

# Practical Guidance for Palliative Care Team

**Ver. 2**

**Japanese Society for Palliative Medicine  
Committee on Specialized & Cross-Sectional  
Palliative Care Promotion**

## Introduction

The first version of Practical Guidance for Palliative Care Team was published by the palliative care team exploratory committee of the Japanese Society for Palliative Medicine in November 2007. In the subsequent five years, the environment for palliative care has gone through great changes. Of these changes, mandatory organization of palliative care teams in the “hub” hospitals for cancer treatment across Japan marked a major turning point. At that point everyone expected this system would ensure provision of palliative care for patients with cancer throughout Japan. Although the Cancer Control Act actually requires early provision of palliative care for patients with cancer, there seems to be many patients who are forced to endure cancer-related pain without receiving effective pain relief. In the meeting of Cancer Control Promotion Council, Ministry of Health, Labour and Welfare, in 2012, the members pointed out the fact that appropriate palliative care was not sufficiently provided even at the “hub” hospitals for cancer treatment.

The present practical guidance was prepared mainly for the palliative care teams that would soon start their activities, those that had no full-time staff, and those that had difficulty in promoting their activities. However, this practical guidance is also useful for the palliative care teams that actively promote their activities.

We revised the former version focusing on the following four points.

- ① We simplified expressions as much as possible.
- ② We selected the practical aspects of palliative care.
- ③ We demonstrated many concrete examples so that the users can gain a clear picture.
- ④ We prepared a section of warnings in which common mistakes associated with each healthcare profession were pointed out.

As demonstrated by the palliative care team registry, other healthcare professionals (psychologists, dietitians, dental hygienists, etc.) also play important roles in each team. However, they were not included in this revised version that focuses on the consultation activity.

There is minimum information that is available for organization of palliative care teams and promotion of team activities. Thus, we compiled this second version as a handbook containing important clinical examples based on multiple experiences and limited the references to the minimum necessary.

To facilitate consultation by a palliative care team at a hospital, team members should acquire special communication skills. Therefore, we added the Japanese translation of ‘Consultation Etiquette Challenges Palliative Care to Be on its Best Behavior’ to this revised version with permission of Dr. Diane E. Meier, a leading researcher specializing in palliative medicine in the U.S. This article contains interviews with U.S. physicians specializing in palliative care that are based on their extensive experience, and offers valuable insight into improvement of palliative care team activities in Japan. We, the editors, also recognize the usefulness of this article and recommend that the palliative care team members read it carefully and repeatedly, irrespective of their experience as team members.

We believe the smooth activities of palliative care teams contribute to the provision of appropriate palliative care for all the patients with cancer. We would be pleased if you could use this practical guidance effectively.

We thank all the people that devoted themselves to this revision project.

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## I. Definition of palliative care team

There are several definitions of a hospital based palliative care team in Japan. The definitions that the Ministry of Health, Labour and Welfare have used in its formal documents are shown below.

- **As a part of the study supported by the Health and Labour Sciences Research Grant in 2008, the definition of a palliative care team was extracted by using the Delphi method.**[<http://kanwaedu.umin.jp/baseline/>]

- **The notification titled ‘Institutional Standard for Palliative Care/Treatment Addition’ that was updated in March 2012 included the definition of a palliative care team as the necessary institution/team standard**

Notification No. 0305-2, Medical Economics Division, Health Insurance Bureau, Ministry of Health, Labour and Welfare: For the institution standard for the basic medical fee and the procedure for its notification, see the list of medical remuneration points and the website of Japanese Society for Palliative Medicine [<http://www.hpcj.org/what/baseline.html#pct>].

- **The notification titled ‘Guideline for establishment of “Hub” hospitals for cancer treatment’ issued to the prefectural governors by the Ministry of Health, Labour and Welfare in 2008 included the definition of a palliative care team.**

Notification No. 0301001, Health Service Bureau, Ministry of Health, Labour and Welfare: ‘[3] Palliative Care Provision System, II Requirements for Designation of Local Cancer Hospitals’ [<http://www.mhlw.go.jp/topics/2006/02tp0201-2html>]

Japanese Society for Palliative Medicine adopts the following definition in its ‘Palliative Care Team Registry’ program.

A palliative care team here indicates the ‘system that enables a team consisting of physicians and nurses specializing in palliative care to provide palliative care.’ Moreover, a palliative care team meets the following two conditions.

- (1) A palliative care team includes at least one regular physician in charge. (The physician is not necessarily a full-time staff member.)
- (2) A system is established that enables comprehensive evaluation of physical pain, mental distress, social stress, and spiritual problems and collaboration

with the experts in the field of alleviation improvement of pain/physical symptoms and those in the field of treatment of psychiatric symptoms on an as-needed basis.

(Pain or distress that a palliative care team should manage is not limited to certain types that are treated at pain clinics or psychooncology clinics but includes all types that patients experience.)

Practical plan for Palliative Care Team Registry, Japanese Society for Palliative Medicine [<http://www.jspm.ne.jp/pct/pct1301.pdf>]

## II. Consultation

Through consultation and discussion, the members with different specialties and roles examine the situation on the basis of their specialties and roles, share their information and issues related to the future plan, and explore the best solutions. What is important in this process is not giving a compulsory order or presenting a unilateral solution but establishing a relationship that promotes maximization of the specialties of the members.

### Points to be considered during the consultation

1. The attending physician and ward staff (nurses, pharmacists) make efforts to improve the patient's condition. Their efforts should not be denied.
2. The attending physician and ward staff have established a relationship with the patient. This relationship should not be destabilized.
3. The attending physician and ward staff finally determine whether the treatment/care plan proposed by the palliative care team is adopted. The team shares the problem-solving process and results with them.

- (1) Those who need help or advice from a palliative care team are the attending physician and ward staff. Therefore, the palliative care team members should consider their situation as 'stressful' and must not approach them arrogantly. For example, the team members must not say 'Ask us after completing the minimally necessary treatment,' or 'Why can't you complete such a simple treatment?' The ward staff will have feelings of helplessness or frustration that they need to ask other specialists for help. The team members should consider their mental stress and create an environment in which they can talk frankly to the members about various issues. Thus, the team members attempt to establish a relationship with the attending physician and ward staff that serves for their accumulation of experience.



- (2) If the palliative care members play active roles in treating a patient, the attending physician and ward staff may lose their roles. Therefore, the team members must not destabilize the relationship between the attending physician and the patient, and that between the ward staff and the patient. Thus, the team members should always support the relationships between the client/consulter with the patient.
- (3) The palliative care team discloses, in an easy-to-understand manner, the ‘method’ to assess a complicated problem and solve it. (For example, the team explores the pathological condition of pain and proposes a treatment method.) For this purpose, discussions between the palliative care team and the ward staff should be indispensable. The palliative care team makes a proposal that the attending physician and ward staff can carry out. The responsibility for the consequence of the proposal should be shared by the attending physician and ward staff, and the palliative care team.

