# Improving Outcomes Through Palliative Care - ICU Collaboration

Tae Joon Lee, MD and Janet Moye, PhD, RN

## Background

Literature has shown the value of palliative care-ICU collaboration in avoiding futile aggressive care at end of life. Involving the palliative care team promotes the opportunity for families to have end of life and goals of care discussions.

**Vidant Health System**

- 909 bed medical center
- 8 hospital system in rural North Carolina serving 29 counties
- Over 65,000 admissions and 270,000 ED visits per year

**Palliative Care Team**

- Focused on being accessible to providers and clinical staff in the ICUs
- Improved communication with the ICU teams by having mandatory verbal discussion for each consultation
- Developed partnerships to provide more timely education and consultation for patients and families
- Increased Palliative Care Provider Team (PCPT) availability to 365 days/year
- Dramatically shortened time from order to completion of consult
- Prioritized completion of consults ordered by ICU (104 beds) and Intermediate Unit (204 beds) providers
- Expedited transfer of ICU patients who wanted comfort care to the PCPT in the PCU


## ACKNOWLEDGMENTS

Susan Albright RN, MSN

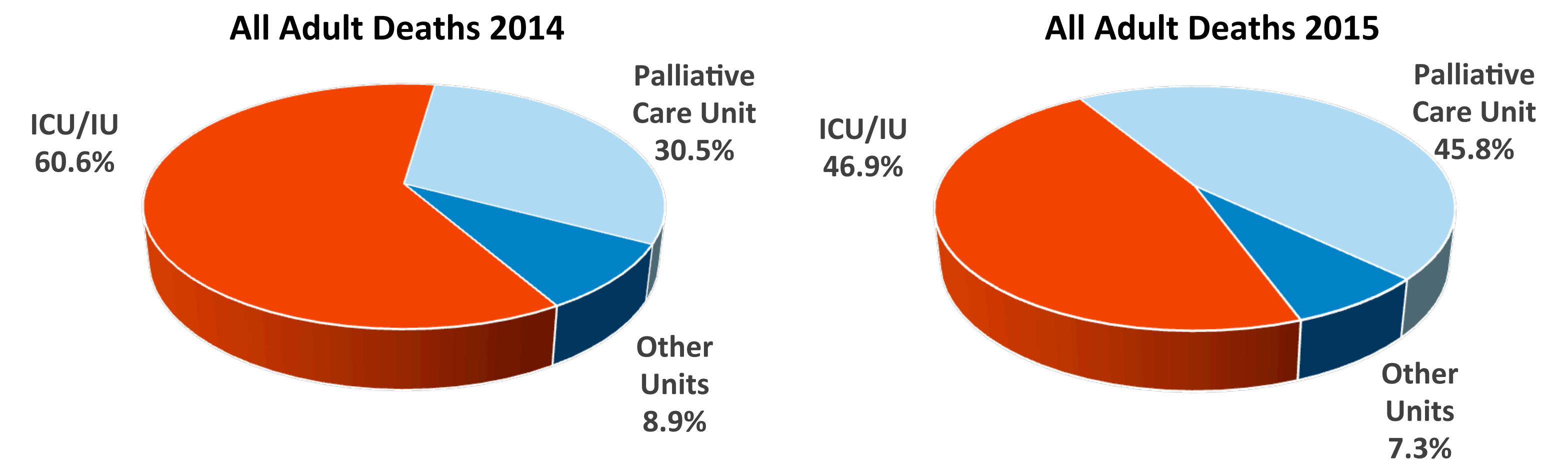
Molly Pleasants PT, DPT

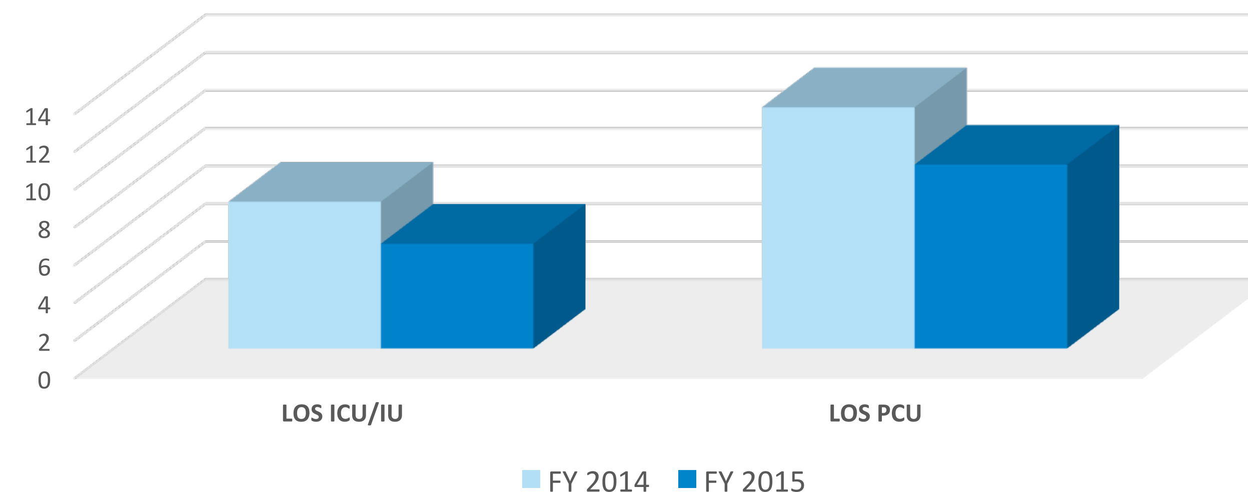
&

Palliative Care Provider Team


## Results

**Since implementing new palliative care processes ICU LOS and deaths in ICU have decreased**




## Next Steps

- Implement comprehensive method to track and review inpatient deaths
- Increase collaboration with medical providers to identify inpatients with high risk for mortality
