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# Palliative Care in the ICU

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# Palliative Care Consultations in Intensive Care Unit

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**Contents**

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## Executive Summary

Death and dying is an evident part of being admitted to the intensive care unit. However, too many times, the end-of-life conversations and palliative care team introduction are done when it is too late. The PICOT question is "In ICU patients (P), how does early palliative care involvement in the death and dying process (I) compared to later palliative care involvement in the death and dying process (C) affect positive patient outcomes (O) within the ICU hospital stay (T)?" The objective of this change project is to instill a sense of urgency in providing palliative consults upon admission as this is vital to each patient's well-being.

Palliative consults in the intensive care unit are vital to each patient's well-being. While this team is normally always involved in their care, earlier involvement is more appropriate to ensure positive patient outcomes. For example, from personal experience, this group of clinicians tend to enter the plan of care for patient's when death is inevitable instead of establishing a baseline with the patient and their family. The research provided shows the evidence of the importance of palliative care participation. Of these studies that have been reviewed and pondered on, all conclude that palliative care is essential especially in the critical care environment. Some studies discuss communication between nurses and their patients, others simply state that earlier palliative care involvement reduces mortality, length of stay, and hospital costs (Kyeremanteng et al, 2018). Implications for future research and clinical practice urge palliative care providers to begin consults and discussions upon admission to the ICU due to positive outcomes. Palliative care is essential to guiding patients and their loved ones through difficult times and decisions. They are an especially important part of healthcare and by timely incorporating their expertise, negative experiences regarding critical care can be limited.

## 1. Rationale for the Project

For ICU nurses, life or death decisions are being made at the bedside of a code. It is difficult for family to comprehend the extent of their loved one's illness without having discussions at the time of arrival. Nurses want what is best for their patients with as little grief on the family as possible, and by having these tough decisions solved in advance, it can save a lot of heart break and stress. While palliative care is normally included in the rounding process, the team doesn't always begin talking with the family until death is imminent and choices are needing to be made. This is doing injustice to the patient and their family.

Health outcomes are significantly improved with the assistance provided by the palliative care team in the intensive care unit. Tough decisions are made at the bedside of loved ones every day. While these are discussed, communication is vital to the family and patient as they embark on possible grief and sadness (Coventry et al., 2017). Even if hospice or end-of-life is not the result of the discussion, education and support from the medical staff enable an easier transition with increased patient and family satisfaction. The involvement of palliative care has the ability to produce more than just end-of-life decisions. This team can assist patients and their families in building skills, individual support in regards to physical and emotional assessment, and self-management going forward (Portz et al., 2021). Sometimes the mention of palliative care can immediately turn one's thoughts to end-of-life, however, this is not always the case. The presence of palliative care in the intensive care unit has shown to decrease in-hospital mortality (Liu et al., 2017). While end-of-life decisions can be made earlier on to avoid some grief and stress, palliative care does much more than this. The team is able to educate and support patients and their families, build skills, and can decrease in-hospital death rates.

### 1.1 Project Goals

The goal of this change project is to bring awareness of the need for and importance of earlier palliative care consultations, especially in the critical care setting. At the end of the day, nurses want what is best for their patients and by providing information and support via palliative care, there is an increase of positive patient outcomes. When considering evidence-based practice, it is vital to make sure to contemplate patient preference for change. Critically ill patients and families want to ensure their values and treatment preferences are upheld in every situation. It is vital to ensure we are advocating for our patients when they can no longer advocate for themselves due to intubation, neurological status, etcetera. In bringing all the evidence together, the question at hand is proven. Earlier palliative care team involvement in the death and dying proves does successfully affect patients and their families within the intensive care hospital stay.

## 2. Literature Discussion to Support Project

When deciding which studies to incorporate in order to promote this change, there were many factors included. For example, all studies chosen were relevant to the current times, meaning published within the last five years. This is important when deciding which literature to use to back up the research done because it may be irrelevant as times are always changing, especially in healthcare. Next, only studies written in English were chosen due to the predicted readers, as well as the person doing the research only speaking this language. The study designs were of three types: randomized controlled trials, qualitative descriptive studies, or systematic reviews and metanalysis. No publication statuses were taken account for since all articles were chosen on databases such as COCHRANE and PubMed. This was done due to reliability

purposes. With all these factors together, these articles were chosen meticulously in order to prove the point that palliative care should be introduced earlier on in the ICU process.

Twelve articles have been chosen that contain strong evidence in proving the question at hand to be evident. In these studies, more favorable outcomes are achieved. For example, utilizing palliative care when compared to continuing the normal patient care process, led to an increase in hospice transfers and more DNR transitions (Ma et al., 2019). Mortality rates and lengths of stay were also decreased when palliative care became involved in the care plan earlier on (Martins et al., 2016). Not only were patient outcomes positively affected in this manner, but intensive care costs were also lowered by the earlier introduction of the palliative care team (Kyeremanteng et al., 2018).

