six informal carers of patients referred to HAH were surveyed six weeks post-bereavement about the quality of terminal care. Carers next completed measures of their own bereavement response and general health six months post-bereavement. There was no evidence that HAH had an impact on bereavement outcome. In contrast, perceptions of inadequate terminal support and high symptom severity were associated with worse carer bereavement response. However, it remains unclear whether carers' retrospective ratings constitute an accurate account of symptoms and care. Home deaths were associated with both better bereavement response and better physical health post-bereavement than were inpatient deaths. Further research is needed to investigate the implications of death at home for the carer.

REF ID: 6139

Level II: Individual experimental study

Topic 4.6: Management-Other

Grande, G. E., Todd, C. J., Barclay, S. I., & Farquhar, M. C. (2000). A randomized controlled trial of a hospital at home service for the terminally ill. *Palliative Medicine*, 14(5), 375-385.

Clinical Trial. Journal Article. Randomized Controlled Trial

This study evaluated the impact of a Cambridge hospital at home service (CHAH) on patients' quality of care, likelihood of remaining at home in their final 2 weeks of life and general practitioner (GP) visits. The design was a randomized controlled trial, comparing CHAH with standard care. The patient's district nurse, GP and informal carer were surveyed within 6 weeks of patient's death, and 225 district nurses, 194 GPs and 144 informal carers of 229 patients responded. There was no clear evidence that CHAH increased likelihood of remaining at home during the final 2 weeks of life. However, the service was associated with fewer GP out of hours visits. All respondent groups rated CHAH favourably compared to standard care but emphasized different aspects. District nurses rated CHAH as better than standard care in terms of adequacy of night care and support for the carer, GPs in terms of anxiety and depression, and informal carers in terms of control of pain and nausea. Thus whilst CHAH was not found to increase the likelihood of remaining at home, it appeared to be associated with better quality home care.

REF ID: 6280

QM: Quality Measures

Topic 3: Assessment; Topic 5: Evaluation/Follow-up

Grbich, C., Maddocks, I., Parker, D., Brown, M., Willis, E., & Piller, N. et al. (2005). Identification of patients with noncancer diseases for palliative care services. *Palliative & Supportive Care*, 3(1), 5-14.

Journal Article, Practice Guidelines, Research, Tables/Charts

Objective: To identify criteria for measuring the eligibility of patients with end-stage noncancer diseases for palliative care services in Australian residential aged care facilities. Methods: No validated set of guidelines were available so five instruments were used: an adaptation of the American National Hospice Association Guidelines; a recent adaptation of the Karnofsky Performance Scale; the Modified Barthel Index; the Abbey Pain Score for assessment of people who are nonverbal and a Verbal Descriptor Scale, also for pain measurement. In addition, nutritional status and the presence of other problematic symptoms and their severity were also sought. Results: The adapted American National Hospice Association Guidelines provided an initial indicative framework and the other instruments were useful in providing confirmatory data for service eligibility and delivery.

REF ID: 6127

Level I:

Topic 4.6: Management-Other

Haddad, P., Wong, R. K., Pond, G. R., Soban, F., Williams, D., & McLean, M. et al. (2005). Factors influencing the use of single vs multiple fractions of palliative radiotherapy for bone metastases: A 5-year review. *Clinical Oncology (Royal College of Radiologists)*, 17(6), 430-434. Meta-Analysis

AIMS: Evidence from a number of randomised trials and meta-analyses supports the use of single-fraction radiotherapy for the palliation of painful bone metastases. This study explores patient and treatment factors that influence the choice of single compared with multiple-fraction radiotherapy for the treatment of bone metastases in clinical practice. MATERIALS AND METHODS: The Princess Margaret Hospital Palliative Radiation Oncology Program Database served as the basis for our report. All courses of treatment delivered for bone metastases were extracted. Courses were classified into single or multiple fractions. Clinical characteristics were compared between the two groups. RESULTS: Between 1998 and 2002, 882 courses of radiotherapy were delivered for the treatment of bone metastases, of which 283 (32%) were a single fraction. The proportion of single-fraction treatments was 37% in 1998, 30% in 1999 and 43% in 2000, but dropped to 26% and 28% in 2001 and 2002, respectively ($P = 0.02$). Patients treated with single fractions were significantly older (68 ± 12 years vs 64 ± 12 years), and had more weight loss and poor performance status. Single fractions included 20% of treatments in palliative irradiation of the spine, 36% in the pelvis and long bones, and 59% in the chest wall ($P < 0.001$). There was no significant difference in patients' gender, primary cancers, number of metastatic sites, treating physicians, enrollment in a clinical trial and general radiotherapy waiting time in our department. Multivariate analysis indicated age ($P = 0.001$), performance status ($P < 0.001$), anatomical site ($P < 0.001$) and year of radiotherapy ($P = 0.006$) as significant. CONCLUSION: One-third of palliative radiotherapy courses for bone metastases in our programme were given as single fractions. Performance status, age and anatomical site were significant factors affecting single compared with multiple fractionation. The variation in the use of single fractions over time may reflect the dynamic process of interpretation and application of evidence from clinical trials to practice.

REF ID: 6217

Level I: Systematic Reviews

Topic 4.6: Management-Other

Harding, R., & Higginson, I. J. (2003). What is the best way to help caregivers in cancer and palliative care? A systematic literature review of interventions and their effectiveness. *Palliative Medicine*, 17(1), 63-74.

Journal; Peer Reviewed Journal

Informal carers in cancer and palliative care are known to have high needs and psychological morbidity, yet a literature review identified few targeted interventions. This systematic review of interventions for carers of patients using home cancer and palliative care services searched Medline, CancerLit, PsycInfo, and Cinahl databases. Papers that reported interventions for adults actively providing informal care for noninstitutionalized cancer and palliative care patients were reviewed. Twenty-two interventions were identified, comprising home nursing care (4), respite services (3), social networks and activity enhancement (2), problem solving and education (3), and group work (10). Of these, 9 were delivered solely to carers (i.e., targeted services). Only 6 of the carers' interventions had been evaluated, 2 of these had used a randomized control trial, 3 employed a single group methodology, and 1 was evaluated using facilitator feedback. There was a lack of outcome evaluation designs, small sample sizes and a reliance on intervention descriptions and formative evaluations. Methodological challenges may mean alternatives to 'pure' RCTs should be considered. The current evidence contributes more to understanding feasibility and acceptability than to effectiveness. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6180

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Head, B. (2001). Hospice outcomes: Meeting requirements and developing a national consensus. *Home Healthcare Nurse*, 19(5), 290-296.

Journal Article

This article describes the rationale for outcome measurement in hospice care and the requirements related to such measurement as stipulated by regulatory bodies, third party payers, and accreditation organizations. Also discussed are the end-result outcomes of hospice care and efforts by the National Hospice and Palliative Care Organization to develop consensus related to definition and measurement of these outcomes.

REF ID: 6170

OM: Quality Measures

Topic 5: Evaluation/Follow-up

Head, B., Ritchie, C. S., Scharfenberger, J., Keeney, C., Hermann, C., & Pfeifer, M. (2004). Kentucky's palliative care report card. *Journal of the Kentucky Medical Association*, 102(2), 57-65.

Journal Article

Last Acts released the first nationwide evaluation of palliative care services in November 2002. Each state was evaluated or "graded" on the following eight measures: advance care planning policies, location of death, hospice use, hospital end-of-life care services, care in ICUs at the end of life, pain among nursing home residents, state pain policies, and palliative care certified physicians and nurses. Kentucky scored well on state pain policies and number of nurses certified in palliative care but received low grades for hospital services and the number of patient deaths occurring in the home. This manuscript explores Kentucky's deficiencies and accomplishments related to the Last Acts evaluation and addresses opportunities for improving end-of-life care across the Commonwealth.

REF ID: 6137

Level II: Individual experimental study

Topic 4.6: Management-Other

Hernandez-Reif, M., Field, T., Krasnegor, J., & Theakston, H. (2001). Lower back pain is reduced and range of motion increased after massage therapy. *International Journal of Neuroscience*, 106(3-4), 131-145.

Clinical Trial. Journal Article. Randomized Controlled Trial

STUDY DESIGN: A randomized between-groups design evaluated massage therapy versus relaxation for chronic low back pain. **OBJECTIVES:** Treatment effects were evaluated for reducing pain, depression, anxiety and stress hormones, and sleeplessness and for improving trunk range of motion associated with chronic low back pain. **SUMMARY of BACKGROUND DATA:** Twenty-four adults (M age=39.6 years) with low back pain of nociceptive origin with a duration of at least 6 months participated in the study. The groups did not differ on age, socioeconomic status, ethnicity or gender. **METHODS:** Twenty-four adults (12 women) with lower back pain were randomly assigned to a massage therapy or a progressive muscle relaxation group. Sessions were 30 minutes long twice a week for five weeks. On the first and last day of the 5-week study participants completed questionnaires, provided a urine sample and were assessed for range of motion. **RESULTS:** By the end of the study, the massage therapy group, as compared to the relaxation group, reported experiencing less pain, depression, anxiety and improved sleep. They also showed improved trunk and pain flexion performance, and their serotonin and dopamine levels were higher. **CONCLUSIONS:** Massage therapy is effective in reducing pain, stress hormones and symptoms associated with chronic low back pain. **PRECIS:** Adults (M age=39.6 years) with low back pain with a duration of at least 6 months received two 30-min massage or relaxation therapy sessions per week for 5 weeks. Participants receiving massage therapy reported experiencing less pain, depression, anxiety and their sleep had improved. They also showed improved trunk and pain flexion performance, and their serotonin and dopamine levels were higher.

REF ID: 6140

Level I: Systematic Review

Topic 6: Comprehensive

Higginson, I. J., Finlay, I., Goodwin, D. M., Cook, A. M., Hood, K., & Edwards, A. G. et al. (2002). Do hospital-based palliative teams improve care for patients or families at the end of life? *Journal*

of Pain & Symptom Management, 23(2), 96-106.

Journal Article. Review

To determine whether hospital-based palliative care teams improve the process or outcomes of care for patients and families at the end of life, a systematic literature review was performed employing a qualitative meta-synthesis and quantitative meta-analysis. Ten databases were searched. This was augmented by hand searching specific journals, contacting authors, and examining the reference lists of all papers retrieved. Studies were included if they evaluated palliative care teams working in hospitals. Data were extracted by two independent reviewers. Studies were graded using two independent hierarchies of evidence. A Signal score was used to assess the relevance of publications. Two analyses were conducted. In a qualitative meta-synthesis data were extracted into standardized tables to compare relevant features and findings. In quantitative meta-analysis we calculated the effect size of each outcome (dividing the estimated mean difference or difference in proportions by the sample's standard deviation). Nine studies specifically examined the intervention of a hospital-based palliative care team or studies. A further four studies considered interventions that included a component of a hospital or support team, although the total intervention was broader. The nature of the interventions varied. The studies were usually in large teaching hospitals, in cities, and mainly in the United Kingdom. Outcomes considered symptoms, quality of life, time in hospital, total length of time in palliative care, or professional changes, such as prescribing practices. Only one of the studies was a randomized controlled trial and this considered a hospital team as part of other services. Most method scores indicated limited research quality. Comparison groups were subject to bias and the analyses were not adjusted for confounding variables. In addition, there were problems of attrition and small sample sizes. Nevertheless, all studies indicated a small positive effect of the hospital team, except for one study in Italy, which documented deterioration in patient symptoms. The Signal scores indicated that the studies were relevant. No study compared different models of hospital team. This review suggests that hospital-based palliative care teams offer some benefits, although this finding should be interpreted with caution. The study designs need to be improved and different models of providing support at the end of life in hospital need comparison. Standardized outcome measures should be used in such research and in practice. [References: 66]

REF ID: 6146

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Hirst, A., & Sloan, R. (2002). Benzodiazepines and related drugs for insomnia in palliative care. *Cochrane Database of Systematic Reviews, (4), 003346.*

Journal Article. Review

BACKGROUND: Insomnia, a subjective complaint of poor sleep and associated impairment in daytime function, is a common problem. Currently, benzodiazepines are the most used pharmacological treatment for this complaint. They are considered helpful for occasional short-term use up to four weeks but longer term use is not advised due to potential problems regarding tolerance, dosing escalation, psychological addiction and physical dependence. There is no consensus on their utility in patients with progressive incurable conditions who may require assistance with sleep for many weeks as their condition deteriorates. **OBJECTIVES:** To assess the effectiveness and safety of benzodiazepines or benzodiazepine receptor agonists such as Zolpidem, Zopiclone and Zaleplon for insomnia in palliative care. **SEARCH STRATEGY:** Several electronic databases were searched including Cochrane PaPaS Group specialized register, Cochrane Library Issue 4, 2001, MEDLINE, EMBASE, BNI plus, CINAHL, BIOLOGICAL ABSTRACTS, PSYCINFO, CANCERLIT, HEALTHSTAR, WEB OF SCIENCE, SIGLE, Dissertation Abstracts, ZETOC and the MetaRegister of ongoing trials. These were searched from 1960 to 2001 or as much of this range as possible. Additional articles were sought by handsearching reference lists in standard textbooks and reviews in the field and by contacting academic centres in palliative care and pharmaceutical companies. There were no language restrictions. **SELECTION CRITERIA:** Studies considered for inclusion were randomized controlled trials of adult patients in any setting, receiving palliative care or suffering an incurable progressive medical condition.

(For example, cancers, AIDS, Motor Neurone Disease, Multiple Sclerosis, Parkinson's Disease, Chronic Obstructive Pulmonary Disease). There had to be an explicit complaint of insomnia in study participants, diagnosed by any of the three main classification systems (DSM-IV (APA 1994), ICD (AASD 1990) or ICD (WHO 1992)), or as described in the study if it involved a subjective complaint of poor sleep. Studies had to compare a benzodiazepine or Zolpidem or Zopiclone or Zaleplon with placebo or active control for the treatment of insomnia. Any duration of therapy were considered. DATA COLLECTION AND ANALYSIS: Abstracts were independently inspected by both reviewers, full papers were obtained where necessary. Where there was uncertainty advice was sought by a third (PW). Data extraction and quality assessments were undertaken independently by both reviewers. MAIN RESULTS: No randomized controlled trials were identified meeting the a priori inclusion criteria. Thirty-seven studies were considered but all were excluded from the review. REVIEWER'S CONCLUSIONS: Despite a comprehensive search no evidence from randomized controlled trials was identified. It was not possible to draw any conclusions regarding the use of benzodiazepines in palliative care. [References: 69]

REF ID: 6300

Level V: Case report

Topic 3: Assessment

Hjermstad, M. J., Loge, J. H., & Kaasa, S. (2004). Methods for assessment of cognitive failure and delirium in palliative care patients: Implications for practice and research. *Palliative Medicine*, 18(6), 494-506.

