

Integrating Palliative Care Screening in the Intensive Care Unit: A Quality Improvement Project

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BACKGROUND Patients admitted to the intensive care unit have complex medical problems and increased rates of mortality and recurrent hospitalization for the following 10 years compared with patients without a history of critical illness. Delayed access to palliative care can result in untreated symptoms, lack of understanding of care preferences, and preventable admissions. Despite studies supporting palliative care screening, there is no standardized method to assess palliative care needs of patients admitted to critical care units.

LOCAL PROBLEM A community hospital critical care team identified a need for an improved palliative care process for patients admitted to the intensive care unit.

METHODS The aim of this quality improvement project was to improve patient access to timely palliative care consultation while increasing the reach of the palliative care team. Guided by the Institute for Healthcare Improvement model of plan-do-study-act cycles, the team created a palliative care screening tool with clinical indicators for nurses to use upon patient admission. Patients with numeric scores indicating positive screening tool results could be automatically referred for palliative care consultation.

RESULTS Of 267 patients, 59 (22%) had positive screening tool results, compared with 31 (11.6%) identified with the traditional consultative method. Descriptive analysis revealed that patients identified for referral without use of the screening tool were hospitalized a mean of 6 days until consultation was requested.

CONCLUSION The screening process can maximize the benefit of palliative care services with early patient identification, improved consultation efficiency, decreased critical care resource use, and reduced readmission rates. (*Critical Care Nurse*. 2024;44[2]:41-48)

CE 1.0 hour, CERP B

This article has been designated for CE contact hour(s). The evaluation tests your knowledge of the following objectives:

1. Describe the benefits of early palliative care referral to identified hospitalized patients.
2. Identify patient risk factors for unmet palliative care needs.
3. Discuss implications for practice with implementation of a screening tool to improve patient access to palliative care services.

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With continued advances in health care technology, medical interventions, and pharmacotherapy, clinicians can provide life-sustaining treatments to patients and improve outcomes. With these advances we are also able to prolong life for some patients whose needs may be best met with palliative care. The cost of providing care at the end of life to Medicare patients constitutes a disproportionate health care expense in the last 6 months of life for patients who continue to receive aggressive and often futile care.¹ Patients who have life-limiting illnesses are often subjected to invasive procedures and interventions that are not aimed at curing their disease and may impose significant pain

and discomfort in their final days. Patients who are admitted to the intensive care unit

The team created a screening tool to increase patient access to timely palliative care consultation and improve the efficiency of appropriate consultations with a nurse-driven screening process.

(ICU) have mortality rates as high as 29% and increased risk of death and recurrent admissions for the following 10 years compared with patients without a history of critical illness.² A recent investigation of end-of-life care in critical care units across the United States identified additional gaps in care delivery related to advance directives. Despite ongoing efforts to reconcile patient preferences for medical care on admission, advance directives were documented for only 40% of patients who died while receiving care in the ICU.³

The number of elderly patients continues to rise. By 2030, the number of people older than 65 years is projected to surpass the number of children for the first

time in the history of the United States.⁴ Advancing age is a significant risk factor for mortality in patients with critical illness. Considering the potential increase in patient needs with an aging population and the current barriers in access to care for vulnerable populations, the need for accessible palliative care services is evident. An expert panel convened by the Center to Advance Palliative Care recommended that every hospital use a screening process to identify patients with unmet palliative care needs upon admission.⁵ The Center to Advance Palliative Care continues to advocate for palliative care screening procedures with a toolkit to help organizations develop protocols that are specific to and fit the needs of the patient population of a particular institution. Increasing evidence supports the use of objective, standardized palliative care screening tools, although few studies have demonstrated the efficacy of these tools.⁶ Screening criteria include life-threatening conditions, frequent hospitalizations, complex care requirements, decline in function or nutritional tolerance, and physical or psychological symptoms that are difficult to control.⁷ Despite these recommendations, palliative care remains underused, with variations in care delivery such as delayed consultation in the critical care setting.⁸ For this project, we identified a need to improve the palliative care process for patients admitted to the ICU in a community hospital in which palliative care consultation traditionally was at the discretion of the attending physician, nurse practitioner, and/or physician assistant.

