



# Introducing palliative care into the treatment of a critically ill patient

Although it often carries a negative stigma, palliative care can greatly improve the quality of life of patients with critical illnesses.

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As the US population continues to live longer, the increasing prevalence of chronic health conditions and the likelihood of individuals requiring admission to an ICU or CCU will also continue to rise. Therefore, it's imperative that healthcare professionals from all disciplines, especially nurses on the front lines, seek opportunities to improve patient care and the overall quality of life of these individuals who are significantly affected in their daily lives, including when they are admitted to the ICU. One method is the incorporation of palliative care (PC) services and interventions into the treatment of a critically ill patient.

## Background

PC is an avenue of care that focuses on a patient's and their family's physical, emotional, and spiritual quality of life while managing symptoms and alleviating suffering associated with debilitating

illness(es).<sup>1</sup> PC can be integrated into the treatment of any chronic or acute disease process that directly or indirectly impacts a patient's quality of life. PC is often collaborative in nature and includes a variety of healthcare professionals, such as healthcare providers, nurses, social workers, physical and occupational therapists, holistic medicine professionals, and chaplains or religious leaders. The use of an interdisciplinary care team (ICT) in PC allows for patients and their families to receive holistic, high-quality care in the environment they choose.<sup>1</sup>

Due to the significant percentage of deaths that occur in a critical care setting, it's important to consider the benefits of PC integration. Typically, critical care is focused on curing a disease process, and the death of a patient is viewed as a failure.<sup>2</sup> However, with the integration of PC, this perspective can be shifted to focus on relieving symptoms and meeting the

patients' goals of care. Early or ongoing PC throughout the illness trajectory is beneficial for both the patient and family.<sup>2</sup> The implementation of PC into critical care prompts the discussion of the patient's and family's goals and values, assessment of and interventions for distressing symptoms, and incorporation of support resources that can address a variety of the patient's and family's needs.<sup>2</sup> PC integration allows healthcare providers to adapt care to suit the patient's and family's wishes and decrease hospital resources and costs. Prolonged and aggressive treatment can result in a long-anticipated care path and/or death, which can be traumatic for the patient, family, and healthcare professionals. This can include the development of postintensive care syndrome, which can result in long-term alterations in physical, cognitive, and psychosocial well-being that exist well beyond the patient's stay in a CCU.<sup>3</sup> The collaboration between PC specialists and ICU teams has the potential to reduce prolonged patient suffering, decrease nurse and physician moral distress, and increase the consideration of support resources for both the patient and family.<sup>2</sup>

As mentioned previously, death in the critical care setting can be viewed as a failure. When PC is implemented, this perspective can be changed, and a comfortable death can be accepted if it's imminent and unavoidable. This can decrease the moral distress of a nurse caring for a patient who's at the end of their life, as the nurse can appreciate that the patient's care goals have been met. ICU patients who received an early PC consultation also had significantly more transfers to hospice care, fewer ventilator days, and fewer readmissions to the hospital compared with patients receiving usual care.<sup>2</sup> Early implementation of PC can lead to increased comfort and symptom management for patients during all care transitions, including transfer out of the ICU.<sup>2,3</sup> Integration into the critical care setting has the potential to increase a

patient's comfort and quality of care, resulting in a more positive long-term outcome for the patient, family, and healthcare team.

## Best practices

PC can be integrated into treatment for patients requiring intensive care and should be implemented into treatment for many diagnoses common in the ICU, such as acute-respiratory distress syndrome, myocardial infarction, heart failure, cerebral vascular accidents, end-stage renal disease, and sepsis. The symptoms associated with these diseases can be targeted by PC because it's an approach that supports the comprehensive care needed for critically ill patients.<sup>4</sup> This is true even in facilities where PC services may not currently exist, as many of the interventions described here can be implemented by any ICT, regardless of the presence of formal PC services. PC aims to prevent and relieve suffering by early identification, assessment, and treatment of physical and psychological symptoms, as well as spiritual distress.<sup>5</sup> Although PC is often thought to be offered to patients near the end of life, it's available for all patients with serious illnesses to improve their quality of life by treating symptoms and diseases simultaneously.<sup>6</sup> This can include prevention and treatment of the aforementioned postintensive care syndrome, which can persist after the patient's transfer out of the CCU.<sup>3</sup>

