



Introducing palliative care into the intensive care unit: An interventional study



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ABSTRACT

Background: Many Intensive Care Unit (ICU) deaths include patient and family suffering. While there is a need to include palliative care in the ICU, such care is often unavailable.

Objectives: To determine whether a course in ICU Palliative Care was associated with changes in participants' palliative care knowledge, attitudes and practices.

Methods: Four cohorts of a national Israeli course in ICU palliative care ($N = 122$) were followed. Data were collected on the first and last day of a six-month course and 2–5 years later.

Results: Statistically significant differences were found in palliative care attitudes and practices, with knowledge levels and quality of death and dying stable after course completion. Participants reported obtaining knowledge and skills necessary to introduce palliative care but were thwarted by organizational barriers.

Conclusions: The course was successful in building participants capacity to provide palliative care however; barriers made introduction of palliative care into the ICU difficult.

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Introduction

The Intensive Care Unit (ICU) was designed to care for patients with acute injuries or diseases and for those were expected to be discharged from the unit in good health.^{1,2} However many ICU patients today have chronic illnesses³ that are associated with an increased risk of mortality. Between 10–29% of adult ICU patients and 1.9–3.4% of pediatric patients die in the ICU or soon thereafter.^{4–6}

The World Health Organization defines palliative care as a treatment approach that attempts to preserve quality of life of those who have a life threatening illness and includes symptom and pain management as well as end-of-life care.⁷ In many cases, an ICU death does not come as a surprise. In most of these expected ICU deaths, a decision was made towards the end of life to either continue life-saving treatment or change the goals of care to comfort or palliative care.⁸ Others report a symptom prevalence in the ICU between 27% (confusion) to 75% (fatigue).⁹ This suggests that there is a need for palliative care in the ICU.

Initially, ICU palliative care was aimed at improving end-of-life care, however it is now understood that palliative care in the ICU also includes symptom management and shared decision-making.¹⁰ These practices are the responsibility of all ICU healthcare

professionals and not just palliative care consultants. Nurses play a critical role in the provision of palliative care as they assess the need for palliative care, serve as communication coordinators between the staff, patient and family while also supporting patients and family. Therefore, it is important that nurses are familiar with palliative care practices.¹¹ In addition, despite the increase in the numbers of specialists in palliative care, it is unlikely that palliative care specialists are able to meet the palliative care needs of all ICU patients and a model that incorporates specialists with unit practitioners is necessary.¹²

Palliative care experts describe two methods of introducing palliative care into the ICU, a consultative model using outside consultants who are not ICU staff members but experts in palliative care or a combination of consultants and unit staff members who provide palliative care as standard care within the unit, otherwise known as an integrated model.¹³ When using the integrated model, it is important for bedside nurses to have knowledge in palliative care, and the involvement of bedside nurses is a necessary condition to the introduction of palliative care into the ICU.^{11,14} However, many ICU nurses are not educated in palliative care and therefore feel uncomfortable when providing it.¹⁵ A systematic review of studies investigating the advantages of providing palliative care education for Canadian nurses found that educational programs improved nurses' knowledge, attitudes and confidence in providing palliative care as well as improving their communication skills and decreasing stress.¹⁶ However, the study excluded specialty areas such as critical care. A study by

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Anderson and colleagues¹¹ found that training palliative care advanced practice nurses and nurse educators to promote palliative care in the ICU was associated with increased nurse ratings of palliative care communication skills. However, advanced practice nurses and nurse educators received the educational intervention and not bedside nurses. Therefore, there is a need to determine whether educating bedside nurses can improve the quality of palliative care in the ICU.

Palliative care can be assessed in several ways. One "objective" method is to test practitioners on their level of clinical palliative care knowledge using an exam. Several studies have used this method and found that objective knowledge of palliative care is generally moderate to low.^{17–19} However having the appropriate objective knowledge does not insure that correct practice will occur.

