

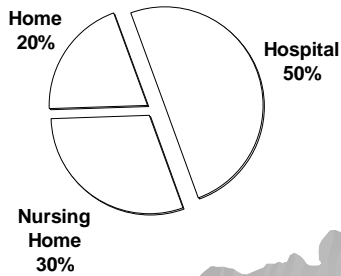
Palliative Care in the Critical Care Setting

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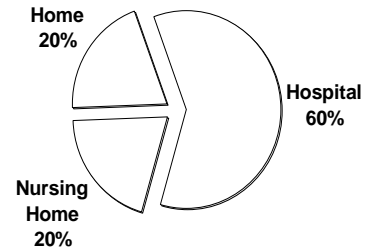
Background: Growth of PC Services

- ◆ An aging population
- ◆ Increased numbers of people with chronic illness
- ◆ Poor pain and symptom management, communication, and decision-making with hospitalized patients
- ◆ Policy mandates make hospice use awkward for patients with chronic life limiting illness

Background: Location of Death (National)



Background: Location of Death (NY)

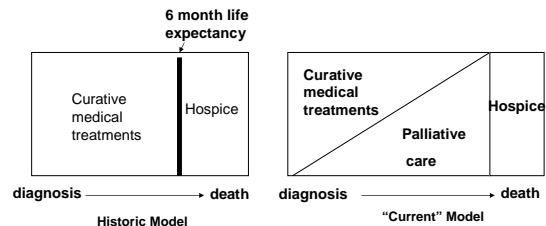


Definition

The Institute of Medicine:

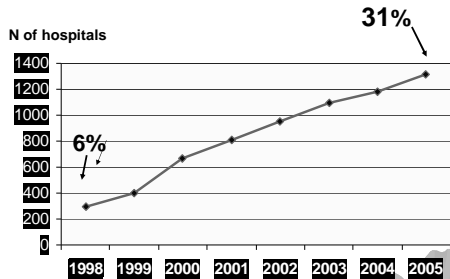
Palliative care seeks to prevent, relieve, reduce or soothe the symptoms of disease or disorder without affecting a cure...is not restricted to those who are dying or enrolled in hospice programs...it attends closely to the emotional, spiritual, and practical needs and goals of patients and those close to them.

Theoretical Boundaries: Old and New



Adapted from Lynn J. Adamson DM. *Living well at the end of life: adapting health care to serious chronic illness in old age*. Arlington, VA, Rand Health, 2003.

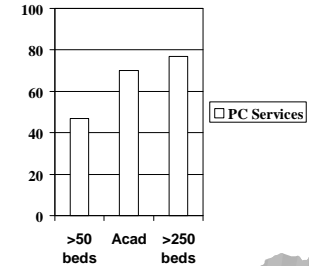
National Context: Evidence of Institutionalization (total hospitals w/PC services)



Source: AHA survey data, years 2000-2005: <http://www.capc.org/news-and-events/releases/> April 14, 2008 Press Release

% Hospital PC Services: 2008

- ◆ 47% of hospitals with > 50 beds
- ◆ 70% of academic health care centers
- ◆ 77% of hospitals with > 250 beds



<http://www.capc.org/reportcard/> accessed Nov. 19, 2008.

National Context: Evidence of Institutionalization

- ◆ 2004: National Consensus Project Clinical Guidelines
- ◆ 2004: Accreditation: National Board for Certification of Hospice and Palliative Nurses, American Board of Nursing Specialties
- ◆ 2006: Specialty Designation & Accreditation: American Board of Medical Specialties, American Council of Graduate Medical Education
- ◆ 2007: 70% of academic hospitals now with inpatient PC services
- ◆ 2008: JCAHO Standards for PC (draft form)

Review of the Literature:

“Changing the Culture around end of life care in the trauma Intensive Care Unit”

- ◆ Mosenthal, A.C. et al.
- ◆ Prospective, observational study on consecutive trauma ICU pts
- ◆ Pre / Post palliative care intervention

Mosenthal, A.C., Murphy, P.A., Barker, L.K., Lavery, R., Retano, A., & Livingston, D.H. (2008) *“Changing the Culture around end of life care in the trauma Intensive Care Unit”*. Journal of Trauma Injury, Infection and Critical Care, 64 (6), 1587 - 1593

Part I Intervention

- ◆ Structured early assessment
- ◆ family bereavement support
- ◆ prognosis assessment
- ◆ assessment of pt/family preferences in care

Mosenthal, A.C., Murphy, P.A., Barker, L.K., Lavery, R., Retano, A., & Livingston, D.H. (2008) *“Changing the Culture around end of life care in the trauma Intensive Care Unit”*. Journal of Trauma Injury, Infection and Critical Care, 64 (6), 1587 - 1593

Part II Intervention

- ◆ Within 72 hours of admission
- ◆ Interdisciplinary family meeting
- ◆ Data on goals of care:
 - code status
 - withdrawal of life support discussions

Mosenthal, A.C., Murphy, P.A., Barker, L.K., Lavery, R., Retano, A., & Livingston, D.H. (2008) *“Changing the Culture around end of life care in the trauma Intensive Care Unit”*. Journal of Trauma Injury, Infection and Critical Care, 64 (6), 1587 - 1593

Findings:
Structured palliative care intervention:

- ◆ Increased goals of care discussion by physicians
- ◆ Earlier psychosocial support to families
- ◆ Earlier institution of DNR orders
- ◆ Increased length of time from DNR order to death
- ◆ Earlier bereavement support

Mosenthal, A.C., Murphy, P.A., Barker, L.K., Lavery, R., Retano, A., & Livingston, D.H. (2008). "Changing the Culture around end of life care in the trauma Intensive Care Unit". *Journal of Trauma Injury, Infection and Critical Care*, 64 (6), 1587 - 1593

"Integrating Palliative and Critical Care: Evaluation of a Quality Improvement Intervention"

- ◆ Curtis, JR et al
- ◆ Pre / Post intervention design of 590 patients who died in the ICU or within 24 hours of transfer
- ◆ Intervention: clinician education, local champions, academic detailing, feedback to clinicians, and system support.

