Integrating Palliative Care in the ICU

Brenda Downs RN, MSN, ACNS-BC
Sharon Lucas MSW, LCSW
W. Donnie Nelson RN, BSN, CHPN
Disclosure

• No one involved in the planning or presentation of this activity has any relevant financial relationships with a commercial interest to disclose.
Objectives

• Discuss the benefits for early integration of palliative care into the ICU for patients and families
• Demonstrate the elements for running a successful family meeting
• Describe how to successfully implement PIC project from a system standpoint across several facilities
• Explore the benefits of implementing the PIC Bundle at one facility; lessons learned and additional benefits noted
Palliative Integrated Care (PIC) in the ICU

Sharon Lucas, MSW, LCSW
Compassionate Care Consulting
What is Palliative Care?

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate an any age and at any stage in a serious illness, and can be provided together with curative treatment.
Once They Know About Palliative Care...

- Extremely positive about it and want access
- >92% say:
  - It is important
  - Patients with serious illness and their families should be educated
  - Likely to consider PC for a loved one
  - It is important that palliative care services be made available at all hospitals
Despite aggressive treatment many ICU patients die or remain critically ill

20% of Americans (500,000 people/year) die in or after ICU care: half of hospital deaths

100,000 ICU survivors continue with critical illness on a chronic basis

For some critically ill patients, ICU treatment is more burdensome than beneficial and/or inconsistent with their values, goals and preferences.
The problem is growing......


- fewer days in hospital
- less likely to die in hospital
- more likely to receive hospice care

**BUT**

- more ICU days
- higher costs
How do ICU Patients and Families Describe the Kind of Palliative Care They Want:

• **Communication by Clinicians:**
  - Timely, ongoing, clear, complete, sensitive addressing condition, prognosis, treatment

• **Patient –Focused Decision –Making:**
  - Aligned with values, goals, preferences

• **Clinical Care of the Patient**
  - Comfort, personhood, dignity, privacy

• **Care of the Family**
  - Proximity/access, support including bereavement care

“In Their Own Words: Patients and Families Define High Quality ICU Palliative Care.” *Crit Care Med* 2010;38:808.
Why should Palliative Care be integrated with critical care from admission to the ICU?

• It’s a clinical practice guideline

• Patients and families want both disease modifying treatment and palliative care

• Clinicians cannot reliably predict who will survive the ICU and who will die or stay chronically critically ill

• Neither clinicians not patients/families can make an abrupt shift from one set of care goals to another

• Palliative care and critical care are mutually enhancing, not mutually exclusive


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Median heart failure patient had a 50-50 chance to live six months, on the day they died, based on both their physician’s prognosis and a statistical model.

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“Do everything” until “there is nothing more to be done” and then give “comfort care”

vs.

“Integrative Palliative Care”

Initiated at the time of diagnosis, independent of prognosis, and delivered in concert with curative/life-extending efforts
Models for Integrating Palliative and Critical Care

- Increase palliative care skills of ICU clinicians (integrative)
- Incorporate palliative care specialists in the ICU (consultative)
- Mixed model incorporating both
  - Training in palliative care for ICU clinicians
  - Palliative care consultation

Nelson, Crit Care Med 2010; 38:1765
Palliative Integrative Care (PIC) Bundle in the ICU Mixed Model

• ICU driven initiative in conjunction with palliative care
• ICU nurses and physicians will take point, utilizing social work, spiritual care and palliative care as needed.
• Applied to all ICU patients upon admission and throughout ICU stay.
• ICU staff trained prior to onset
**PIC Bundle**

**Day 1**
- Identify decision-maker
- Address AD status
- Address CPR status
- Distribute ICU brochure
- Assess Pain as fifth vital sign
- Manage Pain Optimally
  - Begin arrangements for family meeting
  - Palliative Care Screen

**Day 3 or before**
- Social Work Assessment - document psychosocial issues and care plan
- Spiritual Care Assessment - document spiritual issues, resources, interventions and care plan

**Day 5 or before**
- **Interdisciplinary** family meeting takes place
- MD/bedside RN to be present
- Elements: diagnosis, prognosis, goals of treatment, patient/family questions.
- Offer follow-up meeting as appropriate.
Call Referral to: VOICE MESSAGE 616-4844  □ Called in Date _______  Place form under Multidisciplinary Notes