**<Examination of continuation/completion of consultation>**

- (1) When a new problem appears or is pointed out, the palliative care team should discuss the problem with the attending physician and ward staff again.
- (2) When a goal is achieved, the palliative care team should discuss, with the attending physician and ward staff, whether the therapeutic intervention is to be continued. The palliative care team should propose discussing this with them if possible.

**<What communication is needed to establish an ideal relationship with those who need support/advice from the palliative care team?>**

As shown in **Table 1**, the ‘principles of consultation etiquette’ are widely known as one of the guidelines for palliative care team activities in the US. This guideline contains many important insights that are also quite useful in Japan.

These principles are included in the article.<sup>1)</sup> We added the Japanese translation of the entire article at the end of this handbook by courtesy and with permission of Dr. Diane E. Meier, the author of the article. We hope the readers will make the most of the article as a guideline for managing palliative care teams.

Table 1: Principles of Consultation Etiquette<sup>1)</sup>

<p><b>1 Determine the question</b> (How can I help you in your care of patient?).</p> <p><b>2 Triage urgency</b> (emergent vs. urgent vs. elective).</p> <p><b>3 Gather your own data</b> (thorough history and focused physical examination).</p> <p><b>4 Brevity</b> (focus your consult notes on assessment/recommendations).</p> <p><b>5 Specificity</b> (goal-oriented recommendations).</p> <p><b>6 Plan ahead</b> (contingency plans for anticipated future problems).</p> <p><b>7 Honor turf</b> (be careful to address the problem for which you were called).</p> <p><b>8 Teach-with tact</b> (viewing every consultation as a teaching, and marketing, opportunity).</p> <p><b>9 Personal contact</b> (direct to the requesting physician).</p> <p><b>10 Follow-up</b> (including your ongoing role and knowing when to sign off).</p>
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Note) These principles may also be called the ‘ten commandments for effective consultations.’

<Reference>

- 1) Meier DE, Beresford L. Consultation etiquette challenges palliative care to be on its best behavior. J Palliat Med 2007;10(1):7-11.

### III. Organization of palliative care team

The procedures that the hospital management (director, vice director, director of nursing) or the medical professionals involved in cancer treatment adopt to organize and manage the hospital palliative care team are described chronologically.

At some hospitals, palliative care teams have been organized spontaneously. (Their activities may be limited to study meetings or organizational activities.) In this case, the team members can use this information to deepen their knowledge about palliative care team activities.

#### **1. Starting discussion with the chief medical professional in charge of cancer treatment**

Organization of the palliative care team should start with discussion with the hospital management, particularly the chief medical professional in charge of cancer treatment (e.g. director of cancer treatment). Occasionally, the chief medical professional may propose to organize a palliative care team. This discussion is very important because the palliative care team activities should be fully supported by the hospital and should not be categorized as volunteer activities.

The participants discuss the palliative care team operations. For example, they discuss who performs the operations and for what the operations are conducted. More concretely, in the discussion, they should estimate the remuneration for medical services, examine the requirements for being approved as a “hub” hospital for cancer treatment, evaluate the methods for improvement of patients’ symptoms and consider the programs to enhance cooperation with nearby medical institutions.

Once they clarify the objectives, they can determine the necessary members of the palliative care team and their efforts (working patterns: full-time/regular-time/concurrently serving, frequency of joining the team per week, period of joining the team). After organization of the palliative care team, discussions with the chief medical professional should be held regularly or whenever necessary. (The number of requests and problems should be discussed in the regular meetings, while the problems related to operation of the team, such as an unexpectedly small number of requests, should be discussed in meetings organized on an as-needed basis.)

## **2. Determining the efforts with the palliative care team members**

In consultation with the chief medical professional, the team leader is appointed according to the objective of the palliative care team. The details of the team conference (more than once a week) and ward rounds should be determined concretely so that all the essential elements expressed by the four W's (who, when, what and where) and one H (how) can be met.

- (1) Determination of members: The members are selected from those who appointed themselves at the department level or those who were recommended by the department chiefs. The formal notice should be issued to each member so that understanding of the palliative care team activities by the department staff can be promoted.
- (2) Determination of efforts: Ideally, a palliative care team should consist of full-time physicians and nurses. Generally, a hospital needs to manage a palliative care team with regular or concurrently serving members depending on its actual condition. Nurses are medical professionals who can evaluate patients from the aspect of the patients' lives, and thus they should play a particularly important role in bringing the multidisciplinary team's medical care to a successful conclusion. Nurses need to spend as much effort as possible or several nurses should belong to the palliative care team. There may be no Certified Nurses in Oncology or Certified Nurse Specialists in some hospitals. In this case, before starting the team activities, the members need to discuss the necessary training programs with the nursing director and the person in charge of cancer education. The physicians and pharmacists are expected to complete the palliative care seminars.

## **3. Clarifying the actions that the palliative care team takes to cope with problems and the positioning of the team in the hospital organization**

It is necessary to select a person who is responsible for settling the conflict between the staff or troubles that arise from the activities of the palliative care team. (The trouble includes aggravation of a patient's condition after introduction of a recommended treatment plan, and the attending physician/nurse and the patient/patient's family complaint about the medical care provided for the patient.) The full-time physician is the most appropriate for this position. If there is no appropriate person on the team at the time of conflict, a middle or higher level team

physician or the chief medical professional in charge of the palliative care team should play this role. The positioning of the palliative care team in the hospital organization and the responsible person should be officially announced in the hospital so that the team is recognized as a formal organization. In this manner, the risk of being regarded as private activity can be prevented.

(1) The operational regulations should be established. The operational regulations including the procedure for requesting support from the palliative care team should be established, and the contents should be approved in the treatment meeting. In this manner, all the hospital staff know the guidelines. Whether any prescription exists, how to solve problems, and how to settle questions should be asked and the right person to ask should be established. For example, a patient may suffer an adverse reaction a few days after drug administration. In this case, should the ward staff ask the physician who prescribed the drug, the palliative care team physician, or the palliative care team nurse?

(2) Everyone should be kept informed about the practical activities of the palliative care team.

**For medical professionals:** The explanatory meetings should be repeatedly held for the medical offices or departments so that the staff understands how to request support from the palliative care team.

**For patients/patients' families:** Leaflets and brochures should be prepared. (Advise them to access the website of the Japanese Society for Palliative Medicine [<http://www.kanwacare.net/>].)

## IV. Team leader's (team leader physician's) roles

### <Main roles>

- (1) **Setting goals:** Clarifies the needs of patients and consulters who request support from the palliative care team and sets their goals.
- (2) **Communication:** Makes special efforts to maintain the ideal relationship with the clients.
- (3) **Leadership:** Plans conferences and takes the leadership in them.
- (4) **Stress management:** Considers the stress and conflicts among the team members and prevents burnout.

### <Detailed roles>

- (1) A team leader clarifies the problems, and quickly responds to urgent problems.
- (2) A team leader always follows Principles of Consultation Etiquette (**Table 1**).

