Special Section: Quality Improvement Projects

Using the Improving Palliative Care in the Intensive Care Unit (IPAL-ICU) Project to Promote Palliative Care Consultation

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Abstract

Background. The Improving Palliative Care in the Intensive Care Unit (IPAL-ICU) project is an initiative designed to improve the quality of palliative care in the intensive care unit. One of the problems to be addressed is the underutilization of palliative care.

Measures. The percentage change in number of palliative care consults in the Medical ICU (MICU) and Surgical ICU (SICU) compared with the same time period the previous year was used as an objective measure to indicate increased utilization of palliative care.

Intervention. Two hundred seventy-three patients were screened for potential palliative care consultation. After each patient screening, the attending physician was offered the opportunity to consult the palliative care consultation team.

Outcomes. In comparison with the same time period the previous year, an increase in palliative care consults of 113% in the MICU and of 51% in the SICU was noted during the screening period.

Conclusions/Lessons Learned. The IPAL-ICU project framework and recommendations can be effectively used to increase the number of palliative care consults in the ICU. J Pain Symptom Manage 2011;42:672–675. © 2011 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

Key Words
IPAL-ICU, palliative care consultation

Background

Specific efforts have been underway for several years to improve palliative care in the intensive care unit (ICU). These efforts have culminated in the Improving Palliative Care in the ICU (IPAL-ICU) project, which provides tools to assist in the creation of an ICU palliative care initiative. The framework provided by the IPAL-ICU project monographs allows an institution the flexibility to conduct its own needs assessment and subsequent action plan. The goal is to improve palliative and end-of-life care in a manner that is feasible, enduring, and acceptable in the local institutional culture.

The first step toward action plan development is the identification of the problem. Although multiple organizations have published...
the IPAL-ICU provides practical steps to be used in the development of a palliative care initiative. The project defines the following targets: 1) high rates of death or other unfavorable outcomes in the ICU or the same hospitalization; 2) high utilization of critical care resources for patients who are unlikely to benefit, constraining availability for other patients in need; 3) distress or dissatisfaction reported by patients and/or families; 4) delayed and/or inconsistent performance of evidence-based palliative care processes; 5) distress or burnout experienced by ICU staff; and 6) underutilization of palliative care specialists in the care of ICU patients.

There is growing evidence to suggest the value of palliative care consultation in the ICU. However, the need to establish the presence of the palliative care team and increase palliative care consultations in the ICU is paramount to the success of any future initiatives. We conducted this project with the expectation that focused screening of patients appropriate for palliative care would result in an increased rate of consultations.

Measures

The primary outcome variable is the fraction of consults obtained from the total number of patients screened. As indicated by prior research, this measure suggests an improved quality of life. The denominator consisted of patients in our Medical ICU (MICU) and Surgical ICU (SICU) admitted between April 1 and December 31, 2010 with one of the following criteria: 1) age 70 years or older with two or more comorbidities; 2) Stage IV cancer; 3) mechanical ventilation for seven or more days; and 4) exceeding expected length of stay by more than 50%. Screening criteria were chosen based on previously used criteria and areas of concern (high risk of death and long lengths of stay) within the institution. Comorbidities used for the age criteria included the following: 1) congestive heart failure; 2) critical valve disease; 3) coronary artery disease; 4) prior myocardial infarction; 5) hypertension; 6) chronic pulmonary disease; 7) diabetes; 8) cancer (except for Stage IV); 9) prior stroke; 10) renal failure; 11) liver disease; and 12) dementia (all types).

Patients with admissions of less than 48 hours were excluded as these units also are used for short-term, high-risk monitoring. This population represented a wide variety of typical MICU and SICU patients. No specific populations were targeted for screening.

The numerator consisted of the number of palliative care consultations received by the screened population over the same period of time. The number of consultations received during the project time frame was compared with the number of consultations received from the MICU and SICU during the same period the previous year (there were no palliative care projects during the previous year).

Intervention

This project was approved as a quality improvement initiative by The Methodist Hospital’s Critical Care Performance Improvement Committee. Additionally, hospital leadership affirmed the decision of the committee to move forward with the initiative.

