Prioritizing Palliative Care in the ICU through a Goals of Care Bundle

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Objectives

- Understand the key components of the Goals of Care Bundle (GOC) implemented at SMCS
- Identify the roles of interdisciplinary team members for the GOC
- Knowledge of tools used by SMCS to support quality family meetings in the ICU
Sutter Medical Center Sacramento

- Acute care- Adult, Neonatal, Pediatric
- Adult service- tertiary facility for cardiac, neurology, oncology, stem cell transplant, heart transplant/LVAD, bariatric, orthopedic
- ICU beds
  - 24 bed Medical ICU- Pilot location
  - 12 bed Neuro ICU
  - 12 bed Cardiac ICU
  - 12 bed Cardiac Intervention ICU
- Palliative Care Team
  - RN- 1.8 FTE
  - Daily representation of Social Work, Spiritual Care, Hospice, AIM (Home based palliative care through Sutter Care at Home), Respiratory Therapy, Case Management
  - Weekly IDT- Pharmacy, Speech Therapy, Medical Director
How it started

- The Voluntary Hospital Association Transformation ICU national initiative Care and Communication Bundle was introduced to the Regional Director of Palliative Care and discussion began on how to incorporate it at Sutter Health.

**Day 1**
- Identify decision-maker
- Address AD/CPR status
- Distribute ICU brochure
- Assess pain: 5th vital sign
- Manage Pain Optimally
- Arrange family meeting
- Palliative Care Screen

**Day 3 or before**
- Social Work Assessment
- Spiritual Care Assessment

**Day 5 or before**
- Interdisciplinary family meeting
- MD/bedside RN
- Elements: diagnosis, prognosis, goals of care, questions
- Offer follow-up meeting
The Team

An interdisciplinary team assessed current practice in the ICU, brainstormed best practices for patient and family centered care, and developed standard work for a GOC at SMCS

- ICU Social Work
- Chaplain
- Critical Care MD
- Hospitalist MD
- Palliative Care RN
- Bedside RN
- ICU RN Case Manager
- Chief Nursing Executive

- eICU RN
- ICU Respiratory Therapist
- ICU Director
- Social Work Management
- Spiritual Care Director
- Director of Palliative Care
- Director of Care Coordination
- SMCS Medical Director
The Goals of Care Bundle (GOC)

- The GOC is a set of standard work expectations implemented to change ICU culture and practice
  - Identified Metrics
    - Decrease the number of patients dying on “Comfort Care” in the hospital (other than with in-patient hospice)
    - Decrease ICU LOS
    - Decrease readmission rate
    - Increase referrals to Palliative Care, AIM & Hospice
    - Increase patient/family satisfaction
# GOC at SMCS

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<thead>
<tr>
<th>Day 1</th>
<th>Day 2 or before</th>
<th>Day 3 to 5 or before</th>
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<tbody>
<tr>
<td>Identify decision maker and support person</td>
<td>Social Work assessment</td>
<td>Hold interdisciplinary family meeting: includes patient’s diagnosis, prognosis, goals of care, questions &amp; answers</td>
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<td>Address Advance Directive; POLST; CPR status</td>
<td>Spiritual Care assessment</td>
<td>Set-up next family meeting: significant change in patient’s condition or minimum every 7 days</td>
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<td>Orientation to ICU</td>
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<td>Assess pain – 5th vital sign</td>
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<td>Manage pain optimally</td>
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<td>Arrange family meeting to be held in 2 to 5 days</td>
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<td>Complete Palliative Care Screen – Case Management</td>
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The Pilot- Population

- 24 bed Medical ICU
- Patients expected to remain in the ICU for <5 days (MD assessment)
- Admitting diagnosis not a planned surgery
- Admitting treatment not a cancer intervention
The Pilot – New Expectations

- Family meeting content was standardized
  - Pre meeting for the healthcare team
  - Expectations for members of the team
  - Post meeting summary

- Include content of bundle assessments and expectations in daily ICU IDT bedside rounds by attending clinicians

- SW and chaplain shift in triage of cases in the ICU

- SW and chaplain to extend morning huddle to identify the lead clinician for GOC patients

- Addition to admitting RN’s intake assessment and patient/family education
The Pilot- Education

- Education
  - ICU RN – Day 1 standard work, tools, family meeting participation
  - Chaplain - facilitation of family meeting, tools, role of the lead clinician
  - Social Work - tools, role of the lead clinician
  - MD education- Family Meeting expectations
The Pilot- Best Practice

- Search for examples of forms
  - The Care and Communication Bundle [2, 6, 9, 12]
  - Several examples of family meeting summary forms and informational guides were reviewed [3, 8, 11, 13]
  - Patients and families define high quality palliative care as:
    - timely, clear, and compassionate communication
    - Clinical decision-making focused on patients’ preferences, goals and values
    - Patient care maintaining comfort, dignity and personhood
    - Family care with open access… to patients, interdisciplinary support, …and bereavement care [10]
  - Family Meetings are important methods of communication in the ICU [4, 5, 7, 10]
  - SW assessment and intervention can lead to a clarification of choices [1]
The Pilot - Tools

- ICU intro packet
  - Introduction to the ICU
    - Discusses IDT rounds, quiet times, and having a family spokes person
  - Family Meeting Guide
  - Introduction to Spiritual Care
  - Educational pamphlet regarding ICU delirium
  - Brochure regarding the Sutter Resource library
  - Blank notepad
  - MICU business card

- A Guide to Family Meetings in the ICU
- Family Meeting Summary Form
- Room in Use for Meeting
- Palliative Care Screen
- Tracking tool
The Pilot - Tools

• A Guide to Family Meeting in the ICU

An introduction to meeting with your medical team in the ICU.

