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Transitioning with Grace: Improving Quality of Life for Comfort Care Patients in the Intensive Care Unit

People are living longer with complex, chronic medical conditions. Patients with advanced, chronic, incurable diseases receive health care in intensive care units (ICUs), offering technologically advanced medical intervention designed to prolong life. However, when medical intervention fails, or when the patient or surrogate decision maker chooses to change goals of treatment from life preservation to comfort care, institutions oftentimes fall short of optimizing quality in patients' end of life experiences. As Curtis and Rubenfeld (2001) suggest, the challenge is to reconcile the "rescue culture of critical care" with the "hospice culture of palliative medicine" (p. 4).

Literature Review

Much research exists to guide high quality end-of-life care. Ruland and Moore offer the Peaceful End of Life Theory (1998), and the National Consensus Project for Quality Palliative Care (NCPQPC) published Clinical Practice Guidelines for Quality Palliative Care in 2013. The World Health Organization (WHO) defines palliative care as "an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (para. 1).

Nurses provide palliative care in some respect to all ICU patients; however, comfort care describes when a patient or healthcare surrogate changes the goals of patient care from life preservation to promoting comfort while allowing a natural death to occur. Plans of care and treatment interventions change to focus on keeping patients comfortable during the dying

process. Comfort care measures may include withdrawal or withholding of life-sustaining technologies and/or not escalating care. According to Blinderman and Billings (2015), the process of moving to comfort measures requires “meticulous palliation of troubling symptoms and offering of skilled psychosocial and spiritual support to the patient and the patient’s family” (p. 2550). Family, or loved one, inclusion in patients’ transition to comfort care is essential as loved ones have complex needs at such a critical time (Andershed, 2006; Desanto-Madeya & Safizadeh, 2017).

Research exists that identify barriers to providing quality end of life care in the ICU including lack of training, insufficient communication, lack of time, and the ICU being an inappropriate environment, among others (Beckstrand, Callister, & Kirchhoff, 2006; Brooks, Manias, & Nicholson, 2016; Espinosa, Young, & Walsh, 2008; Nelson, Angus, Weissfeld, Puntillo, Danis, Deal, Levy, & Cook, 2006; Attia, Abd-Elaziz, & Kandeel, 2012; Friedenber, Levy, Ross & Evans, 2012).

Research also elucidates many opportunities for improvement to improve end of life care in the ICU including improving the environment, improving communication, standardizing end of life care, providing education, and increasing time at the bedside (Arbour, 2015; Beckstrand, Hadley, Luthy & Macintosh, 2017; Nelson, 2006; Wessmann, Sona, & Shallom, 2015; Weigland, 2016; Fahey, 2017; Crowe, 2017; Ventola, Mitchell, Yoo, & Scoy, 2016; Khan, Chen, Patel & Roadman, 2016; Lau, Stilos, Nowell, Lau, Moore, & Wynnychuk, 2018).

Methodology

The primary aim of this project was to develop and execute a standard protocol of interventions for comfort care patients on a medical intensive care unit. A proposal to conduct research involving human subjects entitled “Human Subjects DNP Project,” was submitted and

reviewed by the Institutional Review Board (IRB) at Southern Illinois University at Edwardsville and found to be exempt from IRB review on April 10, 2018. This quality improvement project took place in a 15 bed medical intensive care unit at a Midwest urban teaching hospital from June 1 until August 11, 2018. Seventeen patients were offered Transitioning with Grace interventions, and staff completed and submitted 12 checklists

Training for healthcare workers in the medical intensive care unit was completed on June 1, 2018 by the project leader at the Unit Based Council meetings and staff huddles during shift change. The training covered project rationale, staff expectations, interventions checklist, supplies for interventions, surveys, and location of intervention resources. Evidence supporting the new protocol was presented to staff to stress the importance of making the time to offer the interventions and illustrate how providing interventions would improve quality of life for comfort care patients at the end of life. Examples of the checklist, surveys, brochures, and resources for interventions were reviewed. -During project implementation, the project leader attended morning and evening shift huddles on weekdays and gave reminders to use appropriate resources for project implementation and answer any questions posed by healthcare staff.

