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Integration of Palliative Care in the Context of Rapid Response

A Report From The Improving Palliative Care in the ICU Advisory Board

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Rapid response teams (RRTs) can effectively foster discussions about appropriate goals of care and address other emergent palliative care needs of patients and families facing life-threatening illness on hospital wards. In this article, The Improving Palliative Care in the ICU (IPAL-ICU) Project brings together interdisciplinary expertise and existing data to address the following: special challenges for providing palliative care in the rapid response setting, knowledge and skills needed by RRTs for delivery of high-quality palliative care, and strategies for improving the integration of palliative care with rapid response critical care. We discuss key components of communication with patients, families, and primary clinicians to develop a goal-directed treatment approach during a rapid response event. We also highlight the need for RRT expertise to initiate symptom relief. Strategies including specific clinician training and system initiatives are then recommended for RRT care improvement. We conclude by suggesting that as evaluation of their impact on other outcomes continues, performance by RRTs in meeting palliative care needs of patients and families should also be measured and improved.

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ABBREVIATIONS: IPAL-ICU = Improving Palliative Care in the ICU; RRT = rapid response team

The rapid response team (RRT), also known as a medical emergency team, was conceived in the 1990s as a strategy to decrease in-hospital cardiac arrests, mortality, and morbidity through earlier identification and intervention when patients are deteriorating. Although impact on these outcomes remains in question,[1-3] the use of RRTs is widespread around the world.[4] RRT clinicians become involved in decision-making about life-supporting therapies and may be in a position to provide emergent

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palliative care. A series of reports suggests that RRTs can effectively foster discussions about appropriate goals of care and address other palliative care needs of patients and families facing life-threatening illness on hospital wards.[5-11] Just as integration of palliative care is increasingly accepted as part of day-to-day practice within ICUs, so also RRT clinicians and others who manage clinically deteriorating patients outside the ICU must consistently attend to communication about care goals, symptom control, family support, and other key palliative care components.

In this article, The Improving Palliative Care in the ICU (IPAL-ICU) Project[12] brings together expertise in critical care and palliative care along with existing data to address special challenges and practical strategies for the rapid response setting. We conducted a comprehensive review of English language articles using the term "rapid response team" or "medical emergency team" and "palliative care," "end-of-life care," "limitation of medical treatment [or life support]," "do not resuscitate," "not for resuscitation," "life support," "advance directive," "goals of care," or "symptom." Based on this literature and the experiences of our interdisciplinary advisory board, we focus on the following questions: (1) What are special challenges for the provision of palliative care by a rapid response team? (2) What knowledge and skills are needed to support the delivery of high-quality palliative care in the rapid response setting? (3) How can integration of palliative care and rapid response intensive care be improved?

What Are Special Challenges for the Provision of Palliative Care by an RRT?

The unique challenge for integration of palliative care in the rapid response context is time. The patient may have been living with serious illness for months or even years, and hospitalized with the present illness for days or at least hours, but now an assessment and plan, and delivery of appropriate care, are needed in minutes. Usually without any prior knowledge of the patient or clinical circumstances, and often relying only on recent entries in the medical record, the RRT must make crucial, complex decisions; for example: Is escalation with intensive care therapy likely to provide more benefit than burden? Is it appropriate in light of the patient's values, goals, and preferences?

As in the ICU, the deteriorating patient on the ward is typically unable to provide information or participate in decision-making. The surrogate decision-maker may not be immediately available and, for some patients, may not yet have been identified. The primary care clinician is often off-site, and the ward team may not be immediately available when the patient's condition triggers a rapid response. Some patients have advance directives, but documentation is not always readily accessible or clearly applicable to the situation at hand. The RRT must then formulate and implement an appropriate plan in the absence of input from either the patient or those with the most relevant knowledge and strongest relationship of trust with the patient and family.

Even if the patient has capacity or the family is available, it can still be difficult to make medical decisions in the midst of a crisis. Few patients and families can fully absorb and integrate information about serious illness in a short time, depending instead on a longer process of "cultivation of prognostic awareness"[13] that allows them to modulate their emotions and eventually face an uncertain or unfavorable future. Yet, although acute deterioration might have been predictable, this process may not have been initiated before the rapid response call. Even a very skilled clinician would find it challenging to communicate with a patient or family about life and death decisions in these circumstances, needing to condense what ideally is a series of incremental, face-to-face discussions led by a familiar primary care provider into a single, brief encounter with strangers under crisis conditions. Most clinicians lack the training or experience to master the necessary skills, and no program that is specifically designed to prepare clinicians for the unique challenges of communicating in the context of a rapid response has yet been disseminated. Some RRT clinicians may view communication about care goals as outside their role and responsibility.

RRT communication and decision-making are further complicated by the absence of tools to assist in prognostication with respect to either hospital or postdischarge outcomes. Sophisticated models have been developed to predict mortality from critical illness based on parameters measured during the first days in an ICU.[14-16] But no model involving rapid response events is available to be used in real time as an adjunct to clinical expertise and experience. Controversy continues about ICU admission criteria,[17-20] and decisions about escalation of care are influenced by a variety of factors at the system-, clinician-, and patient-level, including factors that clinicians may not recognize as affecting their judgments.[21,22] In addition, these decisions may present ethical challenges, a complex topic that is beyond the scope of this article. Further research is needed to clarify current practice