Comfort or Care: Why do we have to choose? Implementing a Geriatric Trauma Palliative Care Program

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Learning Objectives

• Discuss the implementation of a Geriatric Trauma Palliative Care Program (GTPCP), for patients (≥ 65 years of age) utilizing evidence-based practice guidelines.

• Discuss the American College of Surgeons Palliative Care Best Practice Guidelines(2017)

• Discuss palliative program implementation of EBP to improve patient experiences
Disclosure Statement

- Faculty/Presenters/Authors/Content Reviewers/Planners disclose no conflict of interest relative to this educational activity.
Successful Completion

- To successfully complete this course, participants must attend the entire event and complete/submit the evaluation at the end of the session.
- Society of Trauma Nurses is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.
“Although patients aged 65 and older are less likely to be injured than are younger individuals, older patients are more likely to have fatal outcomes from their injuries”—ATLS student manual (ACSCoT, 2012, p. 273)
Problem Description

Problem

• Disconnect for trauma and palliative care teams
• Palliative Care team not comfortable taking care of geriatric trauma patients
• Trauma team not comfortable initiating primary palliative care

Purpose

• Implement a Geriatric Trauma Palliative Care Program (GTPCP) using the Palliative Care Best Practice Guideline (ACS, 2017)
Available Knowledge

• Palliative Care characteristics (Dunn et al., 2009; Gwyther, 2011; NCPQPC, 2013)
  • Care provided by a multidisciplinary team
  • Patients, families and team work to collaborate and communicate regarding information
  • Services rendered in conjunction with curative or life-prolonging care
Available Knowledge

• Clinical Practice Guidelines for Quality Palliative Care, 3rd ed (NCPQPC, 2013)

• 1st collaboration with over five major United States Palliative Care organizations (NCPQPC, 2013)
Available Knowledge

- American College of Surgeons
  - A leading proponent of incorporating palliative care into trauma programs
  - 1st EBP guidelines, Trauma Palliative Care Best Practice Guidelines (ACS, 2017)
<table>
<thead>
<tr>
<th>Highlighted Topics</th>
<th></th>
<th>ACS Palliative Care Best Practices Guidelines</th>
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</thead>
<tbody>
<tr>
<td>• Introduction</td>
<td>• Special Considerations:</td>
<td></td>
</tr>
<tr>
<td>• Interdisciplinary Palliative Care Team</td>
<td>o Geriatric</td>
<td></td>
</tr>
<tr>
<td>• Essential Components of Palliative Care</td>
<td>o Pediatric</td>
<td></td>
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<tr>
<td>• Breaking Bad News</td>
<td>o Spinal Cord Injury</td>
<td></td>
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<tr>
<td>• Palliative Care Assessment</td>
<td>o Traumatic Brain Injury</td>
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<tr>
<td>• Goals of Care Conversation</td>
<td>• Supporting the Healthcare Team</td>
<td></td>
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<tr>
<td>• End-of-Life Care</td>
<td>• Clinical Documentation</td>
<td></td>
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<tr>
<td></td>
<td>• Performance Improvement initiatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Guidelines</td>
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</tbody>
</table>

Adapted with permission, from “Palliative Care Best Practice Guidelines,” by American College of Surgeons Trauma Quality Improvement Program, 2017, Retrieved: https://www.facs.org/~/media/files/quality%20programs/trauma/tqip/palliativecare.ashx
<table>
<thead>
<tr>
<th>Phase</th>
<th>Action Items</th>
<th>Start Date</th>
<th>Due Date</th>
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</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Evaluate current geriatric trauma palliative care practices including Gap Analysis</td>
<td>July 1, 2017</td>
<td>August 1, 2017</td>
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<tr>
<td>Phase 2</td>
<td>Create an action plan based on Gap Analysis and evaluation consistent with best practice guidelines</td>
<td>August 1, 2017</td>
<td>September 1, 2017</td>
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<tr>
<td>Phase 3</td>
<td>Perform retrospective chart review for dependent measures for all geriatric trauma patients</td>
<td>July 1, 2017</td>
<td>October 1, 2017</td>
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<tr>
<td>Phase 4</td>
<td>Implement education on the geriatric trauma palliative care program. Educational materials for both the nursing staff on the trauma floor and the surgical residents rotating on the trauma service will be developed by the APRN that reflects closing the gaps identified.</td>
<td>October 1, 2017</td>
<td>December 31, 2017</td>
</tr>
<tr>
<td>Phase 5</td>
<td>Implement best practice geriatric trauma patient palliative pathway (Figure 1)</td>
<td>February 1, 2018</td>
<td>N/A</td>
</tr>
<tr>
<td>Phase 6</td>
<td>Evaluate geriatric trauma patient palliative program</td>
<td>February 1, 2018</td>
<td>April 30, 2018</td>
</tr>
<tr>
<td>Phase 7</td>
<td>Perform analysis</td>
<td>May 1, 2018</td>
<td>May 30, 2018</td>
</tr>
<tr>
<td>Phase 8</td>
<td>Expand program to at-risk patients (high spinal cord injuries, severe traumatic brain injuries and burns)</td>
<td>June 1, 2018</td>
<td></td>
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Methods

• Level 1 Trauma Center
  • 870 bed teaching facility
  • 2017
    • Trauma Consulted on 318 geriatric trauma patients
    • Trauma Admitted 195 geriatric trauma patients
• Medical record review in EPIC EMR
Methods

- Creation of Geriatric Trauma Palliative Care Program (GTPCP) summer of 2017
  - Gap analysis
  - Development of action plan
  - Chart review
  - Education
  - Implementation
  - Evaluation
  - Expansion
## Gap Analysis Highlights

