

# CUIDADO É FUNDAMENTAL

Escola de Enfermagem Alfredo Pinto – UNIRIO

RESEARCH

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## KNOWLEDGE OF A MULTIDISCIPLINARY TEAM ABOUT PALLIATIVE CARE: QUASI-EXPERIMENTAL STUDY

*Conhecimento de uma equipe multiprofissional sobre cuidados paliativos: estudo quase experimental**Conocimiento de un equipo multidisciplinario sobre cuidados paliativos: estudio cuasi-experimental***Luana Criciele Aguiar da Silva<sup>1</sup>** **Eliane Raquel Rieth Benetti<sup>2</sup>** **Janaina Coser<sup>3</sup>** **João Luiz Almeida da Silva<sup>4</sup>** **Christiane Fátima Colet<sup>5</sup>** **Adriane Cristina Bernat Kolankiewicz<sup>6</sup>** 

### ABSTRACT

**Objective:** to evaluate the knowledge of the multidisciplinary team of a hospital clinical unit, before and after educational actions on palliative care. **Method:** quasi-experimental study, “before and after”, in which there is no randomness in the selection of the population and the control group are the participants who underwent the intervention. **Results:** there was a statistically significant difference in the answers regarding the best time to start Palliative Care (54.3% to 80% of correct answers after the educational actions) after the educational actions. No participant had specific training in the area. **Conclusion:** after this study, there were changes in clinical practice. The institution began training for teams, reinforcing the relevance of studies related to the topic and the need for investment in continuing education in order to change the reality of the health system.

**DESCRIPTORS:** Palliative care; Patient care team; Permanent education;

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## RESUMO

**Objetivo:** avaliar o conhecimento da equipe multiprofissional de uma unidade clínica hospitalar, antes e depois de ações educativas sobre cuidados paliativos. **Método:** estudo quase experimental, tipo “antes e depois”, em que não há aleatoriedade na seleção da população e o grupo controle são os participantes que sofreram a intervenção. **Resultados:** houve diferença estatisticamente significativa nas respostas acerca do melhor momento para iniciar Cuidados Paliativos (54,3% para 80% de respostas corretas após as ações educativas) após as ações educativas. Nenhum participante tinha formação específica na área. **Conclusão:** após este estudo, houve mudanças na prática clínica. A instituição iniciou capacitações para as equipes, reforçando a relevância de estudos relacionados ao tema e necessidade de investimento em educação permanente a fim de mudar a realidade do sistema de saúde.

**DESCRIPTORIOS:** Cuidados paliativos; Equipe de assistência ao paciente; Educação permanente;

## RESUMEN

**Objetivos:** evaluar los conocimientos del equipo multidisciplinario de una unidad clínica hospitalaria, antes y después de acciones educativas sobre cuidados paliativos. **Método:** estudio cuasiexperimental, “antes y después”, en el que no existe aleatoriedad en la selección de la población y el grupo control son los participantes que se sometieron a la intervención. **Resultados:** hubo diferencia estadísticamente significativa en las respuestas respecto al mejor momento para iniciar los Cuidados Paliativos (54,3% a 80% de respuestas correctas después de las acciones educativas) después de las acciones educativas. Ningún participante contaba con formación específica en el área. **Conclusión:** después de este estudio, hubo cambios en la práctica clínica. La institución inició la capacitación de equipos, reforzando la relevancia de los estudios relacionados con el tema y la necesidad de invertir en educación continua para cambiar la realidad del sistema de salud.

**DESCRIPTORIOS:** Cuidados paliativos; equipo de atención al paciente; Educación permanente.

## INTRODUCTION

Palliative care (PC) is defined by the World Health Organization (WHO) as care provided by a multidisciplinary team, with the aim of improving the quality of life of patients and their families, regardless of age, in the face of a life-threatening illness.<sup>1</sup> This concept was updated in 2018 as “an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illnesses” and also “the prevention and relief of suffering through early identification, assessment and treatment of pain and other physical, psychosocial or spiritual problems”.<sup>2</sup>

