Gaps in End-of-Life Care: A Retrospective Review of Mortality Identifying Opportunities for Quality Improvement

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Background

- Traditionally palliative care has gotten involved in near the end of the patient's illness. Patients receive symptoms management during the end stages of life.
- ICU are costly to the health care system. Some of these costs are incurred on the patients that are poor ICU candidates whom are unlikely to survive, who goals of care are not being addresses and the patients would not want heroic measures.
- It has been proposed that proactive or even early palliative care involvement can help reduce ICU admissions, length of stay and improve end of life care
- Much palliative care occurs at end-of-life care when life-prolonging interventions are no longer appropriate, effective, or desired.
- If palliative care is involved from the beginning, symptoms are addressed earlier and often advance care planning is initiated.
- Patients may have a better autonomy to do things such as die at home.
- Studies have shown patients that received early palliative care had improved quality of life measures, decreased hospital admissions, and less aggressive care at the end of life

Objectives

- Identify gaps in services
  - Number of patients receiving aggressive care until the day of death
  - Lack of Palliative medicine consult
- Identify opportunities for improvement
  - Palliative medicine consult in ICU
  - Goals of care discussion in ICU
  - Allows for family/pt informed decision making
- Investigate root causes of deficiencies
  - No standard of practice
- Develop practice changes for improvement
  - Stand practice- GOC/FM for ICU pts with 48 hour of admission to ICU

Methods

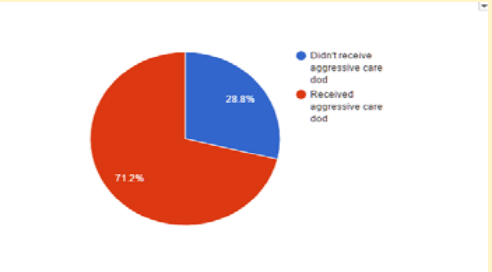
- Retrospective chart review of 200 charts of expired patients from September 2016 and February 2017
- Date of Death (dod): refers to the last 24 hours of a persons life
- Aggressive care: refers to care outside of the comfort care pathway/order set

Statement of the Problem

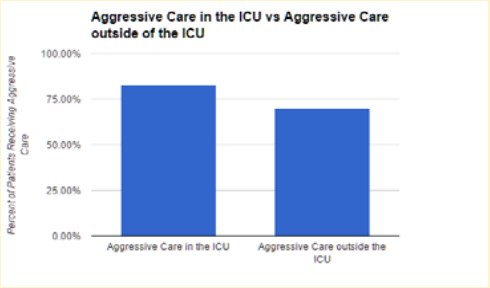
- More than 4 million patients are admitted to ICUs each year in the United States.
- After a year on a mechanical ventilator, the mortality rate for patients in long-term acute care hospitals ranges from 48 to 69.1 percent.
- Patients in ICUs occupy between 5 and 10 percent of inpatient beds in hospitals, but account for 20 to 35 percent of total hospital costs
- Mortality rates in patients admitted to the ICU average 10 to 20 percent in most hospitals.
- Nationally one quarter of Inpatient palliative care referrals come from the ICU
- 72% of hospitals do not have trigger tools for standards of care

Results

Patients Who Received Aggressive Care on the Day of Death



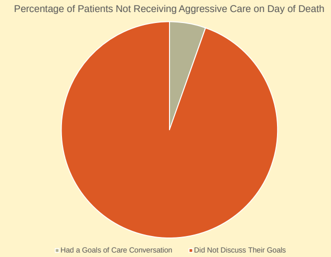
Aggressive Care in ICU vs. Outside ICU



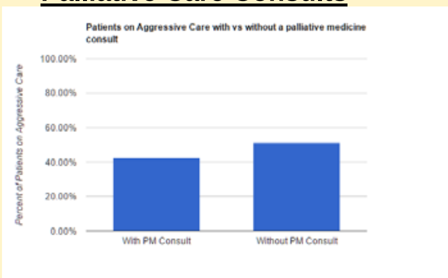
156 (78%) patients in the ICU received aggressive care on the last day of life as compared to 44 (22%) patients who did not receive aggressive care on the dod in the ICU.

Results

Goal of Care



Palliative Care Consults



The results indicated the following deficiencies:

- 92% of patients did not receive palliative care consult in ICU within 48- hours
- There was a statistically insignificant (8.8%) decrease in the number of patients who received aggressive care on DOD if there was a palliative care consult (p=0.289)

Implementation

PM ICU Referral

Presence of a serious illness, any of the above, and one or more of the following:

- Admission from a nursing home
- Two or more ICU admissions within the same hospitalization
- ICU admission after hospital length of stay of at least 10 days
- Prolonged or failed attempt to wean from ventilator
- Multiorgan failure/ failure of three or more organ systems
- Consideration of ventilator withdrawal with expected death
- Metastatic cancer
- Anoxic encephalopathy
- Consideration of patient transfer to a long-term ventilator facility
- Family distress impairing surrogate decision making
- stage IV malignancy
- status after cardiac arrest
- intracerebral hemorrhage requiring mechanical ventilation