<table>
<thead>
<tr>
<th>Status On Admit - Complete Section One Through Four Upon Admission</th>
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</thead>
</table>

**SECTION ONE**

<table>
<thead>
<tr>
<th>Disease Process/Admission Diagnoses</th>
<th>SCORING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Disease Process/Admission Diagnoses:</td>
<td>Score 2 points</td>
</tr>
<tr>
<td>Cancer (Metastases/Recurrent)</td>
<td>□ End stage renal disease</td>
</tr>
<tr>
<td>Advanced COPD</td>
<td>□ Advanced cardiac disease</td>
</tr>
<tr>
<td>New Stroke (with decreased function by at least 50%)</td>
<td>i.e., CHF, severe CAD, severe CM (LVEF &lt; 25%)</td>
</tr>
</tbody>
</table>

**SECTION TWO MAY**

<table>
<thead>
<tr>
<th>Disease Process/Admission Diagnoses</th>
<th>SCORING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concomitant Disease Processes</td>
<td>Score 1 point</td>
</tr>
<tr>
<td>Liver disease</td>
<td>□ Newly Diagnosed Cancer</td>
</tr>
<tr>
<td>Moderate renal disease</td>
<td>□ CHF/CAD</td>
</tr>
<tr>
<td>Moderate COPD</td>
<td>□ Other condition complicating care</td>
</tr>
</tbody>
</table>

**SECTION THREE ECOG Performance Status (Eastern Cooperative Oncology Group)**

**Prior Functional Status of Patient**

**Activity Level Scale Prior to Hospital Admit**

- **Choose One**
  - Fully Active, able to carry on all pre-disease activities without restriction.
  - Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work.
  - Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
  - Capable of only limited self-care; confined to bed or chair > 50% of waking hours.
  - Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair or actively dying in the hospital setting.

**Score 0**

**Score 1**

**Score 2**

**Score 3**

**SECTION FOUR - COMPLEX NEEDS**

- □ Each 1 point

**SECTION FIVE - REASSESSMENT FOR STATUS CHANGE**

Complete New Scoring Tool/Call Referral

- □ 1 Point Each on reassessment

**TOTAL SCORE = < 4**

No intervention needed unless status changes. Continue to screen. May benefit from Pathway/Order Sets.

**TOTAL SCORE = > 4**

Notify Palliative Care Team. Call voice message for referral. May benefit from Pathway/Order Sets.

Signature ___________

Date ___________

**PALLIATIVE CARE SCREENING TOOL**

Catholic Healthcare West 2007 ©

Version 9

Has been raised to 6
VHA Study ICU Palliative Care Bundle Nelson, J 2005

- 10 hospitals, 16 ICU’s participated in 4 week pilot
- Bundle created by larger VHA hospital ICU consortium
- Day 1, Day 3, Day 5 measures
- Results:

<table>
<thead>
<tr>
<th>Decision Maker</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Advance Directive</td>
<td>72%</td>
</tr>
<tr>
<td>Resuscitation Status</td>
<td>58%</td>
</tr>
<tr>
<td>Family Brochure</td>
<td>43%</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>87%</td>
</tr>
<tr>
<td>Optimal Pain Management</td>
<td>85%</td>
</tr>
<tr>
<td>Social Work Support</td>
<td>61%</td>
</tr>
<tr>
<td>Spiritual Care Support</td>
<td>38%</td>
</tr>
<tr>
<td>Family Meeting</td>
<td>40%</td>
</tr>
</tbody>
</table>
Nelson Critical Care 2012 Communication Care Bundle

- 3 ICU’s 11/2007-12/2009 519 patients
- Results based on medical record review of patients with LOS >5 days
- Results:

<table>
<thead>
<tr>
<th>Decision Maker</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directive</td>
<td>30.9 %</td>
</tr>
<tr>
<td>Resuscitation Status</td>
<td>40 %</td>
</tr>
<tr>
<td>Family Brochure</td>
<td>7.5%</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>76. %</td>
</tr>
<tr>
<td>Optimal Pain Management</td>
<td>80.1 %</td>
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<tr>
<td>Social Work Support</td>
<td>33 %</td>
</tr>
<tr>
<td>Spiritual Care Support</td>
<td>30 %</td>
</tr>
<tr>
<td>Family Meeting</td>
<td>19 %</td>
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</tbody>
</table>
IPACC RCT Curtis, R. 2011