This update denotes the decentralization of PC only to terminally ill patients. The integration of the practice in health services has broken down dichotomies and made the approach simultaneous and complementary to disease-modifying measures. As the disease progresses, disease-modifying measures are replaced by exclusive palliative measures, until the moment of death and mourning.<sup>3</sup>

Aging is the result of the accumulation of various molecular and cellular damages over time, leading to a gradual decrease in physical and mental capacities, a greater risk of developing diseases and even death.<sup>4</sup> One of the eligibility criteria for PC is the patient’s involvement in a life-threatening disease and/or condition, regardless of age. The elderly population tends to be more frail and suffer from more comorbidities, resulting in a more recurrent need for PC.<sup>3</sup>

Considering that “palliative care assistance is focused on the person and not on the disease”<sup>5</sup>, it is important to remember aging, in addition to chronic diseases. Senility is the pathological process of aging, i.e. conditions that compromise quality of life, but are not common to all people in the same age group. The

same process occurs with other chronic diseases, which increase as the population ages.<sup>6</sup>

In Brazil, the diseases with the highest morbidity and mortality, especially in the elderly, are those affecting the circulatory, respiratory and endocrine systems and cancer. In this way, unhealthy lifestyle habits are the main risk factors associated with these diseases.<sup>7</sup> Estimates have shown that although longevity is increasing, so is the disability of these individuals, so that skilled professionals, infrastructure and equipment are needed to deal with the particularities of each person.<sup>8</sup>

Hospitalization can be a consequence of this scenario and represents an important alternative in treatment, when necessary. However, repeated or prolonged hospitalizations can cause greater harm to the elderly and accentuate the fragility and decreased functional capacity that are already present in this population and which increase the need for PC.<sup>9</sup> In general, professionals have their training based on curative practices, leaving them unprepared to deal with contrary scenarios. It is therefore necessary to update concepts in the training of these professionals, reviewing and adjusting the curricula of health courses, as well as including them in a transdisciplinary way in the routine of institutions, thus providing safety and knowledge about PC.<sup>3</sup>

The practice of PC should preferably be carried out by a specialized team that cares for the patient and their family as a whole, creating ways of coping with the disease/condition, the possibility of terminality, the dying process and mourning, in accordance with the organization of the service.<sup>11-12</sup> However, according to the new concept, in “simple” cases it is possible for a team with basic training to provide care, which makes it even more necessary to train professionals so that they are able to provide this care in any service in the care network.<sup>3</sup>

Health education is a fundamental tool for professionals, in the search for knowledge and safety, both for the team and the family, especially to rethink inadequate practices due to the accumulation of functions or lack of knowledge in PC, which is still poorly understood, due to the low incentive and investment in both training and education activities in services, which makes professionals unprepared to experience possible frustrations, in addition to not recognizing the benefits involved.<sup>13-14</sup>

With this in mind, this study aims to assess the knowledge of the multi-professional team working in a hospital clinical unit, before and after educational activities on palliative care.

## METHOD

A quasi-experimental "before and after" study, in which the population was not randomized and the control group were the participants who underwent the intervention. The study was carried out with a multi-professional team (nurses, nursing technicians, doctors, nutritionists, physiotherapists and social workers) who were assisting patients in palliative care in an inpatient unit of a philanthropic hospital in southern Brazil.

Professionals who were on vacation or sick leave during the study period (November 2020 to July 2021) were excluded from the study.

Initially, a semi-structured questionnaire was applied, divided into sociodemographic and work-related data and specific knowledge about Palliative Care, consisting of 14 multiple-choice questions with four alternative answers. The questionnaire and correct answers were drawn up by the author of the study based on information from the 2nd edition of the Palliative Care Manual of the National Academy of Palliative Care (ANCP), published in 2012, and WHO definitions. It is worth noting that the 3rd edition of this manual was released in 2021, after the questionnaire had been applied, so the new edition was not taken into account when drawing up the instruments.

Data collection was carried out by the author before and after the educational actions, which she also developed. The first period took place in November 2020 (printed and online questionnaires on the Google Forms platform) and the second in July 2021 (online questionnaire on the Google Forms platform with access link via WhatsApp chat application, due to the impossibility of applying in person, due to the COVID-19 pandemic). In the second stage, only the instrument relating to specific knowledge was applied again.