Patients admitted into the MICU and SICU during the specified time frame (April 1–December 31, 2010) were screened (using the criteria stated above) by a MICU nurse. An institutional grant (Nightingale Fellowship) provided funding for two nurses to work on this project 14–16 hours per week, each for a period of four months. The nurses continued their prior nursing duties part-time during the project period. Because of scheduling issues, the nurses only screened patients two to three times per week. Two nurses were recipients of this grant and performed screening and data collection activities.

After screening, a phone call was placed to the attending physician (a combination of intensivists and academic and private physicians) by the palliative care physician offering palliative care services to the patient. During the phone call, the physician was informed of the screening process in the context of the “national effort to improve care in the ICU.” The domains specifically mentioned in the phone call were the following: communication, decision making, emotional support, and symptom management. There was no standard script used during the phone call. This direct communication between
the palliative care physician and the attending physician represented the intervention.

If a consultation was obtained, the palliative care team (composed of a physician, a social worker, and a nurse practitioner) conducted a needs assessment and initiated a standard intervention, including one or more of the following: 1) pain and symptom management; 2) discussion of advance directives and code status; 3) establishment of goals of care; 4) patient/family emotional support and education; 5) discussion of withholding/withdrawing non-beneficial treatments; and 6) hospice discussion. There were no changes in palliative care staffing during the time frames used for comparison. There were no physician-directed marketing efforts advertising palliative care conducted before, during, or after the project period.

**Outcomes**

Of the 273 patients screened, 97 palliative care consultations were obtained. The proportion of consultations received from the MICU vs. the SICU did not differ statistically. Almost half of the consults (48%) were obtained from intensivists. Other physicians included hospitalists (15%), private internal medicine attendings (19%), surgeons (13%), and the remainder consisted of other internal medicine subspecialties. Of 174 patients screened in the MICU, 60 patients received a palliative care consult (34.5%). Of 99 patients screened in the SICU, 37 received a palliative care consult (37.4%).

The total number of palliative care consultations (project and nonproject patients) received from the MICU and SICU during the project period was 96 (60 patients from screening and 36 routinely obtained consults) and 77 (37 from screening and 40 routinely obtained consults), respectively. This was compared with the number of consultations received from the MICU and SICU, 45 and 51, during the same time period the previous year (April 1–December 31, 2009).

The total number of admissions to the MICU during the project period was 1309 compared with 1383 during the previous year (decrease of 5.5%). The total number of admissions to the SICU during the project period was 1376 compared with 1543 during the previous year (decrease of 11.4%). Consultations increased by 113% in the MICU and 51% in the SICU from 2009 to 2010. The combined increase was 80.2%.

**Conclusions**

The IPAL-ICU project was useful in organizing and restructuring a performance improvement project that was underway within our institution. Our initial difficulty in isolating a primary problem from among the many problems in providing palliative care in the ICU was greatly simplified as a result of using the IPAL-ICU framework. Specifically, the problem of “specialty input” was chosen as a first step to establish a “foothold” in the ICU and foster greater acceptance of palliative care into the overall spectrum of critical care.

The direct communication strategy was not only directed to physicians but to nurses also. The nurse recipients of the Nightingale Fellowship were both MICU nurses. Their role was crucial in engaging ICU nurses in the screening process and explaining the role of palliative care in the ICU. The nurses were encouraged to advocate for patients in need of palliative care.

Our goal of improving the utilization of palliative care services focused on a simple communication with the attending physician. This intervention was chosen based on a prior study that demonstrated its use in proactive palliative care and survey findings related to inadequate communication between the ICU team and other clinicians about goals of care.

The increase in consultations as a result of a palliative care intervention has been previously noted. Norton et al. found that only 8% of “usual care phase” patients received a palliative care consultation. Both the percentage of consults received during the project phase and the percent increase compared with the year before strongly suggest a positive impact of our intervention.

Our future work will focus on the use of established quality indicators that are reasonable given available resources and institutional relevance. The IPAL-ICU process will be an essential component in the planning and execution of those efforts.
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References