In synthesis, of the twelve articles, all of them contain palliative care involvement with the palliative care team. Five of the studies demonstrate a decrease in length of stay in the intensive care unit. Six studies showed a decrease in mortality of intensive care unit patients as well. While palliative care intervention is important in proving this PICOT question, understanding the best ways to do this through communication is vital. Therefore, while half of the articles discuss palliative care interventions and results of the interventions, the other half show that an increase in communication through different aspects of the care team regarding palliative care was almost just as beneficial. In bringing all of this evidence together, the question at hand is proven that earlier palliative care involvement in the death and dying process does positively affect patient outcomes within the ICU hospital stay.

## 3. Project Stakeholders

Understanding those who will be affected will help with project development, planning, implementation, evaluation, and ultimately the success of the evidence-based change. The stakeholders affected by this proposed change are palliative care clinicians and their team, as well as the patient and family. There is opportunity for inter-professional involvement because while the palliative team needs to be involved, the intensivists are also included. With earlier conversations of end of life and goals for the patient, comes a possible change in the plan of care. This would affect everybody on the patient's care team, not just palliative care. Permission will need to be obtained from the palliative care group and possibly the board of doctors, if there is one. The gatekeepers include the manager and supervisors of the ICU unit. Allies would possibly be other nurses on the unit as well as hospice care. The main goal of a nurse is to do what is best for their patient and by implementing this plan, it is enabling the care team to listen and grant the wishes of patients and their families.

## 4. Proposed Outcomes

The palliative team is a crucial factor in the care given to intensive care unit patients. Without this team of providers, end-of-life care would be complicated. The major phases of this implementation plan are research, proposal, approval, collaboration, implementation, and evaluation. In the research phase, the main goal is to understand the current policies and procedures regarding palliative care in the intensive care unit. In the proposal, the research and evidence will be compiled regarding the implementation of palliative care involvement. During the approval phase, the documents will be sent to the managers and physicians in hopes of beginning the implementation. Once approval is given, the collaboration phase requires the entire

medical team of the ICU, including managers, palliative care team, intensivists, and some nurses on the unit in order to develop a feasible plan and work out any issues they might foresee. Implementation is putting into practice palliative care consults upon admission. Lastly, evaluation phase is a debrief session of how this is affecting patient outcomes. A timeline for these activities is listed in Table 1.

Challenges were encountered while attempting to implement earlier palliative care involvement in the ICU. First, I no longer work at the establishment where this vision of increasing palliative care involvement came about. One of the reasons I left this facility was due to a high rate of mortality among the ICU patients, with very few successful outcomes. As a new nurse, this weighed heavy on my heart and the combination of covid led me to burn out pretty quickly. A change of pace was needed to protect myself, so I left this role. However, thinking back to when I was still there, I believe another issue I would have run into was the lack of resources and staffing among the palliative care team. There were two doctors and one nurse practitioner on their team that would round and with the number of patients in the intensive care units, this is inappropriate.

Change management is an important tool to have. Some of the factors for promoting the management of change in practice is to remain persistent and patient and to know when to make the decision to make a change (Melnyk & Fineout-Overholt, 2019). It is essential to be prepared for change when implementing evidence into practice. Even though this change was unable to be implemented into practice, much thought went into it to ensure success. The ability to be creative and persistent are two key traits one must have when discussing this evidence-based change. It is important to advocate for our intensive care unit patients and by ensuring earlier palliative care involvement, this is completed. The evidence is present that this change will produce positive

patient outcomes. Specifically, it "has been proven to decrease mortality, length of stay, and days on the ventilator, while increasing DNR/DNI transitions" (Kyeremanteng et al., 2018). Ultimately, the outcomes to be measured are statistic comparing before and after the intervention for percentages of length of stay, patient morality, DNR/DNI transitions, and hospice transfers. There will be a control group that had the previous protocol for palliative care interventions performed. There are many resources and references that confirm earlier palliative care involvement will improve patient's results in the intensive care unit. Having these strategies and tools to help manage the change process is vital for preparation, implementation, and evaluation.

## 5. Evaluation Design

By evaluating the data of patient outcomes, such as, hospital mortality, length of stay, and patient and family satisfaction, it will be determined if the change was successful. The process of change will be evaluated by innovation and evidence at work through impact and change, specifically, standards affecting the patients in the intensive care unit (Melnyk, p. 371). The step-by-step evaluation is presented in Appendix B. If the project cannot be implemented, education on the importance of palliative care involvement based on the evidence provided can still be executed to the healthcare staff.

## 6. Timetable/Flowchart

The PICOT question was developed in the fall of 2022 based on previous experience and research available. Throughout the next three semesters, a total of twelve articles were found and analyzed to support the change project. Each semester dove a little deeper into the importance of palliative care involvement within the ICU. Each article had a rapid critical appraisal and a general appraisal completed to extract the relevant evidence. After presenting the project to the

hospital, Baylor Scott and White All Saints, it was rejected due to a lack of resources. Since this occurred, during the last semester, the project has continued and will hopefully one day in the future be put into fruition.

