



DILEMMA OF IDENTIFICATION PATIENTS PALLIATIVE CARE NEEDS IN CRITICAL CARE UNIT

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ABSTRACT

Palliative care is start from diagnosis of serious illness until death and bereavement care. But, the term “Palliative Care” often mistakenly regarded identical to “End of Life Care” without any treatments. It’s caused dilemma among nurses to give maximum care of palliative care needs or let the patients get minimum of care. Methods: The aim of this article is to evaluate the dilemma palliative care needs in Intensive Care Unit. This is a case study report used a qualitative approach of 3 palliative patients in ICU used descriptive case study as well as in depth-interviews with patient’s family, nurses and internist. Results and Discussion: We present a case report of 3 patient who had been admitted to hospital with cancer and need palliative care in ICU. Patients subsequently suffered a pulmonary metastase with multiple organ failure. However the goal of end of life care for dying patients is to prevent or relieve suffering as much as possible while respecting the patient’s desires. But it is still a dilemma in Indonesia, especially palliative patients in ICU. According to medical decision, patients in ICU should receive maximum treatment, but if patient is facing multiple organ failure nurse should consider to providing palliative care. Conclusions: Palliative care approaches and provision within intensive care units can significantly impact care outcomes and increase the quality-of life people with end-of life period. Palliative care not to reduce the dose of drugs and patient care.

Keywords: ethics; hospice; intensive care units; palliative care; palliative nursing

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INTRODUCTION

The aim of intensive care is to maintenance of vital functions to reduce mortality and prevent morbidity in patients with a severe critical illness. Although the technology and care of patients always develop, but death rate in intensive care unit (ICU) was always high (Nayak et al., 2022). The mortality rate was high because of the multiple organ dysfunction. People in ICU need a clearly life sustaining therapies goal, but multiple organ failure from people in ICU make a worst of condition be more burdensome than beneficial. But critical care nurse and advanced practice registered nurses frequently face bioethical dilemmas in clinical practice that are related to palliative and end of life care. The dilemmas are associated with decisions made concerning continuing, limiting or withdrawing life-sustaining treatments or implementing palliative care for patients (Maas et al., 2013).

When people in a bad condition without a good prognosis, ICU physicians should provide an acceptable death with palliative care. Palliative care is an interdisciplinary care to optimize physical, psychosocial and spiritual symptoms of patients and their families whose quality of life is impaired by serious, life limiting illness (Glaetzer et al., 2011). Palliative care in for any stage of serious illness and applies to any patients in ICU with continuous illness throughout straight overlapping with end-of-life care. But palliative care is not only end-of-life care. Palliative care is based on needs while end of life care is based on poor prognosis. This definition of palliative care doesn't yet apply in Indonesia well (Pereira et al., 2018).

The World Health Organization (WHO) defined palliative care as an approach that improves the quality of life of patients (adults and children) and their families who are facing problem associated with life threatening illness. Palliative care is the prevention and relief of suffering of any kind-physical, psychological, social or spiritual experienced by adults and children living with life limiting health problems (Rochmawati et al., 2016). Palliative care uses a team approach to support patients and their caregivers. But according to the result of interview to 10 intensive care nurses in Dr. Kariadi Hospital nurses in Indonesia still think that palliative care is end of life care so people with palliative care only people who will die. It's caused a dilemma among nurses about the nursing care of the patients. For example in the case of conditions that lead to sudden death, such as cardiovascular illness or trauma, palliative care should apply to the patients in intensive care unit to prepare patients and family about the readiness of patients and family facing the problems of the patients. But, because there are dilemmas among nurses about palliative care, nurses only follow medical care for patients and give a minimal dose or care to the patients until patients die (Sugianto Hadiyanto et al., 2022). Integration of palliative care in the ICU is opposite care cultures that can be provided simultaneously in order to more effectively meet the patient needs and to alleviate the family burden. Patients in the ICU who are near death must still pay attention to their basic needs (Mulyanti et al., 2021). Palliative care needs that must be considered while in the ICU are communication and decision making, psychological and spiritual support, practical support, information about patients and family, integrated symptoms control, drugs and treatment modalities, psychological social and spiritual support, palliative care and hospice, discuss when to stop fighting for maximum longevity and explore instead what may matter more for them (Vanbutsele et al., 2020).

METHOD

This case study uses a descriptive research design with three case study approach Population, Samples, and Sampling Data collection for this case study was carried out in the work area of the Intensive Care Unit RSUP Dr. Kariadi Semarang and the time of implementation was October 1 -December 11, 2023. The aim of this study is to evaluate the dilemma palliative care needs in Intensive Care Unit. The subject in this case study was three patients in ICU center RSUP Dr. Kariadi handle by palliative care team. The data in this case study was collected using interview techniques, physical assessment, and observation of nursing care document studies. Interviews are carried out by asking questions to the patient and family. The physical assessment is carried out completely head to toe through inspection, palpation, percussion and auscultation. After getting the focus data, nursing diagnosis scoring is then carried out. The main or priority nursing diagnoses are taken based on scoring and appointed as family nursing care by collaborating with other nursing actions. Data analysis used thematic framework to conduct within and between case pattern matching. Thus method enabling a process in which we could identify and explore where participant responses converged/diverged and how this may have been affected by different contextual factors (Tam et al., 2021).