An alternative method is to ask participants their subjective perception of their knowledge, attitudes and practices related to palliative care.^{20,21} This method is based on Self-Efficacy Theory that states that people behave based on the balance between their assessment of a task and their perceived ability to complete it. If a person believes that a task is too difficult or there are many barriers preventing completion of the task, then efforts to complete the task or practice will be low. On the other hand, if the healthcare professional perceives that the practice is doable, then the practitioner will expend more effort to complete it. Therefore, according to Self-Efficacy Theory, empowering a practitioner's understanding and encouraging positive perceptions and attitudes can change practice.^{22,23} Palliative care knowledge is then the subjective, perceived level of self-confidence that a clinician has in his or her acquired knowledge to provide palliative care.²⁰ Attitudes in this context are the self-perceived abilities of a clinician to provide palliative care and to feel comfortable discussing such care with patients and families²⁰, while practices are palliative care acts, such as initiating end-of-life-care discussions with patients or family members.

Israel is a country in the Middle East with a population of about 8.9 million people. The majority of citizens are Jews (about 7 million), many of whom are immigrants or children of immigrants. Many immigrants come from Arab countries in North Africa or the Middle East. In addition, much of the population are Arab Muslims (1.9 million) or Arab Christians (about 173,000).^{24,25} Israel's health care system is based on socialized medicine. Every resident of Israel is entitled to a basic 'basket' of health care services, which include palliative care. However, the general view is that palliative care refers to end-of-life care only. There is also a severe shortage of inpatient hospice beds, the vast majority of which are used by oncology patients. A national review of end-of-life care found that 81% of hospitals had a palliative consultation service; however, guidelines related to the use of palliative care staff were found in only 63% of the institutions.²⁶

The aim of the present study was to determine whether a course in palliative care for ICU nurses was associated with changes in palliative care knowledge, attitudes and practices of over a four-year time span.

Methods

Design

This was a prospective longitudinal, cohort study.

Setting and sample

The sample was a convenience sample of 122 Israeli ICU Nurses from throughout the country who participated in a 112-hour continuing education course entitled, "Palliative Care in the ICU". Four cohorts completed the course, approximately one cohort per year, from 2014 to 2017. Members of the Israel Association of Cardiology and Intensive Care Nurses were contacted by email and invited to

participate in the course. All ICU nurses who registered for the course were asked to participate in the current study. All of the course attendees agreed to participate in the current study. None of the respondents had participated in a palliative course in the past.

Data collection

Data were collected for each cohort at the beginning and end of the six-month course and approximately one year later. In addition, in 2019, the executive board of the Israel Association of Cardiology and Critical Care Nurses decided to convene a half-day seminar to reunite members of the classes and determine the impact of the course on the ICU nursing community. Qualitative data were collected at this meeting using the same methods as during the course, via the use of a Knowledge Café.

Instruments

Two questionnaires were used, a personal and work characteristics questionnaire, and a questionnaire designed by the investigators to measure knowledge, attitudes and practices related to palliative care based on the End-of-Life Care in the ICU Questionnaire²⁰ and the Quality of Death and Dying.²⁷ Personal and work characteristics included demographic data, years of experience as a nurse and as an ICU nurse, nursing education and previous exposure on a personal or professional basis with palliative care. The End-of-Life Care in the ICU questionnaire measures nurses' self-evaluations of their knowledge, attitudes and practices of palliative care in the ICU. The questionnaire consists of 28 questions on a 5 point Likert scale (from strongly disagree to strongly agree). Participants could also respond with "not relevant". Senior ICU nurses familiar with palliative care in the ICU reviewed the questionnaire for its content validity and found it to be valid for this sample. This was a content validity check for the current study. Sometimes questionnaires developed in other countries and in other languages are less appropriate and therefore we checked the reliability and validity for the current study. Some minor revisions were made to the questionnaire following their suggestions. In addition, nurses were asked to rate on a 0–10 visual analog scale their perception of the quality of death and dying on their unit.²⁷

Some minor revisions were made to the questionnaire following their suggestions. Cronbach Alpha reliability ranged from 0.87–0.90 for each of the three times that the questionnaire was administered to each cohort. Cronbach alpha reliability for the total scale was $\alpha=0.89$, and $\alpha=0.89$, 0.66 and 0.88 for the knowledge, attitude and practice sections, respectively.