## 7. Data Collection Methods

Data collection for the study was performed throughout each semester and consisted of assistance from the librarian as well as from reputable databases. Each article was vetted by course faculty and approved for use based on relevance to the change project. Data collection and evaluation of earlier palliative care consultations in the ICU (when approved) will be completed via surveys given to healthcare staff and participating patients and families as well as statistics before and after implementation.

## 8. Discussion of Evaluation

Since this change project was not able to be implemented, this discussion is based off the research found based on earlier palliative care involvement within the ICU. Of the twelve articles found for support on earlier palliative care involvement, over half of them discussed the statistics on decreased length of stay and mortality. At Barnes Jewish Hospital, there was an increase of DNR transitions: 18.6% versus 4.9% in the control group and fewer ventilator days: 4 days versus 6 days in the control group (Ma, et al., 2019). A qualitative study using eight different articles found lower mortality in the intervention group 18% and length of stay decreased by 2.5 days (Martins, et al., 2017). In another qualitative study, palliative care consultations significantly reduced length of stay and costs among patients (Kyeremanteng, et al., 2018). From a sample size of 9.452 patients, there was a 34% reduction of hospital mortality in a systematic review that was done (Liu, et. al, 2017). Not only do numbers prove the importance of earlier

palliative care involvement in the ICU, but the other credible resources also that were found all discuss how imperative the team's presence is for the overall wellness and positive outcomes of patients.

## 9. Costs/Benefits

Palliative care involvement upon intensive care unit admission is feasible now and in the future. Finances are always a big issue when presenting a change to a business such as a hospital and figuring out a way around this was possible. Even though it would be beneficial to obtain more staff for the palliative team, it likely would be rejected due to finances. However, a solution to the monetary issue would be to hire nurse practitioners or even have registered nurses under the providers that are able to do rounds and report back so that money is able to be saved. For example, a palliative care doctor salary is on average $211,000. A nurse practitioner's salary is approximately $106,000 which is less than half of the cost of a doctor on staff. With the addition of these roles, the implementation would be sustainable.

The benefit outweighs the costs for the inclusion of more palliative care team members. Hospitals are a business, and it always comes down to financial means. By using nurse practitioners and registered nurses, costs could be cut, but quality palliative care can still be given. The implementation of more palliative care staff can potentially save lives of patients if utilized.

## Conclusion/Recommendations

In summation, the evidence and supporting articles show that it is best practice to have palliative care involvement early in the hospital admission process. Cost, length of stay, and

mortality rates decreased from palliative care discussions. Whether it is within the clinical environment, collaborating with other research, or forming a discussion group, the outcomes were all the same. All too often in the ICU, end-of-life decisions were made during codes, which is a highly emotional time. Communication is key in this process, and the nurses who deal with these circumstances have different experiences and knowledge on the death and dying process. The overview of the change project process shows that this subject matter can be put into fruition and will be successful in improving positive patient outcomes, when approved. To conclude, it is vital that palliative care consults are done upon arrival to the ICU to ensure positive patient outcomes in many aspects.

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# Appendix A

## Table 1

***Project Implementation Timeline***

| Phase | Timeline | Dates (2022) |
|---|---|---|
| Research | Weeks 1-2 | August 29-September 9 |
| Proposal | Weeks 3-4 | September 12-September 23 |
| Approval | Weeks 5 | September 26-September 30 |
| Collaboration | Weeks 6-8 | October 3-October 21 |
| Implementation | Week 9-10 | October 24-November 4 |
| Evaluation | Weeks 11-12 | November 7- November 18 |

## Appendix B

### Evaluation Step-by-Step

1. During the research phase, the current hospital statistics will be pulled based on length of stay, patient mortality, DNR/DNI transitions, and hospice transfers.
2. Complete weeks 1-10 of change implementation.
3. Throughout the implementation, statistics should be monitored for length of stay, patient mortality, DNR/DNI transitions, and hospice transfers.
4. At the end of implementation, statistics will be pulled for length of stay, patient mortality, DNR/DNI transitions, and hospice transfers for comparison on patients that did and did not receive earlier palliative care.
5. Surveys should also be sent out to the nurses, management on the ICU unit, and techs via email for feedback from the implementation.
6. Surveys should also be sent out to patients and/or family members who give consent to express their thoughts and feelings on the presence of the palliative care team on the unit.
7. Short, scripted interviews will be done with the palliative care team at the end of the process to evaluate from their perspectives.
8. After compiling surveys, interviews, and statistics based on length of stay, patient mortality, DNR/DNI transitions, and hospice transfers, a conclusion will be met on if the change was successful or not.