Bringing Palliative Care to the Surgical Intensive Care Unit

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In August 2010, we began our Beacon journey. During the journey, staff in our 18-bed combined surgical intensive care unit (SICU) and cardiothoracic intensive care unit (CTICU) evaluated many aspects of the care we provided and our unit’s processes. One aspect of care that we identified as underemphasized was extended care and end-of-life care. In this article, we describe the process that we followed in developing and initiating a palliative care program in our SICU/CTICU.

Typically care provided in a SICU is focused on curative therapies. In our unit, when patient care priorities were more in line with palliative care concerns, we had no structured or interdisciplinary process in place to accommodate those needs. Palliative care neither hastens nor postpones death. It supports the patient and family during an illness or at the end of life and helps them to understand and cope with the changes in their condition.

Palliative care is defined by the World Health Organization1 as follows: Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Death is not uncommon in the critical care setting. Despite our best efforts, 10% to 20% of patients in all ICUs will die before discharge. Predicting which patients will or will not survive can be difficult. Of those patients who do survive and are discharged, there are still a significant number who will not survive another 6 months. The elderly and those who require mechanical ventilation are at particular risk. Additionally, long-term cognitive and functional incapacities are significant risk factors for increased morbidity after discharge.2

Surgical critical care typically focuses on curative measures and aggressive therapies. Traditionally, surgical culture is procedure oriented, and death is often seen as a failure.3 Death within 30 days of a surgical procedure is monitored nationally. This places additional external pressure on the surgical team and reinforces a perception of death as failure. It can also discourage openness to a more collaborative model of palliative care.

Critical care nurses often cite a need for improved end-of-life care. In a study by Poncet et al,4 a relationship between burnout syndrome and the stresses associated with providing end-of-life care was identified. Burnout syndrome can occur when excessive energy and resources are used during management of stressful situations. Repetition of these kinds of awkward circumstances can ultimately lead to feelings of frustration and failure when caring for a patient. Conflicts among patients, families, nurses, and physicians frequently occur when patients are near death. In a recent study by Azoulay et al,5 up to 70% of ICU nurses reported such conflicts associated with end of life, which had a negative effect on job stress and...
patient care. Disputes about provision of end-of-life care and disputes arising from problems around communication were recurrent themes. Conflicts in the ICU are noticed by patients and their family members and only add stress to already difficult circumstances. Conflict and distress in the workplace can lead to decreased staff satisfaction, increased turnover rates, and poor outcomes for patients. Interventions aimed at conflict resolution improve the well-being of ICU staff and their patients. Provision of palliative care services will benefit our patients at the end of life and help to address staff concerns as well.

Bradley et al describe an increasing awareness of palliative care as an essential component of high-quality surgical care. Palliative care services use a team approach, which is beneficial in many ways for patients and their family members, as well as for health care providers. Important aspects of care include aggressively managing symptoms, improving communication, and setting clear goals for patient care.

Introducing palliative care services into our SICU environment presented many unexpected challenges. Numerous key persons with a stake in the process are ideally involved in a project of this magnitude. Agreement on the plan of care and mode of communication among the key players has proven complicated.

Additionally, physicians and nurses often misunderstand what palliative care is. Palliative care tends to be thought of as cessation of care. With the historical surgical critical care focus on providing aggressive therapies, many health care professionals think that if we support palliative care, we are somehow “failing” the patient.

We determined that a palliative care program would greatly enhance the care received by our patients and their families. Our initial goals for the SICU/CTICU palliative care program in our unit included (1) educating key persons with a stake in the process and patients/families about palliative care services and their benefits; (2) creating an interdisciplinary team to address palliative care concerns for patients; (3) increasing the number of palliative care consultations provided for patients; (4) improving patient/family satisfaction with symptom management, pain control, communication, and self-determination; and (5) supporting nursing staff in advocating for end-of-life services for appropriate patients.

Before the start of our process improvement project, end-of-life care was provided by the primary surgical teams or the SICU/CTICU intensivists. It consisted mostly of managing cessation of care when all other options had been exhausted. When we began our efforts, staff members expressed concern that our palliative care program would increase the number of patients from whom we would withdraw care. There was a misunderstanding of what palliative care is, and the differences between palliative care and cessation of care. Palliative care services are valuable to patients in surgical intensive care settings. When palliative care is available, improved outcomes are seen in a wide variety of factors including communication, patient and family satisfaction, resource utilization, and staff cohesion.