## Physical symptom management

There are many interventions available for nurses to utilize when providing PC for patients receiving care in ICUs. Following an admission to the ICU, common impairments that may be present in individuals include pain, agitation, delirium, immobility, and sleep disruption (PADIS).<sup>7</sup> Nurses are often the first to identify any changes in a patient's status, especially in patients unable to



self-report any distressing symptoms, and are instrumental in preventing and managing these symptoms during and after treatment.<sup>4</sup> PC offers an opportunity to provide specialized care to help alleviate lingering symptoms that may be present during or after the course of an ICU admission.<sup>7</sup>

### Pain and agitation

Pain and agitation assessments in critically ill patients are necessary considering pain can negatively affect cardiac and respiratory statuses.<sup>7</sup> Pain control includes the utilization of analgesic methods to reduce severity, often occurring synergistically with the use of sedation to decrease associated or concomitant agitation. PC focuses on patient comfort as a primary goal.<sup>7</sup> Frequent assessments are necessary to ensure that the careful titration of analgesics and sedatives are being balanced to provide adequate pain control and patient safety.<sup>7</sup> For critically ill patients who can't self-report pain, behavioral pain assessment tools can be used to determine unrelieved pain by assessing four facial expressions for grimaces, two bodily responses for rigidity, and two verbal responses for any type of moaning.<sup>8</sup> A score is given from 0 to 8, allowing nurses to determine the comfort level of their patient at a given time. If a score is above a 4, severe pain is present and titration or additional doses of pain management or sedation are needed.<sup>8</sup> Pain medications commonly used by PC in the ICU include morphine and fentanyl and common sedatives include midazolam, propofol, and dexmedetomidine.<sup>9,10</sup> PC emphasizes adequate pain control while avoiding oversedation and promoting earlier extubation by customizing titrations and dosages specific to each patient.<sup>7</sup> Frequent assessments performed by nurses are critical because chronic pain is one of the leading persistent problems following a critical care admission due to high-intensity unrelieved

### Consider this

Mr. Lee, age 72, presents to the ED with complaints of shortness of breath and generalized weakness for the past week. He is febrile, tachycardic, tachypneic, hypoxic, and hypotensive. Accessory muscle use is present. The patient is alert and oriented; however, he has difficulty speaking between breaths. Mr. Lee is immediately placed on high flow oxygen with positive effect. The ED physician notes an increased work of breathing and a decreased SpO<sub>2</sub>. Bilevel positive airway pressure (BiPAP) is ordered and an improved SpO<sub>2</sub> is quickly noted. After patient stabilization, labs, EKG, chest X-ray (CXR), and chest computed tomography (CT) angiography are ordered. Bilateral large-bore I.V. access sites are obtained with a fluid bolus ordered, along with a nebulizer, I.V. push steroids, and acetaminophen via I.V. piggyback.

Lab work revealed an elevated white blood cell count, creatinine, lactic acid, along with increased procalcitonin and troponin levels. Arterial blood gases (ABG) demonstrated respiratory acidosis. EKG was unremarkable. CXR and chest computed tomography angiography are consistent with acute respiratory distress syndrome (ARDS). ARDS secondary to pneumonia and exacerbation of chronic obstructive pulmonary disease (COPD) is diagnosed with a high level of suspicion for sepsis. An additional fluid bolus is ordered, and the patient is admitted to the ICU. Overnight, the patient demonstrated increased agitation and respiratory failure, requiring emergent intubation, along with the placement of an arterial line, central venous catheter, orogastric feeding, and urinary catheter.

pain.<sup>11</sup> By using the Behavioral Pain Assessment Tool (BPAT) and the Richmond Agitation-Sedation scale (RASS), a scale utilized to determine an individual's agitation or sedation level, appropriate sedatives can be chosen.<sup>7</sup> Spontaneous awakening trials are also recommended to allow patients to properly "wean off" sedation and pain-relief medications to help achieve pain relief.<sup>7</sup>