- Participate in weekly meeting with ICU medical directors and hospital quality department to review ICU mortality and identify potential areas of improvement
- Improve education about palliative care with providers in ICUs and ED
- Increase utilization of quiet and peaceful environment of the PCU for patients and families choosing compassionate extubation and withdrawal of care
- Partner with leadership to identify additional mission-driven strategies throughout the hospital system

## Case Studies

**Prior to implementation:**

A 66 year old patient was admitted 11/4/2013 status post fall with ICH and midline shift to Neuro ICU. Neurosurgery was performed. Prognosis for functional return was poor per neurology team. Post-op day 4 respiratory status declined, requiring intubation. Trauma team discussed goals of care with indecisive family; patient remained full code. After multiple complications, on Day 14 the PCPT was consulted and a family meeting conducted. Family agreed that patient would not want to live by artificial means and compassionate extubation was elected. Patient died 20 minutes post-extubation in the Neuro ICU unit.

**Post implementation:**

A 74 year old patient was admitted 6/13/15 to the trauma service status post fall with SDH and skull fracture. PCPT consulted within 12 hours of admission to hospital. Goals of care discussed with family. After discussion of quality of life versus invasive interventions, family chose to discontinue aggressive care. On 6/14/15 patient was transferred to PCU with comfort measures only. All symptoms were closely monitored and controlled. Family received education on end of life processes as well as emotional and spiritual support in a quiet, peaceful environment of care. Patient died with dignity on 6/16/15 with family present.

