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Increasing Critical Care Nurse Engagement of Palliative Care During the COVID-19 Pandemic

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Abstract

Background—The coronavirus disease 2019 pandemic has led to escalating infection rates and associated deaths worldwide. Amid this public health emergency, the urgent need for palliative care integration throughout critical care settings has never been more crucial.

Objective—To promote palliative care engagement in critical care; share palliative care resources to support critical care nurses in alleviating suffering during the coronavirus disease 2019 pandemic; and make recommendations to strengthen nursing capacity to deliver high-quality, person-centered critical care.

Methods—Palliative and critical care literature and practice guidelines were reviewed, synthesized, and translated into recommendations for critical care nursing practice.

Results—Nurses are ideally positioned to drive full integration of palliative care into the critical care delivery for all patients, including those with coronavirus disease 2019, given their relationship-based approach to care, as well as their leadership and advocacy roles. Recommendations include the promotion of healthy work environments and prioritizing nurse self-care in alignment with critical care nursing standards.

Conclusions—Nurses should focus on a strategic integration of palliative care, critical care, and ethically based care during times of normalcy and of crisis. Primary palliative care should be provided for each patient and family, and specialist services sought, as appropriate. Nurse educators are encouraged to use these recommendations and resources in their curricula and

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See also

To learn more about palliative care, read “Clinical Nurse Specialists Fostering Palliative Care Skills” by Price and Kocan in *AACN Advanced Critical Care*, 2018;29(1):84–90. Available at www.aacnconline.org.

training. Palliative care *is* critical care. Critical care nurses are the frontline responders capable of translating this holistic, person-centered approach into pragmatic services and relationships throughout the critical care continuum.

As of mid July 2020, more than 12.8 million people had tested positive for coronavirus disease 2019 (COVID-19) and more than 567 000 had died.¹ Health system capacity has been overburdened in many parts of the world, and the distribution of limited resources, including ventilators and critical care beds, is of serious concern.^{2,3} Nurses—approximately 28 million worldwide⁴ and 4 million in the United States alone⁵—constitute nearly 60% of the international health care workforce and compose the majority of frontline clinicians caring for persons across COVID-19 testing, triage, and treatment sites. The consequences of the pandemic are particularly daunting for critical care nurses.

Considering the increased strain on critical care nurses amid the COVID-19 pandemic, there has never been a greater need to integrate palliative care into the intensive care unit (ICU) setting. Palliative care is often and erroneously associated solely with the end of life or the actively dying patient. However, the benefits of palliative care increase multifold when moved further upstream in the care trajectory.^{6,7} Our purpose in this article is to promote palliative care engagement in critical care; share palliative care resources to support critical care nurses in alleviating health-related suffering during the COVID-19 pandemic; and make recommendations to strengthen nursing capacity to deliver high-quality, person-centered critical care. Ultimately, we argue that palliative care *is* critical care. We conclude with a call to action for critical care nurses and settings to fully integrate palliative care throughout the continuum in alignment with nurses' ethical obligations to society and a person-centered model of care.

Background

Critical Care Nurses and COVID-19

Findings show that nurses working in the ICU spend an estimated 86% of their in-unit time in direct patient contact, approximately 73% to 78% greater than that of physicians or other critical staff, respectively.⁸ Not only do nurses have more face-to-face time with patients, they are the largest component of ICU teams across the United States. There are more than 500 000 critical care nurses compared with approximately 130 200 respiratory therapists, 6000 to 7000 critical care pharmacists, almost 30 000 advanced practice providers, and the equivalent of approximately 20 000 full-time intensivists.⁹ In the era of COVID-19, critical care nurses are at extremely high risk of viral exposure, burnout, and moral distress and injury; they shoulder the overall challenge of being the most trusted first responder.

