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Emergency Hospitalization of Neurological Patients with Palliative Care Needs: What are the Reasons?

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Introduction

Acute and unexpected hospitalisation can be extremely distressing, especially for patients who require palliative care. Despite this, the majority of neurological inpatients getting palliative care are admitted through the emergency room. Identifying possibly preventable causes of acute hospitalisation in individuals with neurological diseases or symptoms needing palliative care. Medical records of all patients hospitalised through the emergency department and eventually received palliative care in a neurological unit (n = 130) were reviewed retrospectively. Neurologic disorders are the second most prevalent diagnosis among inpatients getting specialised palliative care, behind cancer [1, 2]. Patients with neurological disorders or consequences, like the majority of inpatients with other life-limiting conditions and palliative care needs, are admitted to the hospital via an emergency department (ED). Due to excessive wait times, a lack of proper communication, and poor symptom management, an acute admission to the ED can cause considerable discomfort in this vulnerable group. ED visits, on the other hand, rise with impairment and decrease with age. In many situations, they result in prolonged hospitalisation [3].

Early inclusion of palliative concepts into the hospital treatment pathway is thus a critical goal. Hospital-based specialised palliative care can be included into the treatment of patients with life-limiting conditions as a supplement to disease management in the primary treating department through consultations with a multi-professional palliative care programme. A palliative care physician and a nurse work alongside and in conjunction with the attending physician. They want to aid with symptom management, defining objectives of care based on the (supposed) patient's wishes, assisting patients with advance care planning, and providing psychosocial support to informal careers. Social workers, psychologists, physiotherapists, occupational and speech therapists, and pastoral care are all part of the multi-professional team approach. An assessment is conducted at the initial expert palliative care consultation to evaluate unmet palliative care requirements on the physical, social, psychological, and spiritual levels in order to build a palliative care treatment plan.

Specialist palliative care consultation can minimize length of stay and total healthcare expenses while improving symptom burden, patient and caregiver satisfaction, and quality of life. When compared to late beginning, early expert palliative care consultation is related with a lower in-hospital death rate. Palliative care in the emergency department has been advocated as a way to shift palliative care "upstream" in the in-hospital treatment process [4]. Education of emergency doctors in palliative care principles to encourage them as primary providers to installation of specialised palliative care consultation by a multi-professional palliative care service as secondary providers in the ED are some of the methods used to attain this aim [4].

Increased recognition of palliative care requirements in the emergency department may allow for earlier palliative care integration in the hospital. Patients with end-stage cancer, patients receiving outpatient palliative care [3], seriously ill older patients with complex medical conditions, and in patients who received palliative care consultation after being admitted via an ED have been the focus of studies over the last decade [5]. The causes of admission of neurological inpatients receiving palliative care, on the other hand, have never been investigated. In this study, we looked at admission and palliative care requirements in a group of ED patients from a big university hospital.

Epileptic seizures (22%), gait difficulties (22%), disturbances of consciousness (20%), pain (17%), dietary issues (17%), or paresis (17%) were the most common causes for acute hospitalization (14 percent). Only 31% reported possible therapeutic limits, (non) existence of a patient decree, or healthcare proxy. Neoplastic (49 percent), neurodegenerative (30 percent), and cerebrovascular (18 percent) disorders were the most common primary diagnosis. Fifty-nine percent were taken to a neurological unit right after, while 25 percent required critical care. It took an average of 24 hours for the palliative care team to get involved. In contrast to previously recorded issues, palliative care assessments indicated psychological issues as major barriers. A specific palliative care programme may be created in 40% of all instances.

We extracted the following variables from palliative care assessments, which are routinely conducted by a multi-professional palliative care service at the initiation of palliative care in all patients: palliative care symptoms [MIDOS], pain assessment (visual analogue scale from 0 = no pain to 10 = worst pain possible), performance status [Eastern Cooperative Oncology Group, ECOG], and (non) existence of a patient. If patients were unable to communicate, families, proxies, palliative care services, or the attending neurologist assessed them.

Acute episodes were the primary cause of admissions. It may be possible to avoid needless hospitalisation by documenting the palliative status and treatment restrictions. Despite the fact that patients enter with a complex symptom load, emergency department evaluations are unable to completely address multidimensionality, particularly in the case of psychological issues. Short screening techniques for identifying palliative care requirements of neurological patients currently in the emergency department should be developed in prospective studies [6].

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