Journal; Peer Reviewed Journal

The most commonly encountered clinical conditions presenting with cognitive failure (CF) are delirium, dementia and amnesic disorders. Of these, delirium is probably the most prevalent in palliative care, and it is potentially reversible. Thus, improvement in diagnostics seems warranted. The objectives of this review were to examine the methods for assessment of CF and delirium in palliative care. Twenty-two studies were reviewed: 64% were published in 2000 or later. Twelve reports focused on delirium, six on CF, while the remaining four assessed confusion (2), hallucinations and general psychological morbidity. Median sample size was 100 (20-393). Ten different instruments were used: The Mini Mental State Exam was used in 13 studies. Five studies were validation reports of new or existing instruments. The term CF is an imprecise description of a loss in one or more of the cognitive functions. The interchangeable use of CF as a description of specific diagnoses should be avoided, as this contributes to prevalence rates that are not representative. Assessment tools that discriminate between the different diagnostic entities presenting with CF should be used in future studies. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6093

Level IV: Non-experimental study

Topic 3: Assessment

Hoekstra, J., Bindels, P. J. E., van Duijn, N. P., & Schade, E. (2004). The symptom monitor. A diary for monitoring physical symptoms for cancer patients in palliative care: Feasibility, reliability and compliance. *Journal of Pain and Symptom Management*, 27(1), 24-35.

Journal Article, Clinical Trial, Questionnaire/Scale, Research, Tables/Charts

The aim of this study was to evaluate the feasibility, reliability and compliance of a new instrument, a diary to monitor physical symptoms for patients with cancer in the palliative phase of their illness. The development of the diary took place in three phases: two pilot studies and one intervention study. In Pilot I, reliability was tested within 13 pairs of patients and their proxy in a patient-proxy comparison. Pilot II was performed to test the feasibility of the instrument among 47 frail elderly. In the intervention study among patients with cancer in the palliative phase, the feasibility as well as the compliance has been tested. The phases have been completed with good results: reliability (ICC) of prevalent symptoms was above 0.75, good feasibility and good compliance. The Symptom Monitor can be used by patients and doctors as an instrument to monitor physical symptoms. The effectiveness of the use of this diary

for improvement in treatment of symptoms in the palliative phase of cancer is being tested in a randomized clinical trial. (C) 2004 U.S. Cancer Pain Relief Committee.

REF ID: 6197

Level I: Systematic Reviews

Topic 3: Assessment

Hotopf, M., Chidgey, J., AddingtonHall, J., & Ly, K. L. (2002). Depression in advanced disease: A systematic review part 1. prevalence and case finding. *Palliative Medicine*, 16(2), 81-97.

Journal; Peer Reviewed Journal

Reviews 46 studies concerning depression in patients with advanced cancer and among mixed hospice populations. Results show that studies were generally small, had high numbers of nonresponders, and rarely gave confidence intervals for estimates of prevalence. The most widely used assessment of depression was the Hospital Anxiety and Depression Scale (A. S. Zigmond & R. P. Snaith), which found 29% of examined Ss exhibiting definite depression. Studies that used psychiatric interviews indicated a prevalence of major depressive disorder ranging from 5%-26%. It is concluded that depression is a common problem in palliative care settings. The quality of much of the available research is poor, based on small samples of patients with very high nonparticipation rates. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6128

Level I:

Topic 6: Comprehensive

Howell, D., & Brazil, K. (2005). Reaching common ground: A patient-family-based conceptual framework of quality EOL care. *Journal of Palliative Care*, 21(1), 19-26.

Journal Article. Meta-Analysis

Improvement in the quality of end-of-life (EOL) care is a priority health care issue since serious deficiencies in quality of care have been reported across care settings. Increasing pressure is now focused on Canadian health care organizations to be accountable for the quality of palliative and EOL care delivered. Numerous domains of quality EOL care upon which to create accountability frameworks are now published, with some derived from the patient/family perspective. There is a need to reach common ground on the domains of quality EOL care valued by patients and families in order to develop consistent performance measures and set priorities for health care improvement. This paper describes a meta-synthesis study to develop a common conceptual framework of quality EOL care integrating attributes of quality valued by patients and their families.

REF ID: 5714

Level II: Individual experimental study

Topic 4.1: Management-General; Topic 4.6: Management-Other

Hudson, P. L., Aranda, S., & HaymanWhite, K. (2005). A psycho-educational intervention for family caregivers of patients receiving palliative care: A randomized controlled trial. *Journal of Pain and Symptom Management*, 30(4), 329-341.

Journal Article, Clinical Trial, Research, Tables/Charts

This study describes an evaluation of a psycho-educational intervention for family caregivers of patients dying of cancer at home. In a randomized controlled trial, participants (n = 106) received standard home-based palliative care services (n = 52) or these services plus the new intervention (n = 54). Data were collected at three time points: upon commencement of home-based palliative care (Time 1), five weeks later (Time 2), and then eight weeks following patient death (Time 3). No intervention effects were identified with respect to preparedness to care, self-efficacy, competence, and anxiety. However, participants who received the intervention reported a significantly more positive caregiver experience than those who received standard care at both Times 2 and 3. The findings indicate that it is possible to increase caregiver rewards despite being immersed in challenging circumstances that often yield considerable negative psychosocial sequelae. Furthermore, it is feasible for health professionals to discuss emotive topics, such as impending death, with caregivers without adverse effects. (C) 2005 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

REF ID: 6271

Level V: Case report

Topic 4.1: Management-General

Hughes, P. M., Ingleton, M. C., Noble, B., & Clark, D. (2004). Providing cancer and palliative care in rural areas: A review of patient and carer needs. *Journal of Palliative Care*, 20(1), 44-49.

There are several ways in which the delivery of cancer and palliative care services in rural areas merits special attention. A number of authors have described differences between the palliative care needs of rural populations and their urban counterparts. Several authors suggest that professional roles differ in rural areas, where health providers may be friends and neighbors, as well as care professionals.

Geography is likely to affect care provision, with access to specialist services a particular issue for rural dwellers, resulting in greater involvement of family members in care giving. We conducted a broadly based review of the international literature on rural palliative care, focused on the question: "What needs of patients and caregivers have been identified in the delivery of cancer and palliative care to rural areas?" A systematic approach was taken, although formal quality scoring was not undertaken. There are limitations to a review of this kind. Geographical locations were varied, although most authors describe a basic problem of specialized services available in urban centers which rural clients can access only with difficulty. Disease stage may also have varied, and care delivered ranged from active treatment of recently diagnosed disease to palliative care at the very end of life. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6145

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Jackson, K. C., & Lipman, A. G. (2004). Drug therapy for anxiety in palliative care. *Cochrane Database of Systematic Reviews*, (1), 004596.

Journal Article. Review

BACKGROUND: Anxiety is common among patients with advanced disease. It can be a natural response to impending death, but may also result from an underlying anxiety disorder, pain, or other untreated or poorly managed symptoms. **OBJECTIVES:** The primary objective of this review was to identify and evaluate studies examining medications used to treat patients suffering from anxiety during the terminal phases of disease. **SEARCH STRATEGY:** We searched the following sources: MEDLINE (1966 to July 2003), EMBASE (1980 to July 2003), CINAHL (1982 to July 2003), PsycLit (1974 to July 2003), PsycInfo (1990 to July 2003), and the Cochrane Library (Issue 2, 2003) for literature pertaining to this topic published in any language using a detailed search strategy. **SELECTION CRITERIA:** Prospective, randomized trials with or without blinding involving the use of pharmacological agents for the treatment of anxiety at the end of life were sought. **DATA COLLECTION AND ANALYSIS:** Six potential studies were identified by the search strategy but none met the criteria for inclusion in this review. Two of these studies assessed the effectiveness of alprazolam in patients with a diagnosis of cancer, but who would not be considered in the end-stage of life. **MAIN RESULTS:** No data were available to enable an assessment to be made of the effectiveness of drugs to treat anxiety in palliative care patients. **REVIEWER'S CONCLUSIONS:** There remains insufficient evidence to draw a conclusion about the effectiveness of pharmacotherapy for anxiety in terminally ill patients. To date no studies were found that met the inclusion criteria for this review. Prospective controlled clinical trials are necessary in order to establish the benefits and harms of pharmacotherapy for the treatment of anxiety in palliative care. [References: 17]

REF ID: 6185

Level V:

Topic 1: Risks

Jayawardena, K. M., & Liao, S. (2006). Elder abuse at end of life. *Journal of Palliative Medicine*, 9(1), 127-136.

Journal; Peer Reviewed Journal

Context: Advances in health care and changing demographics have led to an aging population whose

care at the end of life has become complex. Patients at the end of life, by the nature of their clinical and social circumstances, are at high risk for elder abuse. Underreporting of elder abuse is a growing concern. The clinical presentation of abuse may overlap with the natural dying process, further compounding the problem. Evidence acquisition: Articles were obtained through a PubMed search using the terms "elder abuse" and "elder mistreatment" and from the University of California, Irvine's Elder Abuse Forensic Center library. Additional references were followed through these first set of articles and also from colleagues expert in this field. Evidence synthesis: Multidisciplinary teams have been shown to be the most effective intervention for the assessment and prevention of abuse. Most abuse occurs at home by family members; the hospice team may be the only outside professionals coming into the home. Caregiver stress and victim dependency increase the risk for abuse. Although physical abuse is the most commonly envisioned, neglect is the most common form of abuse. Financial abuse is often the underlying motivation for other forms of abuse. Conclusions: Health professionals have an ethical and legal responsibility to both report and work to prevent suspected abuse. The interdisciplinary team can make a significant impact on elder abuse, a major detriment on quality of life. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6147

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Jennings, A. L., Davies, A. N., Higgins, J. P., & Broadley, K. (2001). Opioids for the palliation of breathlessness in terminal illness. *Cochrane Database of Systematic Reviews*, (4), 002066.

Journal Article. Review

BACKGROUND: Breathlessness is a common symptom in people with advanced disease. The most effective treatments are aimed at treating the underlying cause of the breathlessness but this may not be possible and symptomatic treatment is often necessary. Strategies for the symptomatic treatment of breathlessness have never been systematically evaluated. Opioids are commonly used to treat breathlessness: the mechanisms underlying their effectiveness are not completely clear and there have been few good-sized trials in this area. **OBJECTIVES:** To determine the effectiveness of opioid drugs given by any route in relieving the symptom of breathlessness in patients who are being treated palliatively. **SEARCH STRATEGY:** An electronic search was carried out of Medline, Embase, Cinahl, the Cochrane library, Dissertation Abstracts, Cancerd and SIGLE. Review articles and reference lists of retrieved articles were hand searched. Date of most recent search: May 1999 **SELECTION CRITERIA:** Randomised double-blind, controlled trials comparing the use of any opioid drug against placebo for the relief of breathlessness were included. Patients with any illness suffering from breathlessness were included and the intervention was any opioid, given by any route, in any dose. **DATA COLLECTION AND ANALYSIS:** Studies identified by the search were imported into a reference manager database. The full texts of the relevant studies were retrieved and data were independently extracted by two reviewers. Studies were quality scored according to the Jadad scale. The primary outcome measure used was breathlessness and the secondary outcome measure was exercise tolerance. Studies were divided into non-nebulised and nebulised and were analysed both separately and together. A qualitative analysis was carried out of adverse effects of opioids. Where appropriate, meta-analysis was carried out. **MAIN RESULTS:** Eighteen studies were identified of which nine involved the non-nebulised route of administration and nine the nebulised route. A small but statistically significant positive effect of opioids was seen on breathlessness in the analysis of studies using non-nebulised opioids. There was no statistically significant positive effect seen for exercise tolerance in either group of studies or for breathlessness in the studies using nebulised opioids. **REVIEWER'S CONCLUSIONS:** There is evidence to support the use of oral or parenteral opioids to palliate breathlessness although numbers of patients involved in the studies were small. No evidence was found to support the use of nebulised opioids. Further research with larger numbers of patients, using standardised protocols and with quality of life measures is needed. [References: 70]

REF ID: 6101

Level II: Individual experimental study

Topic 3: Assessment

Jordhoy, Fayers, P., Loge, J. H., AhlnerElmqvist, M., & Kaasa, S. (2001). Quality of life in palliative cancer care: Results from a cluster randomized trial. *Journal of Clinical Oncology*, 19(18), 3884-3894.

Journal Article, Clinical Trial, Research, Tables/Charts

PURPOSE: To assess the impact of comprehensive palliative care on patients' quality of life. The intervention was based on cooperation between a palliative medicine unit and the community service and was compared with conventional care. **PATIENTS AND METHODS:** A cluster randomized trial was carried out, with community health care districts defined as the clusters. Patients from these districts who had malignant disease and survival expectancy between 2 to 9 months were entered onto the trial. The main quality-of-life end points were physical and emotional functioning, pain, and psychologic distress assessed monthly by using the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-C30 (EORTC QLQ-C30) questionnaire and Impact of Event scale (IES). In total, 235 intervention patients and 199 controls were included. **RESULTS:** During the initial 4 months of follow-up, the compliance was good (72%) and comparable among treatment groups. No significant differences on any of the quality-of-life scores were found. At later assessments and for scores that were made within 3 months before death, there was also no consistent tendency in favor of any treatment group on the main outcomes or other EORTC QLQ-C30 scales/items. **CONCLUSION:** A general program of palliative care may be important to ensure flexibility and to meet the needs of terminally ill patients. However, to achieve improvements on a group level of the various dimensions of quality of life, specific interventions directed toward specific symptoms or problems may have to be defined, evaluated, and included in the program. Copyright (C) 2001 by American Society of Clinical Oncology

REF ID: 6299

Level III: Quasi-experimental study

Topic 4.3: Management-Medication

Kamboj, S. K., Tookman, A., Jones, L., & Curran, H. V. (2005). The effects of immediate-release morphine on cognitive functioning in patients receiving chronic opioid therapy in palliative care. *Pain*, 117(3), 388-395.