RESULTS

Case Reports

This case study used 3 patients, with the main diagnoses being cancer and lung metastases. The first patient was diagnosed 10 days ago with post-total thyroidectomy with colly-cancer in the right side of neck, radial neck dissection (RND), tracheostomy, and water-sealed drainage (WSD). On mechanical ventilation with CPAP PEEP and 7FiO₂ 80%, the patient's blood pressure was 91/59 (66) mmHg, his heart rate was 136 beats per minute, his respiration rate was 33 beats per minute, his temperature was 38 degrees Celsius, and his oxygen saturation was 100%. Patient installed WSD with an initial production of 1000 cc of hemorrhagic fluid. The chest X-ray revealed multiple opacity nodules with surrounding infiltrates in the upper middle and lower right lung that were relatively the same, indicating pulmonary metastasis. Opacity on the lateral aspect of the left hemithorax suggestive to pleural effusion and chest wall mass Increased left pleural effusion, subcutis emphysema in the left hemithorax lateral region, and supraclavicular. The patient had been treated at the hospital for 15 days, but due to metastases and difficulty weaning from the ventilator, he was consulted with the palliative care team.

The second patient was a 65-year-old woman with a medical diagnosis after a right hemimandibulectomy and closed defect with a free fibular flap: a mass in the oral cavity suspected of being malignant with extensive pulmonary metastases. The patient underwent the 25th day of treatment. After the tracheostomy, the general condition was seriously ill, blood pressure 116/85 mmHg, heart rate 106x/minute, respiration rate 21x/minute, temperature (T) 36.3 C. SpO₂ is 96% on tracheostomy pressure (SIMV PEEP 5; FiO₂ 40%). Seepage (-) in the neck region attached tracheostomy tube 7Fr cuff, MSCT results of a solid mass contrast head are accompanied by classification on the soft tissue of the mandibular region, which extends to the labium oris inferior and the anterior aspect of the sublingual space, which is attached and difficult to separate from the anterior aspect of the intrinsic muscle (size AP 5.3 x 4.3 x 6.1 cm). The mass appeared to cause destruction of the mandibular symphysis and body of the mandibular bone on the right side. Multiple lymphadenopathies in the colly region, levels 2B right and left, and level 3 left (largest at level 3 left, 1.7 x 0.9 cm). A point lesion on the vertebra cervical 6 is more than suspicious of metastases. There was no infarction, bleeding, or signs of increased intracranial pressure. Maxillary sinusitis, right and left; splenoiditis, right and left. Right otomastoiditis and left mastoiditis.

The third patient was a 65-year-old woman who had undergone a decompressive craniotomy and had a history of fever, a minimal response to steroids, and sputum culture examination results that revealed no germ growth. The patient had lung metastases and is currently sedated with GCS E1M1Vett, with a blood pressure of 100/68 (78) mmHg, a heart rate of 120x/minute, a respiratory rate of 30x, patient using a ventilator with CPAP mode PSV PEEP 5 FiO₂ 32%. The patient is currently intubated, with contact (-), communication (-), vomiting (-), and fever fluctuating for 6 days. The patient was scheduled to have a bronchoscopy, but it was canceled because the hemoglobin level was lower than needed. The patient was still unconscious, did not open his eyes with pain stimuli, and did not make a sound. The patient had 1 seizure for about 5 minutes. The patient was on a ventilator for 35 days

DISCUSSION

A frequently encountered category of patients requiring ventilatory support are those in the immediate postoperative period. This is particularly true of patients following thoracic or cardiac surgery, although changes in surgical and anesthesia techniques have decreased the requirement for mechanical ventilation. Generally, these patients do not present complex

ventilatory management problems and many are extubated within 24 hours – 48 hours (Powell et al., 2017). But operation in patients with cancer must be more carefully because of its risk of bleeding. Bleeding may present as bruising, petechiae, epistaxis, hemoptysis, hematemesis, hematochezia, melena, hematuria or vaginal bleeding (Johnstone & Rich, 2018). Especially operation to people with cancer and lung metastasis. Metastatic lung cancer is lung cancer that has started to spread. Cancer cells can separate themselves from a tumor and travel through the blood or lymph system to other areas in the body. Metastasis is typically a gradual process causing few if any side effects until the tumors become large enough to affect the nearby organ. As cancerous cells accumulate in the lungs, they can slowly invade the healthy surrounding tissues caused malignant central airway obstruction (MCAO) refers to any malignant, mechanical, obstructive process that impedes the airflow within the central airways (trachea, main-stem bronchi, and right bronchus intermedius). Approximately 20%-30% patients with lung metastatic may develop a complication related to central airway obstruction, such as dyspnea, atelectasis, hypoxemia, hemoptysis, post-obstructive pneumonia or respiratory distress that will impact on prolonged mechanical ventilator and risk of difficult weaning from mechanical ventilation (Oberg et al., 2018).