In many ways, ICU-level care has become the standard of patient care during the COVID-19 response. Contingency and crisis beds are being allocated outside of ICUs to strengthen hospital capabilities and effectively treat critically ill patients.¹⁰ With the surge in patient admissions nationally and internationally, hospitals are actively adapting medical-surgical floors and emergency departments into transitory ICUs to meet the needs associated with acute decompensation, symptom exacerbation, and rapid responses. Nurses are certain to be experiencing longer and more traumatic shifts complicated by cumulative patient losses,

moral injury and distress in the setting of complex decision-making, resource constraints, and new and mounting responsibilities, among other considerations.¹¹

The risk of viral transmission is provoking fear across the workforce, particularly when many nurses are experiencing a lack of adequate personal protective equipment (PPE).¹¹ Visitors are being distanced from their loved ones to decrease COVID-19 spread and to improve safety standards, undoubtedly placing a strain on family dynamics and relationships between nurses and patients and their families. Care planning discussions for older patients, those with serious illness, and the immuno-compromised are understandably becoming more difficult to manage. As mortality rates soar during the COVID-19 outbreak,¹ proximity to the dying process, death, grief, and bereavement in the ICU carries a cumulative impact on the mental and emotional well-being of all clinicians. All the while, nurses will continue to be the frontline responders: combining skill, evidence-based practice, ethical integrity, technological savvy, endurance, and compassion. Critical care nurses are truly doing and seeing it all during the COVID-19 emergency, working at the intersection of the scientific knowledge and humanistic care that our patients, families, and communities so desperately require.

The COVID-19 pandemic has underscored the need for advanced skills related to management of ventilators, symptom control, delivery of complex medication regimens (often untested), and essential communication with families and within teams, because patients often decline rapidly. The COVID-19 pandemic has also wrought an emotional burden, overwhelming even nurses in the intensive care field who are accustomed to intensely demanding work. Nurses are speaking to family members who have little understanding of the disease, witnessing patients' rapid physical declines, and seeing patients dying alone. Nurses are holding the phone as families say goodbye to dying patients and they then care for the ravaged bodies after ventilators and proning beds are discontinued. Nurses are also contributing to critical decision-making about sparse resource distribution amid health inequities and cultural divides, while risking their personal safety because of a lack of PPE.

Palliative Care and Integration Into Critical Care

In 2018, the International Association for Hospice & Palliative Care put forth a consensus definition of *palliative care* as

the active holistic care of individuals across all ages with serious health-related suffering due to severe illness, and especially of those near the end of life. It aims to improve the quality of life of patients, their families and caregivers.¹²

Effective, safe, and competent palliative care maintains certain characteristics and may provide a range of benefits to recipients, as shown in Table 1. Multiple organizations and expert-led initiatives call for universal access to palliative care as a human right that should be integrated throughout health systems, specialty areas, and at all levels in conjunction with curative treatments, when appropriate.^{13,14}

Researchers suggest the global burden of serious health-related suffering will intensify by approximately 87% over the next 40 years.¹⁵ The need for universal palliative care as a

crucial component of public health frameworks is becoming more evident against the backdrop of COVID-19. Multidisciplinary advocates have noted the essential role of nurses in achieving universal palliative care access by aligning with global health agendas at local levels; raising the profile and status of nurses; adapting nursing education to the practical needs of clinical settings; and supporting nurses as full interdisciplinary team members to ensure palliative care services.^{16,17} Leaders concur that palliative care accessibility is an ethical and humanistic imperative to alleviate suffering during the COVID-19 pandemic and beyond.^{18–20}

Before the COVID-19 pandemic, approximately 29% of Medicare beneficiaries²¹ and 36% of nonhospice patients with cancer with poor prognosis received ICU care in the last 30 days of life.²² These statistics suggest that critical care nurses are not strangers to suffering, dying, or death. However, we presume these figures will consistently increase throughout the COVID-19 pandemic and as a result of future health crises, increasing critical care nursing proximity to patients at the end of life. Although the focus of admission to critical care is often life-sustaining treatment at all costs,

providing comfort to patients should accompany all ICU care, even during aggressive attempts to prolong life. ... The transition from aggressive care to death preparation has not been well operationalized... . Therefore, it is important for healthcare professionals to integrate palliative care principles early in the patient's ICU stay.^{23(pp624–625)}

There are a number of key palliative care points to consider during any ICU stay that are in alignment with the domains of the *Clinical Practice Guidelines for Quality Palliative Care*²⁴ (Table 2). Many of these care points require distinct attention during the COVID-19 outbreak.

