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Literature Review

Palliative Care Implementation in the Intensive Care Unit

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ABSTRACT

Introduction, Palliative care is a treatment approach whose goal is to improve and optimize the quality of life of patients with serious, incurable illnesses, including ICU patients. The purpose of this study is to see an overview of the implementation of palliative care in the Intensive Care Unit (ICU).

Method. This literature review was conducted by using PRISMA guidance, a literature survey through electronic databases namely CINAHL, Science Direct and Pubmed using the keywords ‘palliative care’, ‘intensive care unit’, and; ‘critical care’.

Result, there were 6628 articles have been identified, there were 4070 duplicates. There were 2,508 articles that were not related to the title. A total of 50 article titles were available to be analyzed worthly and 10 articles were found that matched the criteria, full text, using Indonesian and English, and publications in the range of year in 2013-2023 period.

Conclusion, Palliative care in the ICU has received support from major intensive care organizations such as the American Association of Critical Care Nurses (2017). Despite much support, the quality of palliative care in the ICU has shown little or almost no improvement over time (Ganz & Sapir, 2019). Until now there has been no research that describes the overall implementation of palliative care in the ICU, including in Indonesia. There are still found the obstacles in the implementation of palliative care in the ICU that have not been resolved, so, further research is expected on the implementation of palliative care in the ICU, especially in Indonesia.

INTRODUCTION

The Intensive Care Unit (ICU) is a caring environment that maintains vital functions to reduce mortality and prevent morbidity in patients with critical illnesses. Even though treatment in the ICU is equipped with advanced technology and trained health workers, the mortality rate is still significant, with recent studies citing 13–16% mortality (Sprung et al., 2019). When patients with organ dysfunction no longer respond to treatment, treatment goals can no longer be achieved, or when the prognosis gets worse, health workers must provide a comfortable death process (Ho & Tsai, 2016), one of which is to complement care with palliative care. The World Health Organization (WHO) defines *palliative care* as a caring approach that aims to improve and optimize patients' quality of life with severe, incurable diseases (World Health Organization, 2020).

Patients and their families should receive palliative care throughout a severe illness. Symptom control, psychological and spiritual care, and a holistic approach are essential to palliative care. Palliative care can be provided in conjunction with life support therapy (primary palliative care) and complemented by palliative care consulting services (special palliative care) (Anderson et al., 2017). However, there are still some obstacles to integrating palliative care into the ICU, including inadequate

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palliative training for health workers, wrong perceptions of palliative care, and nurses' unclear roles in palliative care (Adams et al., 2017).

This literature review aims to provide an overview of the implementation of palliative care in the Intensive Care Unit (ICU). The review will be based on research from various countries, including Indonesia. This review is essential to do in order to get an overview and solutions to the problems of the implementation of palliative care in the Intensive Care Unit (ICU).

METHOD

This review of the literature review followed the PRISMA guidelines (Liberati et al., 2009)

a. Search Strategy

Conducted a systematic search through electronic databases namely CINAHL, ScienceDirect and Pubmed. The researcher conducted a follow-up search in the three databases between 2013 and 2023. The combination of keywords used was “Palliative Care' OR 'Palliative Intervention' OR 'Palliative Care' AND 'Intensive Care Unit' OR 'Critical Care'. This search found 78 articles from the CINAHL database, 6355 articles from the ScienceDirect database, and 195 articles from Pubmed. Titles were reviewed to exclude irrelevant and duplicate studies of 4070. Researchers then selected 50 articles based on titles that matched the search objectives. Next, the researcher analyzed the abstracts of all identified articles and 25 articles met the criteria for this study. From the analysis of full text articles, 10 articles were selected that met the criteria. Details of article selection in this literature review (Figure 1).

b. Inclusion/Exclusion Criteria

The inclusion criteria for this review were articles published between 2013 and 2023. The selection of articles was limited to articles in English and Indonesian. The focus of the selection of articles is a description of the implementation of palliative care and obstacles. Exclusion criteria include: published in the format of a dissertation or study review.