We began our efforts by educating key persons, including the SICU/CTICU intensivists, pharmacists, and nursing staff, about palliative care. Our team included 4 staff nurses with an interest in palliative care, including 1 with palliative care certification. We started by reviewing the available literature and found a comprehensive website dedicated to improving palliative care within the ICU (IPAL-ICU) setting. The IPAL-ICU website has educational and training materials for staff and other key parties. It also provides a step-by-step approach to organizing, implementing, and evaluating a palliative care initiative. Support and participation within the unit for this project substantially improved with the education of the key parties and staff nurses.

A unit-specific and hospital-specific needs assessment was then completed. Interdisciplinary palliative care services were already being offered within our facility. We discovered that an inpatient palliative care consultation service was in existence. This consultation service also managed an outpatient palliative care process. In addition, the medical ICU (MICU) also had a palliative care program. A palliative care team, policies, and order sets were already in place in the MICU and served as a partial model for our SICU process improvement program.

Our SICU team met with the palliative and extended care services team for our facility. We invited them to have a greater presence on the SICU/CTICU by (1) increasing participation in our weekly long-term support meetings in order to optimize identification of patients’ needs and to facilitate the initiation
of supportive services and (2) encouraging and facilitating active interaction with ICU physicians, nurses, patients, and patients’ families. The interdisciplinary team worked together to develop criteria and thresholds for placement of palliative care consultations (see Table) and to establish the process by which the consultations would be placed. Additionally, intensivists and pharmacists familiarized themselves with the palliative care order sets that were already being used in the MICU and began to use these orders for SICU patients. Current practices guiding the flow of the existing weekly long-term support meetings were adjusted to optimize identification of the needs of patients and their families and facilitate the initiation of supportive services. Finally, we created a palliative care protocol for the SICU/CTICU.

It has been almost 2 years since we first began our efforts. Our palliative care protocol has now been adopted as unit policy. Despite the consultation criteria, our SICU still experiences missed opportunities for palliative care consultations. Overall, the staff has reported satisfaction with this process improvement program. Staff members report increased comfort levels in initiating early discussions about palliative care with the surgical and critical care teams, as well as a greater appreciation for the value of palliative care.

The palliative care program has given staff nurses a stronger voice in advocating for palliative care services for their patients. Staff nurses are now able to identify appropriate candidates using the protocol and can request palliative care consultations for these patients. A palliative care team of unit-based nurses has also been put in place to facilitate this process. With some persistence, the number of palliative care consultations placed for the SICU/CTICU has increased from almost zero in the year before the project started to 33 consultations since February 2012. Upon review, consultations were typically ordered within 2 or 3 days of admission to the SICU/CTICU.

Table

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<td>Withdrawal of care is being considered or seriously contemplated</td>
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<td>Patient remaining in intensive care unit 30 days or more after surgery</td>
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<td>Patient who has undergone any type of palliative surgery</td>
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<td>Patient has stage 4 cancer and palliative care services are not already involved, regardless of present acuity or time of diagnosis</td>
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<tr>
<td>Patient’s prognosis is poor and/or end-of-life planning is deemed appropriate</td>
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The palliative care service in our hospital provides (1) focused support for patients and their families in managing end-stage conditions, (2) assistance in the decision-making process by coordinating and facilitating family meetings, and (3) consultations with patients regarding their desires for their care. After the 33 consultations just mentioned, 1 patient was transferred to another inpatient facility with palliative care facilities, 8 patients were transferred to the hospital’s palliative care unit and later died, 11 patients remained in the SICU/CTICU and later died, and 12 patients were discharged from the hospital and continued to receive palliative care services on an outpatient basis. One patient was transferred to the MICU and later died. All of the 33 palliative care consultations that occurred after the performance improvement project started were appropriate for the service.

The palliative and geriatrics extended care service conducts regular satisfaction surveys of patients and their families regarding their care experiences. The Bereaved Family Survey provides data about family members’ perceptions of the care that the veteran and they themselves received from the hospital in the veteran’s last month of life. Questions ranged from whether the patients/families felt listened to, were treated kindly, and thought that their pain was adequately controlled to their perceived social and emotional support during the death of a loved one. Satisfaction scores are compiled quarterly. Results compiled after the start of our performance improvement project indicate an overall satisfaction with the palliative care program, with 70% of families rating their care as “very good.”

Moving forward, we would like to develop education handouts and posters for staff, patients, and patients’ families. Additionally, we would like to see increased involvement in the process from the various surgical services that use our unit. Our goal is to have palliative care consultations initiated on 100% of patients that meet the criteria (see Table). Our expectation is that most, if not all, of the patients who die in the SICU/CTICU will have had palliative care consultations before they die.

We are very pleased with our progress to this point and are optimistic that the improvement will
continue in the future. Through this program, many patients have benefited and the SICU/CTICU nursing staff has come to understand the value of palliative care services for their patients.

Financial Disclosures
None reported.

References

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