

A Systematic Review Procedure on Home Palliative Cancer Care by Primary Healthcare

Eren Kuan*

Department of Emergency Medicine, Affiliated Hospital of Southwest Medical University, Luzhou, China

Abstract

In order to maintain the viability of health systems and improve life quality, chronic illnesses like cancer and longer life expectancies necessitate (re)organization of care. Positive effects of palliative care provided by primary healthcare include improved standards of care for the terminally ill, decreased hospitalisations and medical expenses, and increased autonomy for patients to manage their symptoms at home. This is not feasible in many nations, though, since the provision of palliative cancer treatment is isolated or widespread, centralised in hospitals, and devoid of the strategic involvement of primary care. Home care has improved people's chances of obtaining dignified care towards the end of life in many affluent nations when palliative care is provided in an integrated manner. The purpose of this analysis is to assess how primary care has structured home palliative cancer treatment to better utilise healthcare resources and enhance patient quality of life. The Cochrane technique is used in this systematic review procedure to generate a narrative synthesis, and the Preferred Reporting Items for Systematic Reviews serve as a guide for the final report.

Keywords: Palliative care; Neoplasms; Home care services; Primary health care; Organization and administration; Patient care management

Introduction

Palliative care, according to one definition, "is the active, comprehensive treatment of people of all ages who are suffering from severe illnesses and who are especially close to the end of life" [1]. Palliative care focuses with "prevention, early detection, complete assessment and management of medical concerns, including pain and other painful symptoms, psychological suffering, spiritual discomfort and social needs". In order to help family carers wherever they are, the multidisciplinary team's assistance aims to increase comfort and quality of life. The World Health Organization promotes the early integration of palliative care beginning with the identification of a condition that has the potential to endanger life in order to accomplish these goals. The evolution of investments in palliative care happens as a result of people's needs and expectations in the merging of clinical and palliative care. Palliative care, however, becomes more important when the disease does not respond to treatments for cure or control [1,2].

However, palliative care is frequently inadequate and precarious in low- and middle-income countries because, for instance, health professionals' and the public's knowledge of the topic is lacking, there are insufficient resources, and public-private health systems are unable to deliver palliative care with quality and safety [3,4]. Palliative care is often not provided, and dying is frequently met with agony and neglect [5]. The biological paradigm, for instance, suggests that treatment failures for cure should not be accepted, that palliative care patients should be identified later, and that optimistic prognoses should be avoided. Given these restrictions, palliative care is more accepted among cancer patients than it is among those who have illnesses with a protracted course and a poor prognosis [6]. This is the major justification for confining the current review to the field of oncology in addition to its epidemiological significance. Especially when treatment is not integrated with a professional palliative care team for the referral of difficult cases, clinical instability and the worsening of symptoms in advanced cancer patients can result in the use of urgencies and emergencies as well as lengthy hospital admissions. Due to a lack of in-hospital teams, transitional care, and home palliative care, or a

structured network for handling cases of persons with palliative care needs, hospital-based models have substantial financial expenses [7,8].

Many developed nations invest in structured palliative care services, which are typically organised by primary care, in an effort to combat the rising costs of caring for people with chronic illnesses. They do this because they recognise the close relationship between palliative care and primary care. The same values including "equity, solidarity, social justice, universal access to services, multisectoral activity, decentralisation, and community participation" guide both organisations. Changes in end-of-life care practises, such as moving hospice care from hospitals to homes, are part of the palliative care strategy in primary care [9,10]. Palliative care's primary delivery method is home care since it aims to uphold bioethical values like patient autonomy. It is a method for getting palliative care to more individuals. The presence of a family carer who will offer care at home under strict professional supervision is important for home palliative care to be successful. According to demand, the health team conducts home consultations, and nurses frequently manage this care as a member of a multidisciplinary team.

The primary care team can organise home palliative cancer care in a variety of ways to fulfill the needs of patients and families while providing both generalist and specialist palliative care. Care models might vary based on the health system, offering specialist palliative care at home, in a hospice programme, and/or in a hospital. To promote integration with specialist palliative care in any paradigm, primary care

***Corresponding author:** Eren Kuan, Department of Emergency Medicine, Affiliated Hospital of Southwest Medical University, Luzhou, China, E-mail: eren@vip.qq.com

Received: 28-Feb-2023, Manuscript No. jpcm-23-91641; **Editor assigned:** 02-Mar-2023, PreQC No. jpcm-23-91641(PQ); **Reviewed:** 16-Mar-2023, QC No. jpcm-23-91641; **Revised:** 21-Mar-2023, Manuscript No. jpcm-23-91641(R); **Published:** 28-Mar-2023, DOI: 10.4172/2165-7386.1000506

Citation: Kuan E (2023) A Systematic Review Procedure on Home Palliative Cancer Care by Primary Healthcare. J Palliat Care Med 13: 506.

