Integrating Palliative Care Principles into Critical Care Nursing

It’s the “Caring, Compassionate, Holistic, Patient and Family Centered, Better Communication, Keeping my patient comfortable amidst the tubes, lines, machines” Nursing Practice

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Center for Practical Bioethics, KCMO, Clinical Ethics Associate

Objectives

• Describe the role of palliative care in patients who are critically ill: CONTEXTUALIZE
• Discuss the unique role of critical care nurses in patient/family communication: INDIVIDUALIZE
• Describe EBP strategies that integrate palliative care into critical care: STRATEGIZE
What is Palliative Care?

30-second “Elevator Pitch”
- Expert Pain and Symptom Management
- Communication or counseling around difficult issues – patient/family centered
- Assist with dispositions/transitions out of hospital

For patients at high-risk of death
Or
At end-of-life

The Old Paradigm

Life Prolonging Care

Palliative/ Hospice Care

Disease Progression

What’s the Problem with That?

- “Going Palliative!”
- “Withdraw (or stop) care”
- “Why aren’t they a ‘DNAR’?”
- “Death Panel”
The New Paradigm

- Establish relationship with patient/family early
- Assist to improve QOL while patient is going through active treatment
- “The feel better so you can enjoy life” team
- Embedded in heart failure clinic, OP cancer clinics, liver clinic at KU Hospital

Go Palliative Team!!
What does this have to do with Critical Care Nursing?

2002-2004 in Michigan

"MHA Keystone estimates that more than 1,578 lives were saved, reducing hospital days by 81,000 and saving $165 million during the 15-month span." Newsweek, Oct 16 2005

"As a profession, nursing has an obligation to respond to the demands of an aging population, increasing chronic illness and a seriously burdened health care system...quality of life matters, even at end of life" Betty Ferrell, 2001, forward

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- 1 out of 5 Americans will die “in and around an ICU stay” (Angus, et al, 2004, CCM)
- Over 55% of Americans will die in a facility (Hospital, LTACH, NH) (Kaufmann, 2005)
- Aggressive medical and surgical interventions are offered to a growing population of older adults with multiple comorbid conditions

What’s a Critical Care Nurse to do?
Palliative Care Based on Need

Patients:
- Decreased mortality → Increased ICU survivors
- ARDS: symptoms the first year after ICU
  - Debilitating insomnia, fatigue, pain, emotional lability
  - Depression
  - Chronic pain
- Chronically critically ill: vent dependent

Families:
- Anxiety and depression are common
- Complicated grief
- "Post Intensive Care Syndrome" recognized in families and patients

Case Study
- Elderly man, trached, PEG’d, in the ICU
- Palliative Care consulted for goals of care
- Had family meeting with wife, ICU team and PC team
- Plan for transfer to LTACH, continue attempts at wean from mechanical vent
Communication
- With patient
- With family
- With other providers

Family Meeting
- A Palliative Care “Procedure”
- Physician-led is best studied
- Proactive versus reactive
- Multidisciplinary
- “Primary Palliative Care” Intervention

EBP Nurse Communication in ICU
- Nurse-led family interaction in waiting room
- Nurse initiated daily phone call
EBP Nurse Communication in ICU
SUPPORT Study
• Specially trained nurse liaison
• Failed to demonstrate improved communication about CPR, preferences

EBP Nurse Communication in ICU
• APRNs in OP settings: reduce LOS, reduce readmissions (Project ENABLE)
• APRNs In Critical Care (ICS) (Daly, et al., Chest)
• Nurse liaisons (Family Support Specialist) (White, et al., AJCC)
• Nurses “commonly feel constrained” (Slatore, et al., AJCC)

Exploring Perceptions of the Nurse’s Role in the ICU Family Meeting
Case Study
• Nurse did not participate in the family meeting
• Nurse had crucial information
Methods

- Setting: single medical ICU
- Population: ICU nurses
- Procedure: mixed method approach
- Instruments:
  - Experience with Family Meeting Questionnaire
  - Self-Rating Communication Skills Questionnaire
  - Demographic Questionnaire
  - Guided Interview of Perception of Nurse Role

Data Analysis

- Quantitative data collection
  - REDCap Surveys
  - Frequency of responses to survey questions
  - Self-rating scores of "Excellent" and "Very Good"
- Qualitative data collection
  - Guided interviews
  - Open-ended questions to explore the ICU nurse role in family meetings

Quantitative Results

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<th>Characteristic</th>
<th>N= 20</th>
<th>N=5</th>
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<tr>
<td>Age, mean (SD)</td>
<td>31.7 (7.6)</td>
<td>na</td>
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<tr>
<td>Race - White: Num. (%)</td>
<td>17 (85)</td>
<td>5 (100)</td>
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<tr>
<td>Years in Practice, mean (SD)</td>
<td>7.6 (6.6)</td>
<td>6.4 (2.9)</td>
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<tr>
<td>Years in ICU practice, mean (SD)</td>
<td>6.4 (6.3)</td>
<td>4.8 (2.2)</td>
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<tr>
<td>Role - Direct care RN: Num. (%)</td>
<td>16 (80)</td>
<td>5 (100)</td>
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<tr>
<td>Professional Certification: Num. (%)</td>
<td>14 (70)</td>
<td>5 (100)</td>
</tr>
<tr>
<td>Participate in Shared Governance: Num, (%)</td>
<td>10 (50)</td>
<td>4 (80)</td>
</tr>
<tr>
<td>Day Shift: Num. (%)</td>
<td>16 (80)</td>
<td>3 (60)</td>
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Reasons to have family meetings