Using the Standards for Quality Improvement Reporting Excellence 2.0 guidelines, we reviewed current literature to identify relevant peer-reviewed studies of palliative care models in the critical care setting. We searched the CINAHL database using the following search terms: *palliative care, screening tool, quality improvement, end of life, and ICU or intensive care unit or critical care*. We retrieved reports of quality improvement studies, quasi-experimental design studies, randomized crossover trials, and systematic reviews published within the last 10 years. Of the 20 peer-reviewed studies, 12 used a palliative care screening tool within the critical care setting as guided by the Improving Palliative Care in the ICU Project.⁹ Following the Model for Improvement framework by the Institute for Healthcare Improvement, the project team reviewed each study to identify changes in the current palliative care consultation process that could potentially improve early identification of patients for palliative care and

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Table 1 Citation of evidence

Source	Design	Use of palliative care screening tool
Akgün et al, ¹¹ 2015	Systematic review	Review of palliative care screening criteria
Churchill et al, ¹² 2020	Quality improvement, prospective	Yes
Duncan et al, ¹ 2019	Financial evaluation case study	
ElMokhallalati et al, ⁵ 2020	Systematic review	
Hamdan Alshehri et al, ¹³ 2020	Systematic mixed-methods review	
Hurst et al, ¹⁴ 2018	Quasi-experimental study	Yes
Kelley and Morrison, ¹⁵ 2015	Integrative review	
Khandelwal et al, ¹⁶ 2016	Financial evaluation case study	
Kruser et al, ³ 2019	Quality improvement	
Lapp and Iverson, ¹⁷ 2015	Retrospective cohort study	Yes
Ma et al, ¹⁸ 2019	Cluster randomized crossover trial	Yes
Martz et al, ¹⁹ 2020	Quality improvement, retrospective	Yes
McCarroll, ⁸ 2018	Quality improvement, prospective	Yes
Nelson et al, ⁹ 2013	Consensus panel	Yes
Perrin and Kazanowski, ²⁰ 2015	Integrative review	Yes
Venis and Dodek, ²¹ 2020	Mixed-methods study	Yes
Walker et al, ²² 2013	Quality improvement, retrospective	Yes
Yadav et al, ²³ 2017	Systematic review/meta-analysis	
Yen et al, ²⁴ 2020	Quality improvement, prospective	Yes
Zalenski et al, ²⁵ 2017	Quality improvement, retrospective	Yes

increase advance care planning documentation.¹⁰ Table 1 shows evaluation of the evidence.

Methods

Project Design

This quality improvement project used a retrospective in-depth medical record review to test a palliative care screening tool created by the project team. The framework for the project was guided by the Institute for Healthcare Improvement's Model for Improvement using plan-do-study-act cycles.¹⁰

Intervention

The screening tool (see Figure) was based on clinical indicators recognized by the site's existing palliative care team and supported by the Improving Palliative Care in the ICU Project. The project team consisted of a critical care nurse practitioner and 2 palliative care team members (1 registered nurse and 1 advanced practice registered nurse). The team created an evidence-based screening tool to increase patient access to timely palliative care

consultation and improve the efficiency of appropriate consultations with a nurse-driven screening process completed within 24 hours of admission. The site selected for the project was using a traditional consultative model for palliative care referral guided by the discretion of the attending physician, nurse practitioner, and/or physician assistant.

Setting, Participants, and Ethical Considerations

This project was conducted within a single site at a 230-bed, community-based hospital in the midwestern United States. The selected site had a 20-bed mixed surgical and medical ICU with 1 full-time palliative care nurse for the entire hospital. We selected a retrospective medical record review instead of a prospective intervention to explore the feasibility of using a screening tool on admission. Additionally, the project team wanted to compare results of the newly designed palliative care screening tool with those of the existing consultative model already in place. Records of patients admitted to the surgical service were excluded from the review.

