Integrating Palliative Care as Standard Care in Sepsis Treatments

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May 18, 2016
2008 Surviving Sepsis Campaign Guidelines

• Consideration for limitation of support (1D)
  ▫ Discuss end-of-life care for critically ill patients
  ▫ Promote family communication to discuss use of life-sustaining therapies

▫ 1D = Very Low Quality of Evidence

Dellinger RP et al Crit Care Med 2008; 36:296-437
2012 Surviving Sepsis Campaign Guidelines

- Recommendation: Change from 1D (very low grade of evidence) to 1B (moderate degree of evidence)
- Rationale: There has been a synthesis review of 21 trials of intervention studies (4 of which were randomized control trials) aimed at improving communication with family members in the ICU, a number of single center cohort studies addressing palliative care and end-of-life, a multicenter cross sectional study, a Delphi consensus study, several literature synthesis reviews and clinical practice guidelines which reviewed over 300 publications, since the last SCC guidelines revision.
Setting Goals of Care

• **Recommendation 1:**
  ▫ We recommend that identification of goals of care, prognosis for achieving those goals and the level of certainty for the prognosis be discussed with patients and families. (Grade 1B)

• **Recommendation 2:**
  ▫ We recommend that these communications should be incorporated into treatment plans with integration of palliative care principles, and as appropriate, end-of-life care planning (Grade 1B)

• **Recommendation 3:**
  ▫ It is suggested that goals of care be addressed as early as feasible but no later than within 72 hours, depending on cultural considerations (Grade 2C)
What is Palliative Care?

- Specialized medical care for people with serious illness.
- It focuses on providing relief from the symptoms and stress of a serious illness.
- The goal is to improve quality of life for both the patient and the family.
How is it different from hospice?

• Palliative care is for anyone with a serious illness.
  ▫ You can have it at any age and any stage of an illness.
  ▫ You can have it along with curative treatment.
  ▫ It is not dependent on prognosis.

• Hospice is an important Medicare benefit that provides palliative care for **terminally ill** patients who may have only months to live.

• People receiving hospice no longer receive curative treatment for their underlying disease.
Case 1

- Gladys is an 83 year old woman with advanced dementia admitted to the hospital for the third time in the last eight months
  - Admitting diagnosis: aspiration pneumonia
  - Patient is a DNR-CCA
  - Baseline functional status: up in WC, non-ambulatory, assisted feeds and ADL’s, verbal communication is limited
  - Frequent doses of hydrocodone for arthritic pains
  - Daughter is dPOA-HC; spouse deceased
What makes Gladys at risk for sepsis?

- Respiratory infections – most common associated condition
  - Pneumonia is the single most common cause of sepsis
  - Oropharyngeal colonization with GNB
  - “Silent Aspiration”
- Genitourinary infections are second most common
  - Is Gladys at risk for this?
- Age-related comorbidities
- Declining functional status
Ideally...

- Goals setting discussion had on admission that includes:
  - Realistic discussion of resuscitation survival for a patient like Gladys
  - Discussion as to whether repeated hospitalizations really in patient’s best interest
  - Risks, benefits, burdens of antibiotic therapies, artificial nutrition and hydration, and other aggressive treatment options (pressors, etc.)
  - What is Quality of life (versus Quantity)
Let’s assume that discussion didn’t happen...
Gladys’ assessment

- T-38.9, P-98, R-22, BP 101/45
- AAOx1 (daughter)
- Breath sounds coarse rhonchi throughout
- Weak cough; expectorate thick, yellow
- $SpO_2 = 91\%$ on 3L O2 via NC

- What now?
Likely next steps

- Blood draw
- Antibiotics
- ICU
- Telemetry
- Copious IV fluids
<table>
<thead>
<tr>
<th>Perfect World</th>
<th>Probable World</th>
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<tbody>
<tr>
<td>• Gladys responds to fluid resuscitation and antibiotics</td>
<td>• Gladys deteriorates, agitates, desaturates</td>
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<tr>
<td>• Gladys’s condition stabilizes to her prior level of function***</td>
<td>• Gladys has a prolonged ICU stay</td>
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<tr>
<td>• Gladys goes to skilled nursing facility</td>
<td>• Gladys ends up on pressors, intubated, Cdiff from broad spectrum antibiotics, lines, more lines, wounds, tubes, codes, codes, DIES...</td>
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<tr>
<td>• Gladys then returns home to her extended care facility</td>
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Even if Gladys responds to treatment this time...chances are she will re-aspirate, re-admit and repeat her sepsis journey all over again.
What will NOT happen

- Gladys fully recovers from her pneumonia and sepsis
- Gladys never aspirates again
- Gladys’ dementia improves or reverses
- Gladys walks again
- Gladys lives independently
Where do we intervene?