Journal; Peer Reviewed Journal

Morphine and other potent opioids are frequently used in palliative care and pain management. When sustained-release (SR) opioids do not provide adequate background analgesia, additional immediate-release (IR) opioid (e.g. short-acting morphine) may be required to alleviate breakthrough or episodic pain. Despite the frequent use of IR morphine on top of SR opioids, little is known about the effects of such treatment on patients' everyday cognitive functioning. This study therefore used a double-blind, placebo-controlled, cross-over design to assess cognitive functioning in 14 patients receiving palliative care. All patients were taking SR opioid preparations and required ≤ 2 doses of IR morphine/day. Performance on cognitive measures (as well as subjective measures of pain and mood) after a dose of IR morphine was compared with placebo. Patients experienced significantly more pain-reduction following IR morphine ($P=0.03$), while other measures of subjective drug effects (e.g. sedation) were largely unaffected. Patients displayed anterograde memory impairment after IR morphine relative to placebo ($P=0.003$). Intriguingly, patients also had significant 'retrograde' memory impairment: delayed recall of verbal information presented before IR morphine also declined ($P=0.024$). In addition, IR morphine reduced performance on a complex tracking task (Reitan's trails B; $P=0.03$) whilst enhancing it on a simpler tracking task (Reitan's trails A; $P=0.03$). In conclusion, this study suggests that IR morphine, when taken on top of a SR opioid, produces transient anterograde and retrograde memory impairments and a decrement in two-target tracking. These impairments may impact negatively on patients' everyday functioning. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6175

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Kelley, M. L., Sellick, S., & Linkewich, B. (2003). Rural nonphysician providers' perspectives on palliative care services in northwestern ontario, canada. *Journal of Rural Health, 19(1), 55-62.*

Journal Article

Most palliative care in rural remote areas is provided by nonphysicians. This paper reports a survey of interdisciplinary rural health service providers (not including physicians) to identify the strengths and weaknesses in palliative care service delivery in a rural and remote region in northwestern Ontario, Canada. Questionnaires were sent to 156 nurses, homemakers, social workers, and pastoral care workers who care for terminally ill persons and their families, and 122 were completed and returned (response rate 78%). Consistent with practice in most rural areas, 90% of respondents were generalists. Respondents identified several problems with palliative care services, including inadequate training for caregivers, inadequate support services for family and professional caregivers, inadequate human resources, and lack of organized volunteer programs. Suggestions for improvements included better education for service providers; better availability of palliative care services; more counseling and support services for patients, family members, and professionals; and greater availability of respite beds. Overall, respondents rated clients' needs as being better met than their own. The most frequently reported problems for care providers were related to the lack of supports for care provision.

REF ID: 6295

Level V: Case report

Topic 4.3: Management-Medication

Khojainova, N., SantiagoPalma, J., Kornick, C., Breitbart, W., & Gonzales, G. R. (2002).

Olanzapine in the management of cancer pain. *Journal of Pain and Symptom Management, 23(4), 346-350.*

Journal Article, Equations & Formulas, Research, Tables/Charts

In cancer patients, cognitive impairment, psychological distress, and anxiety may accompany and aggravate pain. Neuroleptics are frequently used to control these symptoms and may be used to treat pain that has been unresponsive to more conventional approaches. Because of prominent side effects of traditional neuroleptics and conflicting data regarding their analgesic efficacy, their use in the treatment of pain remains controversial. Olanzapine, an atypical neuroleptic, might offer advantages because of its safer side effect profile. It has also been shown to have an independent antinociceptive activity in animals. The use of olanzapine in the management of cancer pain has not been previously described. We prospectively collected the data on 8 cancer patients with severe pain, uncontrolled in spite of aggressive opioid titration, who received olanzapine to treat severe anxiety and mild cognitive impairment. Patients did not meet criteria for delirium and their cognitive impairment was defined as cognitive disorder not otherwise specified (NOS) according to DSM-IV. Patients received 2.5 to 7.5 mg of olanzapine daily. In all patients, opioid requirements had escalated rapidly prior to starting olanzapine. Levels of pain, sedation, and opioid use were measured 2 days before and 2 days after olanzapine was started. Cognitive state was assessed daily. All 8 patients had marked reduction of the daily pain scores. The average daily opioid use decreased significantly in all patients. Cognitive impairment and anxiety resolved within 24 hours of initiating olanzapine. In these 8 patients, decreased pain scores and opioid requirements may have resulted from improvement in cognitive function and the known anxiolytic effect of olanzapine. Other mechanisms may include independent or adjuvant analgesic effects of olanzapine. We conclude that olanzapine may be useful in the treatment of patients with uncontrolled cancer pain associated with cognitive impairment or anxiety. Further studies to evaluate possible analgesic effect of olanzapine are needed. Copyright (C) 2002 by Elsevier Science (USA).

REF ID: 246

Level VI: Opinion

Topic 3: Assessment

Topic 4.2: Management-Behavior Therapy

King, D. A., Heisel, M. J., & Lyness, J. M. (2005; 2005). Assessment and psychological treatment of depression in older adults with terminal or life-threatening illness. *Clinical Psychology: Science*

and Practice, 12(3), 339-353.

Journal; Peer Reviewed Journal

Depression decreases the quality of life and hinders efforts to palliate symptoms of adults with terminal or life-threatening illness. Nevertheless, depression often may go undetected and untreated in palliative care and hospice settings due to a number of factors, including the overlap of depressive symptoms with those of serious medical illness and concern that frail elderly patients cannot tolerate psychotherapy or antidepressant treatment. In this paper we review the available research regarding assessment and treatment of depression in older adults with terminal or life-threatening illness, focusing on patients who are seen in palliative care, cancer treatment, or hospice settings. Although the prevalence of depression is relatively high in these settings in mixed-age adult samples, studies focused exclusively on older adults are rare and there appear to be no randomized controlled trials of psychotherapy conducted to date that specifically address their needs. There are, however, promising psychological approaches featured in case reports and pilot studies that are consistent with empirically supported therapies for the general treatment of depression in older adults. Based on these preliminary findings and reports, we offer tentative recommendations for the assessment and treatment of depression in terminally ill older adults. We conclude that controlled research on psychotherapy for late-life depression is both feasible and urgently needed in palliative care, cancer care, and hospice settings. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6189

Level II: Individual experimental study

Topic 4.2: Management-Behavior Therapy

Kissane, D. W., McKenzie, M., Block, S., Moskowitz, C., McKenzie, D. P., & O'Neill, I. (2006). Family focused grief therapy: A randomized, controlled trial in palliative care and bereavement. *American Journal of Psychiatry, 163(7), 1208-1218.*

Journal; Peer Reviewed Journal

Objective: The aim of family focused grief therapy is to reduce the morbid effects of grief among families at risk of poor psychosocial outcome. It commences during palliative care of terminally ill patients and continues into bereavement. The authors report a randomized, controlled trial. Method: Using the Family Relationships Index, the authors screened 257 families of patients dying from cancer: 183 (71%) were at risk, and 81 of those (44%) participated in the trial. They were randomly assigned (in a 2:1 ratio) to family focused grief therapy (53 families, 233 individuals) or a control condition (28 families, 130 individuals). Assessments occurred at baseline and 6 and 13 months after the patient's death. The primary outcome measures were the Brief Symptom Inventory, Beck Depression Inventory, and Social Adjustment Scale. The Family Assessment Device was a secondary outcome measure. Analyses allowed for correlated family data and employed generalized estimating equations based on intention to treat and controlling for site. Results: The overall impact of family focused grief therapy was modest, with a reduction in distress at 13 months. Significant improvements in distress and depression occurred among individuals with high baseline scores on the Brief Symptom Inventory and Beck Depression Inventory. Global family functioning did not change. Sullen families and those with intermediate functioning tended to improve overall, whereas depression was unchanged in hostile families. Conclusions: Family focused grief therapy has the potential to prevent pathological grief. Benefit is clear for intermediate and sullen families. Care is needed to avoid increasing conflict in hostile families. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6290

Level V: Case report

Topic 3: Assessment; Topic 4.3: Management-Medication

Klepstad, P., Hilton, P., Moen, J., Fougner, B., Borchgrevink, P. C., & Kaasa, S. (2002). Self-reports are not related to objective assessments of cognitive function and sedation in patients with cancer pain admitted to a palliative care unit. *Palliative Medicine, 16(6), 513-519.*

Journal Article, Research, Tables/Charts

Cancer patients often report complaints of cognitive impairment and sedation. It is not well known if

subjective complaints reflect objective assessments of cognitive function (CF) and sedation. We obtained self-reports of sedation and CF from 29 patients admitted to a palliative care unit and receiving morphine treatment. Sedation was reported on a verbal rating scale (VRS) and CF was reported using the EORTC QLQ-C30 health-related quality-of-life questionnaire CF scale. The self-reports were compared with objective assessments of sedation and CF by applying the Observer's Assessment of Alertness/Sedation (OAA/S) scale and Mini Mental State Examination (MMS), respectively. The assessments were repeated for seven patients who were readmitted to the palliative care unit. The patient self-reports of memory, concentration and sedation were dichotomized into noncomplainers and complainers. The percentages of complainers were 54%, 46% and 37% for memory, concentration and sedation, respectively. Patients who complained from difficulties with concentration or memory did not score differently from noncomplainers on objective assessments of CF (MMS score), but had a significantly higher level of fatigue. Patients complaining from sedation did not score differently from noncomplainers on objective assessments of sedation (OAA/S score). We observed no significant correlations between EORTC QLQ-C30 CF scale scores and MMS scores, or between VRS sedation scores and OAA/S scores. The study demonstrates a lack of relationship between patient self-reports and objective methods for assessing sedation and cognitive failure. This finding illustrates the importance of differentiating between observations and patient self-reports. The results also question the validity of patient self-reports for measurements of cognitive failure and sedation.

REF ID: 6113

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Klinkenberg, M., Smit, J. H., Deeg, D. J. H., Willems, D. L., OnwuteakaPhilipsen, B. D., & van der Wal, G. (2003). Proxy reporting in after-death interviews: The use of proxy respondents in retrospective assessment of chronic diseases and symptom burden in the terminal phase of life. *Palliative Medicine, 17*(2), 191-201.

Journal Article, Research, Tables/Charts

This study evaluates the quality of data obtained from after-death interviews with significant others of deceased older persons regarding the prevalence of chronic diseases and symptoms in the terminal phase of life. These data are compared with reports from physicians and earlier self-reports from the deceased person. There were significant increases in nonresponse and nonavailability of significant others for decedents who had been divorced or had never been married, thus introducing some selection bias. At the level of the total sample, significant others seem to give accurate information about the prevalence of chronic diseases when compared with self-reports and reports from physicians. At the level of the individual sample member, after-death interviews with significant others provide valid information for the assessment of the prevalence of malignant neoplasms, diabetes mellitus, chronic obstructive pulmonary disease and cerebrovascular disease, but not for osteo- and rheumatoid arthritis and arteriosclerotic disease. At the level of the total sample, the prevalence of symptoms assessed by significant others did not differ greatly from the assessment made by physicians. However, at the level of the individual sample member, the validity of symptom assessment by significant others could not be supported by data obtained from the physicians. With regard to the type of significant others interviewed, children reported more symptoms than partners. The use of significant others in after-death interviews can be a valid method with regard to the assessment of chronic diseases and symptoms on a group level. On an individual level this can be concluded only for chronic diseases with clearly observable consequences.

REF ID: 6123

Level VI: Opinion

Topic 4.6: Management-Other

Krau, S. D. (2002). Providers tried to help patients and families make realistic end of life decisions. *Evidence-Based Nursing, 5*(2), 64.

Journal Article, Abstract, Commentary

critique of Original Study: Norton SA, Bowers BJ. Working toward consensus: providers' strategies to

QUESTION: What are the strategies used by providers to assist terminally ill patients and their families in shifting from curative to palliative treatment choices? Design Grounded theory. Setting Madison, Wisconsin, USA. Participants 10 nurses and 5 physicians (12 women and 3 men) who were working in the practice areas of home health and family practice, oncology, and intensive care. Methods Each provider was interviewed once, and 3 providers were interviewed a second time. The interviews were 30-90 minutes in length, and were tape recorded and transcribed verbatim. Analysis was done after each interview and the questions in subsequent interviews became increasingly focused on evolving categories. Theoretical sampling was built into the interviews with questions designed to determine the types of strategies providers use to assist patients to understand their situations and make realistic decisions. Main findings Providers' strategies aimed to help patients achieve a good death (eg, comfortable and peaceful) and avoid a bad one (eg, unnecessarily painful with overly aggressive treatment). The providers' main challenge was getting patients and their families to shift their goals and decisions to realistic ones in the context of a terminal illness. Providers described laying the groundwork so that patients and their families would have the background necessary to make realistic decisions. This was achieved by teaching about prognosis and treatment choices and discussing the possibility of death (planting seeds). Shifting the picture involved helping patients and their families move from unrealistic curative decisions to realistic palliative ones. Providers described the importance of communicating with each other and with patients and families to ensure that everyone had the same information and were working towards a common goal - a good death. Family meetings, including conference calls to out of town family members, provided the mechanism for such communication. Shifting the picture was also achieved by changing the scope of choice by introducing new, realistic choices to patients; changing the value of treatment options so that patient comfort was emphasised over cure; and changing indicators so that patients and their families could correctly monitor the patient's condition. Once patients and families had shifted the picture, providers reinforced the patients' acceptance of the new picture by involving social workers, clergy, or palliative care services; redirecting hope to more realistic goals; and by repeating and reiterating information. Conclusion Providers assisted terminally ill patients and their families in the transition from unrealistic curative goals to realistic palliative goals by laying the groundwork, shifting the picture, and reinforcing acceptance of the new picture.

REF ID: 6179

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Levenson, D. (2001). IOM report: Healthcare system shortchanges dying cancer patients. *Report on Medical Guidelines & Outcomes Research*, 12(14), 7-9.

News

REF ID: 6178

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Lewis, S., Bridge, M., Roughton, D., Barelds, J., Brenton, S., & Cotter, S. et al. (2002). Quality of life issues identified by palliative care clients using two tools. *Contemporary Nurse*, 12(1), 31-41.

Journal Article

Reported are issues impacting upon the Quality of Life (QoL) of 59 palliative care clients within a district nursing service. These issues reinforce the emerging conceptualisation of QoL as being subjective and multidimensional. The issues were identified during a trial of two QoL assessment and measurement tools, the Client Generated Index (CGI) and the McGill Quality of Life (MQOL). In this era of considerable concern about QoL for the terminally ill, the article's intent is to present the QoL issues identified, the grades of impact and priority for improvement of the issues according to the clients, and to discuss these aspects. This information can inform the assessment of palliative care clients (the

CGI tool was found ideal for such an assessment), and may also inform further research on the QoL of palliative care clients.