Recommendations for Practice

Recommendations with relevant resources to direct critical care nurses and health care leaders are provided in the paragraphs that follow. A wealth of resources from experts in the fields of palliative and critical care exists. In addition, professional societies have centralized resources and has made most of them available free of charge amid a socially distanced and strained environment.

First, critical care nurses deserve to practice in a healthy work environment, which includes resources for their own self-care, during times of crisis and times of normalcy. As defined earlier in this article, palliative care is a person-centered approach to alleviating health-related suffering.¹² To sustainably foster environments in which palliative care can be holistic, of high quality, and consistently delivered, nurses working in critical care settings with increased exposure to suffering must care for themselves.^{20,25,26} Both healthy work environments and clinician self-care are critical factors in delivering safe patient care.²⁷

Health care system leaders employing nurses are responsible for promoting and sustaining a healthy work environment. The COVID-19 crisis has underscored this basic need. Though leaders play a critical role in implementing these standards, each team member owns the

health of the team and unit. The American Association of Critical-Care Nurses (AACN) developed the *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence* (Table 3).²⁸ The 6 standards are Skilled Communication, True Collaboration, Effective Decision Making, Appropriate Staffing, Meaningful Recognition, and Authentic Leadership.²⁸

- We recommend that nurses, teams, and health care system leaders access the free, web-based survey to assess the health of an individual work unit (Table 3).
- We recommend mechanisms to promote transparent, open, respectful, and nonretaliatory communication among critical care nurses, all levels of management, and multidisciplinary partners to ensure health and sustainability for all frontline critical care nurses and colleagues.

Beyond considerations for the work environment, nurses (and all members of the ICU team) cannot care for patients and families if they cannot care for themselves. Critical care nurses and the teams they work with are frequently faced with moral challenges. During a national crisis such as the COVID-19 pandemic, these challenges are intensified. Moral distress and burnout have been recognized by AACN and the Society of Critical Care Medicine. These critical care societies provide effective resources for critical care nurses and all health team members. The Critical Care Societies Collaborative (CCSC) comprises 4 critical care societies: AACN, the Society of Critical Care Medicine, the American College of Chest Physicians, and the American Thoracic Society. In 2016, CCSC published a call to action to address the epidemic of burnout in critical care professionals,²⁹ followed by a 2020 report on the national summit to address burnout in critical care.³⁰

Before the COVID-19 pandemic, many clinicians experienced burnout, anxiety, depression, and substance abuse. National attention was being focused on strategies to address this serious workforce issue and promote clinician resilience and well-being.³¹ Now, experts are aware the COVID-19 pandemic is creating even greater workplace stress and moral dilemmas. Each clinician is much too valuable to the workforce, and critically ill patients cannot be cared for if nurses and physicians leave the discipline because of burnout.

The critical care nurse is the interface between advanced lifesaving technology and patient- and family-centered care. The pressures related to the COVID-19 crisis are likely exacerbating moral distress. Nurses and their teams are strongly encouraged to use the recently published AACN position statement, “Moral Distress in Times of Crisis”³² (Table 3). Nurses are also directed to the websites listed in Table 3 and are encouraged to use tools from the CCSC or National Academy of Medicine sites during this COVID-19 crisis and in the future.