In addition, a Knowledge Café was held at the beginning and end of each course and at a half-day seminar in 2019. Participants were divided into groups of 5–6. Each group was asked to elicit responses from all members of the group related to two questions: "What does palliative care mean to you?" "How does your unit practice palliative care?" After all members had discussed their responses in the small groups, a representative of each group reported the responses of the group to the entire class. In this way, all members of the class were represented. These responses were reported and then independently coded into themes by the authors.

Palliative care course

The course met every 2 weeks over a 6-month period for a total of 112 h. The course used a "train the trainer model", where members would serve as champions on their own units. The course contained theoretical and experiential content over a total of 14 days. The course was based on the knowledge and experience of the coordinators of the course, the literature as well as other palliative courses given in Israel and around the world. It was important that the content reflect issues related to palliative care in the ICU in Israel as well

as global aspects. Content of the course included: history and principles of palliative care; symptom management; communication; end of life treatment of chronic illnesses; spiritual care; ethics; legal aspects and its impact on nursing care; and patient and family centered care. Lecturers included known national nursing and physician leaders in palliative and intensive care

Data were analyzed using SPSS Version 24. Descriptive statistics (mean, median, standard deviation and frequency) were computed for all variables. A Repeated Measures Analysis of Variance was conducted on each of the study variables to determine differences over time (at the start and completion of the course, and 2–5 years later at the half day seminar). Dependent t-tests were then analyzed to determine differences between specific periods. Two of the authors analyzed interview data obtained from the Knowledge Cafes independently using a content analysis approach. Each investigator reviewed the responses from the cafes and then categorized them into themes. The authors then met and discussed their results leading to a common list of themes.

Results

One hundred and twenty two nurses participated in the palliative care course across four cohorts of 25–35 participants each. The mean age of the participants was 50.2 years (*SD*= 8.5). The majority were women (*n* = 108, 88.5%), who were married (*n* = 64, 51.2%). The mean number of years as a registered nurse was 19.7 (*SD*= 9.7) with a mean of 14.4 years as an ICU nurse (*SD*= 8.4) and 12.4 years in the current unit (*SD*= 8.5). Most nurses were staff nurses (*n* = 90, 77.6%), and had completed an academic degree (first degree: *n* = 51, 42.9%; master's degree: *n* = 37, 31.1%) and post-basic ICU certification (*n* = 112, 94.1%) (Table 1).

Mean scores of knowledge levels, attitudes, practices and assessment of the quality of death and dying increased over time. A statistically significant difference was found over time on levels of attitudes

(Wilk's Lambda=0.305, *F* (2, 12) =13.68, *p*=.001) and practices (Wilk's Lambda=0.423, *F* (2, 13) =8.87, *p*=.004). However, no statistically significant differences were found on knowledge levels (Wilk's Lambda=0.76, *F* (2, 11) =1.67, *p*=.233) and assessment of the quality of death and dying (QODD) (Wilk's Lambda= 0.668, *F* (2, 12) =2.99, *p*=.088) over time (Table 2). Differences over time were further analyzed using paired t-tests (Table 3). Statistically significant differences were found between T1 and T2 and between T1 and T3. No statistically significant differences were found between T2 and T3.