REF ID: 6114

Level II: Individual experimental study

Topic 4.6: Management-Other

Lewith, G. T., Prescott, P., & Davis, C. L. (2004). Can a standardized acupuncture technique palliate disabling breathlessness: A single-blind, placebo-controlled crossover study. *Chest, 125(5), 1783-1790.*

Journal Article, Clinical Trial, Research, Tables/Charts

STUDY OBJECTIVES: The management of disabling breathlessness is poor, and a standardized form of acupuncture has been reported as offering benefit. This study was designed to evaluate the efficacy of standardized acupuncture treatment. **DESIGN:** A single-blind, randomized, crossover study. **SETTING:** This study was carried out on a domiciliary basis in Southampton (UK). **INTERVENTIONS:** This study evaluated a standardized acupuncture technique vs an appropriately validated placebo/control (mock transcutaneous electrical nerve stimulation [TENS]) for disabling, nonmalignant breathlessness (largely COPD). The acupuncture was provided by an appropriately trained nurse acupuncturist. Each patient received six treatments in each phase of the study, with an intervening 2-week washout period. **MEASUREMENTS AND RESULTS:** The primary outcome was worst breathlessness (visual analog scale, 0 to 100 mm), with the sample size based on an 80% power to detect a 10-mm difference between treatment means. Secondary outcomes included the St George's respiratory questionnaire score and treatment credibility. **RESULTS:** Thirty-six patients were entered into the study (33 with COPD), and 24 patients completed both treatment phases. The primary outcome improved significantly during the course of the study, but there were no significant treatment differences between acupuncture and the placebo/control of mock TENS for either primary or secondary outcomes. The placebo was shown to be a credible control. There was no evidence of a carryover effect from the first to second phase of the study. **CONCLUSION:** This standardized acupuncture technique does not show specific efficacy in disabling nonmalignant breathlessness, but those entered into the study did experience clinically significant benefit from both treatments.

REF ID: 6108

Level III: Quasi-experimental study

Topic 4.6: Management-Other

Lioffi, C., & White, P. (2001). Efficacy of clinical hypnosis in the enhancement of quality of life of terminally ill cancer patients. *Contemporary Hypnosis, 18(3), 145-160.*

Journal Article, Clinical Trial, Research, Tables/Charts

The fact that terminal cancer patients experience considerable psychological distress is now undisputed, but the effectiveness of psychological treatments in relieving this suffering is less clear. The aim of the present research was to evaluate the efficacy of clinical hypnosis in the enhancement of quality of life of patients with far-advanced cancer. Fifty terminally ill cancer patients were randomly assigned to two groups: standard care and hypnosis. Patients in the standard care group received routine medical and psychological care. Their medical treatment included pharmacological management of pain and other symptoms following the World Health Organization's model of palliative care (WHO, 1990). The psychological support consisted of supportive counselling based on the cognitive existential therapeutic tradition. In addition to the standard care, patients in the hypnosis group received weekly sessions of hypnosis with a therapist for four weeks. Outcome measures included quality of life, as measured by The Rotterdam Symptom Checklist (DeHaes, Olschewski, Fayers, Visser, Cull, Hopwood and Sanderman, 1996), and depression and anxiety, as measured by The Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983). Results demonstrated that at the end of intervention patients in the hypnosis group had significantly better overall quality of life and lower levels of anxiety and depression when compared to the standard care group. It is concluded that hypnosis is effective in the enhancement of quality of life in terminally ill cancer patients.

REF ID: 6196

Level I: Systematic Reviews

Topic 4.1: Management-General

Ly, K. L., Chidgey, J., AddingtonHall, J., & Hotopf, M. (2002). Depression in palliative care: A systematic review. part 2. treatment. *Palliative Medicine*, 16(4), 279-284.

Journal; Peer Reviewed Journal

Reviews literature on the treatment of depression in palliative care patients. In Part 1 of this series (see record 2002-02710-001), the authors review prevalence and case finding. Here, all randomized controlled trials (RCTs) of interventions for depression in patients with advanced disease were eligible, although most involved cancer patients. Results show that 3 RCTs assess pharmacological treatments. Of these, 2 are placebo controlled and assess mianserin and thioridazine. The third compares 2 antidepressants. There are no RCTs that specifically assess psychotherapy for patients with depression. The researchers conclude that there are too few adequate studies to draw clear conclusions about management of depression in this setting. The treatment of depression in patients with advanced disease must, for now, be informed by the larger body of evidence on effective treatments for depression in patients with either no physical illness or less severe medical conditions. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6269

Level V: Case report

Topic 4.2: Management-Behavior Therapy

Lyness, J. (2004). End-of-life care: Issues relevant to the geriatric psychiatrist. *American Journal of Geriatric Psychiatry*, 12(5), 457-472.

Most deaths in the United States occur in the context of chronic diseases in later life and are too often accompanied by potentially remediable emotional or physical suffering. Geriatric psychiatrists and other mental health professionals can contribute meaningfully to the provision of optimal care during the final phases of life. This review provides an overview of end-of-life care, focusing on issues most relevant to the geriatric psychiatrist. The author examined palliative care textbooks and review papers to determine the topics to be included in this article, and searched computerized literature databases on these topics. Many of the recommendations provided herein stem from experts' clinical experience; however empirical evidence is also incorporated and critiqued. Topics covered include conversations with patients and families about end-of-life care; the evaluation and treatment of suffering, including pain, depression, suicidality, anxiety, and delirium; the role of individual and family therapies in caring for dying patients; capacity determination; advance care planning; withholding life-sustaining treatments; and "last resort" (and, in some cases, quite controversial) options, such as terminal sedation, assisted suicide, and euthanasia. The author also notes the relevance of such end-of-life-care considerations to patients with dementia. Geriatric psychiatrists' skills across these multiple domains are of particular usefulness. Through such clinical skills and the application of empirical research tools to the many unanswered questions in the care of dying patients, geriatric psychiatry can make increasingly valuable and visible contributions to improving quality of life for people suffering from life-threatening illnesses. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6082

Level I: Systematic Reviews

Topic 4.6: Management-Other

McKee, L. (2005). Palliative radiotherapy for painful bone metastases, single versus multiple fraction treatment: A literature review. *Canadian Journal of Medical Radiation Technology*, 36(3), 7-16.

Journal Article, Research, Systematic Review, Tables/Charts

Background and purpose: Palliative radiotherapy provides pain relief for patients with painful bone metastases. The practice among radiation oncologists as to whether a large single fraction is most effective, or whether multiple smaller fractions are preferable in providing the quickest, most durable pain relief is inconsistent. Material and methods: A literature review was completed to see if there is

consensus about whether there is better pain response and control following single versus multiple fraction radiotherapy. The Pub Med search engine was used to find all reported studies comparing single and multiple fraction radiotherapy for painful bone metastases. Each article was reviewed according to specific criteria. A generalized conclusion was ascertained from each study and then compared. Results: Among the studies reviewed, the consensus concluded that single fraction radiotherapy was the better choice for palliation of painful bone metastases. Conclusions: According to the literature reviewed, single fraction radiotherapy provides adequate pain relief with reasonable duration of pain response.

REF ID: 6104

Level V:

Topic 3: Assessment

McMillan, S. C. (2002). Pain and symptom management, presence and severity of constipation in hospice patients with advanced cancer. *American Journal of Hospice and Palliative Care*, 19(6), 426-430.

Journal Article, Clinical Trial, Research, Tables/Charts

Although constipation is a problem commonly seen in hospice patients it is not often addressed in the literature as a target symptom needing management. The purpose of this study was to assess the levels of self-reported constipation in a group of patients with advanced cancer at admission to hospice and two weeks and one month after admission. The constipation assessment scale (CAS) measured the presence and intensity of constipation. Comparisons between time points were not possible, but trends seem to indicate that patient symptoms are not being successfully managed.

REF ID: 6097

Level II: Individual experimental study

Topic 3: Assessment

McMillan, S. C., & Moody, L. E. (2003). Hospice patient and caregiver congruence in reporting patients' symptom intensity. *Cancer Nursing*, 26(2), 113-118.

Journal Article, Research, Tables/Charts

As healthcare increasingly moves out of hospitals, the care of patients with cancer is provided in the community with the help of family caregivers. In many cases, nurses depend on family caregivers to provide assessment data about patients. This makes the accuracy and dependability of the data given by caregivers particularly important. However, it is not clear whether caregivers can accurately and dependably report such subjective data as symptom intensity. The purpose of this project was to evaluate the ability of the primary caregiver to report the symptom intensity of hospice patients with cancer. The sample consisted of 264 newly admitted adult patients with advanced cancer in hospice home care and their primary caregivers. These subjects were part of a large National Institutes of Health (NIH)-funded randomized clinical trial focused on symptom management and quality of life. The patients were alert and oriented. Among the questionnaires completed by both patients and caregivers on admission were numeric rating scales for pain and dyspnea and the Constipation Assessment Scale. All of these scales were designed to describe the patient's symptom intensity. The patient sample was predominantly white (83%) and male (57%), with a mean age of 71.6 years. The caregiver sample was predominantly white (85%) and female (78%), with a mean age of 62 years. The results indicated that caregivers significantly overestimated symptom intensity for all three symptoms ($P = .000$). Furthermore, the limited variance accounted for by the two sets of scores for each of the symptoms ($R^2 = .16-.26$) indicated much more error in the scores than agreement between patient and caregiver. It appears that family caregivers cannot reliably report patient symptom intensity. Healthcare providers need to train family caregivers in conducting systematic assessments instead of assuming that they understand patient symptoms.

REF ID: 6106

Level III: Quasi-experimental study

Topic 3: Assessment

McMillan, S. C., & Small, B. J. (2002). Symptom distress and quality of life in patients with cancer of newly admitted to hospice home care. *Oncology Nursing Forum*, 29(10), 1421-1428.

Journal Article, Clinical Trial, Research, Tables/Charts

PURPOSE/OBJECTIVES: To evaluate the relationships between quality of life (QOL) and symptom distress, pain intensity, dyspnea intensity, and constipation intensity in people with advanced cancer who were newly admitted to hospice home care. **DESIGN:** Descriptive and correlational. **SETTING:** A large hospice that provides primarily home care. **SAMPLE:** 178 adult hospice homecare patients with cancer who were accrued to a clinical trial funded by the National Institutes of Health focusing on symptom management and QOL. Patients were excluded if they received a score lower than seven on the Short Portable Mental Status Questionnaire. **METHOD:** The patients were invited to participate in the clinical trial within 48 hours of admission to hospice home care. Among the questionnaires they completed were a QOL index and a distress scale. Scales measuring present intensity of pain, dyspnea, and constipation also were administered. **MAIN RESEARCH VARIABLES:** QOL, symptom distress, pain intensity, dyspnea intensity, and constipation intensity. **FINDINGS:** The most frequently reported symptoms among the sample were lack of energy, pain, dry mouth, and shortness of breath. Lack of energy caused the greatest distress, followed closely by dry mouth and pain. The results of the regression analysis indicated that total distress score, pain intensity, dyspnea intensity, and constipation intensity were related to QOL at the univariate level. When all predictors were considered simultaneously, only the total distress score remained a significant predictor of QOL (p less than 0.001), accounting for about 35% of variance. **CONCLUSIONS:** QOL was affected by symptom distress in people with advanced cancer near the end of life. **IMPLICATIONS FOR NURSING:** The symptoms most commonly reported and those that cause the greatest patient distress should be addressed first by hospice nurses. Continued effort is needed in the important area of symptom management.

REF ID: 6283

Level V: Case report

Topic 4.3: Management-Medication

McNamara, P. (2002). Opioid switching from morphine to transdermal fentanyl for toxicity reduction in palliative care. *Pain Reviews*, 9(3/4), 119-130.

Journal Article, Research, Tables/Charts

The study objective was to determine whether switching patients from morphine to transdermal fentanyl resulted in a reduction of morphine-associated side effects, and an improvement in cognitive function and patients' well being while maintaining adequate pain and symptom control. Nineteen patients aged 42 - 86 with terminal cancer, maintained on morphine for pain and distressed as a result of morphine toxicity, were given the dose of fentanyl corresponding to their current morphine dose. Pain control was then maintained (mostly fentanyl 50 - 100 m g/h) over the 14-day study period. Throughout the study, patients' global assessment of well being (primary efficacy variable) was statistically significantly improved. Sleepiness and drowsiness were significantly less of a problem. There was a trend towards improvement in attention span/concentration, and in the power and quality of concentration. Cognitive function tests also revealed a significant improvement in working (short term) and speed of memory although not in secondary (long term) memory. Patients did not experience hallucinations or delusions and there was no change in levels of anxiety or depression (Hospital Anxiety Depression Scale). The incidence of dizziness was significantly reduced, and there was a nonsignificant decrease in number of patients who suffered myoclonus and in the severity of this condition over the 14 days. The investigator's overall impression of treatment with transdermal fentanyl was 'fair', which was not in agreement with the positive impression expressed by patients (score 74, range: 0 worst, 100 best). Further work is required to determine if the improvement in patients' well being and cognitive function is achieved in larger study populations.

REF ID: 6148

Level I: Systematic Reviews

Topic 4.6: Management-Other

McQuay, H. J., Collins, S. L., Carroll, D., & Moore, R. A. (2000). Radiotherapy for the palliation of painful bone metastases. *Cochrane Database of Systematic Reviews*, (2), 001793.

Journal Article. Review

BACKGROUND: Radiotherapy is used commonly to provide pain relief for painful bone metastases, and there is a perception that of the three-quarters of patients who achieve pain relief, half of these stay free from pain. However, the precise contribution from radiotherapy may be unclear because of difficulties in assessing the numbers of people achieving relief, the extent of relief and its duration, and the influence of other contemporaneous interventions, such as analgesics. **OBJECTIVES:** To assess pain relief from: 1. localised bone metastases achieved by radiotherapy, comparing the efficacy of different fractionation schedules 2. more generalised metastatic disease achieved by radiotherapy or radioisotopes. **SEARCH STRATEGY:** Studies were identified by searching Medline (1966 to August 1998), Embase (1980 to 1998), the Cochrane Library (1998 Issue 3) and the Oxford Pain Relief Database (1950 to 1994). **SELECTION CRITERIA:** The inclusion criteria used were: full journal publication, patients with pain due to bone metastases, and random allocation to a radiotherapeutic intervention (either external irradiation or administration of radioisotopes). **DATA COLLECTION AND ANALYSIS:** The number of patients achieving complete pain relief and at least 50% at one month were compared with an assumed natural history of 1 in 100 patients achieving pain relief without treatment to obtain the number-needed-to-treat (NNT). Summed pain relief or pain intensity difference over four to six hours was extracted, converted into dichotomous information yielding the number of patients with at least 50% pain relief, and used to calculate the relative benefit and the NNT for one patient to achieve at least 50% pain relief. **MAIN RESULTS:** Twenty trials reported on 43 different radiotherapy fractionation schedules and eight studies of radioisotopes. Radiotherapy produced complete pain relief at one month in 395/1580 (25%) patients, and at least 50% relief in 788/1933 (41%) patients at some time during the trials. There were no differences in the proportions of patients achieving these outcomes between single or multiple fraction schedules. The number-needed-to-treat (NNT) to achieve complete relief at one month (compared with an assumed natural history of 1 in 100 patients whose pain resolved without treatment) was 4.2 (95% CI 3.7-4.7). No pooled estimates of speed of onset of relief, or of its duration, could be obtained. In the largest trial (759 patients) 52% of those who had complete relief had achieved it within four weeks, and the median duration of complete relief was 12 weeks. For more generalised disease, radioisotopes produced similar analgesic results to external irradiation. Adverse effect reporting was poor. There were no obvious differences between the various fractionation schedules in the incidence of nausea and vomiting, diarrhoea or pathological fractures. **REVIEWER'S CONCLUSIONS:** Radiotherapy is clearly effective at reducing pain from painful bone metastases. There was no evidence of any difference in efficacy between different fractionation schedules, nor indeed of a dose-response with total dose of radiation. For treatment of generalised bone pain both hemibody irradiation and radioisotopes can reduce the number of painful new sites. [References: 27]

REF ID: 6090

Level III: Quasi-experimental study???