The team leader differentiates the roles of the palliative care team from those of the client. For example, who gives an explanation to the patient before anesthesia induction, who prescribes drugs, and who treats adverse drug reactions should be clearly determined. The team leader is responsible for all the palliative care team activities.

The team leader is expected to inform the patient and his/her family of the roles and functions of the palliative care team by using an easy-to-understand explanatory document.

The palliative care team nurses and pharmacists often find it difficult to express their own opinions in front of the attending physicians.

The team leader physician should directly inform the attending physician of the team members' opinions as a policy of the entire team.
- (3) A team leader takes the leadership not only in the regular palliative care team conferences but also in the hospital conferences (i.e., meeting for discussion with the ward staff, discharge conferences) and local conferences (i.e., conferences for case consultation with affiliated hospitals).
- (4) A team leader should carefully consider the palliative care team's policies so that their consistency is maintained.

The team leader, who should take the leadership in conferences, should also

solve problems while taking an approach that respects the technical competency of each medical professional. In the event of any conflict between the staff, a judgment should be made in a manner leading to benefits for the patient and clients.

A team member plays his/her role according to the care plan proposed by the palliative care team. A member may be criticized or may lose his/her confidence in working as a team member. In this case, the team leader should sufficiently protect the member. If a team member failed as a result of insufficient knowledge or experience, he/she should make an apology immediately. This failure should be accepted as an opportunity for further development of the team and members.

The team leader should always consider the possibility that intervention by team members creates any inconvenience, disadvantage, or dissatisfaction for the patient or his/her family. For example, occasionally there are patients who do not like many members to visit their rooms or do not like others to know their disease.

#### <Warnings>

The palliative care team leader instructs the staff members other than physicians in a top-down fashion (the leader disregards other staff members' opinions).

## V. Medical professional roles

### 1–A. Physician (in charge of management of physical symptoms)

#### <Main roles>

The physician in charge of management of physical symptoms should correctly assess the pathological condition of the physical symptom that the client asks him/her to relieve and present the measure that assures maximum improvement of QOL of the patient/patient's family. The physician is responsible for the assessment that the palliative care team conducts and management of the team, and in cooperation with the client, supports the efforts to solve problems. For example, the physician should take care of the patient who is poorly responding to analgesic treatment and he/she should also manage unexpected adverse drug reactions.

#### <Concrete work contents>

##### (1) Assessment of physical symptoms

The physician should collect the data reflecting the past clinical course and relevant information, and examine the patient to clarify the pathological condition accounting for the present symptom.<sup>2)</sup> The physician additionally orders diagnostic imaging or hematology as needed.

In the process of searching for the cause of the symptoms, the physician should make the most of the information collected from the client, the patient's family, and team members.

The physician should consider the possibility that an adverse drug reaction may be involved in development of the symptom concerned (e.g. akathisia).

##### (2) Management of symptoms

#### ■ Management of pain

① The physician examines whether the pathological condition diagnosed can be approached by a specified assessment procedure<sup>2)</sup> and whether causal therapy can be indicated (e.g. bed rest and fixation for pain due to bone metastasis).

② The physician should confirm whether analgesics are prescribed according to the five principles on managing pain specified in the WHO Guideline.<sup>2)</sup> Generally, patients are placed on undertreatment with opioids in Japan.



Effective control of adverse drug reactions<sup>3)</sup> is important: For example, when the use of antiemetics or laxatives is to be recommended, the physician should consider the risk of adverse drug reactions that may develop immediately after opioid induction or escalation (e.g. nausea, constipation, drowsiness, respiratory depression, and delirium) and provide relevant information (factors involved in development of adverse drug reactions: history of postoperative delirium, old age, difficulty of urination, aspiration tendency) for the client.

- ③ If the symptom (e.g. plexus infiltration) can not be treated, nerve block or radiation therapy may be indicated.

■ **Management of other physical symptoms** (For details, see the ‘Guidelines by the Japanese Society for Palliative Medicine.’)

- ① Dyspnea should be managed by using causal therapy, oxygen administration, non-pharmacological therapy, and systematic administration of morphine and anxiolytics.<sup>4)</sup> Fluid administration should be reduced or discontinued. Anxiety should be managed appropriately.
- ② The causes of nausea and vomiting should be investigated (e.g. constipation, hypercalcemia, renal disorder), and the possibility of adverse drug reactions should be examined (e.g. reactions to opioids, antidepressants, or anticancer drugs).
- ③ If the patients complain of insomnia and irritability, the possibility of extrapyramidal symptoms due to dopamine antagonists (e.g. parkinsonian syndrome, akathisia) should be considered.
- ④ In the management of delirium, the physical factors should be investigated and the physical approach should be taken. Even if a psychiatrist belongs to the palliative care team, a physician in charge of management of physical symptoms should participate in treatment of the patient. In the process of searching the responsible pathological conditions, the physician should check a group of diseases associated with drug therapy (e.g. opioid, anxiolytics/hypnotics, H<sub>2</sub> receptor antagonist) and a group of diseases associated with advanced cancer (e.g. electrolyte abnormalities including hypercalcemia and hyponatremia, dehydration, anemia, hepatopathy, renal disorder, fever associated with infection).

- ⑤ The physician should examine whether appropriate management of nutrition/fluid administration is being conducted. He/she should check whether fluid is administered at an appropriate dose, and should consult the nutrition support team or a managerial dietician as needed.
- (3) The physician should periodically evaluate the effect of intervention by the palliative care team. Verbal Rating Scale, STAS-J and Numerical Rating Scale can be used for evaluation.
- (4) If the client is not specializing in palliative care, the physician should demonstrate the pathophysiology and rationale for recommendation (e.g. WHO Guidelines) and proposes a practical plan. He/she should not criticize the situation but take a positive approach (Table 1). For example, the physician should appreciate the efforts that the client has made so far.

<Warnings>

- (1) **Determination of responsibility:** In the event of adverse drug reactions, if the person who prescribes treatment and the person who treats the patient are not determined clearly, the ward nurse and the patient/patient's family feel completely at a loss.
- (2) **Adverse drug reactions:** If the physician prescribes a drug without checking its adverse reactions, detection of adverse drug reactions may be delayed and the patient may suffer a serious reaction (e.g. ileus due to stool impaction, urinary retention, delirium).
- (3) **Sharing problems:** If the physician takes care of the patient suffering from a refractory condition by himself/herself and does not have contact with the client and team members, the patient's conditions can not be improved.

<Reference>

- 2) Takeda F (translation): Escape from cancer pain. Kanehara Shuppan. 1996.
- 3) Compliance and Narcotics Division, Pharmaceutical and Food Safety Bureau, Ministry of Health, Labour and Welfare. Guidance for appropriate use of narcotics for medical use. 2012.
- 4) Mukaiyama T, Uchitomi Y, Ariyoshi H (supervision): ASCO Official curriculum, practical relief of cancer symptoms. Vol. 1-3, 2002.