Participants in the program participated in a Knowledge Café, where all members were asked to describe the meaning of palliative care and how it was practiced on their unit. A summary of the themes is provided in Appendix 1 and 2 and a summary for all data collection points is found in Table 4. For the most part, most participants began the program with some knowledge of palliative care. Palliative care was primarily described as pain and symptom control and providing death with dignity. For example, "The nursing staff is more dominant with symptom control. There is less attention to spiritual and cultural aspects-there is some but not enough" and "Let the family say goodbye to the patient even if the patient is sedated and intubated". Some participants also included aspects of patient or family centered care, such as "Give emotional support to the patient and family".

By the end of the course, six months later, many more participants responded that palliative care included a multidisciplinary approach. For example, "Decisions are made by the whole staff". They reported an increased willingness to initiate palliative care for their patients ("Identify patients in need of palliative care"), including more active listening and direct communication, such as, "Being where the patient wants to be". Participants reported a large range of palliative care practices on their units, from minimal to no palliative care to a full palliative care approach. One participant stated, "There is a big range -from nothing to everything, it depends on the attending physician-on his treatment approach". This range continued for the entire length of the study. Other themes included the role of the nurse and barriers to providing palliative care, training and resources. For example, "Doctors are the ones who make the decisions and the nurses carry them out". At the conclusion of the course, some respondents also described improved palliative care practices and the role of the nurse. Barriers to the implementation of palliative care were reported at all data collections points. These included family, isolation, physicians, nursing support, policy issues, staff support and training, and resources available to provide palliative care. For example, "Palliative care is a real issue that no one wants to deal with" and "It is hard to care for a patient at end of life when you don't have a toolkit."

Discussion

Participants of the Palliative Care in the ICU course increased their perceived knowledge in palliative care and maintained this perception over time. They also improved their self-perceived attitudes and increased their practices related to palliative care, as seen in the statistically significant differences between the start and conclusion of the course as well as participant reports 2–5 years later. Perceived quality of dying in the ICU also improved but differences over time were not statistically significant. These findings along with the qualitative results of the Knowledge Café suggest that the course met its

Table 1
Participant Demographic and Work Variables (*N* = 122).

Demographic Variable	n (%)	Work Variable	n (%)
Sex		Nursing Education	
Female	108 (88.5%)	RN only	31 (26.1%)
Male	14 (11.5%)	RN + Baccalaureate	51 (42.9%)
		RN + Master's Degree	37 (31.1%)
		Missing	3
Marital Status		Post Basic Certification	
Single	32 (26.7%)	Yes	112 (94.1%)
Married	64 (53.3%)	No	7 (5.9%)
Separated/Divorced	18 (14.4%)	Missing	3
Widowed	6 (4.8%)	Current Role	
Missing	2	Staff Nurse	90 (77.6%)
		Assistant or Nurse Manager	21 (18.1%)
Religion		Other	5 (4.3%)
Jewish	107 (89.2%)	Other	6
Muslim	7 (5.8%)	Missing	
Christian	3 (2.5%)	Clinical Experience with PC	
Other	3 (2.5%)	No	69 (58.5%)
Missing	2	Yes	49(41.5%)
		Missing	4
Family Experience with PC			
No	84 (71.8%)		
Yes	33 (28.2%)		
Missing	5		

Table 2
Mean and Standard Deviation Scores of Knowledge, Attitude, Practices and QODD Scores over Time.

	T1 <i>n</i> = 122	T2 <i>n</i> = 110	T3 <i>n</i> = 24
Knowledge	3.9 ± .75	4.4 ± .45	4.3 ± .60
Attitudes	3.9 ± .70	4.3 ± 0.52	4.4 ± 0.61
Practices	2.9 ± 1.0	3.3 ± 0.74	3.6 ± 0.55
QODD	6.4 ± 2.8	6.7 ± 1.9	7.1 ± 1.9

Table 3
Paired t-tests between Knowledge, Attitude, Practice and QODD levels over time.