Topic 4.6: Management-Other

Meyers, F. J., Linder, J., Beckett, L., Christensen, S., Blais, J., & Gandara, D. R. (2004).

Simultaneous care: A model approach to the perceived conflict between investigational therapy and palliative care. *Journal of Pain and Symptom Management*, 28(6), 548-556.

Journal Article, Research, Tables/Charts

Clinical trials of investigational therapy in patients with advanced cancer may not pay sufficient attention to quality of life (QOL) and supportive care issues, resulting in an adverse impact on the quality of care (QOC). We hypothesized that the simultaneous delivery of investigational therapy and a structured program of supportive care would result in measurable improvements in predefined outcomes without adverse events for patients, caregivers, or the physician/patient interaction. This report describes the findings of a trial designed to test the feasibility and initial results of such an approach. Forty-four patients accrued to Phase I or Phase II investigational therapy trials were simultaneously enrolled into a defined home care program focused on supportive care needs of the patient and family, as well as assessment of the toxicities of investigational therapy. These 44 patients constitute the Simultaneous Care (SC) cohort. Twenty patients receiving investigational therapy and the standard supportive care measures available through the Cancer Center served as a control group, designated the Usual Care

(UC) cohort. We measured QOL using baseline and monthly assessments of the Functional Assessment of Cancer Therapy (FACT-G) instrument. This instrument measures four domains of well-being: physical, emotional, functional, and social/family. We prospectively defined QOC as: the percentage of hospice referrals; hospice length of stay; and number of cycles of chemotherapy administered. A summary score for the four FACT domains at each time point for each patient was calculated (FACT 4). The FACT 4 scores of the SC group improved compared to the UC group but did not reach a significant difference. Individual scores reflected a wide range of psychometric variability. A statistically significant difference in referral to hospice was seen in the SC group (35/44) compared to the UC group (8/15) (P=0.034). The median length of stay in hospice was the same for both cohorts but the mean stay was greater in the SC cohort (54 days) compared to the UC cohort (37 days). The mean number of chemotherapy cycles was not different between SC and UC (P=0.25). The self-reported acceptance by patients, caregivers, physicians and Cancer Center support staff was qualitatively excellent. Patients with advanced cancer at the time of enrollment onto investigational therapy should have made an explicit transition to palliative care goals but often have not. In the current health care environment, patients with advanced cancer without curative potential may be forced by their health provider or health insurer to choose between disease-directed therapy (including investigational therapy) or structured best supportive care programs. In this emerging era of targeted therapies, SC provides an approach designed to optimize palliative care goals while supporting the clinical research mission of offering patients with advanced cancer new and potentially better therapeutic interventions. SC is a system of care that enhances patient choice by allowing patients and families to have concurrent access to two beneficial options. SC may enhance coordination of care and facilitate patients' explicit transition from curative intent to palliative intent. In order to validate this approach, a randomized comparative trial evaluating SC has been initiated.

REF ID: 6171

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Miceli, P. J., & Wojciechowski, S. L. (2003). Impacting family satisfaction with hospice care. *Caring*, 22(11), 14-18.

Journal Article

Family satisfaction is one of the most important outcomes for hospice care. A survey conducted in 2001 by Press Ganey Associates found overall high levels of family satisfaction with hospice care, but also highlighted areas needing improvement. Hospices need to pay more attention to ancillary care services, logistical issues, and the problem of late-timed referrals.

REF ID: 5457

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Miller, L. L., & Talerico, K. A. (2002). Pain in older adults. *Annual Review of Nursing Research*, 20, 63-88.

Journal Article, Research, Systematic Review, Tables/Charts

REF ID: 5403

Level V: Case report

Topic 3: Assessment; Topic 4.1: Management-General

Minner, D. M., & Marek, K. D. (2005; 2005). Evidence-based assessment and treatment of persistent pain in the community-dwelling elderly receiving home health services: A pathway. *Home Health Care Management & Practice*, 17(4), 293-301.

Journal; Peer Reviewed Journal

Persistent pain is a problem for a significant portion of the community-dwelling elderly. Many elderly are reluctant to admit to pain because of fears related to areas such as loss of independence and possible addiction. Cognitively impaired elders may have difficulty expressing persistent pain and understanding pain assessment questions. Because of these and other concerns, the home health nurse faces many challenges when assessing persistent pain in the community-dwelling elderly. A persistent pain pathway

was developed to assist home health nurses at Senior Care in the assessment and treatment of persistent pain. Evaluation of its use after 3 months showed an agency-wide increase in client assessment and treatment of pain. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6112

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Mitty, E. L. (2004). Assisted living: Aging in place and palliative care. *Geriatric Nursing*, 25(3), 149-56, 163.

Journal Article, Pictorial, Tables/Charts

Principles of upstream palliative care can guide the planning, programs, and services associated with aging in place in assisted living residences (ALRs). Frail older adults who do not need a nursing home level of care are choosing to live-and die-in ALRs. This article describes the context of assisted living, resident characteristics, key indicators of palliative care, barriers to end-of-life care, and the role, responsibilities, and potential for professional nursing in assisted living. Stakeholder concerns about staff knowledge and skills in care of the elderly, medication management, the risks associated with residential care, and nursing delegation are discussed.

REF ID: 6287

Level V: Case report

Topic 3: Assessment

Moody, L. E., Webb, M., Cheung, R., & Lowell, J. (2004). A focus group for caregivers of hospice patients with severe dyspnea. *American Journal of Hospice and Palliative Care*, 21(2), 121-30, 160, 1.

Journal Article, CEU, Exam Questions, Research, Tables/Charts

The use of focus groups has grown in all aspects of our society, including the areas of politics and business. More recently, clinical research investigators have begun using focus groups to acquire important information from potential study subjects, such as patients and caregivers. Researchers use focus groups to help them design and test data collection measures, assess responses to proposed interventions, and obtain guidance on recruitment and retention methods for clinical trials. This report explains the basic requirements and methods for conducting focus groups. The authors conducted a focus group study based on six former caregivers of hospice patients with severe dyspnea. The paper describes the results of this study and illustrates how caregivers assisted in evaluating potential interventions for dyspnea, which will be tested in a future clinical trial. Subsequently, the researchers used the focus group data to adapt the guided-imagery intervention to the lifestyle and culture of the study subjects and their caregivers.

REF ID: 6281

Level IV: Non-experimental study

Topic 4.3: Management-Medication

Morita, T. (2004). Palliative sedation to relieve psycho-existential suffering of terminally ill cancer patients. *Journal of Pain and Symptom Management*, 28(5), 445-450.

Journal Article, Research, Tables/Charts

To clarify the prevalence and the characteristics of patients who received palliative sedation therapy for psycho-existential suffering, a questionnaire was sent to 105 responsible physicians at all certified palliative care units in Japan. The participants were requested to report the number of patients who received continuous deep sedation for refractory psycho-existential suffering during the past year, and to provide details of the 2 most recent patients. A total of 81 physicians returned questionnaires (response rate, 80%). Twenty-nine physicians (36%) reported clinical experience in continuous deep sedation for psycho-existential suffering. The overall prevalence of continuous deep sedation was calculated as 1.0% (90 cases/8,661 total patient deaths), and a total of 46 patient histories were collected. Performance status just before sedation was 3 or 4 in 96%, and predicted survival was 3 weeks or less in 94%. The suffering requiring sedation was feeling of meaninglessness/worthlessness (61%), burden on others/dependency/inability to take care of oneself (48%), death anxiety/fear/panic (33%), wish to

control the time of death by oneself (24%), and isolation/lack of social support (22%). Before sedation, intermittent sedation and specialized psychiatric, psychological, and/or religious care had been performed in 94% and 59%, respectively; 89% of 26 depressed patients had received antidepressant medications. All competent patients (n=37) expressed explicit requests for sedation, and family consent was obtained in all cases where family members were available (n=45). Palliative sedation for psycho-existential suffering was performed in exceptional cases in specialized palliative care units in Japan. The patient condition was generally very poor, and the suffering was refractory to intermittent sedation and specialized psychiatric, psychological, and/or religious care. Sedation was performed on the basis of patient and family consent. These findings suggest that palliative sedation for psycho-existential suffering could be ethically permissible in exceptional cases if the proportionality and autonomy principle is applied. More discussion about the role of palliative sedation therapy for refractory psycho-existential suffering in end-of-life care is urgently necessary.

REF ID: 6184

Level I:

Topic 4.1: Management-General

Morita, T., Hirai, K., Akechi, T., & Uchitomi, Y. (2003). Similarity and difference among standard medical care, palliative sedation therapy, and euthanasia: A multidimensional scaling analysis on physicians' and the general population's opinions. *Journal of Pain and Symptom Management*, 25(4), 357-363.

Journal; Peer Reviewed Journal

There is a strong controversy about the differences among standard medical care, palliative sedation therapy, and euthanasia in recent medical literature. To investigate the similarities and differences among these medical treatments, a secondary analysis of two previous surveys was performed. In those surveys, Japanese physicians and the general population were asked to identify their treatment recommendations or preferences for intolerable and refractory distress in the terminal stage. The physician responses were clustered into 3 groups: 1) standard medical care, 2) palliative sedation therapy including mild, intermittent deep, continuous deep sedation, and 3) physician assisted suicide (PAS)/ euthanasia. The general population's responses were classified into 3 subgroups: 1) standard medical care, 2) mild and intermittent deep sedation, and 3) a group including continuous deep sedation and PAS/euthanasia. Physicians placed continuous deep sedation closer to mild and intermittent sedation, while the general population mapped it closer to PAS/euthanasia. In conclusion, physicians and general population can generally differentiate the three approaches-standard medical care, palliative sedation therapy, and PAS/euthanasia. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6221

Level I: Systematic Reviews

Topic 3: Assessment; Topic 4.3: Management-Medication

Morita, T., Tsuneto, S., & Shima, Y. (2002). Definition of sedation for symptom relief: A systematic literature review and a proposal of operational criteria. *Journal of Pain and Symptom Management*, 24(4), 447-453.

Journal; Peer Reviewed Journal

Reviews literature on sedation for symptom relief in terminally ill patients. A MEDLINE literature search identified 7 articles meeting inclusion criteria for the 1990 to July 2001 period. All studies included the use of sedative medications or the intention to reduce patient consciousness as an essential element of sedation. All but one study explicitly described the primary aim of sedation as symptom palliation. Three definitions stated that target symptoms were severe, and 4 articles reported the refractory nature of the distress. However, marked inconsistencies were found in definition of degree of sedation, duration, pharmacological properties of medications used, target symptoms, and target populations. These data suggest that sedation includes 2 core factors: the presence of severe suffering refractory to standard palliative management, and use of sedative medications with the primary aim to relieve distress. The marked inconsistencies in the definition of sedation should be considered to be subcategories of palliative sedation therapy, and it is recommended that researchers define the degree of

sedation, duration, pharmacological properties of medications, target symptoms, and target populations in future studies. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6102

Level IV: Non-experimental study

Topic 4.3: Management-Medication

Nugent, M., Davis, C., Brooks, D., & Ahmedzai, S. H. (2001). Long-term observations of patients receiving transdermal fentanyl after a randomized trial. *Journal of Pain and Symptom Management, 21(5), 385-391.*

Journal Article, Research, Tables/Charts

We observed 73 cancer patients receiving transdermal fentanyl for 1-29 (mean 5.5) months immediately after participation in a randomized clinical trial. Of these, 32 received fentanyl until death, 18 were lost to follow-up, 11 required alternative analgesia, and 12 withdrew for other reasons. The median first recorded dose (not necessarily the patient's first fentanyl dose) was 75 microgr/h. The median final dose was 100 micro/h. All but 3 patients required \neq 3 months until death, the median dose was unchanged (100 microgr/h) 3 months before death and at death; 8/16 required no dosage change. The incidence of constipation, skin reactions, nausea, and vomiting was low. No significant respiratory depression was associated with fentanyl. Most patients (85%) and investigators (86%) rated the treatment as good or excellent. We conclude that long-term treatment with transdermal fentanyl is safe and acceptable to many cancer patients. Copyright (C) 2001 by the United States Cancer Pain Relief Committee

REF ID: 6133

Level I:

Topic 4.6: Management-Other

Pan, C. X., Morrison, R. S., Ness, J., Fugh-Berman, A., & Leipzig, R. M. (2000). Complementary and alternative medicine in the management of pain, dyspnea, and nausea and vomiting near the end of life. A systematic review. *Journal of Pain & Symptom Management, 20(5), 374-387.*

Journal Article. Meta-Analysis

To review the evidence for efficacy of complementary and alternative medicine (CAM) modalities in treating pain, dyspnea, and nausea and vomiting in patients near the end of life, original articles were evaluated following a search through MEDLINE, CancerLIT, AIDSLINE, PsycLIT, CINAHL, and Social Work Abstracts databases. Search terms included alternative medicine, palliative care, pain, dyspnea, and nausea. Two independent reviewers extracted data, including study design, subjects, sample size, age, response rate, CAM modality, and outcomes. The efficacy of a CAM modality was evaluated in 21 studies of symptomatic adult patients with incurable conditions. Of these, only 12 were directly accessed via literature searching. Eleven were randomized controlled trials, two were non-randomized controlled trials, and eight were case series. Acupuncture, transcutaneous electrical nerve stimulation, supportive group therapy, self-hypnosis, and massage therapy may provide pain relief in cancer pain or in dying patients. Relaxation/imagery can improve oral mucositis pain. Patients with severe chronic obstructive pulmonary disease may benefit from the use of acupuncture, acupressure, and muscle relaxation with breathing retraining to relieve dyspnea. Because of publication bias, trials on CAM modalities may not be found on routine literature searches. Despite the paucity of controlled trials, there are data to support the use of some CAM modalities in terminally ill patients. This review generated evidence-based recommendations and identified areas for future research.