Palliative care screening tool

Comorbidities

1 Point for every yes, 0 points for every no

Dementia	Yes	No
End-stage renal failure	Yes	No
CHF	Yes	No
COPD/interstitial lung disease	Yes	No
Cancer: metastatic or recurrent	Yes	No
End-stage liver failure	Yes	No
Cardiac arrest	Yes	No
Progressive neurologic disease	Yes	No
Failure to thrive/debility	Yes	No
Chronic tracheostomy	Yes	No
Chronic pain	Yes	No
Class III obesity, BMI ^a >40	Yes	No
Comorbidity score	<input type="text"/>	

Contributing factors

2 Points for yes: ICU readmit in 3 months or any readmission in 30 days

1 Point for all other yes, 0 points for no

Previous ICU admission within 3 months	Yes	No
Readmission to hospital within 30 days	Yes	No
Transfer to ICU for deterioration on other unit	Yes	No
Nursing home patient or bed bound	Yes	No
Limited code status (example: do not intubate)	Yes	No
Family or patient requesting goals-of-care discussion	Yes	No
Chronic enteral feeding or tracheostomy tube being considered	Yes	No
Failed swallow evaluation or history of recurrent aspiration	Yes	No
Social/economic/emotional barriers limiting access to care	Yes	No
Contributing factor score	<input type="text"/>	

Total score from comorbidity and contributing factor section

Total score 4 or greater indicates referral to palliative care:

Reason for consult: "+PCST on ICU admission"

Figure Palliative care screening tool.

Abbreviations: BMI, body mass index; CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; ICU, intensive care unit; PCST, palliative care screening tool.

^a Calculated as weight in kilograms divided by height in meters squared.

For all patients admitted to the medical intensive care service during the project period (October 1, 2019, through December 31, 2019), the electronic health record (EHR) was reviewed to examine demographics including presenting diagnosis, history of chronic illness, and risk factors for unmet palliative care needs. Records of every medical ICU patient were screened with the palliative care screening tool. Scores of 4 or greater were considered positive screening tool results.

A list of all medical patients who were admitted to the ICU during the project period and had critical care admission orders in the EHR was entered into a spreadsheet

(Excel, Microsoft). The project analyst used the palliative care screening tool to review each patient encounter and generate a numeric score on the basis of the history and physical examination sections of the EHR, including the admitting diagnosis and hospitalizations within the previous 90 days. Because this review was retrospective, patient scores were based only on the documented data available on the day of admission. Records of patients with positive screening tool results were compared with those of patients who received palliative care consultation with the traditional method during the same period. The analysis included the date that palliative

care consultation was requested, the number of days until consultation occurred, and outcomes associated with the palliative care referral. The affiliated university and the hospital institutional review boards reviewed this quality improvement project and deemed it not to be human subjects research.

Results

We reviewed records of 267 patients admitted during the project period. Of these, 31 (11.6%) received referral for palliative care consultation using the traditional method (without a screening tool). Fifty-nine (22%) had positive palliative care screening tool results. The mean time from admission until referral for palliative care consultation without a screening tool was 6 days. Consultations were completed within 2 days after referral. Further analysis showed that patients who received a palliative care consultation referral also had positive screening tool results. This finding gave the project team confidence that the screening tool would not only identify patients for whom consultation was appropriate but would also identify these patients earlier in the hospital stay.

Discharge dispositions for the 267 patients fell into 7 categories: self-care (n = 124 [46%]), death (n = 38 [14%]), skilled nursing facility (n = 35 [13%]), home care (n = 31 [12%]), long-term acute care hospital (n = 16 [6%]), hospice (n = 14 [5%]), and other facility (n = 9 [3%]). We further analyzed data for the 35 patients discharged to skilled nursing facilities. Seventeen of these 35 patients (49%) had positive palliative care screening tool results, but only 6 of the 17 patients received referral for palliative care consultation (6 of 35 patients [17%]). A mean of 8.5 days elapsed from their admission until referral. For the patients discharged to skilled nursing facilities, we compared outcomes for those who received a palliative care consultation with those who had a positive screening tool result but did not receive palliative care consultation. Five of the 6 patients (83%) who had a palliative care consultation received a revised code status that included identification of health care decision-makers, demonstrating the effectiveness of palliative care discussions. Of the patients who had a positive screening tool result but did not receive palliative care consultation, 4 (24%) died within 6 months and 5 (29%) were readmitted to the hospital within 30 days, indicating poor outcomes. We also analyzed data for the 17 patients who were discharged to skilled nursing facilities

Table 2 Palliative care screening criteria frequency for patients discharged to skilled nursing facilities (N =17)