Second, care of patients during the COVID-19 pandemic requires a skilled blend of critical care, palliative care, and ethically based care. Table 2 provides several specific suggestions to help integrate palliative care throughout critical care nursing practice. Critical care societies and federal agencies are providing position statements, research, and other resources to guide practice.

Third, palliative care *is* critical care. Thus, critical care nurses and their teams should provide primary palliative care to each patient and consult palliative care specialists in complex cases. Primary palliative care includes pain and symptom management; patient-centered communication; elicitation of the patient's goals of care and alignment of those goals with the treatment plan; family communication and support; skilled and compassionate end-of-life care; and the assurance that ethical standards are abided by at all times. Critical care nurses will have different levels of skill in fully integrating palliative care.

The End-of-Life Nursing Education Consortium curriculum contains 8 complimentary modules providing essential palliative care knowledge and skills related to communication, self-care, symptom management, loss, grief, and bereavement (Table 3). Palliative care competencies are considered essential for all undergraduate and graduate nursing students. The End-of-Life Nursing Education Consortium team developed an online curriculum, titled "Competencies and Recommendations for Educating Nursing Students," comprising six 1-hour modules to help students develop 17 essential competencies (Table 3). These competencies build on the recommendations from the American Association of Colleges of Nursing and are intended for graduate students.

The Center to Advance Palliative Care has advocated the expanded use of palliative care over the past 2 decades and provides extensive resources and toolkits on its website. Some resources are for members only, but many are free at Center to Advance Palliative Care COVID-19 Response Resources (Table 3). Resources include symptom management protocols, pocket cards, team tools, resilience-building strategies, and patient and family support resources. The Center to Advance Palliative Care convened palliative care and critical care experts to develop Integrating Palliative Care in the ICU. Resources, research, articles, and quality improvement toolkits can be found on the center's website (Table 3).

Skilled communication with patients and families during the stress of an ICU admission is essential to patient-centered care. When the uncertainty and high ICU mortality rate of COVID-19 are added, skilled and effective communication becomes as critical as the use of lifesaving technologies. In addition to the aforementioned resources, Integrating Multidisciplinary Palliative Care Into the ICU is also an excellent tool (Table 3). This program is intended for bedside ICU nurses and is a communication skills training program to help integrate palliative care.

The 500 000 critical care nurses that compose the workforce are essential to the care of critically ill patients during the COVID-19 public health emergency and in the future as we care for an aging population. All the recommendations made and resources suggested in this section are relevant to include in the education of new registered nurses and advanced practice nurses. Nurse educators are encouraged to integrate selected materials in their programs and curriculums.

A Call to Action

Critical care nurses have always answered the call to care for the most vulnerable and technologically dependent patients in the health care system. The myriad consequences of

the COVID-19 crisis have illuminated several important aspects of the delivery of high-quality critical care, including the need for palliative care integration across all care settings amid this public health emergency.^{19,20,33}

Nurses and their teams must have the guidelines, equipment, and PPE to provide high-quality care and to be safe in the setting of contagious transmission. Next, though most nurses did not choose the critical care specialty to provide end-of-life care, this pandemic is a stark reminder that death is common in the ICU. Nurses and their teams must integrate primary palliative care for each patient and access specialist palliative care in more complex cases. Palliative care should be routinely practiced by all ICU clinicians as a component of high-quality critical care.³⁴ The use of symptom management protocols, communication frameworks, and goals-of-care discussions as the standard of care, not the exception, is essential. Finally, care of the caregiver—nurses, advanced practice nurses, intensivists, and all members of the ICU team—must be a priority during this crisis, at the unit and system levels, and in the future.

The call to action is clear: it matters that nurses spend the most time with critically ill patients and their families and lead care teams during both normalcy and crises. Critical care nurses can drive full integration of palliative care into the care of all patients, including patients with COVID-19, because they have always put the patient and family at the center of their practice. Palliative care *is* critical care and the time for separation or waiting is behind us.

