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ORIGINAL PAPER

Standard operating procedure – palliative care

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Abstract

Aim: The aim of the research was to determine the fulfilment of the standard operating procedure – "Care of patients with increased risk level" incorporating the JCI AOP 1.7 standard "Patients and their loved ones are investigated and reinvestigated due to their individualized needs" by healthcare professionals of the selected healthcare facility. *Design:* A cross-sectional study. *Methods:* A quantitative survey was selected for data collection. The data were obtained through structured interviews with selected healthcare professionals from the designated facilities conducted by hospital management and recorded in writing in a pre-prepared record sheet. The research sample consisted of 78 respondents, of whom 36 were physicians and 42 were nurses, from 14 facilities. The research was conducted from 15. 1. – 31. 12. 2018. *Results:* From the interviews, we found that respondents regarded terminal patients and their loved ones holistically, but failed to record the information obtained. We also found that there was no difference in the evaluation of the patient and his / her loved ones according to the profession of the respondents, the length of their medical practice, or their workplace. In terms of the respondents' workplace, there was no difference in perceptions of the quality of palliative care provided in the selected hospital. *Conclusion:* Respondents perceive patients holistically and they are assessed as a bio-psycho-socio-spiritual unit, and their loved ones are included in the assessment. However, the information obtained is not fully documented in written form.

Keywords: needs, palliative care, quality of care, standard, terminal condition.

Introduction

Palliative care is defined by the Ministry of Health of the Czech Republic in Act No. 372/2011 Coll., on the health services and conditions of their provision, as care whose purpose is to alleviate suffering and preserve the quality of life of a patient suffering from an incurable disease (Act No. 372/2011). Tomeš et al. (2015) add that palliative care is oriented towards the patient's needs and their fulfilment, regardless of whether the patient is at home or an institution. It honors and protects life and sees death as a natural part of life. Its goal is to ensure the highest quality of life of the patient up to the last moment (Tomeš et al., 2015) and care for the patient's loved ones (Kabelka, 2017; O'Connor & Aranda, 2005), and to alleviate pain and other physical and mental suffering (Skála et al., 2011). Palliative care and treatment does not only concern people immediately before death, but also throughout the course of the disease, when all problems associated with it should be continuously addressed (Marková, 2010). Palliative care strives to provide conditions such that sufferers can live the last period of their lives with their loved ones in a dignified and benign environment, and to offer all-round support to the family and loved ones of terminally ill patients, helping them to manage the grief associated with the death of their loved ones (Sláma et al., 2011). Since palliative care is an integral part of health care in the Czech Republic, the same legislation applies to it as to all other areas of health care. Doctors and other health professionals should provide care that is in line with the current available knowledge of best medical practices (Sláma et al., 2011)

This is reflected in the quality of palliative care provided by facilities. In the modern concept, quality refers to any activity (service) or process that serves to satisfy the needs of consumers, in this case, patients and their families. Quality assessment represents a philosophy closely connected with the corporate culture of the organization, emphasizing reliability and consistency (Škrla & Škrlová 2008). It involves comparing individual characteristics and quality indicators with prescribed or required values such as standards, customer requirements, or competition (Blecharz, 2011). It is not within the power of health professionals to solve all problems that arise for patients with an incurable disease. However, it is appropriate to establish

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priorities with the patient and to clarify the goals of treatment and care. The focus is on the patient, he / she is the one whose opinion is crucial, and he / she decides what needs to be addressed. Based on the goals set, it is possible to assess whether therapeutic care will contribute to their achievement (Sláma et al., 2007). In our study, we compared the quality of palliative care provided in a teaching hospital with the established standard that "Dying patients and their loved ones are examined and repeatedly examined in relation to their individualized needs" as part of the obligatory internal system of quality and safety evaluation by which health establishments try to improve and streamline the quality of provided services (Hulková, 2016) and reduce undesirable events (Šupšáková, 2017).

In the area of palliative care, a significant shift in understanding of the content of care has occurred and it appears that multidisciplinary care, which is aimed at alleviating discomfort in the form of symptoms of the disease and at comprehensive support of patients and their loved ones, is beneficial for patients if it is applied during much earlier stages of incurable diseases, in combination with treatment aimed at influencing the underlying disease. This statement implies that the palliative approach should become part of care as soon as an incurable or life-threatening disease is diagnosed (Gřiva 2018; Sochor, 2018).