Screening criterion	No. (%) of patients
Readmission in 30 days	11 (65)
COPD/interstitial lung disease	10 (59)
Failure to thrive/debility	7 (41)
Dementia	5 (29)
Percutaneous feeding tube	4 (24)
Congestive heart failure	4 (24)
Barriers to care	4 (24)
Progressive neurologic disease	3 (18)
ICU readmission	3 (18)
Skilled nursing facility resident	2 (12)
Goals of care	2 (12)
Recurrent aspiration	1 (6)
Cancer	1 (6)
Chronic pain	1 (6)
Obesity, BMI >40 ^a	1 (6)
End-stage renal disease	1 (6)

Abbreviations: BMI, body mass index; COPD, chronic obstructive pulmonary disease; ICU, intensive care unit.

^a Calculated as weight in kilograms divided by height in meters squared.

and had positive screening tool results to identify trends in screening criteria. Among these 17 patients, the mean age was 73 years, 10 (59%) were female, and 7 (41%) were male.

The criteria most frequently identified on the screening

The project team members were confident that the screening tool would not only identify patients for whom consultation was appropriate but would also identify them earlier in the hospital stay.

tool were hospital readmission in 30 days (n = 11 [65%]), chronic lung disease (n = 10 [59%]), and debility or failure to thrive (n = 7 [41%]; Table 2). The mean (SD) hospital length of stay for patients who were discharged to skilled nursing facilities was 12.3 (6.8) days.

Discussion

Palliative care includes a spectrum of treatments emphasizing improved quality of life for patients and families according to the needs and goals of the patient, independent of the diagnosis. An evidence-based screening tool identifies patients with unmet palliative care needs to improve symptom management, clarify goals

of care, and decrease ICU resource use if aggressive medical treatment does not align with the patient's preferences. Although this project focused on appropriate early palliative care intervention, hospice services are appropriate for patients who have a life expectancy of 6 months or less. Our palliative care screening tool is a flow sheet embedded in the EHR in the admission checklist to be completed by the nurse within 24 hours. The screening tool provides an automatic consultation request to the palliative care team for patients with a positive screening tool result (score ≥ 4).

The project team recognized an opportunity to increase advance care planning discussions for patients who were being discharged to skilled nursing facilities. These patients have an increased risk for recurrent hospitalization given the complexity of their medical needs. Advance care planning is a voluntary face-to-face discussion with a patient to determine health care wishes, including appointing a health care proxy in the event the patient is no longer able to make decisions. These conversations are vital

Advance care planning conversations are vital to understand the wishes of the patient and to designate a health care power of attorney while the patient can be involved in the decision-making process.

to understand the wishes of the patient and to designate a health care power of attorney while the patient

can be involved in the decision-making process. The responsibility of documenting advance care planning can be multidisciplinary. Advance care planning is of greatest benefit when conversations regarding goals of care are timely.²⁴ Conversations regarding treatment goals and discussions of end-of-life care can be challenging for clinicians who do not have training in palliative care.⁷ A systematic review of observed aspects of patient and physician end-of-life conversations found that physicians often focus on medical or technical issues and avoid emotional ones.²⁶ Other perceived barriers to these discussions are the lengthy face-to-face encounters and physicians' feelings of being inadequately trained for compassionate, effective end-of-life conversations.²⁷ Commonly discussed barriers include a misunderstanding of the benefits of palliative care, clinicians' difficulty determining when patients are approaching the end of life, and clinicians' lack of comfort with discussing palliative care with patients and families.²⁰ One of the many strengths

of palliative care professionals is their ability to effectively navigate these difficult conversations.

Patients with documented comorbidities and serious illnesses such as cancer have better overall outcomes when palliative care is introduced early in their care rather than in the last few days of life, allowing patients to receive the most benefit from these services. In addition to providing a holistic approach to treating the patient and family, benefits of palliative care include decreasing pain and improving symptom management, which can simultaneously reduce costs and avoid costly hospitalizations.¹⁵

Limitations

This project was a retrospective medical record review to evaluate the feasibility of using a screening tool created by the project team to identify patients for whom early palliative care referral was appropriate. One of the obvious limitations was that the project involved only 1 medical ICU, so selection bias likely was introduced. Retrospective determination of patient scores was also limited by the completeness of the EHR; incomplete documentation could have resulted in lower palliative care screening tool scores. Another data collection limitation was that a single investigator conducted the medical record review. The project team selected the fall of 2019 for review because the patient data would not be influenced by the COVID-19 pandemic. The pandemic could have affected patient demographic data because of younger patients without comorbidities, a population for whom palliative care discussions are not typically appropriate. We recognize that since the pandemic, many clinicians have become more comfortable with palliative care discussions and understand the benefits of early discussions and advance directives, a situation that could improve the current rate of palliative care consultation without using a screening intervention.