Curtis, J.R., Treece, P.D., Nielsen, E.L., Downey, L., Shannon, S.E., Braungardt, T., Owens, D., Steinberg, K.P., Engelberg, R.A. (2008). "Integrating Palliative and Critical Care Evaluation of a Quality-Improvement Intervention". *American Journal of Respiratory and Critical Care Medicine*, 178, 269 - 275.

- ◆ Findings: no significant improvement in family satisfaction with care, or the family assessment of quality of the dying process
- ◆ Significant improvement in nursing assessed quality of dying
- ◆ Reduced ICU length of stay

Curtis, J.R., Treece, P.D., Nielsen, E.L., Downey, L., Shannon, S.E., Braungardt, T., Owens, D., Steinberg, K.P., Engelberg, R.A. (2008). "Integrating Palliative and Critical Care Evaluation of a Quality-Improvement Intervention". *American Journal of Respiratory and Critical Care Medicine*, 178, 269 - 275.

Proactive palliative care in the medical intensive care unit: Effects on length of stay for selected high-risk patients

- ◆ Norton, S.A. et al
- ◆ Prospective pre/post non-equivalent control group design.
- ◆ 17 bed MICU in 750 bed academic hospital
- ◆ 191 patients, 65 in usual care phase, and 12 in the proactive palliative care phase

Norton, SA., Hogan, L.A., Holloway, R.G., Temkin-Greener, H., Buckley, M.J., & Quill, T.E. (2007). *Proactive palliative care in the medical intensive care unit: Effects on length of stay for selected high-risk patients. Critical Care Medicine*, 35 (6), 1530 - 1535.

Identification of High Risk patients

- ◆ ICU admission following hospital stay of ≥ 10 days
- ◆ Age > 80 years with two or more life-threatening co morbidities
- ◆ Diagnosis of active stage IV malignancy
- ◆ S/p cardiac arrest
- ◆ Intracerebral hemorrhage requiring mechanical ventilation

- ◆ Primary Measures: Patient length of stay:
entire hospitalization
time in MICU
time MICU admission to hospital discharge
- ◆ Secondary Measures:
mortality rates
discharge disposition

Norton, SA., Hogan, L.A., Holloway, R.G., Temkin-Greener, H., Buckley, M.J., & Quill, T.E. (2007). *Proactive palliative care in the medical intensive care unit: Effects on length of stay for selected high-risk patients. Critical Care Medicine*, 35 (6), 1530 - 1535.

Intervention

- ◆ Systematic chart review of all MICU admissions
- ◆ Discussion with attending/resident/nursing staff regarding clinical course, and identification of palliative care needs
- ◆ Basic vs Full consultation
- ◆ Ongoing follow-up of patient's hospitalization

Findings

- ◆ Patients in the proactive palliative care group had significantly shorter lengths of stay in the MICU
(8.96 VS 16.28 DAYS)
- ◆ No differences between the 2 groups on total length of hospital stay, or in MICU to d/c length of stay

Palliative Care: What do we do?

- ◆ Pain & Symptom Management
- ◆ Goals of Care
- ◆ Patient & Family Support
- ◆ Health Care Provider Support
- ◆ Negotiating Complex Systems
- ◆ End-of-Life transitions

Symptom Management

- ◆ Pain
- ◆ Dyspnea
- ◆ Nausea/vomiting
- ◆ Anxiety/depression/agitation
- ◆ Diarrhea/constipation
- ◆ Anorexia
- ◆ Fatigue

Goals of Care

- ◆ Assessment of patient/family understanding of medical issues
- ◆ Assessment of patient and family values, and wishes regarding treatment options
- ◆ Clarification of medical care
- ◆ Assistance with advance directives
- ◆ Facilitation with transitions in care

Patient and Family Support

- ◆ In ICU, many times the focus is on the family
- ◆ Especially in trauma ICUs, patients are often younger, and onset of illness is sudden and unexpected
- ◆ Guidance for families during period of high stress

Health Care Provider Support

- ◆ ICUs are busy and stressful environments for patients, families and staff
- ◆ Nurses deal with complex, critically ill patients, often delivering intense care in seemingly futile situations
- ◆ Interdisciplinary teams care share the complexity of difficult situations

Negotiating Complex Systems

- ◆ Conflict negotiation
- ◆ Patient vs team
- ◆ Patient vs family
- ◆ Team vs Team

End-of-Life transitions

- ◆ Transitioning from acute critical care to palliative/comfort oriented approach
- ◆ Treatment shift
- ◆ Transfer to appropriate place for delivery of ongoing care
- ◆ Hospice referral
- ◆ Bereavement follow-up

- ◆ "The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick."

Eric J. Cassell, MD

"Failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering, but becomes a source of suffering itself."

Cassell, E. J. *"The nature of suffering and the goals of medicine"* (1982). *NEJM*, 306, (11), 639-645.

Summary

- ◆ Palliative Care is a growing specialty within medicine
- ◆ Many patients can benefit from Palliative care involvement at any stage of advanced illness
- ◆ Research supports the value of interfacing ICU and Palliative care services

References

Cassell, E. J. "The nature of suffering and the goals of medicine" (1982). *NEJM*, 306, (11), 639-645.

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