In connection with the fact that hospital establishments are, and for the forseeable future will remain, the place where deaths occur most frequently, every hospital should pay attention to palliative care in its standards to maintain the highest level of quality (Marková, 2010). Palliative care in the Czech Republic lags behind that in more developed countries. It has been developing in this country for approximately 30 years, mainly in the form of specialized palliative care (Bužgová, 2015). In view of the fact that the population is aging, there will be an increasingly closer integration of palliative care with acute treatment of patients with chronic diseases. Therefore, health professionals working with such patients will need a higher level of knowledge of palliative care (O'Connor & Aranda 2005).

Aim

The aim of the research was to verify the fulfilment of the standard "Dying patients and their loved ones are examined and reexamined for their individualised needs" by healthcare professionals in the actual everyday practice of a selected healthcare facility by means of an audit survey.

Methods

Design

A cross-sectional study.

Sample

In the healthcare facility where the research was carried out, palliative care is part of the standard operating procedure – "Care for patients with increased risk level". The healthcare facility is currently accredited by a Czech accreditation company and had an international quality certificate until 2019. Fourteen wards in which care is provided to terminal patients were included in the sample. The wards were selected by the quality manager intentionally. A total of 78 healthcare professionals were included in the sample, of whom 36 were doctors (46%) and 42 nurses (54%).

Data collection

The study was conducted in a teaching healthcare facility and was carried out from January to December 2018. The selection of the ward was intentional. The top management of the health facility identified departments in which adult and child patients with terminal incurable disease are hospitalized and where palliative care is provided.

Data were collected in the form of structured interviews over time so as not to disrupt the operation of the department, and were conducted according to the workload of the respondents.

A check list was created to collect the data. Interview questions were compiled to correlate with a prescribed form known as "Evaluation of terminal patients", which is used for examination of such patients. According to the standard, the examination is carried out by a doctor in cooperation with other members of the health team and should be performed immediately after it is formally stated in the medical documentation that the patient is in a terminal condition. Subsequently, the examination is repeated at least once a week.

The examination of the patient in terminal condition focuses on the patient's health condition, specifically on the symptoms of colds and respiratory problems, factors relieving or exacerbating physical symptoms, and assessment of the patient's current treatment and response to it. The examination does not focus solely on the patient, but also on his / her loved ones / survivors. It includes an assessment of spiritual orientation and the need for inclusion in spiritual groups, mental fears, psychosocial status, and the need for support or relief. It also takes into account the risk factors for survivors, and how they will manage the loss of a loved one (Joint Commission International [JCI], 2017).

The set questions for the structured interview differed slightly in wording according to the competencies of the doctor (examination) and nurses (performance of procedures and cooperation). The check list included a total of 22 questions. In terms of socio-demographic data, we surveyed job placement, place of profession / department, length of overall practice in health care, and length of practice in the current healthcare facility. Other questions investigated the provision of palliative care and its quality, communication skills, evaluation of patients' needs, information transfer between staff, and documentation of care. Interviews were conducted individually, with responses recorded on a prepared record sheet.

Data analysis

Descriptive statistics (number [n], relative frequency [%], standard deviation [SD], minimum [min.], maximum [max.]) were used to describe the data. For statistical processing, the respondents were assigned to two domains by cluster analysis using K-means in the MatLab program in version 2019a for the creation of value domains. A Chi-square test was used for statistical evaluation, and the level of statistical significance was 5%.

Results

In the research group, the average duration of the medical practice of the respondents was 15.55 years (min. = 0.5; max. = 42; SD = 11.23), the duration of practice in a given medical facility was nine years (min. = 0.5; max. = 38; SD = 9.34). All respondents had a terminal patient in their care.

Respondents rated the quality of care provided in their department predominantly as good. In the area of communication with the patient and his / her loved ones / survivors, 51 (65%) considered their communication skills to be sufficient, despite the fact that only 20 (26%) had completed a communication course; nevertheless, 71 (91%) respondents expressed interest in completing a communication course (Table 1).