Implications for Practice

The need for palliative care programs in the critical care setting has gained attention since the pandemic, when specialists trained in end-of-life care provided tremendous support to health care teams around the world. Palliative care within the hospital setting is an emerging field of clinical practice. Collaboration between established palliative care programs and ICU teams is supported in the literature and represents the standard of best practice.²² Patients who are admitted to critical care

units have life-threatening illnesses and often meet criteria for palliative care consultation, but without a standardized screening process, there are gaps in patient access before discharge. Although the literature supports integration of palliative care services in critical care settings, there is no standardized screening tool to assess palliative care needs of patients in the ICU.^{14,17} Objective screening criteria specific to each organization can be compiled from multiple sources, including the clinical knowledge of specialists trained in palliative care, literature reviews, and national palliative care standards. Staff education on the benefits of palliative care, the importance of the screening tool, and competency using the tool is also required to ensure that the screening process is consistent and produces reliable results.

Conclusion

This project demonstrated opportunities to identify patients at risk for unmet palliative care needs by using a screening tool designed with the support of the Center to Advance Palliative Care. The screening tool was designed to be completed on admission by the nursing staff and provides the ability to directly refer patients with positive screening tool results for formal palliative care consultation. Providing the ICU staff the autonomy to consult palliative care services by using an evidence-based tool can improve the efficiency of appropriate consultations while providing opportunities for advance care planning discussions and increasing patient access to palliative care services before discharge. [CCN](#)

Financial Disclosures
None reported.

See also

To learn more about palliative care in the critical care setting, read “Rationale and Resources to Accelerate Advanced Practice Palliative Care Competency” by Koirala et al in *AACN Advanced Critical Care*, 2020;31(2):191-195. <https://doi.org/10.4037/aacnacc2020281>. Available at www.aacnconline.org.

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Integrating Palliative Care Screening in the Intensive Care Unit: A Quality Improvement Project

Delayed access to palliative care can result in untreated symptoms, lack of understanding of care preferences, and preventable admissions. Despite studies supporting palliative care screening, there is no standardized method to assess palliative care needs of patients admitted to critical care units. The authors discuss a quality improvement project to improve patient access to timely palliative care consultation while increasing the reach of the palliative care team.

- The team created an evidence-based screening tool to increase patient access to timely palliative care consultation and improve the efficiency of appropriate consultations with a nurse-driven screening process completed within 24 hours of admission.
- An evidence-based screening tool can be used to identify patients with unmet palliative care needs to improve symptom management, clarify goals of care, and decrease intensive care unit resource use if aggressive medical treatment does not align with the patient's preferences.
- Our palliative care screening tool is a flow sheet embedded in the electronic health record in the admission checklist to be completed by the nurse within 24 hours. The screening tool provides an automatic consultation request to the palliative care team for patients with a positive screening tool result.
- Advance care planning is a voluntary face-to-face discussion with a patient to determine health care wishes, including appointing a health care proxy in the event the patient is no longer able to make decisions. These conversations are vital to understand the wishes of the patient and to designate a health care power of attorney while the patient can be involved in the decision-making process.
- In addition to providing a holistic approach to treating the patient and family, benefits of palliative care include decreasing pain and improving symptom management, which can simultaneously reduce costs and avoid costly hospitalizations.
- The need for palliative care programs in the critical care setting has gained attention since the pandemic, when specialists trained in end-of-life care provided tremendous support to health care teams around the world.
- Palliative care within the hospital setting is an emerging field of clinical practice. Collaboration between established palliative care programs and intensive care unit teams is supported in the literature and represents the standard of best practice.
- Staff education on the benefits of palliative care, the importance of the screening tool, and competency using the tool is also required to ensure that the screening process is consistent and produces reliable results. [CCN](#)

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