• ER physician – can start to prep family for decompensation probability; get gears turning about what pt might have wanted
• Nursing – can prompt family and physician “what about a goals discussion?”
• ICU physician/hospitalist/GME – follow up on these conversations and repeat daily. Be realistic but not dismal. Honesty about what getting better looks like, getting worse.
• Entire team – WWGW? What Would Gladys Want?

***None of this needs to delay sepsis bundles***
Sepsis does not mean dying in pain

• Goals of palliative care remain the same whether dying or recovering:
  ▫ Management of pain, dyspnea, anxiety, restlessness/delirium

• Goals of palliative care at the end of life TAKE AWAY
  ▫ Painful testing – repeat blood draws, arterial lines, invasive monitoring
  ▫ Life (Death) prolonging treatments that can be painful and offer no additional benefit
What if Gladys does survive?

- Palliative care goals don’t have to change!
- Symptom management plan follows her to the ECF
- Consideration of hospice
- Updated DNR status including “no further hospitalizations”
- Discussion with family of benefits/burdens of repeated antibiotics for the next time...
- Discussion with family (and sometimes ECF staff) of artificial nutrition
  - Does not prevent aspiration
  - Found to be as safe as careful spoon feeding
The aftermath

- Infection, sepsis often viewed as acute problems
- Chronically ill patients do not return to normal when infection is “fixed”.
  - On average, elderly sepsis survivors have 1.5 new functional limitations, compared to their pre-sepsis baseline
  - Especially in elderly, decreased functional status, increased reliance on caregivers, more medications for more problems = more side effects
So what if 83yo Gladys is suddenly 43yo George?
Case 2

• George is a 43yo gentleman with borderline htn, HLD and a 15 p/y smoking history. He is married, has 2 kids in high school ages 15 and 17, and works as a manager at the local car dealership.

• George presents with a high fever, chills, rigors to the ER after his wife forced him to come in.

• On further review, you find that George was working in his garage over the weekend and suffered a severe gash to his forearm that he cleaned and bandaged himself.
More about George

• George’s parents are alive and well in their early 70’s.
• George and his wife have a will, because they have kids, but his wife tells you there is no paperwork about end of life care – why would you even ask?!
• She further tells you she is his POA, but on careful questioning, you find out this is financial only.
• They have never had discussions about this sort of thing because they’re not “old” yet.
Likely next steps

- Blood draw
- Antibiotics
- ICU
- Telemetry
- Copious IV fluids

- Looks familiar...
What happens next?

**Perfect World**

- George responds to fluid resuscitation and antibiotics
- George’s condition stabilizes to his prior level of function
- George goes to a skilled nursing facility or home with some HHC or even just home
- George then returns to his old ways (minus the smoking because this is a perfect world) with his wife hovering every time he works in the garage.

- There is little chance that George will experience something like this again as it was a ‘freak’ sort of thing.

**Possible World**

- George has waited long enough to come in OR this infection is so aggressive that George doesn’t respond to fluids and antibiotics.
- George requires ICU transfer, pressors and intubation with mechanical ventilation. He is in septic shock.
- In the ICU it is discovered George has positive blood cultures and a vegetation on his mitral valve. He begins to show signs of heart failure.
- Further, George develops AKI, his lactate level rises, there are troponin elevations...
- George has a prolonged ICU stay
- George develops Cdiff from broad spectrum antibiotics
- George codes, resuscitation attempted but unsuccessful and George DIES....
How similar?

- Septic
- No code status
- Family available and present
- Family has no clue, needs guidance
How different?

- Young
- Healthy
- Kids are kids
- Very different baseline

- This one hurts more, doesn’t it?
How do we treat 43 v. 83?

- Medically, we treat George and Gladys the same
- But ask yourself:
  - Do you take George home with you perhaps a little more?
  - Do you push George’s wife for further, more invasive treatments?
  - Do you allow George to stay on pressors, or intubated, a little longer before “giving up hope”?  
  - Do you postpone or put off end of life or goals of care discussions with George’s wife longer than you would with Gladys’ daughter?
  - Many of us do this (you’re normal)
Why is Prognostication Difficult?