- 15 hospitals: 3 pilot, 12 randomized ICU patients who died
- QI Intervention: (1) Clinician education about PC in the ICU (2) ID and train ICU local champions (3) RN and MD ICU directors to address barriers to good EOL care (4) Feedback of quality data (5) System supports i.e. PC order forms.
- Outcome Measures: Family and RN assessment of QODD, FS-ICU, LOS, 9 elements of palliative care from chart abstraction
Results

- Intervention not associated with any significant changes in nurse or family assessed outcomes. No change in LOS.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Intervention</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>Baseline</td>
<td>Follow up</td>
</tr>
<tr>
<td>Family Conference</td>
<td>78.3</td>
<td>59.8</td>
</tr>
<tr>
<td>Prognosis</td>
<td>43.6</td>
<td>29.8</td>
</tr>
<tr>
<td>PC Consult</td>
<td>9.5</td>
<td>10.2</td>
</tr>
<tr>
<td>Spiritual Care</td>
<td>50.7</td>
<td>57.4</td>
</tr>
<tr>
<td>Social Work</td>
<td>37.7</td>
<td>37.8</td>
</tr>
<tr>
<td>Avoid CPR</td>
<td>87.1</td>
<td>89.1</td>
</tr>
<tr>
<td>DNR orders</td>
<td>82.7</td>
<td>76</td>
</tr>
<tr>
<td>Pain Assess</td>
<td>79.2</td>
<td>82.2</td>
</tr>
<tr>
<td>Life Support</td>
<td>72.3</td>
<td>69.8</td>
</tr>
<tr>
<td>w/drawn</td>
<td></td>
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</tr>
</tbody>
</table>
Results

• Same study in single hospital showed significant reduction in LOS before death and improvement in RN ratings of QODD.

• Study suggests intervention may need more institutional support and more of a mixed model approach.
Proactive Communication in the ICU: What the Data Shows

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Relevant Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>↓Anxiety, Depression, PTSD</td>
<td>Lautrette, NEJM, 2007;356:469</td>
</tr>
<tr>
<td>↑Family Speech=↑Family Satisfaction</td>
<td>McDonagh, Crit Care Med, 2004,</td>
</tr>
<tr>
<td>↓ICU /Hospital LOS</td>
<td>Campbell 2003; Campbell 2004; Norton 2007; Curtis 2009</td>
</tr>
<tr>
<td>↓Use of Non- Beneficial Treatments</td>
<td>Campbell 2003; O’Mahony 2009</td>
</tr>
<tr>
<td>↓Conflict Over Goals of Care</td>
<td>Lilly 2000 Am J Med</td>
</tr>
</tbody>
</table>
Summary

• ICU-palliative care integration is an important priority for improving patient care in the ICU

• Both ICU and palliative care clinicians must contribute to this improvement for the highest level of integration

• There is strong evidence of multiple benefits from proactive communication addressing goals of care and family emotions in family meetings

• Principles/methods of implementing other evidence-based ICU processes are applicable to palliative care improvement.
# Four Study Comparison

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Advance Directive</td>
<td>72</td>
<td>30.9</td>
<td></td>
<td>95</td>
</tr>
<tr>
<td>Resuscitation Status</td>
<td>58</td>
<td>40</td>
<td>82.1</td>
<td>97</td>
</tr>
<tr>
<td>Family Brochure</td>
<td>43</td>
<td>7.5</td>
<td></td>
<td>88</td>
</tr>
<tr>
<td>Pain assessed/managed</td>
<td>86</td>
<td>78</td>
<td>82.2</td>
<td>99</td>
</tr>
<tr>
<td>Social Work support</td>
<td>61</td>
<td>33</td>
<td>37.8</td>
<td>82</td>
</tr>
<tr>
<td>Spiritual Care Support</td>
<td>38</td>
<td>30</td>
<td>57.4</td>
<td>92</td>
</tr>
<tr>
<td>Family Meeting</td>
<td>40</td>
<td>19</td>
<td>59.8</td>
<td>74</td>
</tr>
<tr>
<td>Decision Maker</td>
<td>71</td>
<td>42.9</td>
<td></td>
<td>96</td>
</tr>
</tbody>
</table>
Clinical Operations Improvement (COI) in the ICU: Ventilator Liberation & Palliative Integrative Care Bundles

Brenda Downs, MSN, RN, ACNS-BC
Program Director Clinical Performance Improvement
Top Down Approach
Clinical Operations Improvement?