Patients receiving prolonged mechanical ventilation (PMV) typically experience long-term morbidity, suffering, poor quality of life (QOL) and high mortality. Because the majority of patients with PMV in the long-term care unit have poor consciousness level, decisions about palliative care and ventilator withdrawal often fall to families. But, no one of the families ask to the doctor or nurse about palliative care (Care et al., 2022). Doctor must explain to the families about palliative care and ask for families respond. Families of these patients are often conflicted by a decision to pursue PMV that result in a poor QOL and prolong patients suffering especially for those with consciousness impairment. Physicians in long-term respiratory care facilities often feel reluctant to discuss terminal withdrawal of mechanical ventilation for these patients and it is difficult for them to decide at what point life-supporting agents are no longer indicated (Y. C. Chen et al., 2017)

According to World Health Organization, palliative care aims to prevent and relieve health related suffering on adults, children and their families facing problems associated with life threatening illness. The goal of palliative care is to relieve the suffering of patients and their families by the comprehensive assessment and treatment of psychosocial and spiritual symptoms experience by patients. Helping patients and their families understand the nature of illness and prognosis is a crucial aspect of palliative care near the end of life (Kmetec et al., 2022). Additionally, palliative care specialists help patients and their families to determine appropriate medical care and to align the patient's care goals with those of the healthcare team. Many patients imagine that death comes suddenly, but for many, the knowledge that one's death is imminent comes first. Those with this awareness often must complete certain tasks to allow a peaceful death such as offering forgiveness, being forgiven, acknowledging regrets, finding closure in professional and community relationships, and saying goodbye to family and friends (Creutzfeldt et al., 2017).

Palliative care can be provided any time after the diagnosis of life limiting or life-threatening illness. Some assessment must provide to care patient with palliative care are pain, addiction due to pain, pain drug therapy, active dying, artificial hydration/nutrition, constipation, dyspnea, delirium, nausea and vomiting, depression or anxiety, fatigue, anorexia, cultural consideration, self-care, advance care planning, DNR and ethical issue, breaking bad news, goals of care, family conferences, hospice and last days care, psychosocial and spiritual care (Mercadante et al., 2018). Indonesia is a multi-religious country in South-East Asia that

consists of approximately 17.000 islands and has a population of more than 237 million. The provision of palliative care in Indonesia commenced in the 1990s when palliative care services were established in several public hospitals. In Indonesian culture, religion is very important in everyday life and becomes increasingly important in times of illness. For Indonesian people, it is still difficult to talking about dying for patients who still alive, so many doctors or nurse still difficult to talk about preparing dying to patients and family. This creates a dilemma for patients and families which causes families to have difficulty in making decision. Nurses also experience difficulty in determining appropriate nursing actions whether to maximize treatment or minimize treatment. Nurses, doctor and health workers need to improve their communication skill in conducting assessments of the basic needs of palliative patients in order to achieve an increase in the quality of life of palliative patients (Marwin et al., 2021).

Although palliative care measures were initiated in Indonesian medical education and introduced in 1992, it was only in 2023 that these measures gained official recognition and support. This milestone was achieved through the dedicated efforts of palliative care advocates, including members of academia and community groups (Zimmermann et al., 2014). Under the latest legal decree, palliative care was formally acknowledged in Indonesia as an integral component of medical care, alongside promotive, preventive, curative, and rehabilitative care. So, it is now legal for teaching hospitals to organize specialized/subspecialized educational programs in palliative care. Despite these improvements, however, formal palliative education is not yet mandatory for a teaching hospitals, and much more is needed integrate palliative care in Indonesia ethically (H. Chen et al., 2021). There are many barriers in attempting to integrate palliative care in Indonesia, which include a lack of patient awareness and accessibility, followed by a prevalent knowledge deficit about palliative care among Indonesian health care workers (Care et al., 2022). Despite these challenges, however, there have been significant efforts to provide culturally sensitive approaches to palliative care and ACP. Studies involving 16 Indonesian physicians and 16 nurses found that the health care professionals deem cultural collectivism, communication norms, and the patient's religious beliefs as essential to culturally sensitive approaches to palliative care (Sung et al., 2021).

CONCLUSION

Critical care nurses and APRNs frequently encounter and identify ethical dilemmas and are in the ideal position to collaborate with the interdisciplinary team in creating a solid palliative care team. These often complex issues of most importance is that the patient's wishes are known and respected. Communication must be clear, open, and honest, not only within the team but also between the team and the patient and family. Nurses can seek assistance from members of the palliative care team and the ethics committee in especially complex and difficult cases. Identifying and addressing ethical dilemmas can take time and effort, but patients, families, and providers will benefit.

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