## 1–B. Physician (in charge of management of psychiatric symptoms)

### <Main roles>

The physician in charge of management of psychiatric symptoms should assess the psychiatric symptoms that the client or the team member should ask him/her to treat, and present the causes, prospects and measures that improve QOL of patient's family as much as possible. The physician administers drugs or introduces psychotherapy as needed.

The physician should direct attention to the problems that the patient, patient's family, attending physician, ward staff and team members face, and take action in consideration of his/her role.

The physician should carefully consider mental health of team members and take measures to protect them from 'burnout.'

### <Before practical involvement>

- (1) Ideally, the staff, patient and patient's family know the psychiatrist in advance.  
For this purpose, as a member of palliative care team, a psychiatrist follows the rounds.
- (2) In cooperation with the attending physician, the psychiatrist explains the conditions to the patient's family members and provides them with a situation in which they can receive mental support.
- (3) In addition to a psychiatrist belonging to the palliative care team, a different psychiatrist or physician specializing in psychosomatic medicine who can also support the team should be confirmed.

The following two patterns were created for reference. They can be practiced according to the condition of the medical institution.

#### ■ **Pattern A: Any psychiatric problems were clearly written on the palliative care team request form**

- ① In cooperation with the physician in charge of management of physical symptoms and nurse belonging to the palliative care team, attending physician and ward staff, the psychiatrist checks the contents of a request, the patient's physical condition, details of treatment, the patient's social background, and information about the patient's family.

- ② The psychiatrist checks the psychiatric symptoms requiring a solution and identifies the concrete needs (timing of provision of support, type of support needed, to whom support should be provided, level of support).
- ③ The psychiatrist examines the patient directly or indirectly, and informs the team members, attending physician and ward staff of the assessment results, coping measures, and expected progress. The psychiatrist also informs the ward staff of the important changes in mental and physical conditions to which they should direct attention during observation.
- ④ The psychiatrist takes an opportunity of a conference to discuss the problems among the persons concerned. The psychiatrist may need to solve the problems that the attending physician and ward staff face. For example, the attending physician or ward staff may have negative feeling for a patient or be overwhelmed by a feeling of helplessness. In this case, the psychiatrist should take a careful approach and should not slander any individuals.

■ **Pattern B: If the palliative care team member noticed mental stress**

- ① The psychiatrist checks the circumstances under which the team member recognized the problem, whether the attending physician or ward staff noticed the problem, and how the attending physician or ward staff responded to the problem if they noticed.
- ② The psychiatrist directly identifies what is needed to solve the problem; or if it is necessary to solve the problem.
- ③, ④ (Follow ③ and ④ in Pattern A.)

<Common requests>

- (1) ‘Recently, I explained the condition to the patient. Then, the patient lost their appetite and seems to suffer from depression…’

**Response:** The psychiatrist checks the influence of anticancer therapy, and presence/absence of delirium and dementia. The possibility exists that the physical symptoms including pain may be involved. The psychiatrist should express his/her comments and asks for feedback from the team members.

- (2) ‘The patient can not sleep well at night…’

**Response:** The psychiatrist checks whether or not physical factors are involved,

whether or not mental factors including anxiety are involved, and whether the patient suffers from delirium. A drip infusion may induce the urge to urinate at night or steroid therapy may induce insomnia. The patient may be given haloperidol to control retching or insomnia. In this case, the patient should be carefully monitored for extrapyramidal symptoms including akathisia. If the psychiatrist recognizes the necessity to change current drug therapy, he/she should consider the attending physician's situation and consult about alternative drug therapy.

(3) 'The patient seems to be anxious. Will you offer counseling to the patient?'

**Response:** Even if what the patient experienced is a normal response, the patient asks the psychiatrist to listen to his/her anxiety or problem. The psychiatrist should listen to the patient's anxiety or problem and examine whether it is associated with any pathological condition. Then, the psychiatrist consults the team members, attending physician and ward staff about assignment of roles.

#### <Warnings>

- (1) A psychiatrist gives only an order to 'administer Serenace' to control delirium, but does not follow up the progress.
- (2) A psychiatrist examines the patient by himself/herself without sharing the background or rationale for treatment with the team members.
- (3) A psychiatrist does not clearly determine who prescribes psychotropic drugs or orders continuation of psychotropic therapy.
- (4) If a psychiatrist or physician specializing in psychosomatic medicine suddenly appears in front of the patient or patient's family members, they may reject him/her.
- (5) A psychiatrist may not sufficiently discuss the patient's conditions including delirium at the terminal stage and the goal of care with the attending physician and palliative care team members. This may lead the patient, patient's family members and client to distrust the psychiatrist.

## 2. Nurses

### <Main roles>

- (1) **For the patient/patient's family:** Nurses consider total pain and explore/assess stress that the patient/patient's family experiences. They confirm what treatment, nursing care and lifestyle the patient/patient's family expects and help the patient/patient's family make a decision.
- (2) **For medical providers:** Nurses serve as coordinators. They promote cooperation and linkage with the attending physician, ward nurses, outpatient nurses and other medical teams (including local health-care teams) so that palliative care is provided smoothly and seamlessly for the patient.

### ■ Concrete roles

- A team nurse serves as a receptionist who accepts the client's request.
- A team nurse promotes coordination with the attending physician, ward nurses, outpatient nurses and palliative care team members. For example, a team nurse organizes a conference or an interview.
- A team nurse assesses total stress that the patient/patient's family experiences from the viewpoint of nursing. For example, a team nurse identifies psychological crisis or stress in the daily life, or orientates nursing. Then, the nurse helps the patient/patient's family improve the present condition.
- A team nurse supports cooperation with the local palliative care network. For example, a team nurse organizes a discharge coordination conference.
- A team nurse provides the educational seminars or on the job training (OJT: acquiring knowledge, technology and attitude through practice) programs related to palliative care for medical care providers; mainly nurses specializing in various fields.

### ■ Expected actions and ideal positioning

- A team nurse clarifies the goal of care. Then, the nurse adjusts the goal so that it can be shared with the client and other team members by building consensus with them. For example, the goal of care at the time of a request was pain relief. The goal of care before discharge may be changed and whether the palliative care team is involved in adjustment to home care should be examined.

- A team nurse considers his/her current position and type of service (full-time, regular, or concurrently serving) and evaluates his/her roles and scope of activities.
- A team nurse clarifies the policies of the palliative care team and the roles of members so that clients can understand them. For example, the roles of the palliative care team and the goals of each case should be recorded in the medical chart, and reported in the ward conferences.
- A team nurse prepares the record of intervention by the palliative care team, standardizes the methods for assessing the symptoms adopted by the ward staff and palliative care team, and manages the data of the results of intervention by the team.

#### ■ Expected qualification

A team nurse is expected to have sufficient clinical experience in nursing patients with cancer, and have systematically learned palliative care and cancer nursing (e.g. Certified Nurse Specialist in cancer nursing, Certified Nurse in Cancer Pain Management Nursing, Certified Nurse in palliative care).