Confidential surveys were available for nurses, nurse technicians, respiratory therapists, unit clerks, physicians and advanced practice providers. This survey using Likert-style questions assessed healthcare providers' comfort levels in providing end of life care, perceptions of resource availability, and perceptions of the quality of care currently provided to this target population before and after project implementation. These paper surveys were posted in the staff lounge of the ICU for a two-week timeframe before and after project implementation along with an envelope to place completed surveys.

In addition, checklists were used to determine if staff were implementing the suggested evidenced based interventions presented at the in-services. Transitioning with Grace checklists contained 15 interventions for patients transitioning to comfort care and their loved ones. This checklist contained columns for “offered” and “given,” as well as a “comment” section if the respondent wishes to qualify a response. To assure validity, this checklist was reviewed and approved by a nurse educator and researcher knowledgeable in the field. It was then reviewed and approved by another nurse educator and APRN as well as the Director for Palliative Care at the quality improvement site.

Evaluation

Twenty-five staff members completed the pre-project survey and fourteen completed the post-project survey. Items 8 (Fisher’s exact test $p < 0.001$), 9 ($p < 0.001$), 10 ($p = 0.002$), and 11 ($p = 0.05$) all showed significant improvements in Likert scores in the post-intervention survey when compared to pre-intervention scores. Item 8 addressed staff perception of patients and loved ones having adequate time to create handprints and obtain lockets of hair. Item 9 addressed staff perception of resource availability for providing quality end of life care. Item 10 addressed staff perception of opportunities for comfort care patients and their loved ones to be close. Item 11 addressed staff perception of the ICU being a comfortable environment for comfort care patients and their loved ones, conducive to providing quality end of life care.

Staff completed and submitted 12 checklists. Staff offered all interventions to 75% or more of patients with exception of interventions 6 (58%) and 8 (50%) which entailed asking loved one to bring in patient’s shirt, favorite music, cologne or pictures and obtaining locket of hair, respectively. However, intervention 7, obtaining patient handprints, saw a significant decrease between the percentage of patients given and offered the intervention (Pearson’s $X^2 =$

0.81, $p = 0.04$). Interventions 4 ($X^2 = 2.84$, $p = 0.09$), 6 ($X^2 = 2.84$, $p = 0.09$), and 8 ($X^2 = 3.23$, $p = 0.07$) also saw non-significant trends towards lower numbers of patients actually receiving the intervention compared to those who were offered the intervention.

Of the 14 completed post-project surveys, 5 staff members identified staffing issues and another 5 staff members identified lack of time as barriers to providing quality end of life care. Two staff members identified the ICU environment as an inappropriate environment for providing end of life care as a barrier.

Impact on Practice

Upon implementing Transitioning with Grace, positive informal feedback was presented to the project leader. Nurses relayed stories with great enthusiasm about grateful loved ones who received interventions from the Transitioning with Grace program. Several nurses approached the project and expressed desire to make the protocol implemented a permanent change. Transitioning with Grace improved opportunities for patients transitioning to comfort care to be close with their loved ones, increased ICU staff member's perception that the ICU is conducive to providing end of life care, increased resource availability, and increased available time to create handprints and obtain lockets of hair. With the success of Transitioning with Grace, this project should be expanded to include all intensive care units within the hospital and other general and intermediate patient care areas of the hospital.

Conclusions

One limitation of this project was small sample size. Limited data for analysis leads to potential selection bias. While 17 patients and loved ones received Transitioning with Grace interventions, only 12 checklists were returned for analysis. This nonresponse can lead to selection bias. Unforeseen circumstances, such as patients becoming organ donors, patient lack

of hair, and family refusal of interventions also affected staff ability to implement certain bundle interventions.

While findings from this project are not generalizable, they offer insight into perceptions of staff caring for patients transitioning to comfort care and their loved ones. The findings demonstrates that providing end-of-life education to staff can improve opportunities to create handprints, increase accessibility to necessary supplies, improve opportunities for comfort care patients to be close to their loved ones, and improve ICU environment to one conducive to providing quality end of life care. Further research about patients transitioning to comfort care is needed. Researchers could explore the impact of the Transitioning with Grace project on hospital outcomes such as patient satisfaction scores through surveys-mailed to patients' loved ones when patients die in the hospital. Another research opportunity would be to survey loved ones themselves, although great care would need to be taken in this approach due to the sensitive and unpredictable nature of the grieving process.

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