Copyright: © 2023 Kuan E. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

clinicians must be included. In-home palliative cancer care is required to identify patients at the point of death, provide support in the event of a death at home and during bereavement, prescribe and manage medications, as well as non-pharmacological interventions to control physical and psychological symptoms, offer nursing care for comfort, offer assistance through phone calls, and be ready for anticipatory visits in order to reduce emergency room visits and hospitalisations; and review all necessary records. This assessment of the literature reveals that no studies that focused on the organisation of home palliative cancer treatment by primary care have been done. A comprehensive study can help many nations that urgently need to strengthen their capacity to provide palliative care because the information is diverse and dispersed. The evidence must be reinforced in relation to the ability to enhance the quality of life of patients receiving palliative care in addition to replies pertaining to costs [11]. Hence, in order to optimise the utilisation of health resources and the quality of life for such patients, we sought to assess how primary care organisations organise home palliative cancer care. 90% of the 480,000 annual fatalities in Canada by 2056 are expected to be treatable with palliative care. Palliative care's goal is to enhance the quality of life for patients and their families by preventing and alleviating pain. Patients frequently opt to get palliative care at home. The delivery of specialist palliative care at the patient's home, most frequently by nurses and/or doctors, with or without link to a hospital or hospice, is known as palliative care in the home. Fulfilling a commitment to care for the patient at home, the desire to retain a "normal family life," and prior unpleasant experiences in institutional care settings have all been named as factors in the decision to receive palliative care in the home. More than 70% of Canadians who participated in a recent study of 1200 people said they would rather die at home. Interventions for palliative care in the home can range significantly, from those that try to offer hope to informal carer counselling or after-hours night respite. Palliative treatment is frequently assessed retroactively using proxy reports and systematic data gathering. The cost and resource usage of palliative care have also been assessed. Although the place of death whether it occurs at home or in a hospital—has frequently been used as a metric to assess palliative care in the home, this measurement is heavily questioned since it only takes into consideration the end of the dying process [12-14].

Study strategy

Primary outcomes were used to categorise the included studies. A second reviewer independently and independently confirmed the data extraction, which covered the objectives, methodology, main results, and topics addressed. The Cochrane Risk of Bias (ROB) tool was used to evaluate the study quality of randomised controlled trials [15]. Controlled before and after studies were evaluated using the same standards as randomised controlled trials, but they were shown to have a significant risk of bias with regard to the allocation sequence concealment and random sequence creation [16]. Newcastle-Ottawa criteria were used to assess the quality of cohort studies [17]. The Critical Appraisal Skills Programme Qualitative Checklist was used to evaluate the quality of qualitative investigations, as advised by Cochrane [18,19]. The Cochrane-recommended "Quality assessment tool for quantitative studies" [20] was used to evaluate the cross-sectional study's level of quality. Cost studies did not analyse outcomes, making them inappropriate for use with any currently available, verified quality evaluation techniques.

Discussion

Among the literature on palliative home care, 53 papers of varied

research designs, reporting on various outcomes, and of varying quality were found. It is important to highlight that there are information gaps about the result of carer distress and the issue of improving the quality of palliative care in the home interventions. We are not able to generalise about successful palliative care in the home due to the size and diversity of this body of information. In almost one-third of the studies that were included, palliative care in the home treatments were assessed using the primary outcomes of resource utilisation, cost, or site of death. Others have claimed that these results are insufficient to determine whether the intervention was beneficial. The efficacy metric should be related to the intervention's goal; for example, the location of care before to death may be a more suitable outcome than the site of death. Our findings highlight the need to quantify outcomes that are more closely related to the goal of palliative care in the home by going beyond the normally obtained data. The care providers and intervention elements used in the included interventions varied. The topic of personalised patient centred care was present in 66% of reviewed studies and underlines the focus of these treatments on satisfying patient needs. Generalizations on what elements led to successful results are challenging due to the variety of these treatments. Nine distinct primary outcomes were also found in the papers that were included. It is challenging to determine whether components are helpful or not given the variety of results. The growing corpus of knowledge would be considerably advanced by agreement on the outcomes that would be necessary to prove that an intervention is successful. All intervention assessments revealed favourable results, despite inconsistent quality. This corroborates the commonsense claim that patients benefit from receiving palliative care at home. Yet, publication bias can be to blame for this. Our ability to determine whether trials with negative effects are still unpublished is hindered by heterogeneity in intervention components and primary outcome assessment. An emphasis on the expanded accessibility of healthcare professionals, symptom reduction, and including carers as beneficiaries and participants in care were significant in intervention assessments, much like a meta-ethnography evaluating patient and carer objectives for palliative care in the home. The following are the results of a survey conducted by the American Psychological Association (APA) on the subject of the use of the term psychological assessment in the workplace.