#### ■ Procedures for requesting intervention by the palliative care team (Table 2)

##### ● Clarification of the procedures for request

- The procedures for requesting intervention by the palliative care team should be compiled in a manual. In this manner, all the medical care providers are informed of the procedures in the hospital. The procedures include whom we can ask, how we can make a request, and when can we request.
- Patients/patients' families can directly request intervention by the palliative care team. The procedures for a request should be clearly shown on the website or a poster showing the procedures should be put up in a conspicuous place.

Table 2: Checklist for palliative care team activities (operations)

	Main flow	Detailed operations	Others
1	Request of intervention by the palliative care team	Request form Verbal request	
2	Acceptance of request	Person who accepted the request ( )	
3	Arrangement of initial interview	Selection of the participants in the initial interview (Client/medical team) (patient/patient's family)	
4	Initial interview (client/medical team)	Confirmation of the contents/intention of request of the client (requesting medical team) Confirmation of treatment plan/orientation of nursing care Confirmation of intervention level	
5	Initial interview (patient/patient's family)	Early assessment Direct examination/indirect examination	
6	Evaluation of intervention plans/setting goals	Evaluation of intervention level Evaluation of multidisciplinary approach Evaluation of problems other than the problem concerned	
7	Proposing intervention plans/setting goals (for the client)	Discussion with the client	
8	Determination of intervention plan/setting goals	Estimation of intervention period Determination of assessment schedule	
9	Practical introduction of intervention	Prescription Proposing care Direct examination/indirect examination Supporting the client/medical team	
10	Assessment of intervention (repeated assessment)	Regular conference Conference with the client	
11	Completion of intervention		



## ● Responses to the initial request

### Step 1 Accepting the request

- A team nurse clarifies the details of the request (e.g. symptoms, discharge coordination) by calling the client and judges the emergency level (whether intervention is needed immediately, on the same day, or on the following day).
- A team nurse selects the professional members of the palliative care team for the discussion with the client. Their schedules are appropriately arranged so that they can meet the attending physician and nurses.

### Step 2 Initial discussion with the client (collection of information before intervention)

- A team nurse clarifies the detailed request and the client's needs for the palliative care team.
- A team nurse confirms the treatment plan and orientation of nursing care that the attending physician recommends.
- A team nurse clearly identifies the problem that makes the attending physician and ward staff feel seriously concerned. The nurse also checks whether there are any other problems bothering them.
- A team nurse obtains information based on facts gathered by listening to the client. Moreover, the nurse considers the client's feeling and emotions and takes a supportive approach.
- A team nurse assesses the client and the department concerned, focusing on their experience with use of palliative care and the characteristics of palliative care.

#### **Point**

A team nurse makes an effort to understand the client's problem and prevents the client from having the feeling of being criticized.

**Step 3 Arrangement of schedule of initial visit with the patient**

In consultation with the team physician and other members, a team nurse makes a comprehensive judgment of the emergency level and the severity of the difficulty and determines the schedule of the initial examination. Then, the nurse notifies the team members and the client of the schedule. If the team consists of part-time members, the process of determination and notification of the schedule is an important part of the arrangement of the schedule.

**Step 4 Detailed activity on the initial examination by the palliative care team (limited to a visit with the patient at the bed side)****【What a team nurse should do by himself/herself】**

Minimum activity conducted by a team nurse (this activity should be conducted even if the team provides intervention only about twice a week).

- In consultation with the client, the team nurse and physician determine the intervention level.

**Intervention level**

- Direct intervention

A nurse visits the patient in the room. If the client requests an examination and assessment by the palliative care team. Then, in consultation with the client and the team members, the nurse determines the detailed management.

- Indirect intervention

A nurse does not visit the patient in the room. The followings are common cases.

- ① The client requests advice.
- ② The patient/patient's family does not request intervention by the team or intervention by the team is expected to cause confusion.

- A team nurse exchanges greetings with the patient/patient's family, introduces himself/herself to them and explains his/her roles. The nurse tells them the attending physician and ward staff asked him/her to support the patient. If the ward staff introduce the nurse to the patient/patient's family members, they may feel more comfortable.
- A team nurse confirms that the patient/patient's family agrees to receive intervention by the palliative care team. Then, the nurse hands them the brochure explaining the palliative care team to the patient/patient's family (the materials are available at the website of Japanese Society for Palliative Medicine [<http://www.kanwacare.net/>]). If the patient is a child, or suffers mental retardation, dementia or delirium, the nurse explains the team to a family member designated as the key person. The nurse asks the ward staff who is the key person in advance.
- A team nurse interviews the patient and examines his/her physical conditions. In this manner, the nurse can add this information to the information about the problematic pathological conditions and symptoms obtained from the ward staff. For example, the patient may have pain, dyspnea, digestive symptoms, or psychiatric symptoms.
- A team nurse checks whether there is any gap between the client's needs and the intention of the patient/patient's family. The nurse carries out adjustments or makes up the gap as needed. When the nurse notices the gap, he/she does not point it out as if he/she was criticizing, but discusses it with the client.
- A team nurse explores the anxiety or problems that the patient's family members may suffer. If the nurse finds any problem, he/she helps the family members solve it immediately. For example, the patient's family may face a conflict between family members or financial problems.
- A team nurse explains to the family members that he/she accepts their consultation and helps them solve their problems.

**【What a team nurse should do to support the ward nurse】**

- A team nurse shows and explains to the ward nurse the timing of monitoring and the important points of nursing care and encourages him/her to practice these steps. For example, the ward nurse needs to check whether the patient suffers from constipation due to administration of an opioid and whether the patient is satisfied with the present level of sleep.

- A team nurse advises the ward nurse to consider the physical and mental stress resulting from daily nursing care that the patient's family members provide. For example, the ward nurse needs to consider how hard it is for the family members to take care of the patient suffering from delirium or dyspnea.

#### **Step 5** Setting the goals and presenting concrete management methods

##### **【Roles of the team nurse at the time when the palliative care team sets the goals】**

- A team nurse makes an effort to consider the intention of the patient/patient's family on the goals.
- A team nurse determines the goals and schedule. The team nurse determines the short-term and long-term goals. For example, the patient can sleep without feeling pain within three days. The patient's environment should be improved so that the patient can go back home within one month.
- A team nurse establishes the assessment criteria. The criteria are as follows: assurance of ADL that enables the patient to go back home, having meals in a chair, going to the restroom by himself/herself, learning the technique to use rescue therapy.
- A team nurse helps the client and the team members share the processes and results.

##### **【Presenting the concrete management methods】**

- A team nurse reflects the viewpoint of lifestyle on the treatment/policy of the palliative care team. For example, the methods for oral administration of drugs should be simplified.
- The nursing care roles should be shared between the nurse working with the client and the team nurse, with due consideration of the available time, skill and knowledge of the team nurse. Moreover, the years of experience of the attending nurse and the ward system should be considered.
- A team nurse considers utilization of the hospital resources. There are a large variety of medical professionals in a hospital such as physicians specializing in cancer treatment, radiologists, anesthesiologists, rehabilitation specialists, MSWs, dental hygienists and certified nurse/nurse specialist specializing in cancer treatment.

