Palliative Care: Is our Neuroscience Intensive Care Unit Ready?

Background
A review of literature and current evidence-based practice, in combination with real-time observations of our current practices indicated that patients & families experience a loss of life in our Neuroscience Intensive Care (NICU) needed additional support.

- Palliative care is an evolving revolution and is occurring more frequently in intensive care units.
- NICU lacks an effective palliative care program.
- Nurses visualize the effects of long term and short term illnesses.
- Catastrophic disease, such as ischemic or hemorrhagic stroke occur suddenly and without warning.
- Other diagnoses are made after a length of time where the patient is progressively declining, for instance malignant brain tumors and degenerative processes (Amyotrophic Lateral Sclerosis (ALS), dementia, or Alzheimer).
- NICU nurses see lives prolonged and death delayed due to the lack of communication.
- In other cases, patients and/or families are unable to understand the diagnosis presented is a non-recoverable injury and the patient will not recover to have a meaningful quality of life.

Patients are receiving palliative care consults later on in their stay due to a lack of knowledge regarding the concept and goals of palliative care and the inability to identify crucial palliative care triggers. The literature supports these findings:

- Approximately 20% of all Americans die within, or shortly after leaving the intensive care unit.
- Those patients that survive aggressive treatment continue to suffer with chronic illnesses.
- Aggressive treatment may be contrary to patients and families' preferences and values and often lead to physical and financial burdens.
- Anxiety, depression, and post-traumatic stress disorder (PTSD) are often found in patients and families who have been through a crisis (Center for Advanced Palliative Care, 2010).
- Patients and their family members have difficulty accepting a diagnosis or news that their loved one will not return to a normal quality of life, at best, very difficult.

Developing a Unit-Based Palliative Care Team
A unit-based team was created to establish a foundation and consistent process for palliative care. The team consists of the nurse manager, two charge nurses, two staff members, a chaplain, and the hospital palliative care physician. Each team member was given a reference binder with information and research articles about palliative care. The team reviewed the hospital policy and procedures, updated end-of-life check lists, and ordered reference material for families. An educational bulletin board provided staff nurses, nurses, and other healthcare team members) with information on the Intensive Care Unit, hospital meetings, how to have a family meeting, and the...

A unit project to make teddy bears was launched with a volunteer to sew the bears from donated staff scrubs. The teddy bears were given to children in whom a loved one, or whose family member was in the process of dying, as well as those patients who suffered from a non-recoverable illness. In addition, our team initiated palliative care consults which contain small teddy bear boxes. This small box contains a tea-light candle and a place to store memorable belongings such as the hospital band, a lock of hair, or a poem. A sign with an image of a dove is placed on the outside of the patient’s room to quietly alert staff of the end-of-life care taking place.

The initial step was the creation of the unit-based palliative care team which was driven by the knowledge that several areas for patient and family support were lacking. Among the deficiencies identified were patient and family education, a consistent means of support and communication, and the ability to honor the wishes of the patients and families. Once these issues were identified in the NICU, it became evident that the other adult intensive care units (ICUs) were encountering the same challenges with end-of-life care.

The second step in the process was to initiate a hospital-wide palliative care team for all the adult ICUs. In our hospital there are 54 dedicated Neonatal ICU beds and additional adult ICUs for Medical/Surgical, Trauma, and Cardiac patients – a combined 120 ICU beds. An expanded team brought in more staff nurses, nurses, managers, physicians (other than palliative care), and the palliative care chaplain.

Next Steps
The next steps will be to increase the staff’s knowledge and expertise by offering a two-hour class with continuing education units (CEUs). To supplement the classes, the staff will be provided reference books and pocket guides to reinforce the education. The goal is to have 80 percent of all ICU nurses educated using the core curriculum from the End-of-Life Nursing Education Consortium (ELNEC) train-the-trainer program. The Frommelt Attitude Toward Care of the Dying Scale (FATCOD) will be used to evaluate learning. The classes will be multidisciplinary in order to educate all groups involved in caring for the patient and the family.

Outcomes
The outcome of this project is to enhance the nurse’s knowledge about palliative care and triggers for palliative care consults. Thus, early interventions, i.e. patient/family meetings with providers and the healthcare team will facilitate nursing and a multidisciplinary awareness of the need for supportive and consistent end-of-life care. The strategies learned will create a climate of expectations for identifying patient and family needs with receiving earlier consultations with palliative care providers. Improving the staff’s knowledge and skills will increase their confidence to effectively manage care at end-of-life and provide the necessary support to the patients and families. End-of-life care is difficult for all involved; however implementing strategies and providing the necessary tools for the healthcare team will ultimately have a positive effect for the patient and their family.

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