Palliative Care in the Critical Care Environment

Lori Lupe DNP, CCRN
10/14/11
The Statistics

- There are greater than 2.4 million death annually
- 80% of patients who die are >65 years of age
- 11% of patients on Medicare spend more than 7 days in the ICU within 6 months of death
- 1/5 of ICU patients die while hospitalized

(Beckstand, R.L., et. al. 2005)
Standards?

- IPAL-ICU (2010)
- Improving Palliative Care in the ICU
- Mt. Sinai School of Medicine
- Support from NIH and Center to Advance Palliative Care
- Provides domains, frameworks, clinical recommendations, and measures for improving palliative care in the ICU
Domains

- Symptom management
- Communication within the team and with patients and families
- Patient- and family-centered decision making
- Emotional and practical support for patient and families
- Spiritual support for patients and families
- Continuity of care
- Emotional and organizational support for ICU clinicians
Quality Indicators

- Selected from a sample of 50
- Symptom assessment scales
- Documentation that pain and symptom assessment is part of all members of the critical care team orientation
- Written referenced ICU protocols for management
- Referenced analgesic/benzodiazepine equivalency charts at the bedside
VHA – Care and Compassion Bundle

- Identify the patient’s health care surrogate
- Determine whether the patient has an advanced directive
- Clarify the patient’s resuscitation status
- Assess pain regularly using an appropriate pain scale
- Manage pain optimally
- Offer social work support to patient/family
- Conduct a meeting of interdisciplinary team with the family
Lee Memorial Health System-Qlife
Palliative Care Service

- Adapted from VHA
- Expected transition from curative to comfort care
- Older than age 70 with co-morbidities
- Two or more hospital admissions in the last 6 months for same symptoms
- Address code status/advance directives
- Withdrawal/withhold treatment/discuss artificial nutrition or hydration
LMH- Qlife

- Terminal extubation
- Gold setting
- End stage lung, cardiac, renal, hepatic disease
- Advanced or stage 3 or 4 cancer
- Sudden acute event (CVA, ICH)
- Disease Triggers: aspiration, pneumonia, COPD, CHF, septicemia
- Pain and Symptom Management

(Provided by Karen Washburn – Director Qlife/Palliative Care LMHS)
Quality of Death

- 7 broad domains
  - Physical
  - Psychological
  - Social
  - Spiritual and existential
  - Nature of health care
  - Life closure and death preparation
  - Circumstance of the death

- (Hales, S., Zimmerman, C., Rodin, G., 2010)
Realities of Death Experience

- There is a high prevalence of pain and other symptoms in the last days of life
- There is frequent use of life-sustaining interventions
- A high portion of death occur in the hospital – that is where culturally many people turn to die

(Hales, S., Zimmerman, C., Rodin, G., 2010)
WHY????????

- We have standards
- We have literature
- Why is the death experience not managed better?
How Do We Identify Who Needs It?

- Palliative Care Assessment Components
- Are there distressing physical or psychological symptoms?
- Are there significant social or spiritual concerns affecting daily life?
- What are the goals for care identified by patient, family, surrogate?
  
  Does the patient have an advanced directive?  

(Weissman, D.E., Meier, D.E., 2011)
The Living Will

O From Florida Bar Association – Florida Statute 765.303

O Declaration made this _____day of ______I ____Willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and
The Choices

- I have a terminal condition
- I have an end-stage condition
- I am in a persistent vegetative state
- And if my attending or treating physician and another consulting physician determine there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve
Living Will cont

0 Only to prolong artificially the process of dying, that I be permitted to die naturally with on the administration of medication or performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.
How Do We know?

- What conditions would be terminal?
- What condition would be end stage?
- What is a persistent vegetative state?
- What is artificially prolong?
Real Cases

- Alzheimer's patient in Alzheimer's unit with pneumonia – should we intubate?
- Patient with sepsis in ICU for 4 weeks on vasopressors, ventilator, CVVHD
- End-stage CHF patient in pulmonary edema – do we intubate?
- Ima – surgical patient with rough post operative course
Hastening Death?

Euthanasia – the intentional ending of the life of a person suffering from an incurable or painful disease.

Balance with decisions by health care providers to withhold or withdraw life support.

Terminal weans? D/C inotropes?
Patient A

- Late 50s
- Lung cancer for 14 months with mets to the brain
- Presents with arterial embolism to leg resulting in a BKA
- Develops hemorrhagic stroke
- On mechanical ventilator 2 weeks – unresponsive with no sedating meds
- Physician orders 30 mg/hr morphine for wean
Patient B

- Mid 60’s
- Wide spread metastases treated with chemotherapy
- Develops renal failure, ARDS, Sepsis
- Physician orders discontinuation of vasopressors
Patient C

- Mid 60’s
- Advanced lung cancer
- Respiratory distress, pneumonia, and sepsis
- Family requested comfort care only
- Stop vasopressors, decreased oxygen but maintained vent, sedating with fentanyl and midazolam infusions.
- Patient dies within 2 hours
Patient D

- Mid 50’s
- Colon cancer metastasized to liver – chemo
- Presents with respiratory failure, neutropenia, sepsis, hypotension, and extreme obesity
- Treated with antibiotics, vasopressors, mechanical ventilation – paralyzed and sedated
- Family requests comfort care
- Withdrew vasopressors and paralysis and extubated
The Investigation

- US Department of Veterans Affairs
- OIG
- Office of Healthcare Inspections: Organization and Mission
- Purpose – determine validity of allegations of euthanasia.
- Was there pressure to hasten the deaths to open the ICU beds for other patients?
Findings

- None of the deaths were intentionally hastened
- The family members had requested comfort measures only
- The organization needed clearer policies and procedures for end-of-life care issues
- There was disagreement among the ICU care team on end-of-life issues

DNR does not mean No Care

- Provide meticulous hygiene care
- Offer family beverages, encourage breaks
- Visiting hours? Open? Liberal?
- Involve the multidisciplinary team
- Psychological support for the ICU team – flexible scheduling with release time after death
- Clear policies and procedure
- What to do when the bed is needed?
Opportunities for Improvement

- Identify Bundles
- Care maps to outline activities by day
- Early identification of the health surrogate
- Early meetings with the families and team to communicate
- Symptom management protocols for pain, anxiety, family fatigue, family disagreement
Considerations

- Explore ways to keep family informed that facilitates care and does not take the nurse from the bedside
- Educate physicians and nurses on how to communicate effectively with families
- Develop education for families to facilitate understanding of lifesaving measures and terms
How Do You Monitor

O “To improve palliative care, ICU caregivers need feedback on performance from the measures that are scientifically sound, practical and relevant for daily use”

O (Nelson, J.E., Mulkerin, C.M., Adams, L.L, Pronovost, P.J., 2006)
References