Table 1 Opinion of health professionals on the quality of care provided and communication skills (n = 78)

Items	n (%)
Opinion on the quality of palliative care	
excellent	2 (2.6)
very good	17 (21.8)
good	42 (53.8)
bad	17 (21.8)
very bad	0 (0.0)
Communication skills	
I have sufficient communication skills.	51 (65.0)
I do not have sufficient communication skills.	27 (35.0)
Possibility of taking a communication course	
I had the opportunity.	20 (26.0)
I did not have the opportunity to.	58 (74.0)
Need to take a communication course	
I would like to take this course.	71 (91.0)
I do not need the course.	7 (9.0)

We did not find a statistically significant difference in the perception of the quality of palliative care provided to terminal patients according to the profession of healthcare workers (Table 2) (p = 0.13). Thus, opinions on the quality of palliative care provided to terminal patients were not influenced by the profession of the respondents.

The areas of standard provision in relation to the assessment of the needs of terminal patients and their loved ones are shown in Table 3. Physical needs of patients were evaluated most frequently by the respondents: "physical symptoms, medical condition and patients' healthcare needs"; followed by mental and social needs: "Psychosocial state"; with spiritual needs representing the third area: "Spiritual orientation and needs" and "mental concerns". A total of 32 (41%) respondents believed there was a need for alternative care settings. Besides patient assessment, all other items were evaluated except the assessment of physical needs related to the patient's care. The respondents rated the psychosocial area more frequently than the spiritual area. They focused more frequently on the need for support or relief in the area of supportive communication (n = 73;

Table 2 Differences in respondents' perception of quality of palliative care provided, by profession

Profession	**Excellent and very good n (%)**	**Good n (%)**	**Bad n (%)**	**p-value**[*]
Physician	12 (33)	19 (53)	5 (14)	0.13
Nurse	7 (17)	23 (55)	12 (28)	

[*] *Chi-squared test*

Table 3 Areas for assessing the needs of the patient and their loved ones / survivors (n = 78)

Items		**Yes n (%)**	**No n (%)**	**p-value**
Physical symptoms, medical condition and patient's healthcare needs				
cold and respiratory symptoms, shortness of breath		75 (96)	3 (4)	
factors relieving physical symptoms		75 (96)	3 (4)	
factors aggravating physical symptoms		74 (95)	4 (5)	
response to treatment		78 (100)	0 (0)	
pain		78 (100)	0 (0)	
fatigue		76 (97)	2 (3)	
nausea – vomiting		78 (100)	0 (0)	
intestinal problems		78 (100)	0 (0)	
loss of appetite		78 (100)	0 (0)	
Need for family support or relief				
need for supportive communication		73 (94)	5 (6)	
psychologist's assistance		69 (89)	9 (11)	
Risk factors in survivors				
situation management		69 (89)	9 (11)	
potential pathological response to grief		27 (35)	51 (65)	
Need for alternative care settings		32 (41)	46 (59)	
Active communication with loved ones		74 (95)	4 (5)	
Assessment of patient's loved ones' needs		78 (100)	0 (0)	
Assessment of survivors' needs		78 (100)	0 (0)	
Spiritual orientation and needs				
spiritual orientation	patient	54 (69)	24 (31)	0.467
	family	51 (65)	27 (35)	
the need for inclusion in spiritual groups	patient	27 (35)	51 (65)	0.029
	family	18 (23)	60 (77)	
views on life and death	patient	33 (42)	45 (58)	0.059
	family	28 (36)	50 (64)	
belief in the afterlife	patient	32 (41)	46 (59)	0.366
	family	29 (37)	49 (63)	
the need for spiritual rituals	patient	48 (62)	30 (38)	0.617
	family	50 (64)	28 (36)	
Mental fears				
despair	patient	67 (86)	11 (14)	1.000
	family	67 (86)	11 (14)	
guilt	patient	27 (35)	51 (65)	0.796
	family	28 (36)	50 (64)	
forgiveness	patient	24 (31)	54 (69)	0.366
	family	21 (27)	57 (73)	
repentance	patient	17 (22)	61 (78)	0.739
	family	16 (20)	62 (80)	
Psychosocial state				
family relationships	patient	69 (89)	9 (11)	1.000
	family	69 (89)	9 (11)	
depression	patient	72 (92)	6 (8)	0.166
	family	67 (86)	11 (14)	
anxiety	patient	72 (92)	6 (8)	0.366
	family	69 (89)	9 (11)	
suicidal tendencies	patient	34 (44)	44 (56)	0.005
	family	19 (24)	59 (76)	