REF ID: 6132

Level I:

Topic 4.6: Management-Other

Perez, R. S., Kwakkel, G., Zuurmond, W. W., & de Lange, J. J. (2001). Treatment of reflex sympathetic dystrophy (CRPS type 1): A research synthesis of 21 randomized clinical trials. *Journal of Pain & Symptom Management, 21(6), 511-526.*

Journal Article. Meta-Analysis

A blinded meta analysis was performed on randomized clinical trials (RCT) on the medicinal treatment of reflex sympathetic dystrophy (complex regional pain syndrome type I) to assess the methodological

quality and quantify the analgesic effect of treatments by calculating individual and summary effect sizes. The internal validity of 21 RCTs was investigated and the quality weighted summary effect size was calculated using a fixed effect model (Glass Delta). The methodological quality ranged from moderate to good (average 46%). Differences were found between the trials in inclusion/exclusion criteria, treatment methods, duration of treatments and trials, and measurement instruments. Statistical analysis was possible for four subgroups; one evaluating the analgesic effects of sympathetic suppressors in general (n = 12), one subgroup concerning the analgesic effects of guanethidine (n = 6), one investigating the analgesic effect of intravenous regional sympathetic blocks (n = 9), and one subgroup (n = 5) evaluating the analgesic effect of calcitonin. Except for the calcitonin subgroup (P = 0.002), the quality-weighted summary effect size of these subgroups were not significant. No significant analgesic effect by sympathetic suppressing agents could be established. Calcitonin seems to provide effective pain relief in reflex sympathetic dystrophy patients. The results of the present study show that weighting methodological quality influences the magnitude of the effect sizes of specific treatment methods. Future studies should control for methodological quality.

REF ID: 6188

Level V:

Topic 3: Assessment

Pessin, H., Rosenfeld, B., & Breitbart, W. (2002). Assessing psychological distress near the end of life. *American Behavioral Scientist*, 46(3), 357-372.

Journal; Peer Reviewed Journal

Psychological suffering is one of the most significant and potentially remediable impediments to the dying process for terminally ill patients and their families. This article reviews several of the most common psychological disorders that arise in the context of terminal illness, including depression, anxiety, delirium, and suicidal ideation. Issues related to assessment, measurement, and differential diagnosis are reviewed. Case vignettes are presented regarding differential diagnoses of depression, anxiety, and delirium in 3 end-stage cancer patients. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6194

Level I: Systematic Reviews

Topic 6: Comprehensive

Piggott, M., McGee, H., & Feuer, D. (2004). Has CONSORT improved the reporting of randomized controlled trials in the palliative care literature? A systematic review. *Palliative Medicine*, 18(1), 32-38.

Journal; Peer Reviewed Journal

This study assessed the quality of reporting of randomized controlled trials (RCTs) in the palliative care literature. Three specialist journals were hand searched for RCTs. A checklist was devised based on CONSORT recommendations. Trials looking at pain were compared with those trials looking at other aspects of palliative care. Ninety-three RCTs were identified. The number of trials has increased over time: nine in the first cohort, 37 in the second and 47 in the last cohort. The number of patients in the individual trials has also increased overtime. Generally, the reporting quality was poor, particularly the areas of allocation concealment, randomization technique and intention to treat analysis, where there is empirical evidence, that it leads to trial bias. Although there were more pain papers than non-pain papers, the quality of reporting was only better for blinding and intention to treat analysis. The quality of reporting of RCTs in the palliative care literature is generally poor. However, there has been an increase in the number and the size of RCTs being carried out. This shows recognition of the importance of an evidence base in palliative care. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6266

Level I: Systematic Reviews

Topic 6: Comprehensive

Plonk, W. M. J., & Arnold, R. M. (2005). Terminal care: The last weeks of life. *Journal of Palliative Medicine*, 8(5), 1042-1054.

Background: The care of patients in their last weeks of life is a fundamental palliative care skill, but few evidence-based reviews have focused on this critical period. Method: A systematic review of published literature and expert opinion related to care in the last weeks of life. Results: The evidence base informing terminal care is largely descriptive, retrospective, or extrapolated. While home deaths and hospice use are increasing, medical care near death is becoming more aggressive and hospice lengths of stay remain short. Though the prediction of impending death remains imprecise, studies have identified several common terminal signs and symptoms. Decreased communication near death complicates the determination of patient wishes, and advanced directives prior to the terminal stage are recommended. Anorexia and cachexia are common in dying patients but there is no evidence that this process is painful or responsive to intervention. While there is general consensus that artificial nutrition is not beneficial in dying patients, the use of artificial hydration is controversial, especially in the setting of delirium. Breathlessness has been shown to benefit from oral and parenteral opioids but not anxiolytics. Accumulation of respiratory tract secretions (death rattle) is common and usually responds to antimuscarinics. Physical pain typically decreases toward death but its assessment in dying patients is difficult. Terminal delirium may occur in up to one-third of patients, may have a reversible cause, and may respond to antipsychotics or benzodiazepines. Palliative sedation is controversial but widely used, especially internationally. Caregiver stress and bereavement may benefit from improved communication and hospice involvement. Conclusion: While the terminal care literature is characterized by varying quality, numerous knowledge gaps, and frequent inconsistencies, it supports several common clinical interventions. More research is needed to resolve controversies, define effective therapies, and improve the outcomes of dying patients. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6296

Level V: Case report

Topic 3: Assessment

Potter, T., & PedenMcAlpine, C. (2002). How expert home care nurses recognize early client status changes. *Home Healthcare Nurse, 20*(1), 43-50.

Journal Article, Pictorial, Research, Tables/Charts

This qualitative study examined the characteristics of early recognition of client status changes by expert home care nurses. A text comprised of transcribed interviews with expert nurses about their early recognition experiences was analyzed using a Phenomenological approach. A model of early recognition and three distinct themes are discussed: building a therapeutic relationship, knowing/sensing the moment of early recognition, and the temporal dimension of knowing. Implications for home care nursing practice and education are highlighted.

REF ID: 6126

Level I:

Topic 4.6: Management-Other

Rajasekaran, M., Edmonds, P. M., & Higginson, I. L. (2005). Systematic review of hypnotherapy for treating symptoms in terminally ill adult cancer patients. *Palliative Medicine, 19*(5), 418-426.

Journal Article. Meta-Analysis. Review

The aim of this review was to find the evidence for or against the use of hypnotherapy in the treatment of symptoms in terminally ill adult cancer patients. The title and abstract were evaluated following a search through Index Medicus/MEDLINE, EMBASE, CINHAHL, CancerLit, AHMED, Psychinfo, CISCOM, Cochrane and DARE. Search terms included hypnotherapy, cancer, terminal care and palliative care. Inclusion criteria included systematic reviews, randomized controlled trials, observational and prospective studies, retrospective surveys, case studies and reports. A total of 27 papers were evaluated. Two reviewers assessed the studies, one extracted the relevant data and 10% were evaluated independently by a third reviewer. The 27 papers comprised a randomized controlled trial, an observational study, a retrospective questionnaire and 24 case studies. Hypnotherapy was used to treat a variety of symptoms, including pain, anxiety and depression. The poor quality of the studies

and heterogeneity of the study population limited further evaluation; further research is required to understand the role of hypnotherapy in managing symptoms. [References: 43]

REF ID: 238

Level I: Systematic Reviews

Topic 3: Assessment

Topic 4.1: Management-General

Reiner, A., & Lacasse, C. (2006). Symptom correlates in the gero-oncology population. *Seminars in Oncology Nursing*, 22(1), 20-30.

Journal Article, Research, Systematic Review, Tables/Charts

OBJECTIVES: To review recently published studies that describe the presence of selected cancer-related symptoms and relationships between them in the gero-oncology population. **DATA SOURCES:** Research studies, review articles, and government documents. **CONCLUSION:** Cancer-related symptoms have been studied for over two decades, yet little is known about the functional effects of age on the disease experience. **IMPLICATIONS FOR NURSING PRACTICE:** Nurses are encouraged to consider symptoms related to other chronic illnesses that contribute to an older person's daily living when planning oncology nursing care.

REF ID: 6099

Level II: Individual experimental study

Topic 6: Comprehensive

Ringdal, G. I., Jordhoy, & Kaasa, S. (2002). Family satisfaction with end-of-life care for cancer patients in a cluster randomized trial. *Journal of Pain and Symptom Management*, 24(1), 53-63.

Journal Article, Research, Tables/Charts

The main aim of this study was to examine similarities and differences in satisfaction with care between 112 family members who were close to patients who had participated in an intervention with a comprehensive palliative care program and the 68 family members in a conventional care program (controls). The FAMCARE Scale measured satisfaction with care at one month after the time of death. The majority of respondents reported high satisfaction with care. The respondents related to the patients in the intervention group reported significantly higher satisfaction with care than the respondents related to the patients in the control group. This difference remained unchanged after controlling for a range of other relevant factors: relationship to the deceased, sex and age of the respondent, sex and age of the patient, time since inclusion in the study, and place of death. (C) 2002 by the United States Cancer Pain Relief Committee.

REF ID: 6122

Level VI: Opinion

Topic 6: Comprehensive

Russell, C. K., & Gregory, D. M. (2003). EBN users' guide. evaluation of qualitative research studies. *Evidence-Based Nursing*, 6(2), 36-40.

Journal Article

REF ID: 6087

Level I: Systematic Reviews

Topic 6: Comprehensive

Rutledge, D. N., Bookbinder, M., Donaldson, N. E., & Pravikoff, D. S. (2001). End-of-life care series. part III. learnings beyond the SUPPORT and HELP studies. *Online Journal of Clinical Innovations*, 4(6), 1-60.

Journal Article, Care Plan, Research, Systematic Review, Tables/Charts, Website

Following publication of reports of the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) and the Hospitalized Elderly Longitudinal Project (HELP), interest among consumers and healthcare professionals in end-of-life care has grown steadily. Optimal end-of-life care integrates palliative care principles with more traditional models of care. Ideally, palliative care is available to patients in various healthcare settings to ensure early referral when a serious illness makes death a probability. This review synthesizes findings from research following the

SUPPORT and HELP studies and addresses among other topics, patient preferences for care, outcomes, advance directives, and policy issues. It also includes implications for care.

REF ID: 5242

Level I: Systematic Reviews

Topic 3: Assessment ; Topic 4.1: Management-General

Rutledge, D. N., Donaldson, N. E., & Pravikoff, D. S. (2002). Update. pain assessment and documentation. special populations of adults. *Online Journal of Clinical Innovations*, 5(2), 1-49. Journal Article, Questionnaire/Scale, Research, Systematic Review, Tables/Charts

In 1998, a review published in the Online Journal of Clinical Innovations entitled "Pain Assessment and Documentation, Part II. Special Populations of Adults" described the difficulty in assessing pain in various populations of adults with cognition disorders, altered pain sensations, or substance abuse, among other problems. Since that publication, additional research has been conducted concerning pain assessment of these populations. This current manuscript updates the 1998 review.

REF ID: 6088

Level I: Systematic Reviews

Topic 6: Comprehensive

Rutledge, D. N., Donaldson, N. E., & Pravikoff, D. S. (2001). End-of-life care series. part II. end-of-life care for hospitalized adults in america -- learnings from the SUPPORT and HELP studies. *Online Journal of Clinical Innovations*, 4(5), 1-57. Journal Article, Research, Systematic Review, Tables/Charts

The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) examined over 9,000 seriously ill hospitalized patients in the United States, tracing their hospital experiences and following the course of their illnesses for six months. Its companion study, the Hospitalized Elderly Longitudinal Project (HELP), collected similar data on patient preferences, decision making, and outcomes among persons over the age of 80. Key findings from these studies pertained to communication issues, potential overtreatment and utilization of excessive resources, and potential undertreatment of symptoms such as pain, dyspnea, or confusion. This manuscript reviews published findings from selected SUPPORT and HELP reports and describes their implications for nursing practice.

REF ID: 6177

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Ryan, A., Carter, J., Lucas, J., & Berger, J. (2002). You need not make the journey alone: Overcoming impediments to providing palliative care in a public urban teaching hospital. *American Journal of Hospice & Palliative Care*, 19(3), 171-180. Evaluation Studies. Journal Article

The majority of dying patients continue to receive care in acute, tertiary settings. This has generated the development of hospital-based palliative care (HBPC). The Symptom Management and Palliative Care Program (SMPCP) at LAC+USC Medical Center provides HBPC. The SMPCP operates as an interdisciplinary consultative service, assessing inpatients, and documenting recommendations for primary physicians. Over a 28-month period the SMPCP provided clinical recommendations, education, and research for patients, family members, and hospital staff. Demographic, clinical, psychosocial, financial, and outcome information was collected on 265 patients. The SMPCP documented the attainment of defined quality end-points, including pain control within 24 hours, a Do Not Resuscitate (DNR) discussion with patient and family within 72 hours, and control of nausea and vomiting within 24 hours. Team members also documented impediments to implementing recommendations and the success of interventions to overcome impediments. Results indicated that the SMPCP achieved a high rate of quality end-point attainment when impediments were not present. The most significant impediments resulted from behaviors by primary physicians. The SMPCP's ability to overcome barrier behaviors improved the rate of end-point attainment, confirming the importance of palliative care at the end of life.

REF ID: 6267

Level I: Systematic Reviews

Topic 3: Assessment

Sampson, E. L., Ritchie, C. W., Lai, R., Raven, P. W., & Blanchard, M. R. (2005). A systematic review of the scientific evidence for the efficacy of a palliative care approach in advanced dementia. *International Psychogeriatrics*, 17(1), 31-40.

Background: Patients with dementia often receive poor end-of-life care, with inadequate pain control and without access to the palliative care services that patients with cancer are offered. This has been identified as an area of need in recent U.K. Government reports and by the Alzheimer's Society (U.K.). Our objective was to perform a systematic review of the scientific literature regarding the efficacy of a palliative care model in patients with dementia. Methods: A systematic review was carried out to identify controlled trials that investigated the efficacy of palliative care in patients with dementia. Data sources included were Medline, EMBASE, PsycINFO, CINAHL, British Nursing Index, AMED, Cochrane Database of Systematic Reviews, Web of Science, Cochrane Central Register of Controlled Trials, International Standard Randomised Controlled Trial register, the NHS Economic Evaluation Database and the System for Information on Grey Literature in Europe. Other data was sourced from hand searches of papers identified on electronic databases and review articles. Results: The search identified 30 review articles, but only four papers were eligible for full appraisal and only two of these met the full criteria for inclusion. These papers gave equivocal evidence of the efficacy for a palliative model of care in dementia. Conclusion: Despite the increased interest in palliative care for patients with dementia there is currently little evidence on which to base such an approach. This may in part be due to the ethical difficulties surrounding such research, prognostic uncertainty in clinicians and the lack of clear outcome measures for patients who are unable to express their needs or wishes. Further systematic research is urgently needed to educate an important and developing area of clinical practice. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6096

Level II: Individual experimental study

Topic 4.6: Management-Other

Schofield, P., & Payne, S. (2003). A pilot study into the use of a multisensory environment (snoezelen) within a palliative day-care setting [corrected] [published erratum appears in INT J PALLIAT NURS 2003 apr;9(4):178]. *International Journal of Palliative Nursing*, 9(3), 124-8, 130. Journal Article, Clinical Trial, Pictorial, Research, Tables/Charts

Sensory environments may potentially provide an atmosphere of calm and refreshment. This small pilot study used a randomized controlled trial (RCT) design and semi-structured interviews to investigate the use of the Snoezelen multisensory environment in palliative day care. Its second aim was to explore the feasibility of the RCT design in advance of a possible larger trial. The study compared Snoezelen with a normal 'quiet room' setting. Following screening for anxiety, 26 patients were recruited and randomly assigned to the control or experimental group. Anxiety and depression were assessed using the Hospital Anxiety and Depression scale and quality of life assessed using the European Organisation for Research and Treatment of Cancer Core 30 questionnaire. A significant reduction in anxiety was seen with the experimental group ($P=0.01$) but no changes were observed in any of the quality-of-life subscales. However, the results should be viewed with caution, as there were some differences between the groups in two of the quality-of-life subscales. Data from semi-structured interviews suggested Snoezelen may promote relaxation. It is concluded that Snoezelen is feasible for use with this patient group and recommendations are made for further research.