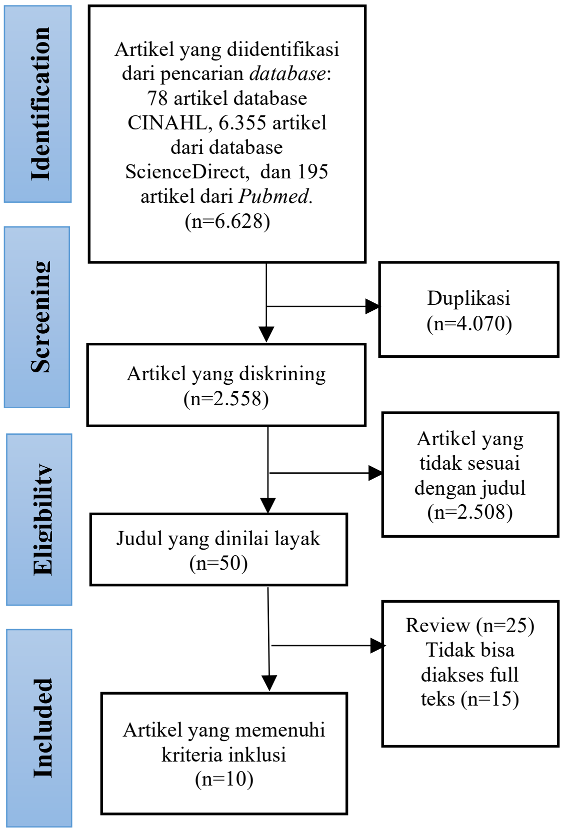

Figure 1 Article Selection Process

RESULT DAN DISCUSSION

Authors	Objective	Methods	Result
(Anissa et al., 2022)	Seeing an overview of palliative care knowledge in ICU nurses at Ulin Hospital, Banjarmasin.	Quantitative descriptive. The sampling technique used is non-probability sampling with purposive sampling. The research sample was 32 practicing nurses in the intensive care unit at Ulin Hospital, Banjarmasin. The instrument uses demographic data sheets and the PCQN-I questionnaire.	The results show that 21 people (65.6%) lack knowledge category and 11 people (34.4%) sufficient knowledge category. Most of the respondents had never attended palliative training and did not understand the general concept of palliative.
(Kurnia et al., 2020)	Analyzing the relationship between knowledge and nurse confidence in implementing PC in the ICU.	Correlational research with a cross sectional approach. The total sampling of all nurses who are actively working in public hospitals in Bandung, West Java, Indonesia is a total of 127 people. Data collection was carried out using a questionnaire. Pearson's correlation test was used for bivariate analysis.	- The majority of respondents have high self-confidence but have less knowledge regarding palliative care in the ICU. - There is a significant relationship between knowledge variables and self-confidence. The results showed that most of the respondents had insufficient knowledge of implementing PCs in the ICU. Therefore, socialization and training sessions are needed in this regard, with a focus on the nurse's belief in her abilities.
(Huriani et al., 2022)	Knowing the relationship between knowledge and confidence in nurses in palliative care in the Intensive Care Room (ICU).	Descriptive research with a cross sectional study approach. The sample of this study were 46 nurses working in the ICU. The research instrument was the Palliative care knowledge test questionnaire and the Palliative care self-efficacy scale.	The results of this study indicate that nurses have less knowledge (97.8%), and have high self-confidence (56.3%). Nurses' knowledge of palliative care is not related to confidence p > (0.005). To increase the knowledge of nurses, it is hoped that there will be training and education about palliative care, so that the knowledge gained will support the confidence of nurses in the ICU.
(Ganz & Sapir, 2019)	describes ICU nurses' perceptions of the quality of palliative care at the end of life, the intensity and frequency of barriers to palliative care and their relationship to one another.	Descriptive, correlational, cross-sectional design. Sample of 126 ICU nurses from two hospitals in Israel. Participants completed three questionnaires (personal characteristics questionnaire, Quality of Palliative Care in the ICU and Survey of Oncology Nurses' Perceptions of End of Life Care). Respondents were recruited during staff	ICU nurses perceive the quality of palliative care at the end of life as moderate despite reports of moderate barrier levels. Barrier frequency is weakly related to quality of end of life palliative care. However, barrier intensity did not correlate with quality of end of life palliative care to a statistically significant degree. Further studies