- **Clinical Operations Improvement (COI) involves...**
  - Applying process improvement principles to problems that involve clinical decisions, primarily those made by physicians
  - Projects selected centrally based on facts gathered from around the system
  - Strategies that are standardized across the system then adapted to the workflows of each hospital
  - Central advisory committees that have been convened around ICU processes to create system-wide guidelines based on best practice and Dignity Health’s internal clinical expertise
COI in the ICU at Dignity Health- FY12 Data

- Dignity Health had 14,000 patients/year who are mechanically ventilated
- 40% of those patients (5,216) were on mechanical ventilation > 96 hours
- 1,500 patients who were mechanically ventilated > 96 hours died (29%)
COI in the Intensive Care Unit at Dignity Health

• Patients who have extended times on the vent lends to longer ICU LOS

• For these patients (and families), how many actually have *timely* assessments for palliative care or discussions on the goals of care and prognosis to help them make informed decisions

• We have many opportunities for improving our ICU LOS and give our patients the best care possible
Roll Out Plan for the System

- We have 35 facilities
- Train the trainer approach
- Regional education classes
- Weekly support calls during the roll out
- Education webinars for nurses and physicians
- SharePoint site to house and share information
Facility Expectations for Implementation

• Have **weekly** team meetings during implementation/roll out to:
  • Prepare required documents – PIC bundle forms, rounding tools etc.
  • Monitor progress of education of all staff
  • Monitor concurrent compliance with measures

• Education of Staff

• Policies/Protocols and Processes should be approved and in place for implementation
COI ICU Roll Out

• Barriers/Obstacles
  - Unjustified clinical variation
  - Inconsistent adherence to evidence based practice
  - Hesitancy to address sensitive physician issues and poor performance

• Use your chain of command – charge nurse, physician lead, ICU Director, VPMA
Standardized Tools for Facilities

• We provided tools for the facilities to help them implement the initiative
  - Family Brochure
  - Standardized Palliative Care Screening Tool in Cerner as well as paper version for non-Cerner sites.
  - ICU Rounding Tools
  - Standardized Family Meeting Documentation Form
Family Meeting Brochure

Did this meeting help you?

Did the health care team members:

☐ Answer your questions?
☐ Listen to you when you expressed your thoughts, feelings or concerns?
☐ Explain the situation?
☐ Explain the next steps?

Do you have more questions or concerns?

Please write your questions down, so you can ask the doctor or nurse.

Notes:

………

………

………

………

………

Meeting with the ICU Team:

A Guide for Families

Prepared by the VA VISN 3 ICU-Palliative Care Taskgroup in collaboration with Judith E. Nelson, MD

St. Rose Dominican Hospitals. A Dignity Health Member

St. Rose Dominican Hospitals. A Dignity Health Member
Helping families prepare for the family meeting

In our intensive care unit (ICU), we meet with you, our patient’s family, to talk about your loved one’s condition and care.

To make the most of our time together at the meeting, you may find it helpful to think about your questions and what you may wish to discuss before we meet. This guide may help you to prepare some questions to ask the ICU team.

You may wish to write notes and bring them with you to the meeting. (There is more space to write your questions and notes on the back of this brochure).

Some questions to think about:

1. What do you know about your loved one’s illness and treatments? (You can check if this information is correct, complete and current when we meet).

2. Do you have any questions and concerns about the treatments or illness?

We will try to answer all your questions and address your concerns.

Other questions some other families have asked us at ICU family meetings

Check the questions that you want to discuss:

- Why was your loved one brought to the ICU?
- What has happened since then?
- What are his or her main medical problems now?
- What treatments are being given or planned?
- What do the doctors expect to happen?
- What are the other treatment choices?
- What medical decisions does the family need to make?