REF ID: 6193

Level V:

Topic 6: Comprehensive

Schofield, P., Carey, M., Love, A., Nehill, C., & Wein, S. (2006). 'Would you like to talk about your future treatment options?' discussing the transition from curative cancer treatment to palliative care. *Palliative Medicine*, 20(4), 397-406.

Journal; Peer Reviewed Journal

Palliative care focuses on improving quality of life for patients with life-threatening illness and their families. There comes a time when actively pursuing aggressive curative treatment may do more harm than good. The cessation of curative treatment is often viewed as a distinct event; however, current practice guidelines suggest that a palliative approach should be gradually adopted as the disease progresses. The challenge is how to facilitate a sensitive transition from curative to palliative care. On the basis of an extensive literature review, recommended steps for facilitating this transition have been outlined. The recommendations cover: the timing of the discussion; preparing for this discussion; the environment and circumstances of the consultation; initiating the discussion; identifying the information to be provided; responding to the person's emotional reaction; introducing palliative care services; continuity of care; family concerns; cultural and linguistic diversity; concluding the discussion. These steps were based on the best available evidence. However, as there is a paucity of research in this area, only three relevant systematic reviews of randomized controlled trials were identified and only one of these reviews related directly to palliative care. The majority of the relevant research was descriptive evidence. There is a need for more high quality research in this area. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6173

OM: Quality Measures

Topic 5: Evaluation/Follow-up

Schulmeister, L. (2003). The first state-by-state report card on end-of-life care: How did your state do? *Clinical Journal of Oncology Nursing*, 7(2), 131-132.

Editorial

REF ID: 6100

Level V:

Topic 4.6: Management-Other

Schumacher, K. L., Koresawa, S., West, C., Hawkins, C., Johnson, C., & Wais, E. et al. (2002). Putting cancer pain management regimens into practice at home. *Journal of Pain and Symptom Management*, 23(5), 369-382.

Journal Article, Clinical Trial, Research, Tables/Charts

The purpose of this study was to describe the difficulties with pain management that patients and family caregivers bring to a nurse's attention during a teaching and coaching intervention. Data were obtained from audiotaped and transcribed interactions between intervention nurses and patients (n = 52) and their family caregivers (n = 33) who were participating in a randomized clinical trial of a nursing intervention called the PRO-SELF Copyright Pain Control Program. Using qualitative content analysis, we found that patients had difficulty in seven areas when they attempted to put a pain management regimen into practice, namely: obtaining the prescribed medication(s), accessing information, tailoring prescribed regimens to meet individual needs, managing side effects, cognitively processing information, managing new or unusual pain, and managing multiple symptoms simultaneously. The findings from this study suggest that the provision of information about cancer pain management to patients and their family caregivers is not sufficient to improve pain control in the home care setting. Patients and their family caregivers require ongoing assistance with problem-solving to optimize their pain management regimen. (C) 2002 by the United States Cancer Pain Relief Committee.

REF ID: 6095

Level IV: Non-experimental study??

Topic 4.6: Management-Other

Shakespeare, T. P., Lu, J. J., Back, J. F., Liang, S., Mukherjee, R. K., & Wynne, C. J. (2003). Patient preference for radiotherapy fractionation schedule in the palliation of painful bone metastases. *Journal of Clinical Oncology*, 21(11), 2156-2162.

Journal Article, Research, Tables/Charts

PURPOSE: The radiotherapeutic management of painful bone metastases is controversial, with several institutional and national guidelines advocating use of single-fraction radiotherapy. We aimed to

determine patient choice of fractionation schedule after involvement in the decision-making process by use of a decision board. PATIENTS AND METHODS: Advantages and disadvantages of two fractionation schedules (24 Gy in six fractions v 8 Gy in one fraction) used in the randomized Dutch Bone Metastasis Study were discussed with patients using a decision board. Patients were asked to choose a fractionation schedule, to give reasons for their choice, and to indicate level of satisfaction with being involved in decision making. RESULTS: Sixty-two patients were entered. Eighty-five percent (95% confidence interval, 74% to 93%) chose 24 Gy in six fractions over 8 Gy in one fraction ($P < .0005$). Variables including age, sex, performance status, tumor type, pain score, and paying class were not significantly related to patient choice. Multiple fractionation was chosen for lower re-treatment rates (92%) and fewer fractures (32%). Single-fraction treatment was chosen for cost (11%) and convenience (89%). Eighty-four percent of patients expressed positive opinions about being involved in the decision-making process. CONCLUSION: Decision board instruments are feasible and acceptable in an Asian population. The vast majority of patients preferred 24 Gy fractionated radiotherapy compared with a single fraction of 8 Gy. These results indicate the need for further research in this important area and serve to remind both clinicians and national or institutional policy makers of the importance of individual patient preference in treatment decision making. Copyright (C) 2003 by American Society of Clinical Oncology

REF ID: 6292

Level II: Individual experimental study

Topic 4.6: Management-Other

Sloman, R. (2002). Relaxation and imagery for anxiety and depression control in community patients with advanced cancer. *Cancer Nursing*, 25(6), 432-435.

Journal Article, Clinical Trial, Research

A community-based nursing study was conducted in Sydney, Australia, to compare the effects of progressive muscle relaxation and guided imagery on anxiety, depression, and quality of life in people with advanced cancer. In this study, 56 people with advanced cancer who were experiencing anxiety and depression were randomly assigned to 1 of 4 treatment conditions: (1) progressive muscle relaxation training, (2) guided imagery training, (3) both of these treatments, and (4) control group. Subjects were tested before and after learning muscle relaxation and guided imagery techniques for anxiety, depression, and quality of life using the Hospital Anxiety and Depression scale and the Functional Living Index-Cancer scale. There was no significant improvement for anxiety; however, significant positive changes occurred for depression and quality of life.

REF ID: 6094

Level II: Individual experimental study

Topic 4.3: Management-Medication

Small, E. J., Smith, M. R., Seaman, J. J., Petrone, S., & Kowalski, M. O. (2003). Combined analysis of two multicenter, randomized, placebo-controlled studies of pamidronate disodium for the palliation of bone pain in men with metastatic prostate cancer. *Journal of Clinical Oncology*, 21(23), 4277-4284.

Journal Article, Clinical Trial, Research, Tables/Charts

PURPOSE: Bone metastases occur in approximately 80% of patients with advanced prostate cancer. Pain is common in these patients. The purpose of this study was to evaluate the effect of an intravenous bisphosphonate, pamidronate disodium, on pain control in metastatic prostate cancer patients. PATIENTS AND METHODS: Two multicenter, double-blind, randomized, placebo-controlled trials were conducted in patients with bone pain due to metastatic prostate cancer, with disease progression after first-line hormonal therapy. Intravenous pamidronate disodium (90 mg) or placebo was administered every 3 weeks for 27 weeks. Efficacy was measured via self-reported pain score (Brief Pain Inventory), analgesic use, the proportion of patients with a skeletal-related event (SRE; defined as pathologic fracture, radiation or surgery to bone, spinal cord compression, or hypercalcemia), and a pilot quantitative measurement of mobility. Laboratory evaluations included serum prostate-specific antigen, interleukin-6, bone alkaline phosphatase, and urinary bone resorption markers. RESULTS: Results of

the two trials were pooled. There were no sustained significant differences between the pamidronate and placebo groups in self-reported pain measurements, analgesic use, proportion of patients with an SRE, or mobility at week 9 or 27. Urinary bone resorption markers were suppressed in the pamidronate group compared with placebo. **CONCLUSION:** Pamidronate disodium failed to demonstrate a significant overall treatment benefit compared with placebo in palliation of bone pain or reduction of SREs. Evaluation of more potent bisphosphonates in patients with prostate cancer is warranted.

REF ID: 6302

Level V: Case report

Topic 3: Assessment

Smith, E. M., Gomm, S. A., & Dickens, C. M. (2003). Assessing the independent contribution to quality of life from anxiety and depression in patients with advanced cancer. *Palliative Medicine*, 17(6), 509-513.

Journal; Peer Reviewed Journal

The objective is to investigate the hypothesis that a) illness severity, pain, anxiety and depression are all associated with impaired health-related quality of life and b) once the effects of illness severity have been adjusted for, there is further independent contribution to quality of life from anxiety and depression. Consecutive patients with advanced cancer under the care of palliative care services were screened. Sixty-eight patients were evaluated for levels of anxiety and depression, severity of illness, pain severity and health-related quality of life. Thirty-three males and 35 females were recruited and had an age range of 41-93 years (median 71). Seventeen (25%) of patients were anxious [anxiety score ≥ 11 on the Hospital Anxiety and Depression Scale (HADS)], 15 (22%) were depressed (HADS depression score ≥ 11). After controlling for the effects of pain and illness severity, anxiety and depression were independently associated with global health status, emotional and cognitive functioning, and fatigue. Anxiety further contributed significantly towards social functioning, nausea and vomiting. This study has confirmed that pain, anxiety and depression were associated with impaired quality of life.

(PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 6183

Level I:

Topic 6: Comprehensive

Solano, J. P., Gomes, B., & Higginson, I. J. (2006). A comparison of symptom prevalence in far advanced cancer, AIDS, heart disease, chronic obstructive pulmonary disease and renal disease. *Journal of Pain and Symptom Management*, 31(1), 58-69.

Journal; Peer Reviewed Journal

Little attention has been paid to the symptom management needs of patients with life-threatening diseases other than cancer. In this study, we aimed to determine to what extent patients with progressive chronic diseases have similar symptom profiles. A systematic search of medical databases (MEDLINE, EMBASE, and PsycINFO) and textbooks identified 64 original studies reporting the prevalence of 11 common symptoms among end-stage patients with cancer, acquired immunodeficiency syndrome (AIDS), heart disease, chronic obstructive pulmonary disease, or renal disease. Analyzing the data in a comparative table (a grid), we found that the prevalence of the 11 symptoms was often widely but homogeneously spread across the five diseases. Three symptoms--pain, breathlessness, and fatigue--were found among more than 50% of patients, for all five diseases. There appears to be a common pathway toward death for malignant and nonmalignant diseases. The designs of symptom prevalence studies need to be improved because of methodological disparities in symptom assessment and designs.

(PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6119

Level VI: Opinion

Topic 1: Risks

Taylor, L. (2006). UK palliative care professionals identified service infrastructure, patient and carer attitudes and characteristics, and practice culture as influencing place of death of patients with cancer. *Evidence-Based Nursing*, 9(1), 32.

Journal Article, Abstract, Commentary

Which factors do UK palliative care service providers identify as influencing the place of death (ie, home, hospice, or hospital) of patients with cancer? DESIGN Qualitative study. SETTING Northwestern UK. PARTICIPANTS A purposive sample of 14 palliative care professionals (11 healthcare professionals, 1 social care professional, 1 hospice manager, and 1 former Health Authority manager with a palliative service remit) and 1 voluntary hospice worker (9 women). 13 participants had direct and frequent contact with patients and carers. METHODS 30 minute semistructured interviews addressed the nature of work and the service provided; factors influencing place of death and preferences of patients and carers; and the ideal configuration of services. Data were analysed using constant comparison. Validity checks included identifying deviant cases and review of draft findings by 3 participants. MAIN FINDINGS Participants identified 5 major factors that influenced the place of death of patients with cancer. (1) Service infrastructure. Place of death options and outcomes were dictated by factors associated with National Health Service (NHS) and local social services funding, budgets, priority setting, and the unpredictability of charitable funding for hospices and voluntary sector support organisations. The 30 available hospice beds were usually occupied, which meant that deaths often occurred in other settings. Local micro-politics influenced place of death as service supply factors were underpinned by managerial and professional status, power, and clinical authority. As well, frontline workers felt that national policies, such as the NHS Cancer Plan's goal of increasing the number of cancer deaths at home, could not be met without increased policy and funding commitments for essential community services to support patients and carers at home (e.g., 24 h district nursing and increased nursing night-sitting service, provision of after-hours palliative care expertise, and social service input). Another factor affecting place of death was the existence of "real" community based multidisciplinary palliative care teams (beyond physician-nurse groupings). (2) Informal carer characteristics. Participants confirmed that place of death was associated with the presence of carers and their health status, coping ability, and motivation. Carers with reliable support from family and friends and from professionals were more likely to be able to cope over time, which allowed the patient to die at home. (3) Symptom severity and management. Participants indicated that death at home was more likely if the symptoms were under control through the availability of necessary equipment and drugs in the home. (4) Patient and carer attitudes. Participants felt that patients or carers with strong preferences about place of death were more likely to achieve those preferences. Often, however, patients changed their preference from home to hospice as symptoms worsened. Patient and carer attitudes that reflected an awareness and acceptance of death were associated with home or hospice deaths. Frontline workers noted that a strong desire not to be a burden to loved ones at home often led patients to select a hospice setting for dying. (5) Cultures of practice. Frontline workers felt that good teamwork within and across service sectors and organisations enabled home or hospice deaths; in particular, teamwork between specialist palliative care professionals and generic primary health and social care professionals was important. The ethics and habits of professional practice with respect to making referrals, giving advice and information, and pursuing specific courses of action affected place of death outcomes by steering patients into specific care settings and arrangements (eg, in one area, hospice referral was seen as "normative;" or what should be done routinely). The societal shift toward greater medical management of terminally ill patients in hospices and the associated increase in patients attending hospices as "day-cases" meant that more patients came into direct contact with hospice services and subsequently formed a preference to die in a hospice setting. CONCLUSION UK palliative care professionals identified service infrastructure, informal carer characteristics, symptom severity and management, patient and carer attitudes, and cultures of practice as factors that influenced place of death of patients with cancer.