After the first stage of data collection, educational actions were carried out through a booklet, based on the 2nd edition of the ANCP Palliative Care Manual, in order to better equip the team, sent via WhatsApp, in addition to an expository class in the Institution's auditorium, based on the problematization methodology and on-site training according to the demand presented in daily practice and multiprofessional rounds.

The database was set up with independent double entry into Microsoft Office Excel software. The results were presented using the absolute and relative distribution (n and %) of the categorical

variables and the mean, standard deviation and range for age, with the study of symmetry using the Shapiro Wilk test. The study lost 30% of the participants compared to the first questionnaire. Therefore, the Stuart-Maxwell Marginal Homogeneity (HMSM) test was used to compare sociodemographic data, respecting the dependence of the data analyzed. The McNemar Browker test was used to compare the proportions of questions on palliative care between the initial and final assessments. The data was analyzed using the Statistical Package for Social Sciences version 20.0 (SPSS Inc., Chicago, IL, USA, 2008) for Windows and, for statistical decision criteria, a significance level of 5% ( $p < 0.05$ ) was adopted.

The study complied with Resolution 466/2012 and was approved under opinion number 4.344.936 on October 18, 2020.

## RESULTS

Initially, 50 employees took part in the study, but 15 participants (30%) were lost in the second stage, leaving 35 professionals. There was a predominance of female participants, with an average age of 33, Nursing Technicians and Doctors.

This study took place during the COVID-19 pandemic, which justifies the loss of participants, since three were relocated to another sector during the study, nine were disconnected and only three did not respond to the survey, even after three attempts to contact them. In this sense, it can be said that the professionals' adherence to the research was a positive point, since most of the team (70%) took part in all stages of the study.

It is worth pointing out that it was not expected to find differences after comparing the participants, since the same people took part in both stages of the study; however, the HMSM test was carried out to justify that the losses that occurred during the process did not cause significant changes in the research population.

Tables 1, 2 and 3 present data relating to the subject of the study. The analysis shows the comparison between the initial and final moments, and therefore only includes the responses of the participants who completed the study (n=35).

The analysis found a statistically significant difference regarding the best time to start PC. In the first questionnaire, 19 (54.3%) answers were correct and, after the educational actions, 28 (80%).

Regarding the concept of PC, there was an increase from 21 (71.4%) to 32 (91.4%) correct answers after the educational activities. Guidance on therapy should be given to the patient and family, to make them the protagonists of the process, according to 33 participants (94.3%). There were 34 (97.1%) correct answers as to when care should be started. Regarding the professional responsible for care, 28 (82.4%) answered correctly in the first stage and 34 (97.1%) in the second. Regarding pain control and palliative sedation, 23 (65.7%) answered correctly. With regard to reporting the diagnosis, 34 (97.1%) answered that pros and cons should be assessed. After the educational activities, the number of correct answers fell to 31 (88.6%).

**Table 1** – Questionnaire on specific knowledge of Palliative Care (PC). Ijuí, RS, Brazil, 2022

Questions	Evaluation period Paired data				P#
	Basal (n=35)		Final (n=35)		
	n	%	n	%	
<b>What is Palliative Care?</b>					0,065
C. Caring for patients with any disease that cannot be cured	25	71,4	32	91,4	
Caring for patients in the terminal phase of a certain disease	10	28,6	3	8,6	
<b>What are the objectives of Palliative Care?</b>					>0,999
C. Promoting quality of life, controlling and treating pain/suffering, comprehensive physical health care...	34	97,1	34	97,1	
Use of invasive treatments and procedures that delay the dying process	1	2,9	1	2,9	
<b>The Palliative Care approach involves:</b>	Da=1				0,214
C. Comprehensive support for patients and their families/caregivers (illness, treatment, bereavement)	30	88,2	34	97,1	
Exhausting invasive treatment alternatives in an attempt to cure the patient	1	2,9			
Accompanying and assisting the caregiver/family member only until the patient's death	1	2,9	1	2,9	
<b>Palliative care is carried out by:</b>					0,155
C. Multi-professional team and family/caregivers	28	82,4	34	97,1	
Nursing staff	1	2,9			
Multi-professional team	5	14,7	1	2,9	
<b>Responsibility for Palliative Care lies with:</b>	Da=2				0,866
C. All of the above					
Basic care					
Hospital care					
<b>Responsibility for Palliative Care lies with:</b>					0,892
C. The multi-professional team, allied to the Palliative Care team	31	88,6	32	91,4	
The doctor responsible for the patient	3	8,6	3	8,6	