Share your concerns

If you have concerns, worries, fears, or other feelings about your loved one’s condition or anything else related to the ICU care, write them down so you can share them with us at the meeting.

Documents to bring to the meeting (if you haven’t done so already)

Bring any documents or papers like a health care proxy or living will that relate to medical decisions for your loved one to the ICU.

Who will come to your family meeting?

Please give the ICU a list of health care team members and family members that you would like to attend the meeting.

Health care team members include:

- ICU doctor in charge
- Any other doctors who are important in your loved one’s care
- Nurse
- Social worker
- Chaplain

When you need to decide on care that is “right” for your loved one

If your loved one can’t talk to you or the ICU team now, please think about:

- What things he or she may have said in the past about ICU treatments.
- What has he or she said to you in the past, when someone else was seriously ill.
- What your loved one would say today, if he or she could talk and make decisions.

When you share this with us, it can help you and the ICU team decide together about care that is “right” for your loved one.

What are your goals for this meeting?
# Family Meeting Conference Log

<table>
<thead>
<tr>
<th>Patient’s Last Name/MRN</th>
<th>Date ICU Admit</th>
<th>Family meeting Due (ICU Day 5)</th>
<th>Family Meeting Scheduled</th>
<th>Date Family Meeting Held</th>
<th>Disciplines present</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
Family meeting documentation form

Family Meeting Documentation

Date of Meeting __________________
Recorder Name and signature ____________________________
Purpose of Meeting (check):

- Education on status of illness
- End of Life Care and Decision Making
- Discharge Planning
- Other _______

Family/loved ones present:
Surrogate decision maker (verbally appointed by patient to MD) ____________________________
Formal Agent (DPOHC appointed in Advance Directive) ____________________________
Others present: __________________________________________________________________

Staff members present: __________________________________________________________________
## Family Meeting Documentation form

### Content presented:

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past history of medical illness</td>
<td>Impact of illness of family evaluated</td>
</tr>
<tr>
<td>Present treatment for medical illness</td>
<td>Spiritual care follow-up indicated</td>
</tr>
<tr>
<td>Proposed treatment options</td>
<td>Palliative Care Consult offered</td>
</tr>
<tr>
<td>Prognosis presented</td>
<td>Follow up with social worker required</td>
</tr>
<tr>
<td>Options for pain &amp; symptom mgt. given</td>
<td>Follow up with case manager required</td>
</tr>
<tr>
<td>Code Status discussed</td>
<td>Bereavement group offered</td>
</tr>
<tr>
<td>Family understanding elicited</td>
<td>Other:</td>
</tr>
<tr>
<td>Goals of Care established</td>
<td>Other:</td>
</tr>
</tbody>
</table>

### Transfer or Discharge Planning

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Facility (SNF, assisted living, hospice residence)</td>
<td>Transfer to medical floor within SMMC</td>
</tr>
<tr>
<td>Specialty SNF for vent or wound mgt.</td>
<td>Home Health Services</td>
</tr>
<tr>
<td>Location of Facility</td>
<td>Hospice Services</td>
</tr>
<tr>
<td>Insurance issues with Facilities</td>
<td>Equipment needed</td>
</tr>
<tr>
<td>Medications &amp; use</td>
<td>Transportation needs</td>
</tr>
</tbody>
</table>

### Summary of Conference:
Metrics to be Measured

- Day 1 activity – identifying decision maker, code status, advance directives, palliative care screening tool completed, Pain assessed, developing plan to optimize pain control, family meeting brochure given to family, discussions of family meeting to be started
- Social Work Assessment on or before Day 3
- Spiritual Care Assessment on or before Day 3
- Physician led Family meeting on or before Day 5
- All or none compliance
Data Collection Methods

- Data placed into a Midas database
- Collection methods varied among facilities
- Best practice approach – during ICU interdisciplinary rounds
- Creating audits within EHR for ease of auditing – real time or retrospectively
- For the PIC metrics – collect all patients with LOS >48 hours
Final Results Overview

• Problems with implementing all of Day 1 activities
• Measured last quarter data for targets due to initial implementation issues
• Last quarter results really reflected positively on facilities work
• Overall, the last 6 months of FY data was positive
All of None PIC Day 1