### Delirium

About 80% of mechanically ventilated ICU patients develop delirium, which can lead to negative outcomes, including cognitive dysfunction.<sup>7</sup> The Confusion Assessment Method for the ICU is used to assess changes in mental status, inattention, altered level of consciousness, and disorganized thinking.<sup>12</sup> These assessments, along with the utilization of the RASS, should be performed both before and after spontaneous awakening trials. Interventions aimed at the treatment of delirium include repeated

### Consider this: Update

Upon consultation with the ICT, it's determined that Mr. Lee's alterations are the direct result of ARDS secondary to pneumonia and exacerbation of COPD with subsequent septic shock. Unfortunately, his chronic lung disease has progressed significantly since last admission and prognosis is poor. Although the patient is currently at full code, there's low likelihood of cardiac arrest survival and recovering to his previous quality of life. A family meeting is called to facilitate communication of such prognosis and to define goals of care. After a lengthy discussion, it's decided by the family to change the patient's code status to 'do not resuscitate'.

RASS goal was adjusted to prevent oversedation and delirium. Scheduled anxiolytics via FT are initiated to allow for decreased I.V. sedation and to ease transition to extubation. A non-verbal behavioral pain scale is also initiated to ensure adequate management of pain to ensure adequate titration of the analgesic I.V. infusion. Scheduled analgesics via feeding tube (FT) is initiated to allow for decreased intravenous analgesia and to prevent breakthrough pain. The registered dietitian is consulted and enteral feedings via FT are initiated to meet metabolic demands. Physical and occupational therapy are also consulted to begin early mobilization.

One week later, the patient is successfully weaned from the mechanical ventilator. He's placed on oxygen via nasal cannula and is cognitively back to his preadmission baseline. The patient agrees to the change in code status and further elects to make himself 'do not resuscitate/do not intubate.' Spiritual care is consulted to assist with needs related to this life-altering decision, including questions about late life and end-of-life care and expression of desired rituals and preferences.

Mr. Lee is transferred to a telemetry floor where the ICT continues to follow and assist in preparing him for discharge. He is comfortable and remains on oxygen via nasal cannula, while continuing to take the prescribed doses of oral analgesics and anxiolytics and demonstrating minimal to no signs of post-intensive care syndrome. He continues to demonstrate increased strength with daily physical and occupational therapy, while continuing to meet with spiritual care. He's discharged home a few days later where a PC home health nurse is facilitating care to ensure he's comfortable with a good quality of life secondary to both his intensive care stay and chronic respiratory disease. All of his previous home medications are ordered, along with tapering doses of oral analgesics and anxiolytics, and meeting regularly with spiritual care, physical therapy and occupational therapy. The plan of care is to continue to monitor and ensure that he's living his best possible life and transition him to hospice care if/when appropriate.

reorientation of patients, minimizing external stimuli, providing hydration and nutrition, and utilizing a patient's eyewear or hearing aids if applicable. In addition, early mobilization may help to decrease delirium, days on ventilation, overall length of stay, and muscle weakness. Mobility exercises can be performed both in and out of bed, depending on RASS scores. PC can refer patients to physical therapy to help patients work on passive and eventually active range of motion. Sleep disruption may also contribute to delirium, and this condition is often more common during mechanical ventilation because of the ventilator settings and alarm.<sup>7</sup> It can be difficult to assess the amount of sleep patients

in critical care settings are receiving. Interventions aimed at sleep promotion should be included, such as assist-control ventilation at night, if possible, as well as music and external stimulus reduction.<sup>7</sup>

### Additional symptoms

There are additional symptoms patients may experience during an ICU admission that can lead to further issues following recovery. PC care should address any skin breakdown by making proper referrals, specifically for patients who are at high risk for skin breakdown.<sup>13</sup> Nurses are instrumental in preventing skin breakdown and providing skin care by incorporating interventions such as frequent skin assessments, proper

## Commonly used medications in palliative care

This list isn't all inclusive but provides examples for consideration.

