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Namaste Care in Managing Terminal Symptoms in Acute Palliative Ward – A Feasibility and Pilot Study

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Background

People with dementia are suffering from a significant burden in the advanced stage of disease despite receiving palliative care [1]. The Namaste Care program is a multi-dimensional care program with sensory, psycho-social and spiritual components, to enhance quality of life and care for people with advanced dementia [2]. Multiple studies including randomized controlled trials supported that Namaste Care has the potential in improving pain and behavioral symptoms of patients with advanced dementia[3][4][5]. However, there is no study known in palliative care setting. Hence, this study aimed to assess the practicality and therapeutic impact of implementing Namaste Care within an acute palliative care setting, in managing of terminal symptoms including pain and delirium.

Methodology

- **Sample size:** 30 patients' encounters (n=30)
- **Duration:** Six months **pre-post pilot trial**
- **Inclusion criteria:** Delirium, contracture patient
- **Activities:** hand and arm massage, afternoon tea, grooming, manicure, music therapy, etc.
- Patients received Namaste Care once to twice weekly, each session lasting 30 minutes.
- Trained staff will provide Namaste Care in an unhurried and loving manner.

Massage

Preferred beverages for afternoon tea

A well lighted and calm environment, scented moisturizer, with music.

Data Collection Tools

Pain Assessment in Advanced Dementia (PAINAD) and Richmond Agitation-Sedation Scale (RASS) were used to observe the changes in terminal symptoms.

PAINAD	0 to 8	Higher scores are indicators of greater pain.
RASS	-5 to +4	Negative values indicates sedation; positive value shows agitation.

Conclusion and discussion

Findings indicate that Namaste Care is a feasible and potentially efficacious adjunct in managing terminal symptoms such as pain, the limitation of sample size and staffing constraints restricted the intervention's frequency and scalability.

Moreover, the short prognostic trajectory of palliative patients hinders the longitudinal evaluation of outcomes. In conclusion, future larger-scale studies are suggested to validate these preliminary findings and to explore optimal implementation strategies.

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Results

Pain Assessment in Advanced Dementia (PAINAD)

P value	0.035	Significant reduction
95% Confidence Interval (CI)	-0.817 to - 0.0495	Shows evidence of a true effect
Cohen's d	-0.404	Small to moderate effect size

The 95% CI did not cross zero, providing evidence of a true effect. The effect size was small to moderate, with the negative value indicating that Namaste care was generally associated with lower PAINAD scores.

Richmond Agitation-Sedation Scale (RASS)

P value	0.095	Nil significant change
95% Confidence Interval (CI)	-0.64 to 0.04	The true effect may range from a small reduction to no change
Cohen's d	-0.315	Small effect size

The 95% CI crossed zero, suggesting that the true effect may range from a small reduction to no change. Despite, the effect size was small, the negative value are indicating a trend towards lower RASS scores post-intervention.

References

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