		meetings or while on duty in the ICU. Ethical approval was obtained for the study from participating hospitals.	investigating other factors related to the quality of ICU palliative care are recommended.
(Ma et al., 2019)	assessed the impact of early palliative care consultation on outcomes of high-risk ICU patients.	Randomized cluster crossover study in two medical ICUs at Barnes Jewish Hospital. Patients (n=199) were admitted to the medical ICU from August 2017 to May 2018 with positive palliative care screening indicating high risk for morbidity or mortality. Medical ICU randomization to intervention or treatment was usual followed by washout and crossover, with independent assignment of patients to each ICU on admission. Intervention arm patients receive a palliative care consultation from an interprofessional team led by a certified palliative care provider within 48 hours of ICU admission.	97 patients (48.7%) were assigned to intervention and 102 (51.3%) to usual care. The transition to do-not-resuscitate/do-not-intubate (DNR/DNI) occurred earlier and significantly more frequently in the intervention group than in the control group (50.5% vs 23.4%, p0.05). Early triggering of palliative care consultations is associated with greater transitions to DNR/DNI and to hospital care, as well as reduced utilization of ICU and post-ICU health care resources. Studies show that routine palliative care consultations can have a positive impact on the care of high-risk and critically ill patients.
(Brooks et al., 2017)	Explore the perspectives and experiences of doctors and nurses who provide EOL care in the ICU. In particular, perceived barriers, supports and challenges to providing EOL care are examined.	Interpretive qualitative with focus groups as a data collection method. The study was conducted in Melbourne, Australia in a 24-bed ICU. Focus group discussions are discipline specific. All focus groups were audio-recorded and then transcribed for thematic data analysis.	Five focus groups were conducted with 11 doctors and 17 nurses participating. The identified themes are presented as obstacles, supports and challenges. Barriers include conflicts between ICU doctors and external medical teams, availability of education and training, and environmental limitations. Supporting factors include collaboration and leadership during the transition of care. Challenges include communication and decision making, and family expectations.
(Wysham et al., 2017)	Addressing the quality gap in intensive care unit (ICU)-based palliative care is constrained by uncertainty about the acceptable models of collaborative specialist and generalist care. Therefore, we characterize the attitudes of doctors and nurses regarding the provision of palliative care in the ICU environment.	Mixed methods study. Setting—medical and surgical ICUs in three major academic hospitals. Participants—303 nurses, intensivists, and advanced practice providers	Most (n=225, 75%) reported that palliative care consultations were underutilized. Consideration of eligibility for specialist consultation with an electronic health record search for the most preferred trigger (n = 123, 41%); only 17 (6%) felt the current process was sufficient. Advanced age, length of stay and duration of life support are the least acceptable. Specialist-led screening or an ICU team are equally

