

Palliative Care in the Intensive Care Unit



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KEYWORDS

- Palliative care • Intensive care • Quality • Patient- and family-centered care
- Complex adaptive system

KEY POINTS

- High-quality care for intensive care patients and their families should include palliative care.
- Nearly half of all patients who die in the hospital receive intensive care services during their terminal admission.
- One of the key goals of health care is to limit costs while simultaneously improving or maintaining the quality of care that patients and families receive.
- Quality measures for palliative care in the ICU are being developed at a national level and can be implemented in diverse ICUs across the nation.

Restorative care and comfort care are often seen as mutually exclusive. Promulgating this misconception are insurance mandates that patients forgo curative treatment when seeking comfort and symptom management in the face of terminal illness. This dichotomy of care has created barriers to early access of palliative services for the patient and their families. Providing quality of care to patients with life-limiting illness is the challenge facing the staff in the intensive care unit (ICU).

IMPORTANCE OF THE PROBLEM

Although the Bible reminds us that “there is a time to be born and a time to die,” we have paid strikingly little attention to the “time to die” until recently. In ancient times, death was quick and often sudden. Now death most often occurs during the course of prolonged chronic illness that may last years. Patients may experience serious physical, emotional, social, and spiritual suffering. In addition, such patients, their families, the physicians and nurses, and others involved in the delivery of care face ethical

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and financial challenges.¹ Curative and palliative care should be provided congruently to meet the needs of all partners in a patient's care. The symptom burden of disease, communication of goals of care, alignment of treatment and therapy to goals, values and preferences, and appropriate, timely transition of care should not be limited by prognosis.²

REVIEW OF THE LITERATURE

The United States has seen a decline in the number of hospitals since early 1986; however, some areas report up to a 26% increase in the number of intensive care beds. Occupancy rates and average length of stay in the ICUs are increasing.³ One in five patients receives terminal care in the intensive care setting.⁴ Approximately 90% of deaths in the ICU occur after discontinuing or limiting treatment.⁵ Of all hospital deaths, 47% receive intensive care services during the terminal admission⁶ with less than 20% of these patients having completed an advance directive.⁷ Do-not-attempt-resuscitation orders are often written within days of death. Because these conversations occur late in the disease trajectory, patients and families perceive this dialogue as a sign of impending doom rather than a result of advance care planning.⁸

Family members making decisions for their loved ones often continue treatment despite prior conversations with the patient to the contrary.⁹ These decisions create emotional distress and financial burden on the family.¹⁰ In turn, the decisions made or not made by the family can cause moral distress for the caregivers as continuing aggressive care becomes more burdensome than beneficial for the patient. Poor understanding of diagnosis, prognosis, and treatment options has been identified in 54% of family members with loved ones suffering serious illness. Families have the perception that health care providers experience stress when discussing end of life in the ICU,⁵ which can often lead to families second-guessing themselves in regards to the care decisions they have made.

It is well documented that the last chapter of life is characterized by three major deficiencies: (1) unnecessary suffering,¹¹ (2) unacceptable variation in treatment with striking excesses in nonbeneficial treatment,¹² and (3) unsustainable costs. Approximately 30% of Centers of Medicare and Medicaid Services dollars have been attributed to end-of-life care.¹³ A total of 40% of Centers of Medicare and Medicaid Services costs occur in the last 30 days of life.¹⁴ The number of Americans age 65 and older will double by 2030.³ Too many patients get too much medical intervention, too little advance care planning, and too little care in the last chapter of life.

In response to these deficits, the National Consensus Project for Quality Palliative Care and the National Quality Forum established standards for high-quality palliative care. The Institute of Medicine, the major societies representing critical care health care professionals, government and industry health care payers, along with large-scale health care systems across the nation agree that palliative care in the ICU should be a quality improvement priority.¹⁰ The Center to Advance Palliative Care developed an ICU-focused initiative (Improving Palliative Care in the Intensive Care Unit) in 2010 where health care systems could assess resources, guidelines, and expertise. These recommendations have been used to guide the development of ICU palliative care programs and establish standards for tracking and benchmarking for quality. A consensus of expert professional opinion developed domains for quality palliative care (**Box 1**). Integrating these features into the ICU can be difficult because each has its own culture created by history, structures of care, policies and procedures, and the attitudes and professional interaction between the different disciplines working in the critical care setting.¹⁵

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