94%) and the assistance of a psychologist (n = 69; 89%). In the area of risk factors, they focused more frequently on the management of the situation (n = 69; 89%) than on the potential pathological response to grief (n = 27; 35%). In the area of active (above standard) communication with the patient's loved ones, with the intention of identifying a specific need or condition, only four (5%) respondents said they did not actively seek communication. In the areas of assessment of the needs of patients, including the period after the death of the patient, all 78 respondents assessed these areas. In a closer assessment of the needs (Spiritual orientation and needs; Psychosocial state) of the patient and his family, we found statistically significant differences between the assessment of the need for "inclusion in spiritual groups" (p = 0.029) and "suicidal tendencies" (p = 0.005).

Table 4 focuses on the area of information deemed important in patient care. All 36 doctors (100%) reported receiving information about the patient's needs and health status, while 30 (83%) received information about the patient's loved ones, and only 15 (42%) reported receiving information about their survivors. Similarly, all 42 nurses (100%) reported informing physicians of patient needs and health status, while 38 (90%) passed on information about their loved ones, and only 12 (29%) passed on information about their survivors. The reason given was that the patient's loved ones and survivors were not officially the subject of their care and, therefore, nurses did not communicate their needs to doctors.

Table 4 Information on patient care

Items	Yes n (%)	No n (%)
Physician – information forwarded by nurse		
about patient	36 (100)	0 (0)
about loved ones	30 (83)	6 (17)
about survivors	15 (42)	21 (58)
Nurse – information forwarded to physician		
about patient	42 (100)	0 (0)
about loved ones	38 (90)	4 (10)
about survivors	12 (29)	30 (71)
Using the Terminal Patient assessment form	15 (19)	63 (81)
Knowledge of the Terminal patient assessment form	11 (17)	52 (83)
Perception of complications in a holistic assessment of the patient and his loved ones	68 (87)	10 (13)
Complications in a holistic assessment of the patient	**n (%)**	
lack of time	38 (56)	
inability to obtain information from the patient	10 (15)	
non-cooperation from loved ones	6 (9)	
incomprehensibility	14 (20)	

Of the 78 respondents, only 15 (19%) used the predefined "Evaluation of terminal patients assessment form" to record patient information. Of the 63 respondents (80%) who did not use the form, 52 (83%) were not aware of it. When asked how else they documented information about patients and their loved ones, all 63 (81%) said they recorded patient information to a limited extent on a daily basis, describing their physical and psychological state. Other information was not recorded.

Respondents who had issues with the assessment of patients and their loved ones gave four reasons for their difficulties. The biggest problem (n = 38; 56%) they perceived was lack of time to address patients' physical, spiritual, and psychosocial state and the related needs or needs of their loved ones. Fourteen (20%) stated that they did not understand exactly what to ask patients and their loved ones and wanted more specific explanations from managers. The third complication they perceived (n = 10; 15%) was that they could not obtain the appropriate information from patients themselves, mostly due to medical conditions that prevented this. The final complication (n = 6; 9%) was the unwillingness of patients or their family members to discuss the matter.

We aimed to find out the differences in the evaluation of patients by health professionals according to their profession, length of practice, and category of workplace, using the Chi-square test (Table 5). There were no statistically significant differences in any of the parameters evaluated: 1) between doctor and nurse assessments (p = 0.75; p = 0.11); 2) duration of practice (p = 0.73; p = 0.93); and 3) place of work (p = 0.18; p = 0.09).

At the end of the interview, the respondents were asked if they would like to comment on their work experience in the area of palliative care. More than half of respondents (n = 42) did not provide additional answers. The responses of the remaining 30 can be divided into three areas: 1) the presence of palliative team experts or the establishment of a palliative department itself with trained staff (n = 25; 83.4%); 2) better education of health professionals about what a patient on the brink of death really needs and what their priorities are (n = 4; 13.3%); and 3) better communication of health professionals with patients (n = 1; 3.3%).