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			preferred. The central theme stems from a qualitative analysis of 65 written responses to open-ended items including concerns about physician and nurse roles, implementation, and impact on ICU team-family relationships.
(Tripathy et al., 2017)	Investigate the knowledge, attitudes and beliefs of intensive care nurses in eastern India towards EOL.	Self-administered questionnaires were distributed to delegates in two regional critical care nurse training programs. The researchers conducted a literature survey; the VENICE tool, which had been used previously was used as a standard guide to allow comparison with international surveys. Two meetings between three researchers (all critical care physicians) and one meeting with two senior critical care nurses were held to modify and construct questions according to cultural and regional practice.	Of the 178 questionnaires distributed, 138 were filled out, with a response rate of 75.5%. About half (48.5%) had ICU experience of more than 1 year. The majority (81.9%) agreed that nurses should be involved and initiate (62.3%) EOL discussions. The terms "EOL care or palliative care in the ICU" were new to 19.6%; 21% and 55.8% respectively disagreed with allowing peaceful death in terminal patients and unrestricted family visits. Work experience was associated with desiring unrestricted family visits, discontinuing monitoring and investigations in EOL, equating with withholding and discontinuing medication, and being part of EOL team discussions (P = 0.005, 0.01, 0.01, and 0.001), respectively respectively. Religious was associated with a greater desire to initiate EOL discussions (P = 0.001).
(Gulini et al., 2017)	Knowing the perceptions of health workers in the Intensive Care Unit towards palliative care.	Descriptive and qualitative based on a convergent care approach performed in an intensive care unit in Southern Brazil. Semi-structured interviews were used to investigate the understanding of palliative care professionals in this unit.	Participants included 37 professionals (12 nurses, 11 nursing technicians, 5 physical therapists and 9 doctors). The key ideas extracted from the interviews were: care in the late stages of life that avoids wasted steps; comfort care; lack of standard care and lack of team training. Professionals consider palliative care appropriate in the last stages of life, without the need for futile care or as a measure of comfort. However, they recognized the lack of standardization and lack of capacity building in this area, which led them to regard palliative care as terminal care, and

			recommended steps to remove this stigma.
(Zalenski et al., 2017)	know the outcome of receiving palliative care consultation (PCC) for patients who screened positive on palliative care referral criteria.	In retrospective analysis, the covariate-balancing propensity score method was used to estimate the conditional probability of receiving PCC and to balance important covariates. For patients with and without PCC, the study outcomes were: 1) change to "do not resuscitate" (DNR); 2) discharged to the hospital; 3) 30 days return receipt; 4) Length of stay (LOS); 5) total direct hospital costs.	In the 405 patients who screened positively, 161 (40%) received PCC compared with 244 who did not. Receiving PCC in the ICU was significantly associated with more frequent DNR code status and hospice referrals, but not with 30-day readmission or hospital utilization. Early PCC is associated with significant LOS and direct cost reduction. Providing PCC early in the ICU should be considered.

In recent years, ICU care has been expanded to improve survival outcomes and quality of life for critically ill patients. Palliative care is based on reducing symptoms, establishing clear and sensitive communication, providing treatment according to patient preferences, and providing family support. Palliative care aims to improve the quality of life of patients and their families facing problems associated with life-threatening illnesses. In the articles above, we will discuss and describe how palliative care has been implemented in the ICU.

Implementation of palliative care in the ICU

The implementation of palliative care in the ICU has been gaining momentum worldwide. Palliative care in the ICU has received support from major intensive care organizations (American Association of Critical Care Nurses, 2017). The goals of palliative care include symptom relief, establishing effective communication, aligning treatment with patient preferences, supporting family members, and planning transitions. Considering palliative care is for patients nearing death, it is considered appropriate in the ICU (Gulini et al., 2017). However, there is evidence that the quality of ICU-based palliative care could improve. Many hospitals need help to change structural barriers related to resources and the availability of specialists that limit response to this quality gap (Wysham et al., 2017).

In the ICU, health workers make decisions about life support care. However, knowing when palliative care is more appropriate than curative care for critically ill patients is challenging. A dying patient in the ICU wants respect, symptom relief, and to be with their loved ones. ICU healthcare workers also have to overcome one of the challenges associated with end-of-life care: interdisciplinary collaboration, including disagreements about patient recovery potential, communication between interdisciplinary teams, and the need for more participation of nurses in decision-making processes. Health team communication must be improved so that practice can be standardized. Communication is essential for professionals working in palliative care because it increases access to and approaches to the patient's emotional dimension, thus improving patient care (Gulini et al., 2017).

