

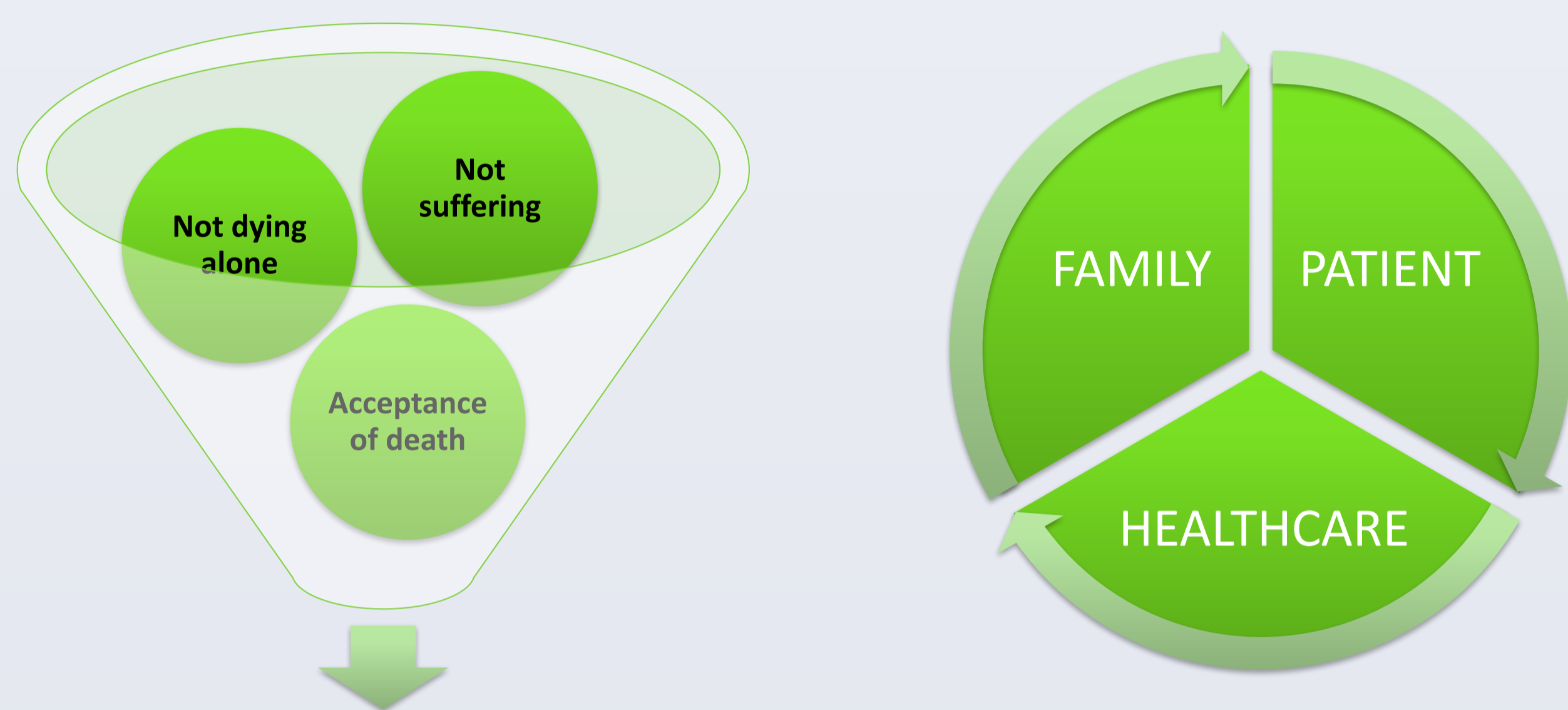
# A service provision and quality improvement project: Palliative Care in the ICU setting

C Burke, N Feely, P Sheahan

University Hospital Kerry Palliative Care Department in conjunction with the ICU

## Background

The problematic nature of providing expert palliation in critical and acute settings has been well recognised. What is a “good death”? SUPPORT study shows that over aggressive management, inadequate pain control and poor communication is present with a significant number of patients who went on to die. 38% of patients with advanced disease spent at least 10 days in ICU. The ETHICUS study demonstrated huge variation in withdrawal of treatment in ICUs across Europe. Dying with dignity is a topical issue in the ICU setting. In terms of health economics - earlier timing for Palliative Care Consultation in ICU is associated with lower length of stay, decreased cost and improved patient care. Palliative Care consultation is associated with appropriate and structured DNAR orders and decreased length of stay for terminal medical patients.



What is a “good death”?