Table 5 Differences between the profession of a healthcare professional and the value domain – assessment of a terminal patient (n = 78)

Items	**Patient assessment**			**Family assessment**		
	Domain 1[+] n (%)	**Domain 2[++] n (%)**	**p-value***	**Domain 1[+] n (%)**	**Domain 2[++] n (%)**	**p-value***
Profession						
nurse	26 (62)	16 (38)	0.75	27 (64)	15 (36)	0.11
physician	21 (58)	15 (42)		29 (81)	7 (19)	
Length of practice						
0–10 years	20 (61)	13 (39)	0.73	24 (73)	9 (27)	0.93[a]
11–20 years	10 (53)	9 (47)		13 (68)	6 (32)	
21–30 years	12 (71)	5 (29)		12 (71)	5 (29)	
31 and over	5 (56)	4 (44)		7 (78)	2 (22)	
Category of workplace						
1	11 (61)	7 (39)	0.18	10 (56)	8 (44)	0.09
2	12 (67)	6 (33)		14 (78)	4 (22)	
3	17 (71)	7 (29)		21 (88)	3 (12)	
4	7 (39)	11 (61)		11 (61)	7 (39)	

**Chi-square test p < 0.05; For statistical evaluation it was necessary to merge the categories with the lowest frequencies into one to fulfill its validity. The categories 21–30 and 31 and more years were merged; [+]Included by cluster analysis of 27 nurses and 29 physicians; [++]Included by cluster analysis of 15 nurses and 7 physicians; Workplace 1 – hematooncology, oncology, intern, long-term hospital; 2 – cardiovascular, neurology, neurosurgery; 3 – gynecological-obstetric, pulmonary diseases and tuberculosis, surgery, urology; 4 – pediatric medicine, oral, jaw and facial surgery, burn medicine and reconstructive surgery*

Discussion

The aim of the audit study was to determine whether the JCI standard – “Dying patients and their loved ones are examined and re-examined for their individualized needs” – is incorporated into the hospital standard operating procedures from the perspective of the healthcare workers (nurses and doctors) working in the hospital facility who are not professionally trained in palliative care and thus provide general palliative care. This is defined by Marková (2010) as the care that must be provided by each health facility within its specialty.

Areas included in the audit survey were the opinion of healthcare professionals on the quality of care provided to terminal patients by healthcare professionals themselves and their communication skills (Table 1). Respondents to the audit survey without distinction of profession (Table 2) rated the care provided as good on average. Kabelka et al. (2016) report that there is no systematic collection of data on the quality of palliative care provided in bed establishments in the Czech Republic. Rather, there are several case reports that indicate certain differences between individual establishments, as well as between workplaces in the same department. Despite the fact that our group rated the care provided as good, they observed several shortcomings that reduced the quality of care. They saw the biggest obstacle as being the lack of time for patients in the practical operation of the hospital, which prevents them from attending to patients to the extent that they deserve and which they might receive in a hospice. Sochor (2018) states that general palliative care emphasizes the management of physical and psychological symptoms and that it is completely unrealistic to expect full consideration of patient difficulties caused by the progression of the disease, precisely due to time constraints. It also mentions the limited availability of psychosocial support, and lack of experience and interest in palliative care of health professionals. Gřiva (2018) states that every health professional must understand the concept of palliative care as an integrated system of services intended for patients with life-threatening diseases. According to international recommendations, palliative care is distinguished from general and specialized care. The two levels cannot be completely separated, but, on the other hand, it is important to maintain sufficient communication links between them (Kabelka, 2017).