<table>
<thead>
<tr>
<th><strong>Strength</strong></th>
<th><strong>Weakness</strong></th>
<th><strong>Future Consideration</strong></th>
</tr>
</thead>
</table>
| - Communicating bad news after death  
- Organ donation procedures  
- Family visitation and support  
- Early Physical Medicine & Rehabilitation consults  
- SICU nursing documentation of advanced directives  
- Comfort care order set  
- Use of trauma psychosocial team and family support teams | - Advanced care plan implemented and documented during admission  
- Advanced care plan documented with 24hrs of admission  
- No early discussions with family/surrogate regarding goals of care and prognosis  
- Staff training on palliative care  
- Use prognostic tools to guide family discussions  
- No frailty assessments documented | - Develop a palliative care screening tool  
- Create goals of care template progress note  
- Begin using Time Limiting Trials in the SICU  
- Create a protocol for comfort care and withdrawal of care |
Geriatric Trauma Palliative Care Pathway

Throughout Hospitalization
- Pain and symptom management
- Family/friends access to patient
- Family/friend emotional support

24 hrs
- Identify health care proxy
- Obtain Advanced Directive Documents
- Create urgent and focused goals of care conversation
- Document care conference note in EMR
- Provide emotional support for patient and family

72 hrs
- Family meeting
- Goals of Care discussion
- Care conference note updated in EMR
- Time limiting trials as appropriate
- Transition to end of life care
Ethical Considerations

• Moral distress causes unintended negative consequences when implementing palliative care programs
  • Double effect
  • Futility of care
## ACS Benchmarks

### Performance Improvement Measures

<table>
<thead>
<tr>
<th>Geriatric (≥ 65 years of age) patients admitted to Trauma Service</th>
<th>Benchmark</th>
</tr>
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<tbody>
<tr>
<td>1. Implementation and documentation of advanced care planning before discharge</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>2. Completion of frailty assessment within 24 hours of admission</td>
<td>≥85%</td>
</tr>
<tr>
<td>3. Implementation and documentation of advanced care planning within 24 hours of admission</td>
<td>≥90%</td>
</tr>
<tr>
<td>4. Implemented comfort care and/or withdrawal of support for geriatric trauma deaths reviewed through the trauma performance improvement patient safety process</td>
<td>100%</td>
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Adapted with permission, from “Palliative Care Best Practice Guidelines, “ by American College of Surgeons Trauma Quality Improvement Program, 2017, Retrieved: [https://www.facs.org/~/media/files/quality%20programs/trauma/tqip/palliativecare.ashx](https://www.facs.org/~/media/files/quality%20programs/trauma/tqip/palliativecare.ashx)
Results

- 3-month retrospective data analysis and a 3-month post-implementation data analysis

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>46</td>
<td>48</td>
<td>94</td>
</tr>
<tr>
<td>Age Range</td>
<td>65-90</td>
<td>65-96</td>
<td>65-96</td>
</tr>
<tr>
<td>Age Average</td>
<td>77</td>
<td>75</td>
<td>76</td>
</tr>
<tr>
<td>Male</td>
<td>24</td>
<td>24</td>
<td>48</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>24</td>
<td>46</td>
</tr>
</tbody>
</table>
## Results

- Comparison of descriptive statistics using $\chi^2$ and Fisher Exact Test

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Cohort 1: Pre %</th>
<th>Cohort 2: Post%</th>
<th>$\chi^2$</th>
<th>$p= value$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>17.39%</td>
<td>58.33%</td>
<td>16.66</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>2</td>
<td>0.00%</td>
<td>43.75%</td>
<td>25.91</td>
<td>&lt;0.001$^a$</td>
</tr>
<tr>
<td>3</td>
<td>13.04%</td>
<td>50.00%</td>
<td>14.77</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

$^a$ Fisher’s Exact Test = 0.000
Discussion

Accomplishments:
- Created a Geriatric Palliative Care Pathway to trigger identification of geriatric trauma patients at high risk for poor functional outcome or mortality
- Created a Care Conference template
- Created educational opportunities for nurses and providers
- Utilized frailty screening tools
- Have goals of care conversations earlier to identify a health care proxy, and secure advance directive documents
- Avoid or limit care that is contrary to a patient’s wishes
- Optimize quality of life by improving the care, pain and symptom management
- Trauma Nurses performing frailty screening
- Expansion to severe traumatic brain injury and cervical spine injury
Limitations

- Occurred at a single Level 1 Trauma Center in Dallas, Texas
- Seasonal variations in geriatric trauma
- Data for 6 months
- Single data collector
Implications for Practice

• Avoid or limit care that is contrary to a patient’s wishes
• Optimize quality of life by improving the care, pain and symptom management
• Team must be confident and comfortable discussing palliative and end-of-life care issues
• Expansion to severe traumatic brain injury and cervical spine injury
Key Points

• Implementing the ACS Palliative Care Best Practices Guidelines (2017) provides improvement for geriatric trauma patient care by optimizing quality of life and by improving the care and pain and symptom management.

• Palliative care screening should not be limited by age or severity of illness; it should be included concurrently with lifesaving therapies.

• The multidisciplinary team must have basic competencies in primary palliative care, pain and symptom management, and end-of-life care.
References

• **Key Words:** palliative care, geriatric trauma, trauma palliative care, American College of Surgeons (ACS), symptom management and trauma end of life care


• American College of Surgeons Committee on Trauma (2012). *Advanced trauma life support for doctors: ATLS, student course manual, 9th ed.* 272-284.