Impact of Improvement

Referral and Consultation

- PM consult placed within 24 hours of admission.
- PM continues as integral part of the ICU care team
- Presented to patient and family PM is "normal and integral" part of the patients care
- Surrogate decision maker identified upon admission
- Goals of care discussion started within 48 hours and continued
- FM held within 48-72 hours

Conclusion

- The results indicated deficiencies in care for patients receiving aggressive care on the last day of life.
- The results indicated deficiencies in care for patients who did not receive palliative care consult in ICU.
- The results indicated improvement when PM was consulted within 48 hours of admission to the ICU.
- Number of pts in ICU who received aggressive care on the last day of life is considerably higher than on regular floors.
- Early intervention with palliative care with goals of care conversation can decrease the use of aggressive care on day of death for patients in the ICU.

Future Directions

- Create standard of practice for PM consult as standard of practice for ICU stay for select patients
- Create PM triggers for select patient populations admitted to ICU
- GOC and FM conversations earlier in ICU stay: within 48 hours of less
- Provide education on PM consult within 48 hours of ICU stay

References

Aiken, L.H., Clarke, S.P., Cheung, R.B, Sloane, D.M., & Silber, J.H. (2003) Educational levels of hospital nurses and surgical patient mortality. *J. Am. Med Ass.* 290(12), 1617-1623.

Aiken, L.H., Cimotti, J.P., Sloane, D.M., Smith, H.L., Flynn, L., & Neff, D.F. (2011). The effects of nurse staffing and nurse education on patient deaths in hospitals with different nurse work environments, *Med Care*, 49*(12)*, 1047–1053. doi:10.1097/MLR.0b013e3182330b6e.

Blake, N., Leach, L., Robbins, W., Pike, N., & Needleman, J. (2013). Healthy work environments and staff nurse retention: The relationship between communication, collaboration, and leadership in the pediatric intense care unit. *Nurs. Admin. Q., 37*(4), 356-370.

Fletcher, K. (2006). Beyond dualism: Leading out of oppression. *Nursing Forum,* 41(2), 50-59. doi: 10.1111/j.1744-6198.

Hurd, C. & Curtis, J.R. (2014). Education about palliative care in the intensive care unit: rediscovering opportunity. *Journal of Graduate Medical Education,* 13, 167-169.http://dx.doi.org/10:4300/JGME-D-13-00429

Institute of Medicine (2010). The future of nursing: Leading change, advancing heath. Washington, Dc.

Khandelwai, N., Kross, E.K., Engleberg, R.A., Coe, N.B., Long, A.C., & Curtis, J.R. (2015). Estimating the effect of palliative care interventions and advance care planning on ICU utilization: A systematic review. *Crit Care Med,* 43(5), 1102-1111. doi:10.1097/CCM.0000000000000852.

Laschinger, H., Wong C., & Grau, A. (2012). The influence of authentic leadership on newly graduated nurses experiences of workplace bullying, burnout and retention outcomes: A cross-sectional study, *International Journal of Nursing Studies, 49*(2012), 1266-1276.

Lee, B., Peck, C., Rutherford, P. & Shannon, D. (2008) Transforming care at the bedside How-to Guide: Developing front-line nursing managers to lead innovation and improvement. Cambridge, MA: Institute for Healthcare Improvement. Available at: http://www.ihi.org.

May, P., Garrido, M.M., Cassel, J.B., Kelley, A.S., Meier, D.E., Normand, C., Smith, T.J., Stefanis, L., & Morrison, S. (2015). Prospective cohort study of hospital palliative care teams for inpatients with advanced cancer: Earlier consultation is associated with larger cost-savings effect. *J. Clin. Oncol 33, 2745-2752.*doi:10.1200/JCO.2014.60.2334.

Mun, E., Ceria-Ulep, C., Umbarger, L. & Nakatsuka, C. (2016). Trend of decreased length of stay in intensive care unit (ICU) and in the hospital with palliative care integration in the ICU. *The Permanente Journal,* 20(4), http://dx.doi.org/10.7812/TPP/16-036

Murphy, L. (2005). Transformational leadership: A cascading chain reaction. *Journal of Nursing Management*, *13*(2), 128-136.

Nelson, C., Chand, P., Sortais, J., Oloimooja, J. & Rembert, G. (2011). Inpatient palliative care consults and the probability of hospital readmission, *The Permanente Journal,* 15(2).

Nelson, J.E., Cortez, T.B., Curtis, J.R., Lustbader, D.R., Mosenthal, A.C., Mulkerin, C., Ray, D.E., Bassett, R., Boss, R.D., Brasal, K.J., Campbell, M.L., & Weissman, D.E. (2011). Integrating palliative care in the ICU: The nurse in a leading role. *J. Hosp Palliat Nurs,* 13(2), 89-94. Doi: 10.1097/NJH.0b013e318203d9ff.

Weissman, D., & Meier, D. (2011). Identifying patients in need of a palliative care assessment in the hospital setting: A consensus report from the center to advance palliative care. *Journal of Palliative Medicine.* 14*(1)*, doi: 10:1089/jpm.2010.0347.