Nurse-Driven ICU Palliative Care Triggers

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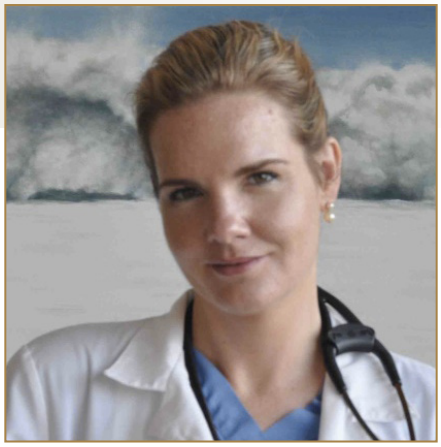

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Background and Significance

Palliative care offers a means of providing patient and family centered care in hospital settings by placing emphasis on communication of patients' knowledge and understanding of prognosis and expectations of care; providing family support and education on mitigating symptom burden and transitional care planning. Several models for palliative care delivery in intensive care settings have been implemented and reported with varied success. Barriers experienced include possessing an open versus closed intensive care unit (ICU) model with several teams managing patient care, surgical intensive care units (SICU) compared to medical ones, and utilization of only one approach versus a combination of consultation and integrative palliative care delivery models. Even with examples of improved integration of palliative care services in an ICU setting there is ample room for further evidence of success. To date there has been no research looking at the impact of nurse-driven palliative care triggers in a medical-surgical ICU setting.

Our Unit and Trigger List Development

The UC San Diego Health System Thornton Intensive Care Unit (TICU) is a 12-bed medical-surgical ICU that specializes in oncology, bone marrow transplant, and neurovascular, cardiothoracic and vascular surgeries before the opening of the Sulpizio Cardiovascular Center in 2011.

Afterwards, the TICU experienced a significant shift in its population towards medical and surgical oncology patients, many of which have terminal conditions with prolonged and complicated ICU stays.

In anticipation of this shift change, the ICU leadership, which included the medical director, nurse manager, unit educator, along with several clinical nurses, reached out to the Howell Service to co-develop a palliative care educational plan and palliative care consult triggers with the goal of expanding palliative care utilization in TICU. Another goal was that palliative care education and trigger implementation would provide tangible tools to empower the ICU clinical nurses to advocate for patient and family centered care and possibly reduce moral distress.

The trigger list was established with true interdisciplinary collaboration including clinical, management and educational nursing staff, nurse practitioners, physicians, and social workers. Based on published data, along with unit specific cultural considerations eight PC triggers were selected:

- Family request
- Death expected within ICU stay
- ICU stay > 10 days
- Diagnosis with median survival <6 months
- Advanced malignancy
- Permanent severe cognitive impairment
- Conflict in goals of care
- Poorly controlled symptoms despite current treatment.

These triggers were initially

approved in the TICU and CCU, and disseminated through e-mail, badge cards, meetings and palliative care classes and conducted by clinical nurses in conjunction with the Palliative Care Service.

Implementation and Outcomes of Trigger List

ICU patients are evaluated daily by the bedside or charge nurse to determine if they meet one or more palliative care (PC) triggers.

Recommendations for a palliative care consult are communicated with the primary team, and documented in the data collection tool created by the team. The majority of the TICU staff has attended UCSD's palliative care class that provides background information on how to approach the primary team for a consult as well as provides two role play situations wherein the class works through the process of how to approach a physician for a consult. This is done with the medical director of the Howell Service and another physician. The activity is conducted in an interactive and lively manner, which encourages the audience to share their experiences of what has worked and not worked for them. Emphasis is placed on the process of a culture change within a unit and how it takes time and energy.

In looking at our preliminary data, we found that 93% of our patients met at least one trigger. The frequency of each trigger being met individually from highest to lowest is as follows:

- Advanced malignancy
- ICU stay > 10 days
- Diagnosis with median survival <6 months
- Poorly controlled symptoms despite current treatment
- Death expected within ICU stay
- Conflict in goals of care
- Permanent severe cognitive impairment
- Family request

The number of palliative care triggers resulting in consults has increased steadily after the establishment of the triggers and educational classes. To date our committee has held eight classes with more than 450 interprofessional attendees from within and outside UCSD. We will continue to offer classes on an annual basis and are looking for representatives from each unit to attend our hospital-wide meetings to share their experiences and needs regarding palliative care.

TICU Palliative Care Consults trends from January 2010 through May 2013.