Percent Compliance with All or None PIC Day 1
Jan 2013 - Jun 2013

Dignity Health System - 75%
Social Worker Assessment by Day 3 Compliance

Percent Compliance with Social Worker Assessment
Jan 2013 - Jun 2013

Dignity Health System - 82%
Spiritual Care Assessment by Day 3 Compliance

Percent Compliance with Spiritual Care Assessment
Jan 2013 - Jun 2013

Dignity Health System - 92%
Family Meeting with Physician and Nurse by Day 5

Percent Compliance with Family Meeting
Jan 2013 - Jun 2013

Dignity Health System - 74%
All or None PIC Bundle Compliance

Percent Compliance with All or None PIC Day 1
Jan 2013 - Jun 2013

Dignity Health System - 75%
ICU LOS Comparative Results – Improvement of 0.3 days

Dignity Health ICU Length of Stay

Baseline Year ICU ALOS (FY11) vs. Current Year ICU ALOS Thru June 2013

Baseline Mean 3.54 vs. Current Year Mean 3.24
Palliative Care Consults in the ICU

Baseline Year (FY11) ICU Pall Care Cases

FY13 ICU Pall Care Cases
Patients with Palliative Care Consult Length of Stay

- FY11 Pall Care ICU LOS
- FY13 Pall Care ICU LOS
- FY11 Pall Care ALOS
- FY13 Pall Care ALOS
System Cost Savings

ICU Savings - Final FY13 Total

Estimated YTD Savings 10.2 million
5 day Interdisciplinary Meetings: Bringing Palliative Care to the ICU

W. Donnie Nelson RN, BSN, CHPN
Palliative Care Coordinator
Saint Francis Memorial: Who We Are

Mission Statement: The mission of Saint Francis Memorial Hospital, as a member of Dignity Health, is to dedicate our resources to: delivering compassionate, high-quality, affordable health services for our sisters and brothers who are poor and disenfranchised; and partnering with others in the community to improve the quality of life.

- Community hospital that serves the Tenderloin, Chinatown, Downtown, Nob Hill, and Russian Hill neighborhoods.
- 160 bed hospital with average daily census of 105
- 18 Critical Care beds and 10 Burn Unit beds
Palliative Care Team

Palliative care team to draw upon when needed:

- Spiritual care
- Pharmacy
- Case management
- Social Work
- ST/OT/PT
- Cultural Ambassadors/ Interpreters
Changing the Culture

- Palliative Care Champion
- Tools
- Daily Monitoring/ Audit
- Grand Rounds
- Hospitalist Incentive
Tool 1: PIC Bundle in Paper Chart

5 Day COI ICU PIC Bundle Measure List

Day 1: Date

1. Identify Primary Decision Maker / Next of Kin
2. Advance Directive / POLST?
3. Code Status Addressed?
4. Assess Pain as 1st vital sign?
5. Pain Managed?
6. Family Meeting Arranged?
7. Palliative Care Screen

Day 2: Date

1. Spiritual Care Consult?
2. Social Worker Consult?
3. Palliative Care Consult?

Day 3-5: Date

1. Interdisciplinary Meeting - at the very least, this meeting MUST HAVE the MD and RN. Meetings must address Diagnosis, Prognosis, GOC, Code Status, Primary Decision Maker declared.
2. Documented in physician note OR the interdisciplinary note.
3. Follow up meeting offered.

IMPORTANT: PLEASE OBTAIN CONTACT INFO FROM VISITORS AND FRIENDS OR ANYBODY WHO VISITS PATIENT.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Completed / Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Order for Consult to Case Management for Family Search</td>
<td></td>
</tr>
<tr>
<td>2. Order for Consult to Spiritual Care for Family Search</td>
<td></td>
</tr>
<tr>
<td>3. Current Search for any previous medical record/past admissions</td>
<td></td>
</tr>
<tr>
<td>4. Valuables/Personal items searched for identification</td>
<td></td>
</tr>
</tbody>
</table>

PRIMARY DECISION MAKER: NAME______________________________
Relationship________________ contact info:______________________________