**Table 2** – Questionnaire on specific knowledge of Palliative Care. Ijuí, RS, Brazil, 2022

Questions	Evaluation period Paired data				P#
	Basal (n=35)		Final (n=35)		
	n	%	n	%	
<b>These are forms of pain control:</b>	Da=1				0,677
C. All alternatives are correct	21	61,8	23	65,7	
Acupuncture, massages and relaxation			2	5,7	
Use of non-opioid analgesics, opioids and anti-inflammatory drugs	13	38,2	10	28,6	
<b>These are dispensable practices when caring for a patient who is actively dying:</b>	Da=1				>0,999
C. Antibiotic therapy, enteral diet and artificial hydration	25	73,5	26	74,3	
Adjusting drug prescriptions - painkillers, opioids, sedatives	8	23,5	6	17,1	
Mobilization and decubitus change	1	2,9	1	2,9	
<b>What is hypodermoclysis?</b>					0,833
C. Type of subcutaneous puncture widely used in palliative care	34	100,0	33	94,3	
Processo de sedação do paciente terminal			2	5,7	
<b>When the family doesn't want to tell the patient diagnosis or prognosis, what should be done?</b>					0,365
C. Evaluate the positive and negative factors of informing the patient, together with the family, and thus avoid	34	97,1	31	88,6	
Don't tell, because it's a decision that should be made solely by the family and there are no negative factors in	1	2,9	3	8,6	

**Table 3** – Questionnaire on specific knowledge of Palliative Care. Ijuí, RS, Brazil, 2022

Questions	Evaluation period Paired data				P#
	Basal (n=35)		Final (n=35)		
	n	%	n	%	
<b>Effective communication is an important tool for ensuring safe care and trust in the team. It is therefore correct to say that:</b>					>0,999
C. Guidance on therapy, conduct and decisions should be given to patients when they	33	94,3	33	94,3	
Palliative care guidelines involve decisions that are the sole responsibility of the doctor			1	2,9	
It's not necessary to train all professionals in communication, because it's not their job to do so	1	2,9			
It's not necessary to have a specific place to give guidance on Palliative Care	1	2,9	1	2,9	
<b>The following drugs are used in palliative sedation:</b>					0,801

C. Midazolam, Haloperidol, Chlorpromazine and Morphine	24	68,6	23	65,7
Tramadol, Metoclopramide, Morphine and Midazolam	11	31,4	12	34,3
<b>When should palliative care be started?</b>				<0,001
C. As early as possible, combined with other therapeutic measures used for relief	19	54,3	28	80,0
In the active process of dying, as this is the goal of Palliative Care	15	42,9	7	20,0
Only when it is necessary to sedate the patient, but invasive measures should not be suspended	1	2,9		

Although 48.6% of the team had completed or were in the process of specializing, none of the professionals had specific training in PC.

## DISCUSSION

The predominance of female participants corroborates the "Profile of Nursing in Brazil" survey 15, carried out by the Oswaldo Cruz Foundation (FIOCRUZ) at the initiative of the Federal Nursing Council (COFEN), which states that 85.1% of the country's nursing professionals are women. In addition, the Brazilian Medical Association (AMB) in conjunction with the University of São Paulo Medical School (FMUSP) published the study "Medical Demography in Brazil (DMB) 2023" which shows that in 2022, 48.6% of professionals in the category were women, however, the projection for 2024 is that women will be the majority (50.2%).<sup>16</sup> Thus, the findings of this study, related to gender and profession, corroborate current data on the subject found in the literature.

