A Practical Approach to Palliative Care in the ICU

Wendy Anderson, MD MS
Critical Care Medicine and Trauma
May 31, 2013

Objectives

1. Discuss need for and challenges in integrating palliative care into the ICU
2. Define and identify key domains of ICU palliative care
3. Discuss keys to communicating about prognosis and goals of care in the ICU
4. Describe models for optimizing ICU palliative care

ICU Patient, Family, Clinician Needs

- High risk of poor outcomes
  - 20% of Americans die after ICU care
- High symptom burden
  - 40-80% of patients report uncontrolled symptoms
- Prevalent conflict, misunderstandings
  - 70% of providers, 40% of family members
- Psychosocial and spiritual distress
  - 1/3 families anxiety, PTSD, complicated grief
- High risk workplace
  - 1/3 of providers report PTSD

Disclosure Statement

Dr. Anderson has no relevant financial relationships to disclose.
Benefits of Palliative Care in the ICU

- Improved management of patients’ pain and other distressing symptoms
- Improved emotional support for families
- Ensure patients receive care they want
  - Reduced ICU LOS (no change in mortality)
- Improved job satisfaction and decreased distress for clinicians

Models of Palliative Care in the ICU

- Primary palliative care
- Consultative

Primary Palliative Care

- Palliative care provided by patients’ ICU clinicians
- Interventions
  - Palliative order set
  - Guidelines for ventilator withdrawal
  - Proactive family meetings
  - Palliative care and communication training

Consultative Model

- Interdisciplinary team of PC experts
- Triggers, case finding, or regular rounding
- Recommendations for symptom management
- Patient, family, and provider support
- Participate in, facilitate, or lead family meetings
  - Clarify prognosis, goals of care
Palliative Care: History & Challenges

- Recognized medical specialty: 2006
  - Most American hospitals have consult services
- Lack of clarity about what palliative care is
- Unclear which patients need consultative model, when primary palliative care is best
  - ICU clinicians constantly provide palliative care
  - Yet another team involved
  - Not enough specialists to see all patients

Case: Mr. P

58 year old man with refractory AML
Cardiomyopathy from chemotherapy
HD with chemotherapy to manage volume
Hypotension -> transferred to ICU for CRRT

- Mr. P: Uncontrolled pain, nausea, LE edema
  - Unable to walk, eat
- Mr. P’s wife: Distressed and confused
- ICU clinicians: Unsure of goals of care

Palliative Care: Goal

- Maximize quality of life for patients, families, and clinicians

Palliative care: Definition

- Specialized medical care for people with serious illnesses
- Focused on providing relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis
- Goal is to improve quality of life for both the patient and the family
- Appropriate at any age, stage of illness; provided with curative or life-prolonging treatments
Primary Palliative Care Assessment

- **Pain/Symptom Management**
  - Does the patient have uncontrolled symptoms?
- **Family Support**
  - Is the patient's family emotionally distressed?
- **Communication and Goals of Care**
  - Does the surrogate understand the prognosis?
  - Do clinicians understand the patient/family goals?
  - Are the patient’s treatments consistent with these?

---

Mr. P: Palliative Care Assessment

- **Pain/Symptom Management**
  - Uncontrolled pain, nausea, LE edema
- **Family Support**
  - Mrs. P: distressed and confused
- **Communication and Goals of Care**
  - Mr./Mrs. P’s understanding of prognosis not known
  - Team does not understand goals of care
  - Unclear if ICU, CVVH, chemo consistent with goals

---

Mr. P: Palliative Care Action Plan

#1: Control pain, nausea, LE edema
#2: Support Mr. and Mrs. P
#3: Discuss prognosis & goals of care – develop further treatment plan

---

Mr. P: Palliative Care Action Plan

#1: Control pain, nausea, LE edema
#2: Support Mr. and Mrs. P
#3: Discuss prognosis & goals of care – develop further treatment plan

*The ICU team is just meeting this patient - How can they honestly and sensitively discuss prognosis and goals of care?*
Prognostic Challenges

- Families have overly optimistic expectations for ICU patients’ recovery
- Families frequently do not recall prognostic discussions
- Even when discussions occur, families optimistically interpret clinicians’ estimates
- Use other sources to assess prognosis
- Clinicians’ estimates are frequently inaccurate, overly pessimistic

Communication Conundrum

Families doubt our ability to prognosticate (88%)
But they still want to hear the medical prognosis (97%)

Keys to Discussing a Poor Prognosis

- Qualitative study of surrogates and clinicians at 3 medical centers + national experts
- 3 key elements of effective and sensitive communication about prognosis:
  1. Honest and early communication
  2. Understanding prognosis is a process
  3. Relationship-based communication

Honest and Early Communication

- All surrogates felt clinicians should not avoid discussing a poor prognosis
- Timely and transparent communication of clinician estimates and concerns to family
  - Alert families to the possibility of death
  - Discuss certainty or uncertainty of estimates
Understanding Prognosis is a Process

- Prognostic communication not one event
  - Continuous process over the course of an ICU stay
- Repetition, reinforcement of information
- Time to see trajectory, make own assessment
- Support to come to an emotional acceptance

Facilitators of Key Elements

- A multidisciplinary team-based approach
  - One clinician not expected to meet all family needs for information, reinforcement, support
  - Each discipline involved in a way that maximizes training and abilities
- Adequate staffing
- Places to talk
- Clinician education

Relationship-Based Communication

- Trusting clinician-family relationship
- Valuing families and communication
  - Being available, approachable
  - A few words of compassion, empathy
- Tailor communication to each family
  - Getting to know the patient and family as people
  - Discussing prognosis in teams of goals and values

Mr. P: Goals and Treatment Plan

- Knew that he was in the last stage of his illness, wanted to return home
- ICU interventions:
  - CRRT: aggressive fluid removal
  - Intensive management of pain and nausea
  - Midodrine: BP up for HD on discharge
  - PT: up out of bed, walking
- Went home with hospice – eating & walking
**Optimizing ICU Palliative Care**

- Systematic screening of patients to identify and address palliative care needs:
  - Symptom management
  - Family support
  - Clear communication about prognosis & goals
- Match disciplines to patients’ needs
- Support for ICU clinicians
- Timely palliative care consultation if needed

**UC ICU-Palliative Care Collaborative**

- Communication workshop for ICU nurses
  - Defined role as coordinator of communication about prognosis & goals of care
  - Skills to communicate with families & MDs
- Systems to support palliative care and nurses
  - Multidisciplinary ICU Palliative Care committee
  - Enhanced palliative nursing support
  - Family meetings, documentation, info sheets

**Multidisciplinary ICU Palliative Care**

Primary Palliative Care Assessment & Treatment:
- Symptom management
- Family support
- Communication

**Enhanced Palliative Nursing Support**

- ICU & Medical Teams
- Palliative Care Consult Service
- Palliative Care Nurse
- Palliative Care Resource Nurse
- Social Work
- Spiritual Care Service
Take Home Points

- Key palliative care domains in the ICU are:
  - Managing pain & distressing symptoms
  - Family emotional support
  - Matching of treatments to patient/family goals
  - Supporting ICU clinicians
- Consultative model remains important for most complex patients
- Systems and nursing-led interventions promising for primary palliative care

Resource: IPAL-ICU
Improving Palliative Care in the ICU
http://www.capc.org/ipal/ipal-icu

Contact: Wendy Anderson, MD MS
Wendy.Anderson@ucsf.edu