Variable	Difference between T1-T2 t (df), p	Difference between T2-T3 t (df), p	Difference between T1-T3 t (df), p
Knowledge	5.59 (65), <i>p</i> =.05	.80 (12), <i>p</i> =.438	1.98 (16), <i>p</i> =.065
Attitudes	4.47 (65), <i>p</i> =.0001	.37 (14), <i>p</i> =.719	4.32 (16), <i>p</i> =.001
Practices	3.61 (65), <i>p</i> =.01	.386 (14), <i>p</i> =.706	4.62 (16), <i>p</i> =.0001
QODD	1.67 (85), <i>p</i> =.098	.635 (13), <i>p</i> =.537	3.10 (16), <i>p</i> =.007

objectives, to increase self-perceived knowledge and attitudes towards palliative care while empowering participants to practice palliative care with confidence on their units. According to Self-Efficacy theory, if practitioners perceive that they have increased their knowledge and have improved attitudes towards palliative care, then their actual practices should also increase. This result was confirmed in a meeting with the graduates 2–4 years later.

When comparing the results of this study with a previous study using the same instrument, course participants reported lower initial levels of perceived knowledge, attitudes, and practices.²⁰ While levels improved over time in the current study, even at the conclusion of the course, knowledge and practice levels remained lower than those reported in this previous study. This discrepancy can be partially explained by the fact that the sample in this study were nurses while the original study included nurses as well as other healthcare professionals. A study of 137 German ICU physicians was conducted to determine their level of knowledge and self-confidence delivering palliative care²⁸. Knowledge was measured as correct answers to a multiple-choice questionnaire while self-confidence was measured similar to the knowledge and attitude sections of the current study. Participants scored a median of 2.7 (out of 5) on the self-confidence measure with more than half reporting being rather confident or confident of their ability to deliver palliative care. These results are similar to the scores of the current study.

Another possible explanation for lower scores in the current study is the local culture and healthcare environment. While many participants reported that their practice has changed because of the course, they also reported that barriers within the healthcare system delayed the introduction and initiation of palliative care in the ICU. Some graduates described their personal frustration at having the ability to provide palliative care but were unable to do so due to unit and personnel barriers. Others expressed a conflict between their willingness to provide palliative care and their ability to provide it. A significant barrier was physicians who are not open to the use of palliative care on their unit. Barriers in the care environment and differences of opinion between clinicians, patients and family members can limit such behaviors.²⁰ Despite its very western approach to healthcare,

physicians with a paternalistic approach manage many units. Some of these physicians are not familiar with the advantages of palliative care and as a result act as a barrier to the introduction of palliative care practices such as increased family visiting hours or frequent family meetings.

Participants in this study also reported resistance from fellow nurses when they tried to incorporate some of the knowledge they received during the course. One of the major barriers found to decrease the quality of palliative care in the ICU is a lack of palliative care education to medical personnel²⁹, also found in the current study.

Our results are similar to other interventional studies aimed at improving practitioners' ability, self-efficacy and self-confidence to deliver palliative care to their clients. These studies reported improved communication skills¹¹, participant knowledge and attitudes towards provision of inter-disciplinary palliative care³⁰ and confidence in providing a family nursing approach to palliative home care.³¹ In a correlational study, Ransie and colleagues³² found that perceived increased access to educational opportunities (similar to knowledge in the current study) of Australian ICU nurses is associated with increased use of interpersonal practices and family centered decision making and support (similar to palliative care practices in the current study). They also found that positive attitudes towards palliative care values was associated with increased practice intentions, results similar to the current study.

Limitations

The course was conducted with a relatively small number of nurses from one country who volunteered to participate in the course. Therefore, the results must be generalized with caution. The study questionnaire was translated and therefore some questions may not have been measured as originally intended. In addition, one of the sub-sections, the attitude section, had only a moderate level of internal consistency reliability. Knowledge, attitudes and practices of palliative care were measured as self-perceived levels of self-efficacy and not as "objective" measures of palliative care knowledge or observed practice behaviors. Many of the participants did not complete the questionnaires at all three points in time, which may also affect the generalizability of the results. This is because many participants did not complete the third data collection, one year after completion of the course.