Conclusion

Given the financial burden that cancer and other chronic diseases place on society, it is essential to provide rapid and innovative solutions to the needs of people who are nearing the end of their lives. This study will synthesise the data that may support the extension of palliative cancer care in primary care, namely in-home care, in line with the goals of sustainable development and the advancement of public policies globally. In order to do this, the authors want to publish a final report in a journal indexed in global databases in addition to the scientific rigour that will be used in this review in terms of distribution.

Acknowledgement

Not applicable.

Conflict of Interest

Author declares no conflict of interest.

References

1. International Associations for Hospice and Palliative Care (IAHPC) (2018) Global Consensus Based Palliative Care Definition.
2. World Health Organization (WHO) (2018) Integrating palliative care and symptom relief into primary health care.

3. Clelland D, van Steijn D, Whitelaw S, Connor S, Centeno C, et al. (2020) Palliative Care in Public Policy: results from a global survey. *Palliat Med Rep* 1:183-190.
4. Carvalho GAFDL, Menezes RMPD, Enders BC, Teixeira GA, Dantas DNA, et al. (2018) Meanings attributed to palliative care by health professional in the primary care context. *Texto Contexto Enferm* 27:40016.
5. Worldwide Hospice Palliative Care Alliance (2020) *Global Atlas of Palliative Care*.
6. Jordan RI, Allsop MJ, ElMokhallalati Y, Jackson CE, Edwards HL, et al. (2020) Duration of palliative care before death in international routine practice: a systematic review and meta-analysis. *BMC Med* 18:1-25.
7. Nishimura F, Carrara AF, Freitas CE (2019) Effect of the Melhor em Casa program on hospital costs. *Rev Saude Publica* 53:104.
8. Haj-Ali W, Moineddin R, Hutchison B, Wodchis WP, Glazier RH (2020) Role of Interprofessional primary care teams in preventing avoidable hospitalizations and hospital readmissions in Ontario, Canada: A retrospective cohort study. *BMC Health Serv Res* 20: 782.
9. Hackett J, Ziegler L, Godfrey M, Foy R, Bennett MI (2018) Primary palliative care team perspectives on coordinating and managing people with advanced cancer in the community: A qualitative study. *BMC Fam Pract* 19: 177.
10. Abel J, Kellehear A, Karapliagou A (2018) Palliative care-The new essentials. *Ann Palliat Med* 7:3-14.
11. Plas AG, Pasmán HRW, Schweitzer B, Onwuteaka-Philipsen B (2018) Improving palliative care provision in primary care: A pre- and post-survey evaluation among PaTz groups. *Br J Gen Pract* 68:351-359.
12. Higgins JPT, Thomas J, Chandler J, Cumpston MLT, Page M, et al. (2022) *Cochrane Handbook for Systematic Reviews of Interventions Version 6.3*. John Wiley & Sons: Hoboken, New Jersey, USA.
13. Silva M, Barros T, Baixinho C, Costa A, Sa E, et al. (2023) The Effectiveness of Home Care Coordinated by Primary Health Care to Improve the Care Management of People in Palliative Cancer Care: A Systematic Review Protocol.
14. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, et al. (2021) The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ* 88:906
15. Stone MJ (2001) Goals of care at the end of life. *Proc Bayl Univ Med Cent* 14:134-137.
16. Nordly M, Vadstrup ES, Sjogren P, Kurita GP (2016) Home-based specialized palliative care in patients with advanced cancer: a systematic review. *Palliat Support Care* 14:713-724.
17. Stajduhar KI, Davies B (2005) Variations in and factors influencing family members' decisions for palliative home care. *Palliat Med* 19:21-32.
18. Wilson DM, Cohen J, Deliens L, Hewitt JA, Houttekier D (2013) The preferred place of last days: results of a representative population-based public survey. *J Palliat Med* 16:502-508.
19. Duggleby WD, Degner L, Williams A, Wright K, Cooper D, et al. (2007) Living with hope: initial evaluation of a psychosocial hope intervention for older palliative home care patients. *J Pain Symptom Manag* 33:247-257.
20. Walsh K, Jones L, Tookman A, Mason C, McLoughlin J, et al. (2007) Reducing emotional distress in people caring for patients receiving specialist palliative care. *Br J Psychiatry* 190:142-147.