**Points**

- A team nurse repeatedly confirms the request of the patient/patient's family.
- In the goal setting process, a team nurse may notice a large deviation from the actual condition. Then, the nurse presents 'sub-goals' that can be achieved in a stepwise manner.

**Step 6** Practical introduction of intervention**【Principles of intervention】**

- A team nurse adheres strictly to the intervention level discussed in advance.
- A team nurse attempts to share not only the results but also the processes of intervention with the team physician.
- A team nurse explains the management method reported by the attending physician to the ward nurse. The team nurse clarifies the actual roles of the ward nurse and helps him/her fulfill his/her roles. For example, the team nurse explains the PCA pump and how to use it to the ward nurse.
- A team nurse checks if the client/consultant and the ward nurse can conduct the nursing care (e.g. strict management of narcotics by the client/consultant or the ward nurse) recommended by the team.
- A team nurse explains the monitoring process (e.g. details of the effect and an adverse reaction and expected timing of their appearance) needed after intervention (e.g. initiation of analgesic therapy) to the ward nurse. The team nurse should have the opportunity for discussion with the ward nurse and to determine their respective roles in advance.

**【Preparation of the palliative care protocol (chart at the end of this document) and fulfillment of the conditions specified by the medical fee system (chart at the end of this document)】**

- ① Symptom that the client complains of
- ② Orientation of treatment
- ③ Strategy of the palliative care team
- ④ Signature of the person in charge
- ⑤ Signature of the patient/patient's family

**【Intervention in/support for drug therapy (A team nurse consults the palliative care team and pharmacists about their respective roles.) 】**

A team nurse helps the client fulfill his/her role.

- ① A team nurse checks the patient for his/her level of understanding of drugs (negative attitude toward drug therapy), and gives him/her an explanation about drugs according to his/her level of understanding. The team nurse also explains the drugs to the patient's family as needed. The team nurse uses an explanatory document (The materials are available at the website of Japanese Society for Palliative Medicine [<http://www.kanwacare.net/>]).
- ② A team nurse confirms the patient's request. The team nurse asks the patient what he/she would like to do if pain is relieved.
- ③ A team nurse checks that the drug therapy allows the patient to work or perform various activities.
- ④ A team nurse checks the effect of rescue and how to use it. The team nurse also checks how the patient manages the rescue by himself/herself.
- ⑤ A team nurse adjusts drug therapy in a manner that the patient can recognize that he/she controls drug therapy by himself/herself.
- ⑥ A team nurse explains monitoring of adverse drug reactions (e.g. nausea, drowsiness, constipation) and coping measures to the patient. The team nurse also explains them to the patient's family as needed.
- ⑦ A team nurse checks not only the patient but also the patient's family for the degree of satisfaction with drug therapy. The patient's family may restrict medication.
- ⑧ A team nurse informs a pharmacist of the management method of the palliative care team and asks him/her for cooperation.
- ⑨ A team nurse discusses, with the team members and ward staff, whether the above roles (①–⑧) can be shared with them or actually fulfilled.

**Points**

- At first, the palliative care team may play a leading role. In the course of time, however, the team encourages the client to practice recommended nursing care and provide support.
- The client may use a new drug. In this case, a team nurse explains to the ward nurse what the drug is used for and its effect and adverse reactions.

### **【Round by a team nurse】**

A team nurse conducts rounds in order to examine the patient, interview the patient's family and support the client. The team nurse examines whether the patient has any negative feeling against drug therapy, and explains how to control adverse drug reactions.

How the team nurse conducts rounds, the schedule, frequency (rounds/week), and attendants should be determined within the palliative care team.

- A team nurse intensively examines the patient/patient's family from the viewpoint of total pain. Therefore, the team nurse should examine the patient every day if his/her condition is unstable. In consultation with those concerned, the team nurse determines rounds in consideration of the system and situation.
- A team nurse should know the busy time in each ward and arrange the opportunity for consultation depending on the situation.
- A team nurse should understand the characteristics of the ward nurse (strengths and weaknesses of the ward nurse) and provide appropriate advice, consultation and support for him/her.

#### **Points**

- A team nurse should always take a supportive attitude towards the ward nurse.
  - ① A team nurse asks the ward nurse whether he/she has any trouble. If he/she has any trouble, the team nurse shares it with him/her.
  - ② A team nurse takes a positive approach to evaluate the nursing care, skill and knowledge of the ward nurse.
  - ③ A team nurse explains the drug therapy and nursing care recommended by the palliative care team to the ward nurse. The team nurse also shows, in an easy-to-understand manner, the interpretation and results of the recommended therapy and care.
- A team nurse plays the role of coordinator for the palliative care team and the ward staff.
 

A team nurse checks whether there is any difference between the intentions of the attending physician, patient, ward nurse and ward manager and the intention of the team. If the team nurse finds any difference, he/she asks the team physician to adjust their intentions.

### **Step 7 Evaluation of intervention (monitoring of efficacy of intervention)**

#### **【Periodical evaluation】**

- ① A team nurse shows the evaluation items, and observation and recording methods.
- ② A team nurse always exchanges, with the ward nurse, information about efficacy and methods for control of adverse reactions.
- ③ A team nurse discusses, with the attending physician and ward nurse, whether the treatment strategy should be changed or adjusted. The team nurse holds a team conference as needed.
- ④ A team nurse conducts assessment every day. Moreover, the team nurse regularly records progress.

#### **【Additional contents of plan and points to be considered in taking a multidisciplinary approach】**

- ① For excretion, sleep, nutrition, movement and maintenance of cleanliness, a team nurse provides support on a daily basis.
- ② A team nurse asks/recommends the rehabilitation staff to provide lymphatic drainage for the patient.
- ③ A team nurse asks/recommends the dietician to check the nutrition method and menu.
- ④ A team nurse discusses whether the MSW's support is needed to alleviate the stress associated with social affairs (property, employment, utilization of social resources).

### **Step 8 Completion of intervention**

- ① Intervention is completed when the problem concerned is solved and the client or the patient/patient's family requests completion of intervention. The team nurse accepts completion of intervention.
- ② Intervention is completed if the patient is discharged, transferred to a different hospital or transferred to a palliative care ward.



**Points**

- A team nurse considers how to follow-up with the ward staff after completion of intervention. The team nurse may have a staff interview or access the electronic medical charts. The team nurse can also have contact with the ward staff by telephone.
- A team nurse considers the patient's outpatient visits and discusses, with the client, how to manage symptoms.

**【Supporting discharge coordination】**

- ① Participation in the discharge coordination conference  
The palliative care team provides the information needed for home health-care for the patient/patient's family.
- ② A team nurse provides the relevant information for the home-visiting nurse and supports continuous nursing care.