Results of the current study show that ICU nurses can be empowered to provide palliative care. We therefore suggest that efforts be made to provide palliative care education to bedside nurses as well as their physician colleagues. It is also recommended that continued research be conducted that investigates the introduction of palliative

Table 4
Themes for How Palliative Care was Practiced in the ICU.

Start of Course	End of Course	Meeting of all Cohorts 2019
Participants understood the need for palliative care (pain management, decrease suffering, die with dignity)	* Increased awareness of palliative care * Some improvement in palliative care * Improvement in communication with families and within the staff	Reports of increased ability and confidence to provide and initiate palliative care
Lack of ability to provide palliative care	* Some frustration due to conflict between willingness to give palliative care and ability to provide it * Unit barriers	* Increased initiative to act as unit consultants (graduates act as consultants) to families and peers
Lack of palliative care in the unit	* Increased awareness of palliative care * Some improvement in palliative care * Improvement in communication with families and within the staff * Some frustration due to conflict between willingness to give palliative care and ability to provide it * Unit barriers	* Increased use of palliative care consultants (outside experts) in the ICU * Increased doctor use of consultants * Improved nurse and doctor communication related to end-of-life * Unit barriers remain * Use of palliative care very dependent on physician in charge

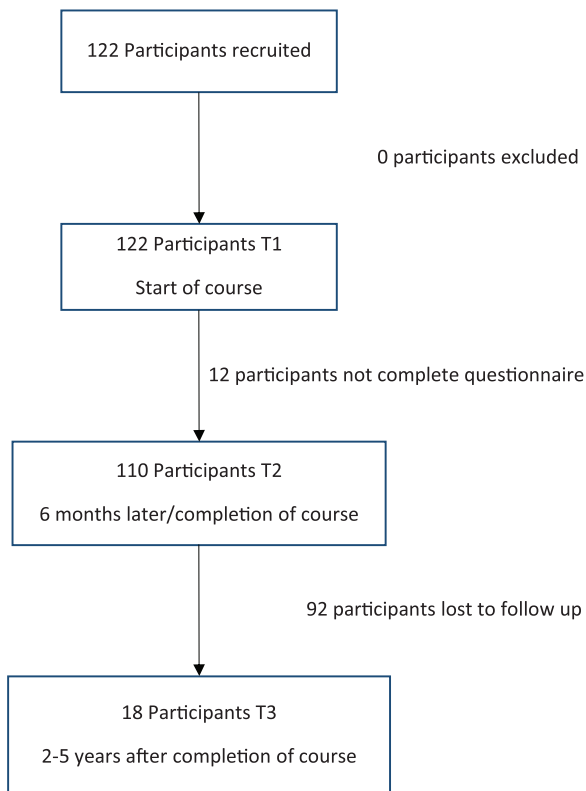


Fig. 1. Flow Diagram of Subject Participation.

care into the ICU with a larger and more culturally diverse sample. Future studies could include other measures of palliative care such as objective measures of knowledge or other methods of measuring practice behaviors. In addition, alternative methods of introducing palliative care into the ICU should be studied, including multi-disciplinary approaches.

Conclusions

This mixed methods study demonstrated that a palliative care in the ICU course met its objectives of increasing levels of critical care nurse self-efficacy related to providing palliative care on their units. Their self-perceived palliative care knowledge and attitudes improved and remained stable over time while practices and assessments of the quality of death and dying improved slightly. Based on the results of this study, it is recommended that further research be conducted to determine effective methods of educating multi-disciplinary teams of differing cultures and environments in palliative care and that more critical care professionals participate in palliative care educational projects (Fig 1).

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Declaration of Competing Interest

There are no conflicts of interest related to the manuscript, INTRODUCING PALLIATIVE CARE INTO THE INTENSIVE CARE UNIT: AN EDUCATIONAL INTERVENTION.

