

## Implementation of Modern Technologies in Palliative Care to Address Structural Problems in the Management of Neurological Patients

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### Abstract

Telemedicine offers a way to deal with the health-care system's scarcity of resources and money. Although palliative care has been advised for an increasing number of patients with neurodegenerative illnesses, these patients frequently lack access to either palliative care or neurology. Palliative care is a multidisciplinary approach, thus using palliative care structures as a foundation makes sense. In an outpatient context, there is no systematic access to neurological expertise. A palliative care strategy has the potential to identify and enhance key patient and caregiver outcomes. As a relatively new use of palliative care, research is needed to adapt, develop, and deploy ways to address the specific demands of this group.

**Keywords:** Palliative care; Neurological patients

### Introduction

In severe neurological disorders, a multimodal palliative care strategy improves patient quality of life and symptoms. Because illness trajectories in neurological diseases are less predictable than in cancer patients, end-of-life care might be difficult. Furthermore, either palliative care knowledge or neurological expertise may be insufficient among neurologists or palliative care professionals. Outpatient palliative care is a multidisciplinary strategy centered on a core team that is supported by a network. Currently, the most appropriate kind of palliative care is specialised outpatient palliative care (SPC) support, which allows patients to remain at home. In most SPC teams, neurological competence is insufficient, making it challenging to deal with patients who have neurological disorders or symptoms. In most countries, there is no defined regulated route to a neurological consultant in an outpatient context [1].

All clinicians, including neurologists, should be knowledgeable with and comfortable with some basic palliative care skills, such as conveying bad news, assessing and managing nonmotor symptoms, advance care planning, and caregiver assessment. Referral to palliative care specialty teams, such as inpatient palliative care consultation, outpatient palliative care clinics, home palliative care, or hospice, may be recommended for more difficult or advanced patients. To demonstrate for the first time that telemedical support for SPC teams focusing on neurological patients or neurological symptoms in oncology patients is technically viable and supports the team's treatment in this small pilot trial. It allows teams to quickly obtain neurological and neuropalliative care knowledge while maintaining communication with the patient. There was no clear structure in place in the teams dealing with these difficulties until today, which generated a lot of problems because neurological expertise is usually only available during hospitalisation. Patients with advanced neurological disorders, on the other hand, are generally bedridden and have severe communication impairments, making transportation to a hospital or even a palliative care unit challenging. As a result of telemedical consultation, the patient was allowed to remain at home while the SPC team served as the primary provider of care by providing expert opinion on demand. The patient's bond with the SPC team was also reinforced as a result of this.

SPC teams rarely treat patients who have a neurological diagnosis. We recommend a growing number of neurological patients in specialised outpatient teams as awareness of the benefits of a

multimodal palliative strategy in progressing neurological disorders grows. The telemedical project provided clearly defined consultative mechanisms, which increased the SPC teams' work quality and job satisfaction. Patients have a high level of acceptability of the telemedical application, according to physician interviews. It's worth noting that in some circumstances when we couldn't help with symptom control, the patient's understanding of comprehensive medical care was all that was needed. To get an unbiased view of patient's acceptance further interviews with the patients and caregivers have to be performed. The proposed system provides more safety in the care of neurological palliative outpatients, particularly because it allows for visual appraisal. Furthermore, the system is tiny, portable, and stands out due to its straightforward application. The telemedical approach offers technical components which are easy to handle and have stable communication lines even in remote areas. The telemedical "home visitation" of a specialized neurologist has been well accepted by the teams. It provides an easy and effective way of symptom discussion and treatment evaluation [2-6].

### Conclusion

Few therapies for heart failure family caregivers have been thoroughly tested and shown to be effective. This was the largest and most ethnically diverse trial of a nurse coach-led palliative care intervention for family caregivers of patients with severe heart failure that we were aware of. The trial was well-designed, but it failed to show that caregivers benefited from it after 16 weeks. Future interventions should be shorter, target more disturbed caregivers than those in our sample, and examine benefits on patient outcomes, according to our findings. The development of consistently effective therapies for a wide range of heart failure family caregivers remains elusive, but it is critical enough that ongoing research and testing are required to optimise culturally appropriate assistance for this underserved workforce.

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