In addition, healthcare workers are often faced with ethical dilemmas associated with emerging technologies and more outstanding treatment options. All these elements point to the challenging nature of communication in the ICU. The primary source of conflict in the ICU is near-death care due to problems related to decisions and communication (Grant, 2015). Despite much support, the quality of palliative care in the ICU has shown little or no improvement over time (Ganz & Sapir, 2019). Until now, no research has described the overall implementation of palliative care in the ICU, including in Indonesia. The Indonesian government has supported written palliative care in the Decree of the Indonesian Ministry of Health number

812/Menkes/SK/VII/2007, but until now, the application of palliative care still needs to be improved, and there has been no development. Rochmawati et al. (2016) found cultural and socio-economic factors, perceptions of patients and their families, attitudes of health service providers, a lack of education and training for health workers, unequal distribution of palliative care facilities, a lack of coordination, and limited funds were obstacles to the implementation of palliative care in Indonesia.

Barriers to the implementation of palliative care in the ICU

Several studies from around the world have reported significant barriers that hinder the implementation of palliative care in the ICU ((A'la et al., 2020; Anissa et al., 2022; Brooks et al., 2017; Enggune et al., 2014; Ganz & Sapir, 2019; Gulini et al., 2017; Huriani et al., 2022; Kurnia et al., 2020; Tripathy et al., 2017). These barriers include inadequate staff training in palliative care, ICU cultural norms that encourage therapy continuation at all costs, resistance from family members to change treatment goals due to unrealistic expectations, and communication between staff and families. In their research, Beckstrand et al. (2017) report that some of these barriers have increased in the last 17 years. For example, more nurses report that families do not accept or understand a patient's poor prognosis.

Other strong points were the perception that health workers in the ICU needed more time to be ready to handle patient palliative care, a lack of knowledge, appropriate training, and the involvement of all multi-professional team members. So, even though this is a place where death is constantly present, the professionals providing intensive care are not sufficiently trained or qualified for near-death care. The training aims to provide a multidisciplinary communication approach to families of critical patients and improve communication between health workers (Gulini et al., 2017). Lack of palliative care education is the most common reason. These findings are reflected in the perceived quality of palliative care and barriers to care. Several other studies and reviews of nurse and physician perceptions from around the world report similar findings (Anderson et al., 2016; Aslakson et al., 2014; Holms et al., 2014; Korzeniewska-Eksterowicz et al., 2013; Mathews & Nelson, 2017).

Research conducted in Indonesia found that most ICU nurses needed knowledge about palliative care (Anissa et al., 2022). Nurses' knowledge of palliative care is an important key. Lack of knowledge can affect the inability of nurses to provide optimal palliative care; it can cause stress, anxiety, and mistrust in nurses. This lack of knowledge can affect a nurse's confidence. Research Tripathy et al. (2017) identified attitudes, beliefs, and knowledge about palliative care among critical care nurses in eastern India. Differences were found between senior and junior nurses. Younger nurses are uncomfortable with increased family visitation privileges. This may indicate that the younger/less experienced ICU nurse is nervous and unsure about families when working with patients. Experienced nurses are also more likely to have palliative care discussions with families. Only 40% of all nurses carry out palliative discussions. This may indicate a lack of systematic policies to invite nurses to be part of the team during discussions with families (Tripathy et al., 2017). Research supports (Kurnia et al., 2020) that the highest confidence in palliative care was found in nurses aged between 36 and 45 years. It is seen that the more mature a person is, the stronger the mindset and the better the performance. In addition, educational background was also found to affect self-confidence. Most respondents (55.5%) with bachelor's and master's degrees in nursing have high self-confidence. However, self-confidence can also be increased through non-formal education because self-confidence is formed by knowledge that can be obtained in various ways. This study also found that 74.8% of respondents stated that they had never received education regarding palliative care for patients in the ICU (Kurnia et al., 2020).