Appendix 1: "What is the meaning of palliative care to you?"

At the Start of the Course

Symptom control, especially pain control

"The nurses demand from the doctors to give analgesics"
"Pain control and nursing care while supporting the patient and family"

"The nursing staff is more dominant with symptom control. There is less attention to spiritual and cultural aspects-there is some but not enough"

Death with dignity

"Let the family visit the patient before death"
"To die with dignity, in peace, pain control, cooperation with family"
"Let the family say goodbye to the patient even if the patient is sedated and intubated"

Patient /family centered care

"Teach the family throughout the ICU stay"
"Give emotional support to the patient and family"
"To put the disease outside the door and take care of the patient"

At Completion of the Course

Multidisciplinary care

"Use a Multidisciplinary team"
"Decisions are made by the whole staff"
"Consulting with a palliative care expert"
"Involvement of all of the stakeholders-religious people, psychologists, social workers"

Initiate palliative care

"Identify patients in need of palliative care"
"Initiate discussions"
"Go to the shiva and send condolence letters"
"Give a feeling of confidence that we are there"
"Goal setting"
"Provide maximal support to the family"
"Not just at end of life but when the patient gets admitted to the ICU, help families, give information. . ."
"Stop the medical discussions and move to a discussion of palliative care"

"Get family feedback and flow with it"

"Make goals with the family that are realistic and help the family develop methods of thinking that are different"

Active listening/ direct communication

"Listen to the patient"
"Being where the patient wants to be"
"Don't be afraid to talk about death"
"To accept an unknown future"
"Give peace and quiet. It is a hard situation for the family but we give peace, control, identify the problems, what we need to do next, let them let go, the family is part of the process"
"Pay attention to how the family interprets what the doctor says"
"Ability to talk directly"
"Fulfill the nursing approach in the most basic level in supporting the patient and family"

Appendix 2: How is palliative care practiced on your unit?

At the Start of the Course

Range of palliative care practice

"There are different approaches between the ICUs". "There is a big difference between the ideal and practice-it depends on the unit, the doctors and the head nurse". "There is a big range -from nothing to everything, it depends on the attending physician-on his treatment approach"

Little to no palliative care

"Keep going till flat line. Don't decrease medical care despite the futile care" "Even when there is brain death they continue to treat" "In difficult cases will treat to the end and no doctor will take a risk with his license"

Middle ground

"Don't get psychosocial support but get pain management." "Pain management, talk to the family, let the family stay by the patient's bed, privacy..."

Higher level of PC:

"In the CCU we respect the wishes of the family and treat less." "There are doctors who are connected to the topic and discuss with the family..." "Some places have family meetings, every day there is a meeting with a physician and there are palliative care consults"

Role of nurse

"Doctors are the ones who make the decisions and the nurses carry them out". "If you know the family you can ask them but nurses do not initiate the discussion. It is not accepted- this is an issue for the doctors. "No one asks nurses but we often are the leaders who lead the discussion in the right direction"

Barriers to providing palliative care

Policy

"No clear policy. Practice is based on the opinion of the unit director, no clear practice protocol". "There is no policy or red lines for when treatment is stopped".

Staff support

"Palliative care is a real issue that no one wants to deal with". "Doctors don't want to take it on themselves". "The staff doesn't always want or can give support." "The staff shoves it to the next shift so that they don't have to cope with death," Doctors are not connected to it, they don't have the orientation and they do not have the tools and do not know when turn to them [palliative care experts]".

Training

"No training for staff." "The staff does not have the appropriate skills to lead palliative care or to explain to the family." "It is hard to care for a patient at end of life when you don't have a toolkit."

Resources

"There is no time to talk to the family." "When they decide in the end, it is hard to give the appropriate care to the family. We are very busy because of pressure of the work and time pressure."