Conclusions

The COVID-19 pandemic has made explicit the need for palliative care integration throughout settings in hospitals and communities worldwide as the suffering of patients and families is exacerbated. We call for palliative care integration throughout the practice of high-quality critical care to ensure the holistic needs of patients and families are met in these uncertain times. Achieving this ideal will require leadership, advocacy, persistence, and a rapid shift in perspectives and protocols. Palliative care *is* critical care; and critical care nurses are ideally positioned to ensure this congruence is realized, disseminated, and empathically translated into practice toward improved quality outcomes and person-centered care.

Financial Disclosures

None reported.

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Table 1

Elements of palliative care¹²

Inclusive of prevention, early identification, comprehensive assessment, and management of physical health challenges (eg, pain, other distressing symptoms)
Includes psychological and spiritual distress, as well as social needs
Uses evidence-based interventions when possible
Supports patients to live as fully as possible until death through effective communication strategies and help to clarify goals of care
Can be applied throughout the course of an illness as dictated by the patient's needs
May be used in conjunction with disease-modifying therapies as needed
Positively influences the disease trajectory
Does not hasten nor postpone death, is life-affirming, and acknowledges dying as a natural process
Offers support to family and patient caregivers throughout the course of illness and into the bereavement phase
Is given with respect for all cultural values and beliefs of the patient, family, and community at hand
Is appropriate to be used in all health care settings and at all levels
May be used by interdisciplinary professionals with basic palliative care training
Requires specialist-level palliative care provided by a multiprofessional team for complex case referrals

Adapted with permission from the International Association for Hospice & Palliative Care. Radbruch L, De Lima L, Knaut F, Wenk R, et al. Redefining Palliative Care – a New Consensus-based Definition. *Journal of Pain and Symptom Management*. 2020. <https://doi.org/10.1016/j.jpainsynman.2020.04.027>

Table 2

Domains of quality palliative care with considerations for critical care nurses during the COVID-19 pandemic²⁴

Domain	Considerations
1: Structure and Processes of Care Interdisciplinary approach to patient- and family-centered care, including elements of palliative care delivery and systems and processes considerations	Deliver primary palliative care for all patients (eg, symptom management, advance care planning guidance, health proxy and decision-making support) Ensure timely specialist consultation of palliative care as needed, given visitor restrictions and rapid decline of patients Identify pathways for rapid consultation and involvement of palliative care team within health system/institution
2: Physical Aspects of Care Palliative care assessment, care planning, and treatment of physical symptoms, emphasizing holistic patient- and family-directed care	Advocate for adequate sedation of patients receiving mechanical ventilation when appropriate Educate patients and families about proning therapy for ARDS Ensure adequate pain management for patients with chronic or cancer pain, in addition to sedatives and necessary anxiolytic support Treat dyspnea, gastrointestinal distress, and other symptoms to optimize comfort and function Partner with palliative care pharmacist and other specialists for complex symptoms and patients with multimorbidity
3: Psychological and Psychiatric Aspects of Care Assessing psychological and psychiatric needs in serious illness context	Assess for underlying psychological and psychiatric needs Provide ongoing support through therapeutic presence, active listening, and other communication strategies, as possible Partner with palliative care social workers and psychiatric practitioners to address the impact of COVID-19 in the ICU and in conjunction with serious illness
4: Social Aspects of Care Addressing support needs of patient and family	Identify patient/family relationships, dynamics, and support systems in place Foster relationship with proxy and/or surrogate given likelihood of patient receiving mechanical ventilation in the ICU Engage family through telemedicine, phone, or other means to promote social cohesion during visitor prohibition
5: Spiritual, Religious, and Existential Aspects of Care Emphasizing spiritual, religious, and existential care, including eliciting unmet needs	Assess for spiritual, religious, and existential needs early in the ICU stay Considerately elicit any specific rituals or considerations related to dying, death, and bereavement given high mortality rates once patient is receiving mechanical ventilation Collaborate with palliative care chaplain to assess and attend to spiritual injury, existential anxiety, and so forth
6: Cultural Aspects of Care Exploring how culture influences delivery of palliative care and the patient/family experience of the care received throughout the trajectory of illness and into bereavement	Promote care that is culturally competent and humble to the expertise of individuals, families, and various cultural communities Assess patient's and family's understanding of COVID-19, if the disease has any specific meaning for them, and if they are seeking any treatment in alignment with cultural traditions Ensure interpreter services early in relationship, as needed to ensure transparency and clear understanding
7: Care of the Patient Nearing the End of Life Focusing on symptoms and situations most common in final days and weeks of life	Foster relationship-based care early in the ICU stay, inviting difficult conversations for patients and family members as appropriate Identify signs of anticipatory bereavement and support with coping strategies Collaborate with palliative care team to help patients and families process their grief and feel supported at the end of life
8: Ethical and Legal Aspects of Care Advance care planning, surrogate decision-making, regulatory/legal considerations, related palliative care issues; focusing on	Even if uncomfortable, ensure advance care planning discussions and identifications of proxy/surrogate upon ICU admission, given unpredictable COVID-19 trajectory Promote communication of moral distress openly with members of interdisciplinary and palliative care team to promote healthy and supportive work environment

