Palliative Care for High Risk Geriatric Trauma Patients

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Introduction

Goals of care discussions (GOCD) are important for all populations but especially for geriatric trauma patients who may receive care incongruent with their wishes. The increasing population of geriatric trauma patients (GTP) raises significant concerns among trauma care providers in terms of disparate outcomes compared with younger trauma patients, limited geriatric care workforce, costs, and end of life issues. Morbidity and mortality, in GTPs, results from a combination of factors, including injury severity, co-morbid conditions, aging physiology, and pre-morbid function. GTP at high risk of poor outcomes following injury will benefit from proactive palliative care which includes discussions about prognosis, realistic discharge expectations and documentation of advanced care planning.

Frailty has been shown to be predictive of poor functional outcome and mortality. Several tools are available to screen for frailty as a marker of high risk.

The use of advance practice providers in palliative care on a generalist level is necessary to meet the needs of the growing aging population. Advance practice nurses are ideally suited for this type of work as they are clinically knowledgeable, collaborative and advocate for quality care.

This project took place in an academic, inner city, safety net hospital.

Aims

The aim of this project was to improve patient centered care by identifying geriatric trauma patients at risk of mortality or poor functional outcome and initiating GOCD.

The secondary aim was to explore the feasibility of advanced practice providers as palliative care generalists.

Methods /Measures

Four Plan-Do-Study-Act rapid cycles of change were used to evaluate attainment of goals and institute changes to the plan. Run charts were used in each cycle to track changes and visualize improvement over time.

APPs were educated using role play workshop and the End of Life Nursing Education Consortium Courses.

Team
- Advance practice providers
- Performance Improvement Coordinator

Trauma environment
- Chaotic, stressful
- No previous relationship with patient /family
- Often urgent choices

Measures

1. Education of APPs on palliative performance scale (PPS) and leading goals of care conversations.
2. Percentage of GTPs screened with PPS within 24 or 48 hours.
3. Percentage of completion of palliative care bundle with high risk GTPs

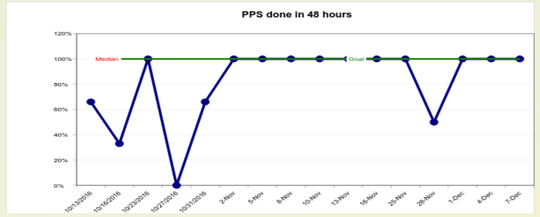
Palliative Performance Scale

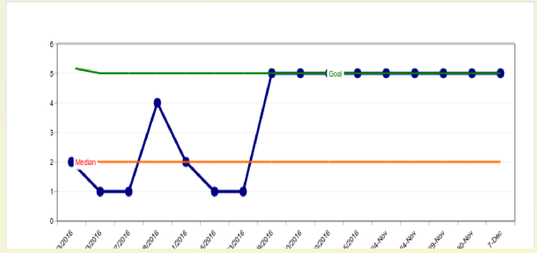
PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Palliative Care Bundle
1. PPS
2. Advance directive
3. Health care proxy
4. If PPS 80% or less

Goals of care conversation /Referral to palliative care service.

Results





The 48-hour run chart revealed an increase in the 48-hour screening after additional education and the emergence of 2 APP champions. Chart # 2 shows completion of palliative care bundle which improved after initiation of a structured conversation tool, EPIC checklist chart note, and partnering with intensive care fellow for GTPs admitted to the Intensive Care Unit.

100% of APPs were educated on PPS & leading goals of care conversations.

Conclusions

Implications for practice: The ability to identify GTPs who are at high risk of poor outcome early in their hospitalization is crucial. This allows for timely goals of care discussions and enhances patient and family centered care.

Education and coaching enable APPs to identify at risk GTPs and function as palliative care generalists.

This project is applicable to all emergent hospital admissions.

Implications for Future Study: Future quality improvement studies should evaluate patient and family satisfaction with goals of care discussions and seek to improve screening within 24 hours of admission.

Lessons learned: This is a labor intensive project, APPs need to be educated and supported in this new role. Initiating goals of care conversations are difficult especially in the acute setting with no prior relationship with patients and families.

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