Cultural differences may explain some of the conflicting results. Research by Koh & Hwee (2015) discusses that, in Asia, doctors are more aggressive in their treatment compared to the West. This is due to expectations from families, often due to respect for elders, and the fact that death is considered taboo in their culture, which leads to a lack of discussion about dying. In a study of nurses from five countries (Brazil et al.), differences were found between nurses' and doctors' attitudes regarding end-of-life decision-making; however, one common thread is that nurses do not feel that they have to make decisions but are active in seeking consensus among stakeholders. This includes persuading, informing, and enabling participants in decision-making (Ganz & Sapir, 2019).

Then, the ICU care environment was identified as a barrier to the provision of palliative care due to the lack of privacy in the open space of the ICU, as well as the worrisome noise from monitors and ventilators. In a study by Brooks et al. (2017), the ICU has six single rooms, often occupied by patients who require infection isolation. Health workers in the ICU discuss plans and how they contribute to the limitations of the ICU environment. Environmental limitations are related to the inability of health workers to discuss palliative care options because of their proximity to other patients and the presence of family members visiting other patients. The officers also thought that the ICU environment was not the right place to provide palliative care because of the lights and noise, not like a palliative care ward where everyone spoke softly, the lights were dimmed, and music was playing. Officers have tried to provide privacy, but environmental conditions are not always possible (Brooks et al., 2017).

Efforts to improve the implementation of palliative care in the ICU

In a multidisciplinary and multi-institutional study, Wysham et al. (2017) discovered essential and new insights that directly address knowledge gaps for integrating palliative care into ICU care, establishing acceptable screening standards for the eligibility of palliative care, and effectively leveraging technology-based systems to improve quality of care. Collaborative models of palliative care are mandatory for all ICU teams and establish the role of ICU nurses in screening and enabling palliative care consultations. Nurses reported wanting to participate more actively in delivering palliative care in the ICU. Nurses focus on symptomatic care and, as staff who work 24 hours a day with patients, have a more significant opportunity to provide an assessment of the needs and benefits of palliative care (Wysham et al., 2017). Another effort is to assess the feasibility of receiving palliative care by systematically assessing unmet palliative care needs, combining this knowledge with health status, and prioritizing the delivery of care widely agreed upon by doctors and nurses (Cox & Randall Curtis, 2016). This strategy can address concerns about the misdirection of palliative care. Recognizing discrepancies in physician-perceived versus family-voiced needs in a timely manner may also enhance the therapeutic relationship (Huff et al., 2015).

Ma et al. (2019) and Zalenski et al. (2017) researched to improve the quality of multi-hospital services. These studies found that patients and families who received palliative care counselling before admission to the ICU were statistically more likely to be coded as do not resuscitate (DNR) than as maximal care. Patients and families who received palliative care counselling at the start of their hospital stay were significantly more likely to have lower hospital costs and shorter lengths of stay (LOS). Early screening is a strategy used to promote early consultation (Zalenski et al., 2017). Research by Ma et al. (2019) based on previous studies using palliative care screening tools to identify newly admitted ICU patients with the highest risk of morbidity and mortality followed by a patient-centred palliative care consultation within 48 hours. The multidisciplinary palliative care team interacts with patients, families, and the primary team on several occasions during facilitating symptom reduction, setting appropriate expectations, and explaining the goals of care. Code status changes significantly increased in the intervention group. Then it was found that there was a significant difference in the cost of pharmacological therapy between groups, which may reflect a decrease in invasive procedures (Ma et al., 2019).

CONCLUSION

The current description of the implementation of palliative care in the ICU still has much homework to do to achieve optimal care. There are still many obstacles to implementing care that have yet to find solutions or alternatives, even though we know that the ICU is the right place for implementing palliative care. The implementation of palliative care in the ICU requires the cooperation of a multi-professional team, including doctors, nurses, physical therapists, psychologists, psychiatrists, nutritionists, speech therapists, social workers, pharmacists, and spiritual counsellors to make care more comprehensive and provide critically ill patients with every possible treatment options, thus ensuring a better quality of life.

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