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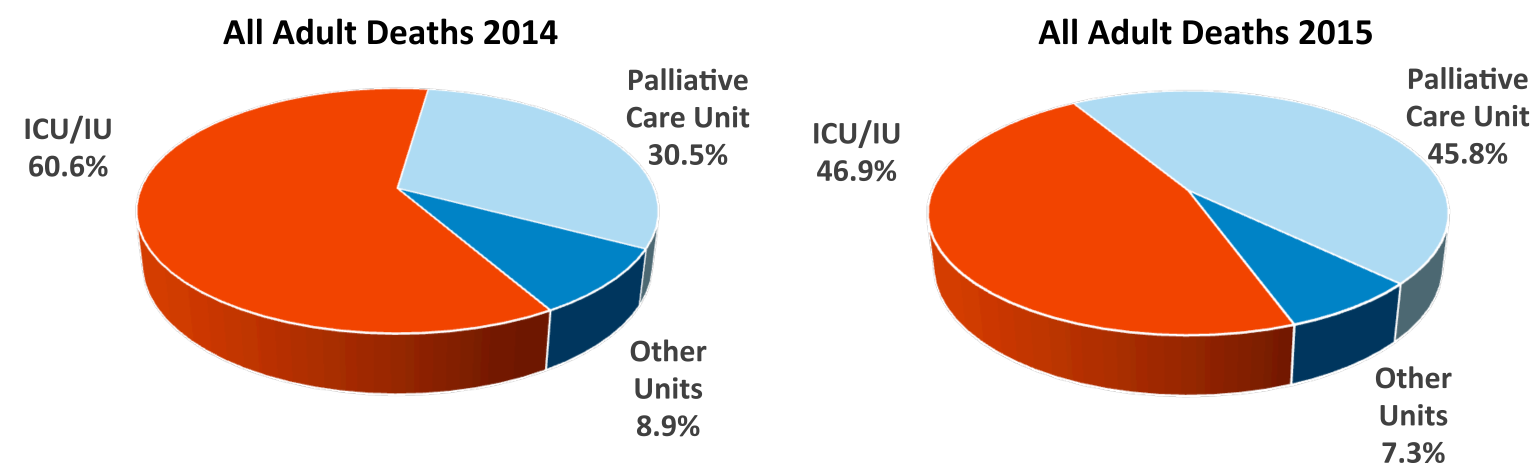


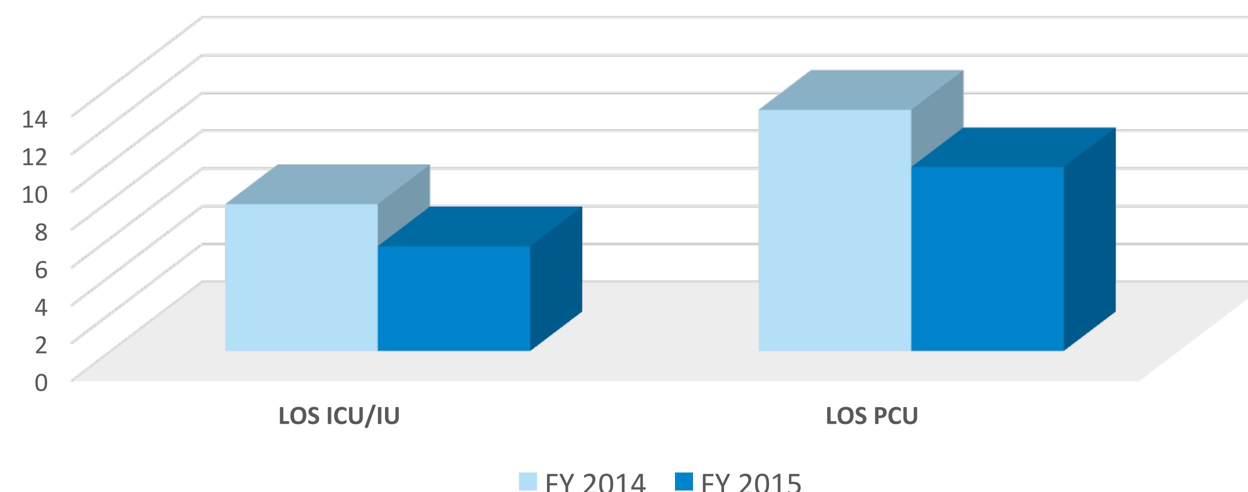


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