## Aims and Objectives

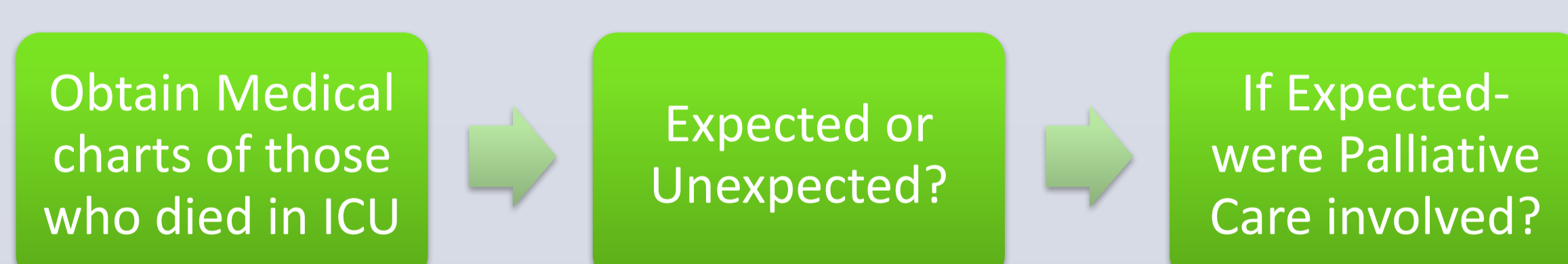
### Aims:

- Improve patient care and enhance dignity at end of life
- Develop links between Palliative Medicine and ICU
- Generate awareness of the need for communication, planning and discussions around ceilings of care in frail patients with multiple comorbidities
- Focus on quality improvement, education and structure to enhance continuity of care
- Increase awareness of healthcare costing and resources

### Objectives:

- Retrospectively gain insight into the prevalence of Palliative Care consultation in patients who have died in ICU.
- Analyse whether Palliative Care consultation may have improved patient care and if an opportunity was missed.

## Methodology



This was a retrospective chart review. It has both qualitative and quantitative elements. A review of the literature was performed. The number of deaths in the ICU in UHK in 2016 was quantified at 40. Charts were obtained and analysed for the following data:

Was the death was expected or unexpected?

If expected was the palliative care team involved?

If palliative care was not involved - could they have improved care?

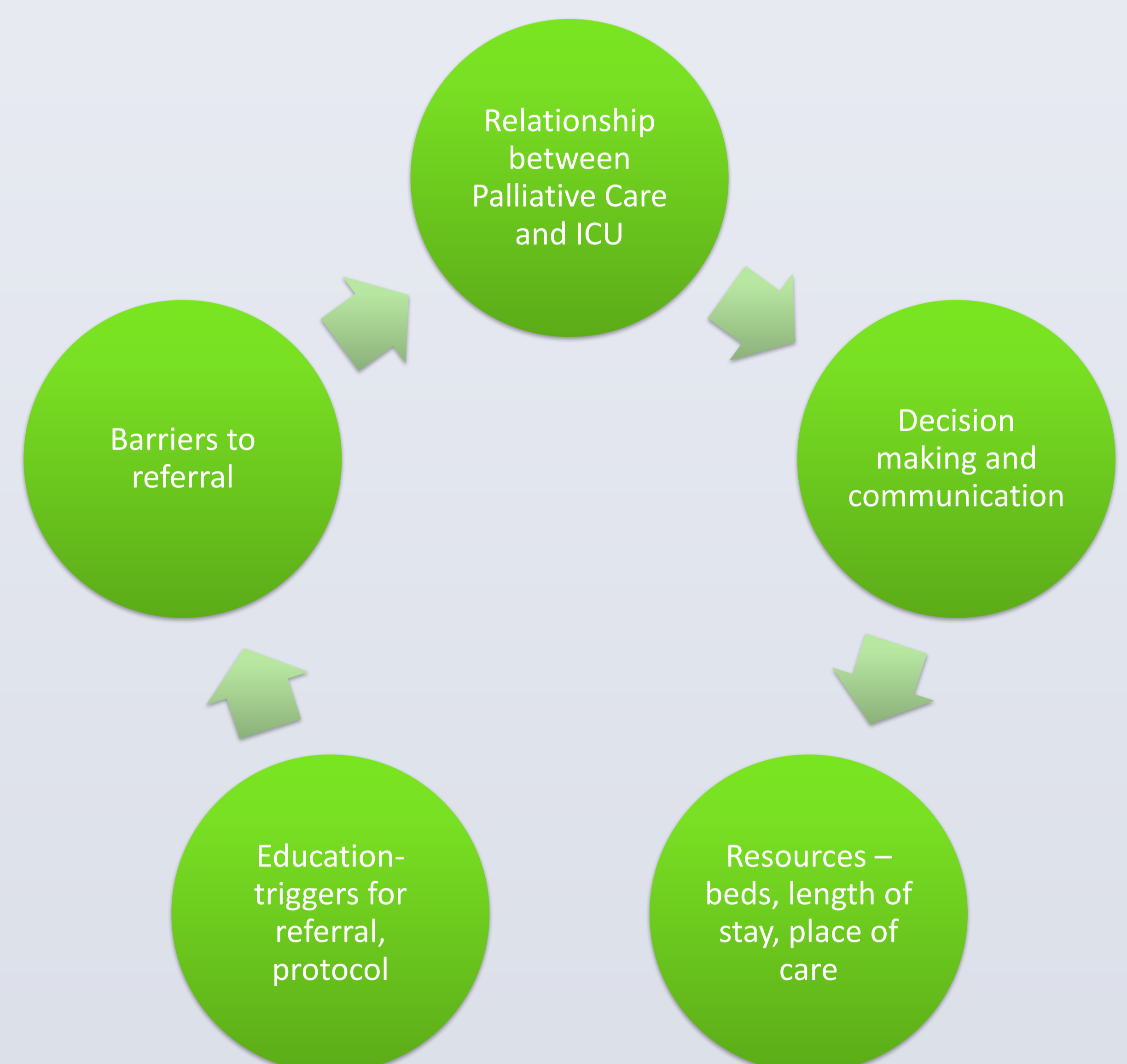
Was there any missed opportunities for Palliative consultation?