**3. Pharmacists****<Main roles>**

A team pharmacist is positioned as a medical professional specializing in drug therapy. The team pharmacist plays the leading role in palliative drug therapy in the department of pharmacy.

- (1) A team pharmacist assesses the patient's symptoms and the treatment plan from the pharmacological viewpoints. The team pharmacist examines the efficacy of drugs and their dosages, validity of drug therapy, adverse drug reactions, and contraindicated drugs. The team pharmacist also prepares the treatment plan. The pharmacological viewpoints include organ function, pharmacokinetics, pharmacological characteristics, drug interactions, adjustment of drug combinations/doses, and the possibility of hospital preparation, insurance coverage and cost-effectiveness.
- (2) A team pharmacist provides information about the drugs that contribute to solving problems for the client; including the attending physician and ward staff and the team members. For example, the team pharmacist explains akathisia associated with administration of antiemetics and the interaction between warfarin and oxycodone.
- (3) A team pharmacist supports the ward pharmacists (e.g. pharmacists in charge of drug administration guidance). The team pharmacist also gives them important advice.

- (4) A team pharmacist keeps everyone in the department of pharmacy informed about the special use of drugs for palliative care. The team nurse explains how to use analgesic adjuvants and hospital preparations.

■ **Participation in the problem-solving process**

- ① A team pharmacist assesses the causes of physical and psychiatric symptoms. The team pharmacist examines whether the problematic symptom is induced by any drugs or develops as a drug interaction.
- ② A team pharmacist collects the data needed for pharmacological assessment (laboratory results, past history, contraindicated drugs, history of drug use, history of adverse drug reactions, history of treatment) by himself/herself, and minimizes the risks associated with drug therapy. For example, the team pharmacist monitors the renal function after administration of zoledronic acid and the blood glucose level after administration of olanzapine.
- ③ A team pharmacist informs the attending physician and attending nurse of warnings, points requiring careful monitoring (e.g. respiratory rate at the time of achievement of peak effect after opioid rescue medication), and coping measures. The team pharmacist also advises the ward pharmacist to explain drug therapy to the patient and his/her family. The team pharmacist may directly explain drug therapy to them as needed.
- ④ A team pharmacist collects information from the assessment, conference and rounds of the palliative care team, and provides the information to the ward pharmacist.

■ **Improvement of palliative drug therapy in the hospital**

- ① A team pharmacist prepares the supplementary tools such as opioid conversion table, analgesic treatment manual, and explanatory leaflets for patients.
- ② A team pharmacist provides information about palliative drug therapy in the study meetings. Moreover, the team pharmacist provides the knowledge needed for palliative drug therapy for other pharmacists, and explains the important points of intervention. In this manner, the team pharmacist instructs them and gives them practical advice.

<**Rules to be followed by a concurrently serving pharmacist**>

A concurrently serving pharmacist should clarify his/her contact information. (Use of PHS is recommended.)

- (1) It is the responsibility of a concurrently serving pharmacist to respond to inquiries as soon as possible. The pharmacist should take a collaborative approach with the drug information specialist and the ward pharmacist.
- (2) A concurrently serving pharmacist should clarify his/her emergency contact information (e.g. emergency telephone number). In this manner, the team members can get in touch with the pharmacist even if he/she is busy or absent.
- (3) A concurrently serving pharmacist may receive a direct inquiry about a user of intervention. In this case, the pharmacist shares the details of the inquiry with the team members.

#### <Warnings and coping measures>

- (1) A team pharmacist often examines the patient's symptoms only from the aspect of drugs.

Not only adverse reactions and interactions but also electrolyte abnormality and organic problems may be involved in development of problematic symptoms. Therefore, a team pharmacist should consider measures for alleviation of symptoms other than drug therapy (e.g. surgery, radiation therapy, nerve block, mental care, alternative therapy).

- (2) If a team pharmacist directly gives drug administration guidance, the ward pharmacist may have no role to play. The team pharmacist should take an educational approach, encourage the ward pharmacist to acquire the relevant knowledge and skill needed for drug administration guidance, and demonstrate a good example of drug administration guidance.

- (3) A team pharmacist handles only the drugs that the client requested.

The team pharmacist provides the information about anticancer drug therapy and overall drug therapy as well as the information about palliative drug therapy using narcotics for medical use.

- (4) If a team pharmacist directly asks the attending physician a question about drug therapy (e.g. lack of prescription of laxatives), the attending physician may feel uncomfortable with the palliative care team.

The team pharmacist should discuss with the team physician first and then ask the attending physician the question.

## 4. Medical social worker (MSW)

### <Main roles>

A medical social worker (MSW) attempts to solve the patient's or his/her family's psychosocial problems (e.g. anxiety about recuperation, health-care expenses) by providing consultation/support for them. A MSW provides relevant information and helps them make a decision.

#### ■ How to support the patient and his/her family

- In principle, a team MSW takes care of a patient/patient's family only when the palliative care team members ask him/her for help. In the case conference organized by the palliative care team, the MSW provides relevant information from his/her viewpoint based on his/her experience as an MSW.
- The patient, his/her family, the attending physician or ward nurse may directly ask a team MSW or the consultation office to provide support. In this case, the MSW consults the attending physician about the necessity for intervention by the palliative care team.

#### ■ Relationship between an MSW and ward staff

- A team MSW collects the relevant information and obtains the results of decision making. Then, the MSW discusses and shares the information and results with the team members then notifies the attending physician and ward nurse of them. For example, the patient or his/her family decides that the patient will spend the final days of life at home or will be transferred to hospice.
- If any ward MSW or attending MSW takes care of the patient, the team MSW serves as a consultant and provides the information he/she obtained for the attending MSW.

<List of problems requiring support>

- Financial problems (e.g. health-care expenses, property, pension, adult guardianship)
- Conflict between family members
- Patient's anxiety and mental stress
- Employment problem (e.g. change in employment pattern)
- Educational problem (e.g. temporary leave from school, return to school, transfer to another school)
- Social resources needed for visiting some places or staying out overnight (e.g. nursing care taxi, support by helpers)
- Support for selecting the facilities for the patients requiring nursing care (e.g. staying at home, hospice, or other facilities)
- Cooperation with the organizations concerned (e.g. home-visit nursing station, clinic, operation center) after determination of discharge
- Problem of nursing care (e.g. application for the nursing care insurance payments, outsourcing of nursing care service, procurement of welfare equipment)
- Procedures to be completed after death (particularly important for a single patient) (e.g. disposal of household goods, funeral)
- Uncompleted procedures [e.g. inheritance, will/body donation/organ donation, property division (notary public office)]

If a team MSW examines the checklist and finds any problems such as stress associated with physical symptoms, anxiety, disagreement among family members and financial problems, the MSW shares them with the palliative care team members and notifies the attending physician and ward staff of the problems.