REF ID: 6120

Level VI: Opinion

Topic 6: Comprehensive

Taylor, L. (2005). Palliative care involved a specific concept of care focusing on life and optimising patient quality of life. *Evidence-Based Nursing*, 8(2), 62.

Journal Article, Abstract, Commentary

From the experiences of patients, their relatives, and their professional caregivers, what are the processes occurring within a residential palliative care unit? DESIGN Grounded theory approach within a symbolic interactionist frame-work. SETTING 2 residential palliative care units in Belgium. PARTICIPANTS 8 patients who were admitted to the palliative care unit with terminal illness and an estimated lifespan of 3 months; 9 relatives of patients (not relatives of the patients interviewed); and 24 team members of the palliative care unit (3 doctors, 1 physiotherapist, 1 pastor, 1 social worker, 11 nurses, 1 nurses' aide, 2 psychologists, and 4 volunteers). METHODS Data were collected by semistructured indepth interviews lasting 30 minutes to 1.5 hours. Interviews were loosely structured, using an interview guide. Data were also collected from observations of care, team meetings, and analyses of patient records. Data collection and analysis used an iterative process, and questions were added to the interview guide to explore emergent themes. Interviews and team meetings were tape recorded and transcribed verbatim. Interview and team meeting transcripts, field notes, patient records, and observations were coded and analysed. Themes and concepts that reflected the palliative care experiences of patients, relatives, and caregivers were identified. Findings were presented to palliative team members external to the study to check the interpretation of the data. MAIN FINDINGS Findings showed a high correspondence between the experiences of patients, relatives, and caregivers. The specific concept of palliative care shown in this study was a focus on life, with the objective of optimising quality of life. The caregiving process focused on creating opportunities for patients to live and enjoy life as much as possible. Maximising quality of life was ensured by a combination of strategies and conditions. The caregivers sought to use strategies to create space for living for the patients. These strategies included controlling the symptoms (eg, use of effective pain management), creating a safe environment, alleviating anxiety (eg, helping patients to express feelings of anxiety), accompanying patients in truth (eg, keeping patients and relatives informed about the illness so that decisions about death could be made and lives could be lived as fully as possible), and giving physical care in a respectful manner. Caregivers also searched for ways to help patients fill the space in their lives as meaningfully as possible, using strategies such as regarding the patient as the "norm" (eg, accepting patient needs and wishes), providing creative and active care, providing comprehensive care, and giving physical care. All participants identified several conditions that were essential to good palliative care: sufficient time to get to know patients, caring attitude of caregivers, competence in providing creative and active care, interdisciplinary team work, and characteristics of the setting (small units, homelike infrastructure, and non-hospital environment). These strategies were used to ensure that patients enjoyed life as much as possible even in the face of death. The conditions permitted patients and relatives to experience effective and high quality palliative care. CONCLUSIONS Palliative care involved a specific concept of care with the central focus on life and the goal of optimising quality of life. The processes of palliative care involved 2 strategies: creating space to live by taking the focus off the illness and filling the space as meaningfully as possible so that patients could fully enjoy life. Certain conditions determined the effectiveness of the strategies and the quality of the palliative care experience.

Teno, J. (2007). Facts On Dying: Policy relevant data on care at the end of life [incomplete citation info]

REF ID: 6125

Level I:

Topic 4.6: Management-Other

Thomson, C. E., Crawford, F., & Murray, G. D. (2005). The effectiveness of extra corporeal shock wave therapy for plantar heel pain: A systematic review and meta-analysis. *BMC Musculoskeletal Disorders*, 6(1), 19.

Evaluation Studies. Journal Article. Meta-Analysis. Review

BACKGROUND: There is considerable controversy regarding the effectiveness of extracorporeal shock wave therapy in the management of plantar heel pain. Our aim was to conduct a systematic review of randomised controlled trials to investigate the effectiveness of extracorporeal shock wave therapy and to

produce a precise estimate of the likely benefits of this therapy. **METHODS:** We conducted a systematic review of all randomised controlled trials (RCTs) identified from the Cochrane Controlled trials register, MEDLINE, EMBASE and CINAHL from 1966 until September 2004. We included randomised trials which evaluated extracorporeal shock wave therapy used to treat plantar heel pain. Trials comparing extra corporeal shock wave therapy with placebo or different doses of extra corporeal shock wave therapy were considered for inclusion in the review. We independently applied the inclusion and exclusion criteria to each identified randomised controlled trial, extracted data and assessed the methodological quality of each trial. **RESULTS:** Six RCTs (n = 897) permitted a pooled estimate of effectiveness based on pain scores collected using 10 cm visual analogue scales for morning pain. The estimated weighted mean difference was 0.42 (95% confidence interval 0.02 to 0.83) representing less than 0.5 cm on a visual analogue scale. There was no evidence of heterogeneity and a fixed effects model was used. **CONCLUSION:** A meta-analysis of data from six randomised-controlled trials that included a total of 897 patients was statistically significant in favour of extracorporeal shock wave therapy for the treatment of plantar heel pain but the effect size was very small. A sensitivity analysis including only high quality trials did not detect a statistically significant effect. [References: 39]

REF ID: 6098

Level II: Individual experimental study

Topic 4.3: Management-Medication

Todd, J., Rees, E., Gwilliam, B., & Davies, A. (2002). An assessment of the efficacy and tolerability of a 'double dose' of normal-release morphine sulphate at bedtime. *Palliative Medicine*, 16(6), 507-512.

Journal Article, Research, Tables/Charts

This study was a prospective, randomized, open, crossover study comparing a double dose (DD) of normal-release (NR) morphine at bedtime with a single dose (SD) of NR morphine at bedtime and 4 h later. Twenty patients completed the study. Four patients required breakthrough analgesia during the SD phase of the study, whilst 11 patients required breakthrough analgesia during the DD phase of the study (P = 0.016). Moreover, all of the pain scores were worse during the DD phase (overnight pain, P < 0.01; morning pain, P < 0.01), and some of the opioid-related side effect scores were worse during the DD phase (xerostomia, P = 0.033; vivid dreams, P = 0.05). This study does not support the European Association for Palliative Care (EAPC) recommendations on the use of a double dose of NR morphine at bedtime.

REF ID: 6275

QM: Quality Measures

Topic 5: Evaluation/Follow-up

van Iersel, T., Timmerman, D., & Mullie, A. (2006). Introduction of a pain scale for palliative care patients with cognitive impairment. *International Journal of Palliative Nursing*, 12(2), 54-59.

Journal Article, Questionnaire/Scale, Research, Tables/Charts

Aim: To describe the development and introduction of a pain scale for patients with cognitive impairment who are admitted to homes for older people and nursing homes in the region of northwest Flanders in Belgium. **Design:** A questionnaire comparing the Abbey and Pain Assessment in Advanced Dementia (PAINAD) scales was distributed in 17 homes; 185 care providers participated, evaluating 157 patients. **Findings:** Approximately half of the care providers evaluated both scales as being good measures of pain and easy to use. Of the different items scored in both scales, care providers agreed upon three indicators as being most valuable to use for measuring pain: facial expression; vocalization; and body language. **Conclusion:** The findings were not conclusive for the introduction of either Abbey or PAINAD. Based on the results, a simplified pain observation scale consisting of three items was developed. It has been introduced in the homes of the region and is being tested currently.

REF ID: 6129

Level I:

Topic 4.6: Management-Other

Wai, M. S., Mike, S., Ines, H., & Malcolm, M. (2004). Palliation of metastatic bone pain: Single

fraction versus multifraction radiotherapy - a systematic review of the randomised trials.

Cochrane Database of Systematic Reviews, (2), 004721.

Journal Article. Meta-Analysis. Review

BACKGROUND: Recent randomised studies reported that single fraction radiotherapy was as effective as multifraction radiotherapy in relieving pain due to bone metastasis. However, there are concerns about the higher re-treatment rates and the efficacy of preventing future complications such as pathological fracture and spinal cord compression by single fraction radiotherapy. **OBJECTIVES:** To undertake a systematic review and meta-analysis of single fraction radiotherapy versus multifraction radiotherapy for metastatic bone pain relief and prevention of bone complications. **SEARCH STRATEGY:** Trials were identified through MEDLINE, EMBASE, Cancerlit, reference lists of relevant articles and conference proceedings. Relevant data was extracted. **SELECTION CRITERIA:** Randomised studies comparing single fraction radiotherapy with multifraction radiotherapy on metastatic bone pain **DATA COLLECTION AND ANALYSIS:** The analyses were performed using intention-to-treat principle. The results were pooled using meta-analysis to estimate the effect of treatment on pain response, re-treatment rate, pathological fracture rate and spinal cord compression rate. **MAIN RESULTS:** Eleven trials that involved 3435 patients were identified. Of 3435 patients, 52 patients were randomised more than once for different painful bone metastasis sites. Altogether, 3487 painful sites were randomised. The trials included patients with painful bone metastases of any primary sites, but were mainly prostate, breast and lung. The overall pain response rates for single fraction radiotherapy and multifraction radiotherapy were 60% (1059/1779) and 59% (1038/1769) respectively, giving an odds ratio of 1.03 (95% confidence interval [CI], 0.89 - 1.19) indicating no difference between the two radiotherapy schedules. There was also no difference in complete pain response rates for single fraction radiotherapy (34% [497/1441]) and multifraction radiotherapy (32% [463/1435]) with an odds ratio of 1.11 (95%CI 0.94-1.30). Patients treated by single fraction radiotherapy had a higher re-treatment rate with 21.5% (267/1240) requiring re-treatment compared to 7.4% (91/1236) of patients in the multifraction radiotherapy arm (odds ratio 3.44 [95%CI 2.67-4.43]). The pathological fracture rate was also higher in single fraction radiotherapy arm patients. Three percent (37/1240) of patients treated by single fraction radiotherapy developed pathological fracture compared to 1.6% (20/1236) for those treated by multifraction radiotherapy (odds ratio 1.82 [95%CI 1.06-3.11]). The spinal cord compression rates were similar for both arms (odds ratio 1.41 [95%CI 0.72-2.75]). Repeated analyses excluding dropout patients gave similar results. **REVIEWERS' CONCLUSIONS:** Single fraction radiotherapy was as effective as multifraction radiotherapy in relieving metastatic bone pain. However, the re-treatment rate and pathological fracture rates were higher after single fraction radiotherapy. Studies with quality of life and health economic end points are warranted to find out the optimal treatment option. [References: 68]

REF ID: 6182

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Weissman, D. E., Griffie, J., Muchka, S., & Matson, S. (2001). Improving pain management in long-term care facilities.[see comment]. *Journal of Palliative Medicine, 4(4), 567-573.*

Journal Article

REF ID: 6192

Level II: Individual experimental study

Topic 4.6: Management-Other

Westcombe, A. M., Gambles, M. A., Wilkinson, S. M., Barnes, K., Fellowes, D., & Maher, E. J. et al. (2003). Learning the hard way! setting up an RCT of aromatherapy massage for patients with advanced cancer. *Palliative Medicine, 17(4), 300-307.*

Journal; Peer Reviewed Journal

Aromatherapy massage is used in cancer palliative care to improve quality of life but there is little evidence for its effectiveness. A large pragmatic multicentre randomized controlled trial was set up to examine the effectiveness of aromatherapy in improving psychological distress and quality of life in

patients with cancer. This paper examines the challenges encountered in the design and execution of the study. The original design, i) focused on palliative care patients with advanced disease; ii) had both a no-intervention and a treatment control group (relaxation therapy); and iii) adopted 90% power for sample size calculations. A varied measurement strategy was employed. Recruitment proved difficult, referrers were 'gate-keeping', patients were often too ill to approach and others declined. The trial was modified to ensure viability. Eligibility was extended to all patients with cancer irrespective of stage, the relaxation group was removed and the power reduced to 80%. Although it is not generally good practice to change a study design once recruitment has started, the changes were consistent with the original basic study aims and design principles. The data collection phase was successfully completed in July 2002. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 6169

QM: Quality Measures

Topic 5: Evaluation/Follow-up

White, D. B., & Luce, J. M. (2004). Palliative care in the intensive care unit: Barriers, advances, and unmet needs. *Critical Care Clinics*, 20(3), 329-343.

Journal Article. Review

The concept that critical illness and terminal illness are necessarily distinct entities has given way to the understanding that they often exist on the same spectrum. Consequently, there is growing consensus that palliative treatment must coexist with attempts at restorative treatment in the intensive care unit (ICU). Palliative care in the ICU has evolved from a relatively one-dimensional construct of terminal sedation in dying patients to a multidisciplinary field addressing symptom control, physician-patient-family communication, spiritual needs, and the needs of health care providers. As ongoing research efforts yield new insights, our ability to practice evidence-based palliative care in the ICU will grow, and new avenues for improvement will become evident. [References: 96]

REF ID: 5507

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Wu, N., Miller, S. C., Lapane, K., Roy, J., & Mor, V. (2005). The quality of the quality indicator of pain derived from the minimum data set. *Health Services Research*, 40(4), 1197-1216.

Journal Article, Equations & Formulas, Research, Tables/Charts

OBJECTIVE: To examine facility variation in data quality of the level of pain documented in the minimum data set (MDS) as a function of level of hospice enrollment in nursing homes (NHs). **DATA SOURCE:** Clinical assessments on 3,469 nonhospice residents from 178 NHs were merged with On-line Survey Certification and Reporting data of 2000, Medicare Claims data of 2000 and the MDS of 2000-2002. **STUDY DESIGN:** Using the same assessment protocol, NH staff and study nurses independently assessed 3,469 nonhospice residents. Study nurses' assessments being gold standard, we quantified and compared quality of NH staff's pain rating across NHs with high, medium, or low hospice use. Multilevel models were built to assess the effect of NH hospice use levels on the occurrence of false positive (FP) and false negative (FN) errors in NH-rated "severe pain." **PRINCIPAL FINDINGS:** Of 178 NHs, 25 had medium and 41 high hospice use. NHs with higher hospice use had lower sensitivities. In multilevel analysis, we found a significant facility-level variation in the probability of FP and FN errors in facility-rated "severe pain." Resident characteristics only explained 4 and 0 percent of the facility variation in FP and FN, respectively; characteristics and locations (state) of NHs further explained 53 and 52 percent of the variance. After controlling for resident and NH characteristics, staff in NHs with medium or high hospice use were less likely to have FP or FN errors in their MDS documentation of pain than were staff in NHs with low or no hospice use. **CONCLUSIONS:** The examination of data quality of pooled MDS data from multiple NHs is insufficient. Multilevel analysis is needed to elucidate sources of heterogeneity in the quality of MDS data across NHs. Facility characteristics, e.g., hospice use or NH location, are systematically associated with overrated/underrated pain and may bias pain quality indicator (QI) comparisons. To ensure the integrity of QI comparison in the NH setting, the government may need to institute regular audits of MDS data quality.