## Results and Conclusions

40 patients died in ICU in UHK in 2016. 35 were expected and 5 were unexpected. Of the 35 expected- there were 9 incidences of palliative care involvement. There were 8 missed opportunities where Palliative Care involvement could have improved patient care.

Examples of cases where a consult would have been appropriate included:

- Prolonged ICU stays >20 days in patients frail with multiple comorbidities not responding to aggressive treatment
- A discussion around intensive care and ventilation for a patient with end stage muscular dystrophy
- Where there was documented distress or suffering in the last days
- A patient intubated and kept in ICU >72 hours post DNAR order and deemed not fit for disease modifying treatment.



What's next?

1. Educate ICU staff on the possibilities of palliative care involvement
2. Explore how can ICU staff use the principles of palliative care to enhance care offered
3. When to refer to Palliative care? Access to the Palliative Care needs assessment guidance (National Clinical Programme for Palliative Care)
4. End of life care committee in the hospital to liaise with ICU: potential for an algorithm on symptom management

## References

- World Health Organisation: <http://www.int/cancer/palliative/definition> [accessed 30/07/17]
- Lanken PN, Terry PB, Delisser HM et al. An official American Thoracic Society clinical policy statement: Palliative Care for patients with respiratory diseases and critical illness. *Am J Respir Crit Care Med* 2008; 177 (8): 912-927
- Singer, P.A., Martin, D.K., Kelner M. Quality of end of life care: patients perspectives. *JAMA* 1999; 281:163-168
- Bratcher, J.R. How do critical care nurses define a “good death” in the Intensive Care Unit? *Critical Care Nursing Quarterly* 2010; 33(1), 87-99
- Hamel, M.B., Davis, R.B., Teno, J.M. et al. Older age, aggressiveness of care and survival for seriously ill, hospitalized adults. SUPPORT investigators. Study to understand prognosis & preferences for outcomes and risks of treatments. *Ann Intern Med*, 131 (1999), pp.721-728
- Sprung, C.L., Cohen, S.L., Sjobqvist P. et al. End of life Practices in European Intensive Care Units. The Ethicus study. *JAMA*. 2003; 290(6): 790-797
- Cook, D., Rocker, G. Dying with dignity in the Intensive Care Unit. *N Engl J Med* 2014; 370: 2506-2514
- Kelly, A.S., Meier, D.E., Palliative Care- A Shifting Paradigm. *N Engl J Med* 2010; 363: 781-782
- Pereira, S., Kozikowski, A., Pekmezaris, R. et al. The relationship between the timing of a palliative care consult and utilisation outcomes for ventilator-assisted intensive care unit patients. *Pall Support Care*. 2015 April; 13(2): 217-21
- Penrod, J.D., Deb, P., Dellenbaugh, C., et al. Hospital-based palliative care consultation: effects on hospital cost. *J Palliat Med*. 2010 Aug; 13 (8): 973-9
- Walker, K.A., Mayo, R.L., Camire, L.M. et al. Effectiveness of integration of palliative medicine specialist services into the ICU of a community teaching hospital. *J Palliat Med*. 2013 Oct; 16 (10) 237-41
- Lustbader, D., Pelmezaris, R., et al. Palliative Medicine Consultations impacts DNR designation and length of stay for terminal medical MICU patients. *Palliat Support Care*. 2011 Dec; 9(4): 401-6
- Wysham, N.G., Hua, M., Hough C. L., Gundel, S. et al Improving ICU based palliative care delivery: A multicenter, multidisciplinary survey of critical care, clinicians attitudes and beliefs. *Crit Care Med*. 2017 Apr; 45(4) e372-e378
- Kartekar, M., Collier, B., Parish, A., Olson, L. et al. Utilisation and determinants of palliative care in the trauma ICU. Results of a national survey. *Palliat Med*. 2014 Sept; 28 (8):1062-8