<Warnings>

A client may directly visit a team MSW for consultation or the team MSW may find new problems. If the team MSW does not share the information obtained with the palliative care team, this may cause confusion among the palliative care team, patient, patient's family and ward staff.

## 5. Rehabilitation

### <Concept of rehabilitation in the field of palliative medicine>

The Latin origins of ‘rehabilitate’ mean ‘to bring back into former condition.’ In the palliative care field, rehabilitation should be regarded as care based not only on muscle training but also on the concept of restoration of impaired activities of daily living (ADL) or prevention of further loss of ADL

National qualifications as rehabilitation specialists include occupational therapist, physical therapist and speech therapist.

### <Main roles>

- (1) A team therapist improves QOL that deteriorated by ADL impairment.  
A team therapist provides lifestyle guidance serving for pain relief (e.g. postural change, movement, walking, excretion, dressing, eating). The team therapist also helps the patient take a bath.
- (2) Even if introduction of rehabilitation does not contribute to improvement of ADL, this intervention may relieve psychosocial pain or spiritual stress. A team therapist regularly visits the patient and spends some time with him/her. By continuously taking this approach, the therapist can contribute to the alleviation of the patient’s mental stress, and the patient may have feelings of ‘being abandoned’ less frequently.
- (3) A team therapist explains the ‘details of palliative rehabilitation (significance of palliative rehabilitation)’ and provides relevant information for the palliative care team and ward staff in conferences and study meetings.

### <Concrete work contents>

- (1) Practical instruction for patients
  - ① Direct instruction (e.g. walking with a cane or a walker, standing up easily from the bed or sitting down smoothly on the bed, transferring to a wheelchair in the case of paraplegia, prevention of disuse syndrome using the slope)
  - ② Indirect instruction (e.g. instructing the attending nurse or the patient’s family how to support the patient using the above techniques)

## (2) Setting the goals according to the symptoms

A team therapist collects information about the patient's ADL from the team physician and team nurse and his/her examination results and predicts the prognoses for ADL.

The team therapist predicts the prognoses for ADL in the following three stages: functional recovery stage, functional support stage and functional deterioration stage. The predicted prognosis should be positioned as the goal of the palliative care team in each stage and shared with other team members.

- ① Functional recovery stage: the therapist promotes concomitant improvement of ADL and QOL
- ② Functional support stage: the therapist promotes maintenance of ADL and QOL
- ③ Functional deterioration stage: the therapist attempts to improve QOL although decline in ADL can not be prevented

## (3) Providing mental support through palliative rehabilitation

A team therapist promotes supportive rehabilitation so that the patient/patient's family can still have fun and the patient can maintain his/her will to live. The team therapist promotes communication with them through conversation and touching.

## (4) Maintaining ADL and preventing decline in ADL (so called conservative rehabilitation)

If a patient is confined to bed and his/her ADL can not be improved, a team therapist provides rehabilitation to maintain his/her QOL. Aiming to maintain remaining abilities (e.g. roll-over, movement of hands and feet), the team therapist prevents progress of disuse syndrome.

## (5) Rehabilitation for elimination of pain

To the patient, a team therapist explains how to move himself/herself without enhancing pain and proposes some goals (e.g. sitting on the bed, standing up and going to a restroom). The team therapist also instructs his/her family member (care-giver) how to move him/her without causing excessive pain and how to assist him/her. The team therapist provides the health-care professionals, patient and his/her family with the information about risk management from the viewpoint of rehabilitation (e.g. how to prevent the patient from falling or suffering severe pain).

## (6) Rehabilitation for patients with motor paralysis

Some patients suffer from impaired movement such as paraplegia due to spinal metastasis. A team therapist shows these patients how to move from the bed and toilet seat to the wheel chair in a horizontal manner.<sup>5), 6)</sup> This instruction serves for reduction of the burden on the patient/patient's family member (care-giver). For example, the therapist instructs them how to use a slider board.

## (7) Improvement of living environment

- A team therapist can improve the patient's basic ADL (e.g. walking, excretion, bathing). For example, the therapist contributes to improvement of QOL of the patient/patient's family by changing their living environment (recommendation of use of welfare equipment and self-help equipment). The therapist does not necessarily aim to improve patient's ability.
- A patient may leave the hospital to receive home-based nursing care. In this case, a team therapist should obtain the layout and pictures of the patient's house or visit there in advance. The therapist examines the information obtained and gives the patient/patient's family the professional advice that enables reduction of their burden (e.g. fixing a rail or a slope, assurance of the space for movement of a wheelchair and appropriate arrangement of a bed).

## (8) Prevention of accidental fall/fracture

The patient may break his/her loaded bone (e.g. spine, femur) during movement. The patient may also fall after feeling light headed because of various reasons [e.g. lower-extremity muscle weakness, edema, drug therapies (opioid, hypnotics)]. The therapist should recommend the measures to prevent these accidents or explain that they can be predicted. For example, the therapist recommends that the patient use a walker or that the patient's family can improve the living environment.

## (9) Efficacy of reduction of social stress by introduction of rehabilitation

If a therapist visits a patient regularly and provides rehabilitation for him/her for some time (regular rehabilitation method) (some patients can go to the rehabilitation center), this approach is likely to reduce social stress, a part of patient's holistic stress.<sup>7), 8)</sup> A team therapist needs to consult the palliative care team and ward staff about the indications. This is an approach that should be more widely disseminated so that more people understand its efficacy.



### <Skill upgrading>

For skill upgrading, a team therapist needs the basic knowledge of oncology. Currently, there is no systematic cancer rehabilitation education program in Japan. The therapist can obtain necessary knowledge from the academic books or use the e-learning course provided by Japan Society of Clinical Oncology [<http://www.cael.jp/>]. The therapist can introduce the manipulations in different rehabilitation fields (e.g. orthopedic rehabilitation, rehabilitation for stroke, respiratory rehabilitation) to learn more about rehabilitation techniques.

### <Warnings>

- (1) Patients/their families and medical care providers often associate training with ‘rehabilitation.’ Therefore, rehabilitation has not been disseminated widely. Team therapists are expected to apply rehabilitation as a means to bring about comfortable feelings (e.g. massage, postural change, passive movement).
- (2) Team therapists may overlook acute pain or aggravation of paralysis (e.g. development of paraplegia due to spinal metastasis or compression fracture). They should prevent new injuries by immediately reporting the changes to the ward staff and team members.
- (3) Patients may ask team therapists difficult questions. For example, ‘If I can regain my strength through rehabilitation, can I receive cancer treatment again?’ They may also make difficult requests. Then, team therapists may give them inappropriate answers. For example, to the above question they might say, ‘Yes, you can.’

There may be a gap between reality and expectation. This gap should not always be filled. The patient’s questions and requests are his/her natural reactions. A therapist should not deny his/her expectation but should show sympathy with his/her feeling. For example, a therapist can say, ‘It is natural to think so.’ The therapist should thank the patient for expressing his/her feeling and promise that his/her feeling will be shared for further discussion among the palliative care team members and attending physician.

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