Patient without Representation

Dignity Health
### Tool 2: Patient Care Boards

<table>
<thead>
<tr>
<th>CRITICAL CARE 8TH FLOOR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CODE STATUS:</strong></td>
</tr>
<tr>
<td>Advance Directive:</td>
</tr>
<tr>
<td>POLST:</td>
</tr>
<tr>
<td><strong>HEALTHCARE TEAM</strong></td>
</tr>
<tr>
<td><strong>DOCTORS:</strong></td>
</tr>
<tr>
<td><strong>UNIT DIRECTOR: GLORIA LAU</strong></td>
</tr>
<tr>
<td><strong>REGISTERED NURSE:</strong></td>
</tr>
<tr>
<td><strong>CHARGE RN:</strong></td>
</tr>
<tr>
<td><strong>CHAPLAIN:</strong></td>
</tr>
<tr>
<td><strong>GOALS OF CARE:</strong></td>
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</table>
Tool 3: Nursing Communication

5 Day ICU Meetings: Charting Interdisciplinary Meetings

- Name of all Staff – Must have RN and MD at the very least need to be present for an Interdisciplinary Meeting.
- Next of Kin Present (NOK) / Primary Decision Maker (PDM) present.
- Please Include: Prognosis, Goals of Care, Symptom Management, Code Status, Advanced Care Planning, and Point of Contact/Primary Decision Maker (PDM) discerned.

Any Questions Please contact Palliative Care at ex: 6856/ Pager 201-9246
Tool 4: Guideline for Family Meetings

Please chart under Interdisciplinary Notes C/O put "The Physicians Note" in interdisciplinary note if Dr. Chart meeting.

Please provide this copy to physician for preparing the interdisciplinary/family conference note in Power Chart.

This document is NOT a part of the medical record.
Interdisciplinary Approach

- **Family Meeting must consist of MD, RN and Patient and/or Decision Maker.**
- **Team Members can include:**
  - Chaplain
  - Social Worker
  - Case Manager
  - OT/PT/ST
  - Consulting Doctors
  - Interpreter
  - Palliative Care
Palliative Integrative Care Bundle: First 48 hours

1. Establish **PATIENT APPOINTED** Surrogate Decision Maker
2. Address Code Status
3. Assess for Advance Directive
4. Palliative Care Screen
5. Assess and Manage Pain Optimally
6. Establish a Spokesperson
7. Set date for an Interdisciplinary Meeting
Palliative Integrative Care Bundle: Day 3 or Before

• By Day 3:
  
  Social Work Assessment – w/in 72 hours
  
  Spiritual Care Assessment –w/in 72 hours
Palliative Integrative Care Bundle: Day 5

- RN coordinates Meeting
- Prep Family before Meeting
- Establish key team member's needed: Doctor and RN and Decision Maker MUST be present to count as an Interdisciplinary Meeting
- “Pre-Conference” w/ team before meeting with family/surrogate decision maker
Elements to Cover in the Meeting

- Establish family/ surrogate decision maker’s understanding
- Diagnosis
- Prognosis: MUST HAVE! Good/ Poor/ Dismal etc...
- Goals of Care: Is the treatment appropriate to the diagnosis?
- Address Code Status
- Offer follow-up meeting as appropriate
Results

- 90-100% of all patients that qualified for a 5 day Meeting received an Interdisciplinary Meeting since First Quarter 2013
- For half the meetings held, an average of 50% changed code status that were appropriate to prognosis and patients wishes.
- A marked decrease was shown in code blues since the start of the PIC bundle in FY Quarter 2012
Quarterly Code Blue Data

- Q1 2012
- Q2 2012
- Q3 2012
- Q4 2012
- Q1 2013
- Q2 2013
- Q3 2013
- Q4 2013
- Q1 2014
- Q2 2014

Code Blues

Dignity Health
Code Blue by Location Q 1 - 13 to Q 2 - 14

Column 1

- ICU
- ICB
- Tele
- Med Surge
- Other
Hospitalist Meetings

Number of Code Status Changes

2 Q 13 3 Q 13 4 Q 13 1 Q 14 2 Q 14
The Family Meeting

Sharon, Brenda and Donnie
Why include the Nurse?