Due to understaffing in wards, staff do not have enough time to tend to the needs of patients (Cho et al., 2015; Jarošová et al., 2021; Plevová et al., 2021; Zeleníková et al., 2020). Healthcare facilities include care of the dying in the basic care activities involved in the normal operation of the ward. Meanwhile, there has been a lack of expansion of care in the home environment or in hospices. Since 2007, data on the place of death have been collected in the Czech Republic as part of the statistics on deaths. In 2020, almost 2/3 of all deaths occurred in a hospital or therapeutic institution, and another 10.7% of deaths occurred in a social care facility. More than a fifth of people died at home (Institute of Health Information and Statistics of the Czech Republic [IHIS], 2021). Similar data were also included in the 2018 yearbook (IHIS, 2019; 2021). The data do not show how deaths may increase in hospices or at home with specialized palliative care. Since hospitals will most likely remain the place where deaths will occur most frequently for the foreseeable future, they should strive to determine their own development in the area of palliative care and treatment. Developing a culture of palliative care that includes the whole family means strengthening the component of social work with the family of the dying person (Marková, 2010). In 2002–2017, Abbasi et al. (2021) analyzed the involvement of palliative care / hospices during hospitalization of patients with multiple myeloma in terminal state. In 2002, palliative care / hospices were consulted only in the case of 67 hospitalized patients from a total of 1,260 (5.3%); in 2017 the number of consultations increased to 321 from 1,021 hospitalizations (31.44%) ($p < 0.01$) (Abbasi et al., 2021). In 2019–2021, the Ministry of Health of the Czech Republic announced the project Promotion of Palliative Care, to increase the availability of health services in the area of palliative care in acute and follow-up care hospitals by creating a new separate subsidy program for palliative care and setting and verifying methodologies for the implementation of palliative care (Ministry of Health of the Czech Republic, 2020). The project focused on the development of general and specialized palliative care in hospitals in the Czech Republic, which is not adequate for patients at the end of their lives. As part of the project, an electronic questionnaire survey on the availability of palliative care in acute and follow-up care beds was conducted. Of the 75 hospitals that participated in the survey, 20% reported that they had a comprehensive palliative care program, 28% had palliative care consulting teams, and 21% had a palliative medicine outpatient clinic. The health establishments have stated that they are working to continue to develop in this area (Ministry of Health, 2018). The 2030 Health Strategic Framework also addresses the issue of palliative care, and one of the partial objectives is to increase the availability of palliative care in all forms – palliative care consultancy in hospitals, mobile specialized palliative care, home care, and hospice care (Ministry of Health, 2019). There is a corresponding need for respondents to receive training on these issues. The majority of respondents (90%) reported the need for a course focusing on communication skills with those dying, their loved ones, and survivors (Table 1). The results of a qualitative study by Seccareccia et al. (2015), and Wentlandt et al. (2016), confirmed that communication is a central element of the quality of care and satisfaction of patients and their family caregivers in palliative care units.

Supervision should also be an integral part of health practice, according to respondents, especially for helping professions. Sochor et al. (2019) describe it as an important tool, helping health professionals reflect on their own work, cope with the challenging situations they experience in their practice, better understand these situations, and find new solutions.

Care of terminal patients, anchored in the standard, is based on the current concept of palliative care and the World Health Organization (WHO) definition: "an approach that seeks to improve the quality of life of patients and families facing problems associated with life-threatening diseases, through prevention and alleviation of suffering, early recognition and appropriate evaluation and treatment of pain and other physical, psychosocial, and spiritual problems" (Kabelka et al., 2016). In our study, we found that the evaluation of the patient and their loved ones / survivors is comprehensive (all areas of needs were evaluated), and is performed similarly by both nurses and physicians. Based on the results, we can further conclude that neither the length of their medical practice nor the workplace influences this evaluation (Table 5). Doctors and nurses were more or less in agreement on the perception of the needs of terminal patients and their loved ones throughout the spectrum of workplaces. However, differences in their evaluation were found. Respondents had no problem assessing the physical needs of both patients and their loved ones / survivors. In the area of needs assessment – Psychosocial state, they had problems addressing needs in the area of "suicidal tendencies"; and in the area of spiritual orientation assessment, they had problems addressing the "need for inclusion in spiritual groups" (Table 3). Consistent satisfaction of all human needs at the end of life can be a key aspect of terminal illness management. Patients expect medical staff to respect their religious and spiritual beliefs, as well as their concerns. In palliative care, the addressing and satisfaction of spiritual needs is a high priority and can be a key aspect of psychological intervention. (Hajnová Fukasová et al., 2015) In the area of "suicidal tendencies" assessment, according to Kohoutek (2010), it is important to identify suicidal risk and adequately address it. Praško (2006) recommends asking about suicidal thoughts even if the patient does not talk about them. A study by Mithrason et al. (2018) confirmed that the psychosocial aspect of the patient generally remains unsatisfied. Health professionals should preemptively focus on areas that the WHO recommends as protective, e.g. strengthening ties to the family, strengthening personal, social, cultural, and religious beliefs that discourage suicide and promote self-preservation, and making it possible to mediate help in cases of mental and physical illness. (WHO, 2012)