Domain	Considerations
ethical mandates to promote patient autonomy	Collaborate with palliative care and ethics committee members when available to address ethical or legal concerns, questions, and to optimize patient autonomy throughout the ICU experience

Abbreviations: ARDS, acute respiratory distress syndrome; COVID-19, coronavirus disease 2019; ICU, intensive care unit.

Used with permission from the National Consensus Project for Quality Palliative Care.²⁴ *Clinical Practice Guidelines for Quality Palliative Care*. 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. <https://www.nationalcoalitionhpc.org/ncp>

Table 3

Recommended resources to support critical care nurses during the COVID-19 pandemic

Healthy work environment and self-care	
<i>AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence</i> ²⁸	
www.aacn.org/WD/HWE/Docs/HWEStandards.pdf	
AACN Healthy Work Environment Assessment Tool (HWEAT)	
www.aacn.org/nursing-excellence/healthy-work-environments	
AACN Position Statement: Moral Distress in Times of Crisis	
www.aacn.org/-/media/aacn-website/policy-and-advocacy/stat-20_position-statement_moral-distress.pdf	
Critical Care Societies Collaborative	
ccsconline.org	
National Academy of Medicine: Resources to Support the Health and Well-Being of Clinicians During the COVID-19 Outbreak	
nam.edu/initiatives/clinician-resilience-and-well-being/clinician-well-being-resources-during-covid-19/	
Resources to support the combination of palliative, critical, and ethically based care	
AACN COVID-19 Resources	
www.aacn.org/clinical-resources/covid-19	
SCCM COVID-19 Disaster and Emergency Resources	
www.sccm.org/disaster	
Centers for Disease Control and Prevention	
www.cdc.gov/coronavirus/2019-ncov/index.html	
Palliative care education and COVID-19 resources	
ELNEC Support for Nurses During COVID-19	
www.aacnnursing.org/ELNEC/COVID-19	
ELNEC Competencies and Recommendations for Educating Nursing Students	
www.relias.com/product/elneec-training	
Center to Advance Palliative Care	
www.capc.org/covid-19/	
Integrating Palliative Care in the ICU	
www.capc.org/toolkits/integrating-palliative-care-practices-in-the-icu/	
Integrating Multidisciplinary Palliative Care Into the ICU	
www.vitaltalk.org/resources/impact-icu/	

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Abbreviations: AACN, American Association of Critical-Care Nurses; COVID-19, coronavirus disease 2019; ELNEC, End-of-Life Nursing Education Consortium; ICU, intensive care unit; SCCM, Society of Critical Care Medicine.