- Tools out there but not aware or utilized
- Tough questions may penetrate our “shield” or increase responsibility in decision making
  - “Doc, what should I do?”
  - “What if it was your mother/father/husband/daughter?”
- We are humans
  - Emotionally difficult
  - Our own mortality
  - Our own baggage
- We do not like to take away hope
Prognostication Tools

- **Intensive Care Unit**
  - **APACHE II (Acute Physiology and Chronic Health Evaluation)**
    - Estimates ICU mortality based on a number of laboratory values and patient signs taking both acute and chronic disease into account.
  - **SAPS (Simplified Acute Physiology Score)**
    - Designed to measure the severity of disease for patients admitted to ICU ages 15 or more. Calculates mortality risk from 0% to 100%.
  - **ProVent Score**
    - A prognostic model for one-year mortality in patients requiring prolonged mechanical ventilation.
Harm with poor prognostication?

- Large number of DNR orders are written in last 48 hours of life and patient preference is poorly known.
- May lead to late hospice referrals (days vs. months)
  - LOS decreasing – 17 days
- Leads to patients/families requesting futile care
Doctors are Overly Optimistic

- One study asked 343 US doctors to provide survival estimates for 468 new hospice enrollee with a cancer diagnosis.
- Only 20% of predictions were within 2-3 weeks of actual survival.
- Over 60% overestimated by a factor of 3-5.
- Worse accuracy the longer the doctor-patient relationship.
Why should we involve Palliative Care Teams?

• Prognostication is difficult. Even in the ICU, a second opinion on dying can be valuable.
  ▫ Chance to be wrong

• Recent medical traditions show physicians, nurses:
  ▫ Not taught natural history of illnesses
  ▫ No emphasis on best therapy at end of a disease
  ▫ No prognostication training or mentoring in clinical setting
  ▫ No feedback or reflection on outcomes
  ▫ Dying is not emphasized and often lose continuity of care
    • “Hot Potato Syndrome”
Difficult Conversations

• Never easy to tell someone they or a loved one is dying – even in hospice/palliative medicine.
• Key Phrases
• Get to know your audience
• Stop talking (Listen!)
• Ask – Tell – Ask
How: Ask - Tell - Ask

- **Ask**
  - If it is ok to talk about prognosis at this time
  - Review what they already know, and sources of information

- **Tell**
  - Give information in small amounts
  - Build on what they already know
  - Use simple straight-forward language

- **Ask**
  - Repeat understanding of what has been said
  - If they would like to hear more
  - Repeat as needed
When to call Palliative Care?

Criteria for a Palliative Care Assessment at the Time of Admission

- A potentially life-limiting or life-threatening condition and . . .
- Primary Criteria
  - The “surprise question”: You would not be surprised if the patient died within 12 months or before adulthood 23–25
  - Frequent admissions (e.g., more than one admission for same condition within several months)
  - Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)
  - Complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings)
  - Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)
- Secondary Criteria
  - Admission from long-term care facility or medical foster home
  - Elderly patient, cognitively impaired, with acute hip fracture
  - Metastatic or locally advanced incurable cancer
  - Chronic home oxygen use
  - Out-of-hospital cardiac arrest
  - Current or past hospice program enrollee
  - Limited social support (e.g., family stress, chronic mental illness)
  - No history of completing an advance care planning discussion/document
What if there is no Palliative Care team at my hospital/facility?
Resources

- CAPC (Center to Advance Palliative Care)
  - Hospitals can have membership
  - User-friendly, goldmine of palliative care information, resources and metrics
  - [https://www.capc.org/](https://www.capc.org/)
- IPAL-ICU (Improving Palliative Care in the ICU)
- FAST FACTS
  - Practical & peer-reviewed summaries on key topics important to *palliative* care clinicians and trainees
  - App Store – “Palliative Care Fast Facts”
Resources

- **Death Foretold: Prophecy and Prognosis in Medical Care** – Nicholas Christakis
- **Ira Byock, MD**
  - *The Four Things that Matter Most*
  - *Dying Well*
- **Atul Gawande, MD**
  - *Being Mortal*
- **Maggie Callanan, RN**
  - *Final Gifts*
  - *Final Journeys*
- **Tuesdays with Morrie** – Mitch Albom
References