PALLIATIVE CARE
CASE OF THE MONTH

"The Huddle before the Family Meeting"

by

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Case: Mr. H. M. is a 56-year-old man with advanced squamous cell carcinoma of the tonsils who presented to an outside hospital with increasing shortness of breath and stridor. He underwent nasotracheal intubation and was transferred to our institution for further evaluation. Tracheostomy was not feasible, given the extensive tumor growth blocking all access points to his airway. Symptomatically, he was stable on a continuous fentanyl infusion and had minimal oxygen requirements. He enjoyed spending time with his adult sons, putting together puzzles in the intensive care unit.

The primary team asked palliative care to evaluate the patient and assist with goals of care discussions. His discharge options varied from being discharged home with a goal of terminal extubation or going to inpatient hospice while nasotracheally intubated for as long as he could tolerate. During the initial consultation, the patient emphatically wrote, "I would like to know what is going on" and "how much time do I have?" Some physicians had told him he would die immediately after extubation, while others said he could live "days." Prior to scheduling a family meeting, the palliative care team requested a pre-meeting huddle with otolaryngology, critical care and a hospice representative to ascertain that everyone was on the same page about the patient's prognosis and discharge options.

Discussion: Introduction: Family meetings are important to ensure that families understand what is going on with their loved one, to support the family members and promote shared decision-making.[1] Typical topics include delivering bad news, discussing goals of care and bringing up dispositional issues. Pre-meeting huddles among providers are critical for family meetings to run smoothly.[2] Our goal is to describe the empirical data supporting pre-meetings and provide a practical structure for holding a huddle.

Evidence supporting the use of pre-meeting huddles
There is no specific data on the effectiveness of huddles prior to family meetings in the ICU. However, huddles, defined as a structured meeting of health care providers to plan a treatment prior to a medical intervention have been used for coordinating care in different settings, ranging from neurosurgery to post anesthesia care units. Evidence suggests huddles identify safety challenges,[3] decrease laboratory and pharmacy costs[4] and improve family and provider satisfaction.[5]

The goals of a huddle are: (1) achieve common understanding of the biomedical facts, (2) agree on the family meeting's purpose, (3) discuss what is known about the family and their concerns, and (4) determine who will facilitate the family meeting.

The huddle typically occurs immediately before the family meeting and includes all relevant specialists, the social worker, the bedside nurses who know the patient/family or charge nurse. Huddles take between 5-15 minutes.

The first task of the huddle is to ensure that everyone is on the same page about the medical facts. The clinician leading the huddle, might say, "I want to make sure we all have the same view about what is wrong with the patient and what we think his future might be." In cases where health care providers have divergent thoughts, it might help to discuss the best and worst-case scenarios and the milestones that will help us determine how the patient is doing.

Second, the team should come to an agreement regarding the family meeting's purpose. The family is likely to be confused if some health care providers are asking about the patient's values while others are viewing the meeting merely an opportunity to update the family or discuss disposition. Clarifying the meeting's purpose and what, from the health care providers' point of view, is an acceptable outcome helps avoid mixed messages.

Third, the huddle is the time for health care providers to share information about the family structure, how the family makes decisions and places where the meeting might "go off track." Given not all health care providers have met all family members, the huddle can update everyone on family dynamics, ("the children always defer to their mom" or "the cousin is a nurse and has lots of biomedical questions"). The social worker and nurses are particularly important as they have spent more time with the family and may have a different view and experience of the family than physicians.

Finally, it is important to decide who will lead the family meeting. Depending on the purpose of the family meeting, the leader is often a physician or a nurse clinician, especially if biomedical facts are being shared. The meeting leader clarifies with other providers that they will be called upon to give specific information for e.g., the oncologist may be asked to talk about the treatment options available for a critically ill cancer patient.

Case follow up: During the huddle, the otolaryngology fellow, critical care NP, the palliative care physician and the hospice representative reviewed the medical facts, established a worst case scenario of terminal extubation and likely death in the hospital and a best case scenario of discharging the patient nasally intubated but close to home in a hospice unit. The hospice representative confirmed that the hospice agency would care for the nasally intubated patient.

(Discussion continued)

The bedside nurse brought up concerns about the patient's son who was having trouble coping with his father's condition and worries about his children's coping. With the social worker, we brainstormed on ways to support him (Legacy Project) and also on transportation barriers that we might encounter in sending the patient home. The palliative care physician was chosen to lead the meeting.

Following the huddle, the palliative care physician presented to the family the view that the patient was dying. Having heard this information, the patient and family were able to tell the clinical team what was most important to the patient - time and being home. When offered the best and worst case scenarios the patient and family elected to be discharged to an inpatient hospice with nasotracheal intubation. Twenty-four hours after the meeting, the patient was discharged with optimal symptom management.

References:

1. Hudson P, Quinn K, O'Hanlon B, Aranda S. Family meetings palliative care: Multidisciplinary clinical practice guidelines. BMC Palliat Care. 2008;7(1). doi:10.1186/1472-684X-7-12.
2. Singer AE, Ash T, Ochotorena C, et al. A Systematic Review of Family Meeting Tools in Palliative and Intensive Care Settings. Am J Hosp Palliat Med. 2016;33(8):797-806. doi:10.1177/1049909115594353.
3. Setaro J, Connolly M. Safety Huddles in the PACU: When a Patient Self-Medicates. J Perianesthesia Nurs. 2011;26(2):96-102. doi:10.1016/j.jopan.2011.01.010.
4. Chan AY, Vadera S. Implementation of interdisciplinary neurosurgery morning huddle: cost-effectiveness and increased patient satisfaction. J Neurosurg. 2017:1-4. doi:10.3171/2016.11.JNS162328.
5. Awdish RL, Buick D, Kokas M, et al. A Communications Bundle to Improve Satisfaction for Critically Ill Patients and Their Families: A Prospective, Cohort Pilot Study. J Pain Symptom Manage. 2017;53(3):644-649. doi:10.1016/j.jpainsymman.2016.08.024.