Health professionals can have a positive effect on terminal patients under certain conditions. These patients and their families need health professionals who can provide psychological and spiritual support, decision making assistance, and communication, in addition to medical and nursing activities (Arisanti et al., 2019). Tomeš et al. (2015) sees the problem in that general palliative care is regarded as a tool to alleviate pain and other physical symptoms, while other elements, such as providing support to patients and their loved ones, are attributed to specialized care. Sláma et al. (2016) agree, arguing that if the topic of palliative care at the level of inpatient care is addressed by a standard, it is almost exclusively concerned with the care of imminently dying patients. This may be due to a misconception that palliative care is provided only to dying patients and, consequently, many patients are not treated in a timely manner (Arisanti et al., 2019). Our study focused on monitoring compliance with the JCI – based standard. Similarly, Penrod et al. (2012) and Mroz et al. (2021) conducted a prospective observational study of key processes of palliative care performed in intensive care units (ICU). The authors relied on the Care and Communication Bundle (CCB), which provides a standardized procedure for the provision of effective palliative care services in ICUs (Mroz et al., 2021). Although in Penrod et al. (2012) no workplace achieved the best results in the nine measures, performance varied greatly depending on department, with the greatest differences between workplaces observed in the establishing of resuscitation preferences and in spiritual support. In the study by Mroz et al. (2021), results showed compliance with CCB standards, including excellent consistency in establishing patient-focused communication and referral to support services (e.g. social work, spiritual support). They see the scoring system as an opportunity to motivate improvement and reduce differences in the integration of palliative care (Mroz et al., 2021). In both studies, and our own, there is a difference in the approach of staff to meeting the standard. In our study, information obtained was not recorded in the pre-prepared form as required by the standard. In the study by Penrod et al. (2012), in one of the workplaces, there was a lack of performance documentation for more than 70% of patients for all measures except assessment and pain management. However, although the audited standard used in our research reflects a broader issue, focusing not only on patients, but also on their loved ones / survivors and on all areas of need, respondents were unable to work with it, with some unaware that the evaluation form was used in the healthcare facility (Table 4). Respondents also reported that in some cases they were unable to obtain significant information from patients due to their unfavourable health conditions, and noncooperation from their loved ones. Another complication was a lack of comprehension of what is required in an examination of a terminal patient. Respondents did not know precisely what information to obtain from patients and loved ones or how to go about obtaining it, despite the established standard. Filej et al. (2018) consider it a problem when the needs of a patient with an incurable disease are misunderstood. Some respondents stated that there was a need to increase the knowledge of medical staff regarding the needs of the patient and loved ones in relation to dying, which would facilitate many aspects of this evaluation. As Sochor (2018) states, a sophisticated system of education in this field and general education about palliative care is necessary for the future. Kabelka (2017) supports the opinion that certain aspects, in particular general palliative care, are completely underrepresented in medical school training. Since 2018, there have been changes in specialization training for nurses in the Czech Republic, with an extension of training in the new specialization of home care and hospice care (Act No. 164/2018).

Conclusion

Despite the fact that the audit study found that the standard was not fully met by the respondents, caregivers perceived the needs of patients holistically and did not neglect the loved ones of patients in their care. Palliative care is an important component of the care of patients with incurable diseases in a hospital setting. It should be seen as fully-fledged care and its philosophy should be respected. On one hand, there are the needs of patients and their loved ones; on the other, caregivers lack awareness of the needs of the dying and are limited in their ability to provide care. It is important to address this topic in the future, since, with an aging population, there will be an increasing number of geriatric patients, and increasing public awareness of the need for palliative care; thus, palliative care in hospital facilities will be increasingly needed. Our audit study shows that it is necessary to ensure better information is obtained by health professionals in the provision of care to terminal patients within a given healthcare facility, to familiarize health professionals with the recommended procedures and documentation management, and thus also to eliminate differences in care within departments and between professions.

Ethical aspects and conflict of interest

The authors declare that there was no conflict of interest regarding the study and that ethical aspects were considered while processing the results. All literature sources were properly cited.

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Author contributions

Conception and design (LK, IP), data collection (LK), data analysis and interpretation (LK, IP), manuscript draft (IP), critical revision of the manuscript (IP, LK), final approval of the manuscript (IP).

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