Use	Medication/treatment
Management of constipation	<ul style="list-style-type: none"> <li>Laxatives (bisacodyl, docusate sodium, senna polyethylene glycol)</li> </ul>
Management of diarrhea	<ul style="list-style-type: none"> <li>Loperamide</li> <li>Skin barrier ointment (to protect perianal region)</li> </ul>
Management of fever	<ul style="list-style-type: none"> <li>Antipyretics (acetaminophen, naproxen, ibuprofen, aspirin)</li> </ul>
Management of pain	<ul style="list-style-type: none"> <li>Acetaminophen</li> <li>NSAIDs (naproxen, ibuprofen)</li> <li>Opioids (hydrocodone, oxycodone)</li> <li>Steroids (prednisone, prednisolone)</li> <li>Anticonvulsants (gabapentin)</li> <li>SSRIs (duloxetine)</li> </ul>
Management of anxiety	<ul style="list-style-type: none"> <li>Anxiolytics (lorazepam, diazepam)</li> </ul>
Management of delirium/agitation	<ul style="list-style-type: none"> <li>Antipsychotics/mood stabilizers (haloperidol, quetiapine, olanzapine)</li> </ul>
Management of sleep disturbances	<ul style="list-style-type: none"> <li>Melatonin</li> </ul>
Management of shortness of breath	<ul style="list-style-type: none"> <li>Antibiotics (in acute exacerbations)</li> <li>Bronchodilators (albuterol, salmeterol, formoterol)</li> <li>Anticholinergics (ipratropium, tiotropium)</li> <li>Diuretics (bumetanide, furosemide)</li> <li>Morphine (if end-stage/terminal)</li> <li>Oxygen</li> </ul>

positioning, hygiene, and any prescribed dressings.<sup>14</sup> Proper nutrition is also important in preventing skin breakdown, as well as other debilitating symptoms. PC can facilitate proper referrals to dietary services to ensure nutrition needs are being met to promote healing and meet energy demands of the body.

Enteral nutrition is recommended as the first line of treatment for patients in critical condition, and parenteral nutrition may be considered when energy needs aren't being met or when enteral nutrition results in complications related to the medication regimen (including pain medications) or immobility. Constipation may occur, which can cause abdominal distension that affects the lungs' ability to expand, leading to prolonged mechanical ventilation.<sup>15</sup> PC should evaluate the underlying cause and

aid in the treatment, which can include correcting electrolyte abnormalities, assessing the need for pain medications, and adding a laxative.<sup>15</sup> Through the use of a nurse-driven multidisciplinary team, PC can integrate the described interventions into the existing treatment plan to focus on these kinds of symptoms to provide relief for patients and prevent further complications that can arise following an ICU admission.

### Effective communication

Because PC is a fairly new field of medicine, misconceptions about PC exist among patients, family members, and physicians. PC has been shown to carry negative stigma, such as the association with only end-of-life situations or hospice care. Effective communication should be based upon patients'

knowledge and perception of their condition and addressing patients' and family members' concerns and questions about the disease process.<sup>16</sup> Also involved in the PC cycle are the ethical and legal conversations surrounding decision-making, transition planning, support for families, and care during the dying process.<sup>5</sup> The complexity of these issues surrounding the transition to end-of-life situations in the ICU is why effective communication between the healthcare provider, patients, and family is essential.

Communication between healthcare providers is just as essential when utilizing PC in the ICU setting. If healthcare providers could effectively communicate accurate information about the services that PC offers with each other, more referrals could be made as opposed to the hesitation that exists now. ICU physicians should be further educated regarding the knowledge and skills necessary to provide symptom management, proper communication, and guidance in decision-making for family members. Further, ICU physicians may benefit from additions of PC physicians as well as specific PC guidelines to meet the increasing needs of patients and their family members.<sup>5</sup> PC services can then further facilitate communication between healthcare providers to lead to other necessary ICT referrals such as physical therapy, occupational therapy, speech therapy, and so on. Early discussion is key in the process of caring for critically ill patients because early implementation of PC has shown to improve quality of life and outcomes for these patients. By communicating patient goals early in the PC process, nurses have the opportunity to advocate and address care for curative and palliative treatments and provide physical and psychosocial support for the patient and their family.<sup>17</sup>