Despite being an ancient practice, PC is still seen as synonymous with terminality, which makes it difficult for professionals to identify eligible patients.<sup>17</sup> The ANCP recommends that the approach be applied from the beginning of the illness until bereavement. In this sense, the correct answers obtained after the educational actions reinforce the relevance of the study and the need to invest in continuing education for the multi-professional team.<sup>3</sup>

The PC approach is based on the premise of comprehensive care and bioethical principles, since nowadays diseases that threaten the continuity of life are also considered. In addition, this care needs to be shared between health services, so that the patient can be dehospitalized, providing a better quality of life until the moment of death.<sup>3,18</sup>

A study carried out with 14 doctors, with the aim of understanding their opinion on communicating bad news, showed that 71.4% of the participants defined this practice as an experience that causes significant emotional impact, since, in addition to the patient, it involves the expectations created by the family and/or caregivers, especially in cases where there are no curative possibilities.<sup>19</sup> This impact may be a determining factor in the

decline of correct answers about communicating the diagnosis, since traditional training aims to cure, as described above.

The third edition of the ANCP Palliative Care Manual<sup>3</sup> emphasizes the importance of multi-professional care in PC, in order to "alleviate all the human dimensions of suffering". From the point of view of comprehensiveness, having a multiprofessional and transdisciplinary team has a direct impact on the quality of life and survival of these patients, regardless of their diagnosis. In this sense, the population participating in the study has a positive point in its diversity, which makes a difference to the quality of care.

An exploratory study carried out in the municipality of João Pessoa/PB found that patients preferred professionals with the knowledge and skills to meet their needs in a variety of aspects, such as spirituality and bereavement, and not just physical needs. In addition, communication was also pointed out as indispensable in the work of the multi-professional team.<sup>17</sup>

The Ministry of Health<sup>20</sup> defines permanent health education as educational actions aimed at changing professional practice and work processes through problematization. In addition, the ANCP stresses the importance of multi-professional action in PC and points to it as one of the pillars of this practice, acting in a complementary way and respecting each other's knowledge, with a common goal.<sup>3</sup> In this sense, it is essential that the subject is addressed in the training of professionals, to qualify assistance and guarantee comprehensive care, which makes clear the need to be a cohesive and trained team in caring for these patients, reinforcing the relevance of this study.

It is inherent in PC to seek relief from symptoms and to promote quality of life.<sup>3</sup> Pain can therefore be identified as one of the main distressing factors. According to the International Association for the Study of Pain (IASP), pain is "an unpleasant sensory and emotional experience associated with, or similar to, actual or potential tissue injury". Treatment can depend on different strategies to be effective, such as analgesic and opioid drugs, as well as non-pharmacological methods such as yoga, meditation and others.<sup>21</sup>

Palliative sedation was also addressed in the study, since it aims to control refractory symptoms in patients whose death is imminent and is part of the palliative approach, which makes

knowledge on the subject indispensable.<sup>3</sup> A study published in 2020, with the participation of 324 doctors, evaluated the prevalence and frequency of the use of palliative sedation in the state of São Paulo and concluded that, although the prevalence is high, mainly for pain treatment, the frequency is low due to the lack of eligible patients. Only 26% of the doctors who took part had specific theoretical training in PC, which may have contributed to the low frequency of use of this resource.<sup>22</sup>

When evaluating the perception of the multi-professional team about the practice of PC, one study pointed out that although professionals understand the need to control symptoms, they still have partial knowledge on the subject, which can hinder them when deciding to start therapy.<sup>23</sup> Communication is also a fundamental factor in this process, as it directly influences understanding and acceptance, which corroborates the results found in this study, as most of the responses were in favor of the guidance given to patients and families, to make them the protagonists of this process. Clear and effective communication requires scientific knowledge, as well as listening, welcoming and humanizing care, since its function is to minimize suffering and anguish at not being able to do "more".<sup>23</sup>

Knowing how to listen to patients in order to prioritize and respect their needs sets limits according to their perception of health. Autonomy is paramount to guaranteeing the patient's well-being, making it essential to consider it when communicating the diagnosis and prognosis. Communication has the power to strengthen ties between the patient/family and the team, which favors the decisions that may be necessary during the process.<sup>24</sup>

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