- RN has current information on patient status
- Often has most knowledge of, and strongest, most trusting relationship with family
- Hears communications (often disparate) with family by multiple clinicians
- Must implement the care plan
- Has a professional obligation to participate
VALUE: 5-step Approach to Improving Communication in ICU with Families

V... **Value** family statements
A... **Acknowledge** family emotions
L... **Listen** to the family
U... **Understand** patient as a person
E... **Elicit** family questions

Curtis, J Crit Care, 2002; 17:147
Roles for RN in Family Meeting

• Convening: making sure meeting takes place
• Checking: is family hearing conversation? Are doctor and other professionals hearing family?
  (Sensitive interpretation/ clarification)
• Caring: naming emotions; responding to feelings
• Continuing: following up after meeting
N.U.R.S.E.

- **Naming:** “It sounds like…”
- **Understanding:** “I’m hearing you say…” or “I cannot imagine what…”
- **Respecting:** “I am impressed that...”
- **Supporting:** “I’ll be available for you...”
- **Exploring:** “It would help me to know more about...”

Pollak, K et al., J Clin Onc, 2007
Ask - Tell - Ask

Doctor: “She has renal failure, and we haven’t been able to stabilize her electrolytes. At this point, we’re looking at long term renal replacement therapy.”

Husband: “Ok.”
Nurse (Ask): “Dr. Taylor, may I interrupt? I just want to make sure we’re being clear. Mr. Davis, could you tell me what you’ve understood of the conversation so far?”

Husband: “It’s kind of confusing actually.”

Nurse (Tell): “If I understand correctly, Dr. Taylor is worried that your wife will need dialysis, perhaps permanently.”

Nurse (Ask): “Does that make sense?”

Husband: “Yes – I’m not sure she’d want that.”
Family Meeting Tips

- Physician and bedside nurse at a minimum. Invite other relevant disciplines who might be helpful
- Have patient decision maker present
- After introductions: First ask family their understanding of patient’s condition, then clarify any misunderstandings
- Deliver diagnosis/prognosis in language that is understandable to lay person and presents “big picture”
- Try to stick to purpose of meeting: if issues become too big arrange for a meeting with palliative care or set another time
- Remember: This is a first meeting! You can set a follow up meeting.
Roadmap: Conducting a Family Conference

1. Prepare for the conference (participants, privacy, clear purpose).
2. Introduce everyone present, and explain the purpose of the meeting.
3. Assess what the family knows and expects. (Ask-tell-Ask)
4. Describe the clinical situation. (Ask-Tell-Ask)
5. Ask the family for questions and concerns. (Ask-Tell-Ask and "NURSE")
6. Propose goals for the patient’s care, and be prepared to negotiate.
7. Provide a concrete follow-up plan.
8. Document the family meeting in the chart.
**Family Meeting Role Play Scenario**

**Family meeting scenario example:**

The patient is a 62 YO African American male. He has diabetes, CHF and ESRD. He is a “frequent flier” at St. Elsewhere’s Medical Center and gets readmitted to the hospital regularly (about once a month).

He was admitted last night after having a fall, which was a result of weakness and SOB. The patient is on bedrest, and his vitals are being continuously monitored. He is getting IV Lasix to deal with the CHF exacerbation. The patient is full code.

At home, besides taking his regular medications, he is on 02 and he gets dialysis 2-3 times/week. Family consists of his wife and 3 grown sons (33, 31 and 29 years old).

The patient has reported to the physician that he feels “very depressed” about his declining health. The physician has attempted to discuss changing the code status, but the patient wants his wife to participate in this decision. The wife states, “He’s a fighter. God will take him when it’s his time.” The physician reported that the patient was quiet during this conversation.

After the family left the bedside this evening, the patient tells the nurse, “I know I’m getting sicker. I’m tired of all this. My family wants me to keep hanging on, but this is no way to live.”

A family meeting is suggested to discuss code status. Using the above information, form a small group to play the roles of the patient, the patient’s wife, the nurse, and the physician.
Summary & Conclusions

• Front-line nurses are in a unique position to understand the specific needs and preferences of patients and families, to provide information to them, and to enhance consistent communication among patients, families, and other members of the health care team.

• Resources including the IPAL-ICU Project exist to assist with successful implementation of communication skills training for ICU nurses, which can be applied to other practice settings.