### **Psychosocial and spiritual support**

PC services in the ICU, which encompass the psychosocial and spiritual aspects of

care along with the physical, are essential regardless of the disease progression and can extend beyond the patient's condition to family members who are trying to cope with a nearing death.<sup>18</sup> In the US, half of hospital deaths occur during or following an ICU stay, and two-thirds of these deaths involve decisions to withhold or limit treatment.<sup>19</sup> In such situations, many patients can't make decisions for themselves, putting major healthcare decisions in the hands of family members or surrogate decision-makers.<sup>19</sup> The integration of PC services allows for nurses and other healthcare professionals to extend care and psychosocial support to not only the patient, but to their family members and loved ones as well. In general, nurses provide personal care to their patients, allowing them to develop trusting relationships with patients and families.<sup>19</sup> The holistic nature of PC allows them to do this at an even greater magnitude in the ICU dealing with critical patients.

Because spiritually sensitive care is also a main aspect of the PC approach, the integration of PC into the ICU setting allows for patients and family members to express their spiritual views on illness and death, conduct any prayers or rituals, and address any questions or hesitations surrounding the critical illness and perhaps end of life. Often, critical illness/conditions bring about spiritual or existential questions for patients and family members, and the PC approach makes it so that any preferences of this nature can be integrated into care. There can be many unknowns in the ICU in terms of disease progressions and patient outcomes, so it can be comforting for patients and families to embrace spirituality during these difficult times. Although healthcare professionals may not be familiar with all religious practices regarding end of life, they should understand how the spirituality aspect of PC can influence coping, grief, and decision-making.<sup>18</sup>

## Barriers to care

Implementing PC into an ICU or critical care setting has barriers that must be addressed to care for patients effectively. Barriers have been identified in various domains, including providers, families, and facilities. Within CCUs and ICUs, there's a noted lack of understanding of PC uses and goals among healthcare providers, including physicians, residents, and nurses.<sup>20</sup> This dearth of knowledge is often compounded by a shortage of PC staff and lack of integration into critical care settings, leaving a large gap in an area of significant specialty.<sup>20</sup> A study by Kyeremanteng and colleagues identified that within ICUs with a poor presence of PC, 78% of respondents (physicians, nurses, administrators) agreed that increasing PC in critical care venues is necessary for improving appropriate end-of-life care to the critically ill population.<sup>21</sup>

Patient and family expectations of critical care is another significant barrier to implementing PC in an ICU. Often, ICUs are associated with aggressive treatment. Palliative intervention is often hindered by the presence of aggressive options, such as intubation and resuscitation.<sup>20</sup> Differing goals between families and ICTs, as well as communication and knowledge barriers, were identified as hindering effective implementation.<sup>20</sup> Finally, ICUs can be overwhelming and chaotic environments, which may not be conducive to difficult conversations concerning goals of care and prognosis.<sup>22</sup>

Within ICUs, procedural and structural aspects of care can also hinder PC intervention and effectiveness. The lack of specific guidelines and procedures, combined with lack of clarity to employees, hinders effective PC.<sup>20</sup> Examples of appropriate guidelines within critical care venues can include adequate staff ratios, increased amount of staffing, and increased staff time at the bedside. Without policies specific to PC, staff who are otherwise not

specialized are acting without specific guidance.<sup>20</sup>

It's important to recognize potential barriers in order to effectively overcome them. Solutions to overcome identified barriers, include educating providers on PC, encouraging development of formal ICTs to provide care, and creating specific PC guidelines within organizations to give providers enhanced instructions for working with families on common patient goals.<sup>22</sup>

## Conclusion

As Americans continue to live longer with more comorbid conditions, the likelihood of persons needing critical care interventions will continue to rise. It's imperative that healthcare professionals and laypersons understand the importance of PC and how it can improve their quality of life, decrease hospital costs and resources, and enhance the care received. As nurses, we need to advocate for PC resources and their appropriate utilization to ensure that our patients are receiving the care that they deserve. ■

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