Every person who comes through our doors is different and special to us. It is important for us to know what is most important for you so that we can coordinate care that supports your wishes and needs. We want you to get the most out of what your care team has to offer.

In order to coordinate your care, we may request to meet with you and your support person(s) in the first week of your ICU stay. Our social worker, chaplain or nurse will be with you and/or your recognized surrogate decision maker to set up this meeting. He/she or they will work with you to identify who should be there and what is important to you to have discussed.

Here are some of the normal things that might be discussed in a family meeting:

- Initial medical needs and diagnosis
- Current condition
- Patient's known medical wishes
- Options for treatment
- Plan for testing and treatments
- Limits to treatment
- Symptom control
- Support needs

We know that being in the ICU can be a stressful time for patients and those who care for them. It may feel overwhelming to try to think of questions about what is happening. Here are a few things you may want to consider in preparation for your meeting:

- What is the most important thing for our team to know about you, your loved one, and/or your family?
- Who do you want with you when you speak with your medical team?
- Do you have any concerns or worries you should know about?
- Have you completed an Advance Health Care Directive or POLST and do we have a copy?
- Have you discussed your medical wishes with your loved one(s)? If the patient is not able to talk right now, can you recall things they have said about life support or other procedures? Have they talked about other people they knew who had been in the hospital? If they were with you right now, can you imagine what they might want to know or to talk to us about?

We may not have all of the answers, but we will do our best to provide you and your loved one(s) with the support you need to manage this ICU stay. Please let us know how we can help.
The Pilot - Tools

- SMCS Patient and Family Meeting Summary Form
The Pilot - Tools

This room will be in use for a meeting on
_________/_________/____________________
from _________am/pm to _________am/pm
for a family to meet with the medical team.

There are several other areas available to you at SMCS. There are family waiting areas located at either end of the ICU and on the second floor of the Ose Adams building there is a quiet space for meditation and prayer. Please ask any staff member for assistance in locating these areas if needed during this time.

Thank-you
The Pilot - Tools

• Palliative Care Screen
  ◦ To be completed by the ICU case manager for each new admit
The Pilot- Day 1

### Standard Work
- The GOC is initiated for patient’s who qualify by the admitting RN via electronic referral to the social worker.
- RN provides an ICU introduction packet including handout “SMCS ICU Family Meeting Guide” to patient or family.
- ICU case manager completes Palliative Care Screen and informs MD if patient meets criteria for referral.
The Pilot- Day 2-3

**Standard Work**

- Triage of new referrals during morning huddle to assign lead clinician
- Lead clinician meets with patient and family
  - Assess/Identify:
    - medical decision maker
    - health care literacy
    - language of choice
    - spiritual support needs
    - psychosocial needs
  - Set up meeting with clinical staff for day 3-5.

**In practice**
The Pilot- Day 3-5

Standard Work

- Prior to the family meeting
  - Facilitator to review SMCS ICU Family Meeting Guide and discuss patient/ family goals
  - Medical team to participate in pre-meeting to discuss patient and family goals and address any staff concerns

- Family meeting is facilitated by lead clinician.

- Patient and Family Meeting Summary Form to be completed by the facilitator with support from medical team during a post meeting

- Form provided to patient or medical surrogate and scanned into medical record

In practice
The Pilot- Day 6 and up

**Standard Work**
- Follow-up family meetings for 7 days post initial meeting

**In practice**
Results- The Numbers

- Let us consider this the “soft opening” of our GOC
Results- The Experience

- Practice normalizations
  - Terminology- goals of care
  - Family Meetings by day 3-5
  - Discussion of Quality of Life goals at rounds
  - Team Trust that the conversation is happening

- This bundle might have helped to educate nursing and physician staff to SW and Palliative Care referrals post implementation of the EHR.

- Accept that sometimes the barrier is time
Results- Contrast of Cases

- **GOC patient**
  - Goals identified at Day 3-5
  - Preparation for long term care, discharge, or end of life begin earlier
  - Normalizing stress, ambiguity, and ICU norms (changing providers, learning staff families align with) offered
  - Normalize patient and family communication
    - Questions and concerns
    - Participation in rounds
    - Getting to feel heard
  - Quality of Life discussed as early as possible
  - POLST, AHCD honored closer to admit

- **Non-GOC patient**
  - Plan of care established without clarification of goals
  - Patient and family frustration from not speaking with physician or hearing conflicting information
  - Examples-
    - Tracheostomy without goals of care discussion
    - Tracheostomy the day of withdrawal
    - Family offered new dialysis catheter at morning rounds, but with social work and palliative Care RN intervention family identified goal to prolong life only until further family could come to visit
Where to We Go from Here

- Add a pamphlet regarding Palliative Care to the ICU intro packet
- Change the population criteria to an established set instead of an >5 day guess
- Produce tools to identify patient and staff goals for the family meeting [5]
- Better education to nursing staff about GOC and role
- Better education to chaplain(s) regarding facilitation of a family meeting
- Increase case management communication regarding results of Palliative Care Screen
- Commitment from the team to follow the recommendations regarding pre and post meeting
- Improve compliance
- MD education of hand out aides available to them
Bibliography