- Patient critically ill
- Patient has a DNR
- Other major care decisions
- Need to communicate family and patient
- Need to arrange for end-of-life care
- Long-term stay in ICU
- Other

Reasons for not attending family meetings

- Desire of the patient or family
- Time constraints
- Other
- Other

Quantitative Results

- Self-rating skills in family communication: “Excellent” or “Very Good”
- Most nurses confident about:
  - Communicating patient needs to ICU physician
  - Ensuring that family has opportunity to meet IDT
  - Responding to questions about condition, treatment and goals of care
- Most nurses not confident about:
  - Addressing the emotional needs of the family
  - Responding to questions about prognosis
Spearman’s Rank Correlation Between Self-rated Communication Skills and Nurse Characteristics of age and years in practice

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<tr>
<th></th>
<th>Age</th>
<th>Years</th>
<th>Consistent comm</th>
<th>Interview</th>
<th>Active Participant</th>
<th>Investigate</th>
<th>GOC</th>
<th>Emotional needs</th>
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<tr>
<td>Total</td>
<td>.120</td>
<td>.297</td>
<td>-.028</td>
<td>.373</td>
<td>.583**</td>
<td>.415</td>
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</table>

*significant at 0.05 level
**significant at 0.01 level

Qualitative Results

• Three types of family meetings
  – Formal family meeting
  – Informal family meeting
  – Emergent/Urgent family meeting

• ICU Nurse Role
  – Information reconciliation
  – Balanced Advocacy
  – Skills needed: know the patient, educate patient/family, honest communication
Conclusions

- Nurses perceive a limited role, little influence in formal family meetings
- ICU nurses frequently participate in informal, impromptu family meetings
- Older, more experienced ICU nurses self-rate higher in discussing difficult topics
- Targeted education of EBP strategies about family meetings is needed
- ICU nurses can take lead in improving communication with patients and families

Unique role of critical care nurse

Case Study:
- Elderly man, chronic vent, trached, PEG'd, planning to discharge to LTACH?
- Nurse facilitated repeat family meeting at bedside and advocated for patient to tell wife his wishes
- Patient went home that evening, with hospice, died the next morning at home

What next?

- Better integration of palliative care principles into critical care
- Emphasis on primary palliative care for the bedside provider
- Education
  - Provider education: Physician, Nurse, Allied Health
Barriers to Better Integration

- Unrealistic expectations of therapies
- Misperceptions that palliative care and critical care are mutually exclusive
- Palliative care equals hospice care
- Palliative care means “no care”
- Will hasten death

Aslakson, Curtis & Nelson, CCM, 2014

Barriers to Better Integration

- Insufficient training in communication and other skills
- Competing demands without adequate compensation
- Failure of effective approaches for system or culture change

Aslakson, Curtis & Nelson, CCM, 2014

Consultative vs. Integrative Model

Palliative Care Team
Palliative Care Consultation
Usual ICU care by Critical Care Team

Palliative Care Principles embedded in typical ICU care

Nelson, et al., CCM, 2010
Creating a Screening Tool

• Who are the stakeholders?
• What is your process?
• How do you evaluate? Outcomes?
• Primary palliative care vs. Palliative Care consult?

Screening Tool Examples

Structured Approaches to Communication

• Usually pre-post design
• Associated with significant reductions in resource utilization
• Family Meetings
  – ICU team
  – Palliative Care Team
  – Ethics Consultants/Committee
• Brochure
Surgical ICU Interventions

• Before and after interventions: multi-faceted, multidisciplinary intervention to integrate palliative care principles into usual or “standard” care in an “open” ICU
  – Earlier consensus around goals of care
  – Earlier more frequent use of DNAR and withdrawal of artificial life sustaining treatments
  – Shorter SICU LOS, unchanged mortality

Support for Families and Surrogates

• Involvement in daily rounds
• Designated staff to support families
  – SW, Nurse
  – Chaplains
  – Advance Practice Nurses
• Require further evaluation
• RCT eval of SW or Nurse as liaison
  
Decision Support Tools

• Admission assessment tool to identify surrogate decision-makers and clarify decision-making
• A decision-aid for surrogates for patients on prolonged mechanical ventilation
ICU Protocols

- Diaries
- Standardized order sets
- Clinician debriefing

Nurse-led Interventions

- Implement nurse-initiated communication bundle that culminates in family meeting,
  1. identify health proxy or surrogate
  2. determine presence of AD
  3. clarify the code status
  4. assess pain regularly
  5. manage pain optimally
  6. offer SW support
  7. offer spiritual support
  8. conduct multidisciplinary family meeting

Day 1
Day 3
Day 5

Nurse-led Interventions

- Involve others: SW, Case Managers, Chaplains
- Come to the table!
Web-based Resources

• IPAL: The Improving Palliative Care in the ICU Project: https://www.capc.org/ipal/ipal-icu/

Web-based Resources
Education:
• ELNEC
• Central Plain Geriatric Center

Professional Practice Recommendations
American Association of Critical Care Nurses
Professional Practice Recommendations

Society of Critical Care Medicine

Professional Practice Recommendations

American Heart Association and American College of Cardiology Foundation

Where do we go from here?
Thank you for your attention!

Questions?