At the Completion of the Course

Progress of introduction of palliative care

Yes, there is progress

"There is a willingness in the air that influences the staff. There is an increase in awareness". "In light of the course, we managed to arrange organized meetings with family members every day- we are only at the very basic level." "I feel like we have started." "There is a change in the organizational culture." "There is a change in our unit- there is a doctor in charge in the area and the awareness had increased but there still is a problem with the doctors of the previous generation." "We are slowly openly discussing what they think -it is a big project but will get there one patient at a time- each incident is a victory". "It is complicated- are trying to work according to the approach but we have a long way to go to implement it."

No, there is no progress

"Talk a lot but de facto there are no decisions to stop aggressive treatment -we do more for ourselves and less for our patients". "Not implemented, we are just beginning- just the first step, there is some beginning discussions with families." "Gap between what we want and what is done -as head nurse try to change tone but is still hard. The situation is not where we want it" "There are doctors who do not agree and do not cooperate." "It is not practical- must come from the doctors and we can't fight it."

Role of the nurse

"There is no doctor awareness. The nurses have more information." "We argue with the doctors in order to implement it." "Increased awareness of nursing staff and initiate bringing up the subject with the doctors".

Barriers

Families

"We started to speak with the families. They are not used to it- they think we gave up on them but if we started it from the beginning of the hospitalization the process would be different."

Isolation

"It is all individual initiative –there is no support." "Most are not with you"

Physicians

"Doctors still avoid it– sometimes we ask them to talk to the families and they avoid them". "There still is a lot of personal ego involved- do everything till the end ... fear of death by the staff". "The doctor may decide to not be aggressive but if the doctor does not write down the decision, then there is no policy for the nurse to follow." "Doctors back each other up and nurses accuse one another instead of backing each other up."

Nursing Support

"If a nurse does not agree with aggressive treatment, and then a new nurse comes on shift, the new nurse says that the first nurse didn't do anything for the patient- and says, "Now I will take care of the patient." "Many nurses deny end of life because they are afraid of what the family will see."

Staff

"Palliative care is not seen because the staff does not totally agree with it. There is a conflict between the doctors and the nurses. The doctor feels responsible for the life of the patient and is reluctant to move to palliative care."

Resources

"You cannot always give the time, quiet or attention or the correct environment." "You do not have time for the patient who is to die or with the family. It is usual to assign a palliative care patient to a nurse with other patients cause there is 'nothing to do' for this patient."

Final meeting

Progress

"Before there was little awareness, got a lot better after the course- helped and promoted the staff." "Before just cancer patients now include those with heart failure and others, sharpened it for us." "In 2014 there was no awareness among the doctors. Nurses brought in palliative care in an active way and slowly gave lectures to the doctors. Today there is a lot more awareness and progress in understanding the rights of the patient to say what he wants." "Doctors are now inviting more families for discussions and are initiating more discussions with nurses and social workers."

However, others report that there is "Only partial utilization- symptoms and pain control but still treat to the end." "The Medical Director does not fly the palliative care flag." "When there is a medical director who believes, he pulls the entire staff with him."

Nursing Role

"The course gave us the power to operate and oppose doctors. There is the will to invite the palliative care team. The doctor is not G-d and we have the power to do so." "More nurses are talking to families." "The course gave us the courage to cope with the family and have the courage to discuss..."

Barriers

Doctors

"No collaboration, especially to move to palliative care, a lot of ego, it isn't always easy for them [the doctors], especially the surgeons." "Many directors set in their ways." There is a lot of disagreement between doctors so they don't decide- they just take care of symptoms." "The biggest problem is communication with doctors."

Policy

"Still no one policy of how to care for the patient." "Still not clear orders don't say what to do when syringe finishes, depends on how you interpret the order."

Families

"Families that don't want to discuss the issue. They have a lot of hope and they do not want to break the hope. The ultra-orthodox say that life is the holiest of the holies and the Muslims say that all is from G-d and that is a serious barrier."

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