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Clinical Practice Guideline for Palliative Care Referral

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Abstract

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MS, Walden University, 2018

BS, Our Lady of the Lake, 2015

AS, Passaic County Community College, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Palliative care is a type of specialty care that focuses on the improvement of the quality of life and prevention of suffering of those with progressive serious illnesses by addressing the physical, emotional, and spiritual needs of patients and families. There are many misperceptions about palliative care by providers, patients, and their families. Inconsistent interventions and a lack of palliative care education for providers results in delayed palliative care involvement. Delayed involvement results in patients with unmet palliative care needs. The purpose of this project was to develop clinical practice guidelines to ensure appropriate care based on the best available evidence, reduce variability in practice, provide criteria for referral, focus on education, and promote efficient use of resources. Mishel's uncertainty in illness theory and the peaceful end of life theory were the conceptual frameworks used to guide this project. An expert panel was developed consisting of two nurse practitioners, two physicians, a chaplain, and an ethicist to determine what current evidence-based practices would facilitate high-quality nursing practice to identify and address patients with unmet palliative care needs. The panel used the Fineout-Overholt tool to rank and score the 14 research articles and assisted with identifying recommendations used for the development of the clinical practice guidelines. The AGREE II tool was used to evaluate the final clinical practice guidelines. The expert panel rated the guidelines' overall quality as 94.5%, and each member recommended the guidelines for use. The clinical practice guidelines impact social change by contributing to the health and wellness of society by providing a standard of care for those with serious illnesses and resources for health care providers.

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Dedication

This project is dedicated to my loving and supportive husband, Sean L. Jones, and my parents, Richard and MaryAnn Jennings. They continuously inspire me to do my best and have given me the encouragement, support, and reassurance I needed throughout this process. To my sister and brother, thanks for continuously cheering me on.

Acknowledgments

I would like to thank my chair, Dr. Lynda Crawford, and co-chair, Dr. Ruth Politi, for their guidance, feedback, and patience with this project. I would also like to thank my family and friends, who have been my ultimate supporters throughout my academic journey.

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Section 1: Nature of the Project

Palliative care is an interprofessional specialty that aims to improve the quality of life of patients with progressive serious illnesses by addressing symptom burden, communication, and decision-making needs (Hui et al., 2017). According to the National Consensus Project (2019), individuals who are seriously ill need care that can meet their specific needs and align with their patient-family preferences and goals. Palliative care providers have expertise in communicating about advanced care planning and managing symptoms related to advanced serious health issues such as cancer, heart disease, lung disease, and cirrhosis (Reynolds et al., 2019).

Despite the growth and popularity, palliative care in the local settings continues to be inconsistent and fragmented, and healthcare professionals report feeling unskilled in decision-making related to treatment de-escalation and complex symptom management (Monterosso et al., 2016). Studies show that early palliative care involvement improves patient outcomes, quality of life, symptom control, and patient satisfaction (Hui et al., 2017; Reynolds et al., 2019). The purpose of this project was to develop clinical practice guidelines related to palliative care to ensure appropriate care based on the best available evidence, reduce variability in practice, provide a rationale for a referral to the palliative care team, focus on education, and promote efficient use of palliative care resources. In the following section, I discuss the problem statement, purpose, nature of the project, and its significance.

Problem Statement

Palliative care is an interdisciplinary specialty that focuses on the improvement of the quality of life and the prevention and relief of suffering by addressing the physical, emotional, and spiritual needs of patients and families and can be offered in conjunction with other active treatments (Sharp et al., 2018). Palliative care is often involved late in the course of disease after curative measures have been exhausted, which often results in suboptimal symptom management, increased suffering, failure to address advanced care planning, and unexpected hospital deaths (Fink, 2015). In the local hospital setting for this project, palliative care needs are often addressed late in the disease trajectory after multiple hospitalizations and, on average, 96 hours after admission, according to the medical director of the palliative care program. Nationally, the average number of days to referral for palliative care can range from 2.5 to 21.4 (Fink, 2015).

Much of the delay for palliative care referral is related to misperceptions by providers, patients, and their families regarding the available services (Tehrani et al., 2016). Patients, families, and some healthcare providers often associate palliative care with hospice or end-of-life care (Reynolds et al., 2019). Palliative care referrals are based primarily on clinician judgment, which requires recognizing palliative care needs and results in a high variability of the timing of palliative care referrals (Hui et al., 2017).

Despite multiple studies on the benefit and effectiveness of palliative care, standardized referral criteria do not exist, and healthcare providers are uneducated about the benefits and appropriateness of palliative care referrals (Monterosso et al., 2016). Palliative care is also underused in serious nonmalignant illnesses (Sharp et al., 2018).

For optimal high-quality care and appropriate referrals, health care providers require knowledge and skill to identify patients needing palliative care (Monterosso et al., 2016).

The need for palliative care services often exceeds the ability to meet the demand (Frendak et al., 2019). When faced with limited resources of palliative care workforces, providers and payers are faced with deciding which patient populations to focus on and prioritizing when implementing new palliative care services (Singer et al., 2016). Optimizing the allocation of palliative care resources to determine for whom the most significant benefit will be is an essential practice in the palliative care referral process (Frendak et al., 2019). The current timing of palliative care referrals may limit the benefits these referrals offer to patients. When referrals are made early, palliative care involvement has been shown to improve symptoms, reduce unplanned hospitalizations, minimize aggressive end-of-life care, and empower patients to make choices about end-of-life care (Bennett et al., 2016; Hui et al., 2017).

Palliative care is focused on enhancing the quality of life of patients and families who are experiencing serious illnesses. Early involvement of palliative care has been recommended by multiple studies (Singer et al., 2016; Wolf et al., 2019). Nurses who work collaboratively with the palliative care team work to promote health and prevent suffering (Coghlan et al., 2019). Because nurses care for patients with serious and chronic illnesses and spend more time with individuals throughout their illnesses and at the end of life than any other healthcare professional does, nurses' involvement in palliative care is crucial (Russell et al., 2018). Moral distress is often experienced by nurses who care for patients with unclear goals of care, prolonged dying, lack of consensus regarding the plan of care, and providing false hope to patients (Wolf et al., 2019). Palliative care has changed healthcare by encouraging a more holistic focus on comfort and improving the quality of life by clarifying goals of care and aligning the care plan to the goals of the patients and families (Hospice and Palliative Nurses Association [HPNA], 2013).

Purpose

Despite rapid growth in palliative care services, access, and referrals to palliative care are inconsistent and underutilized (O’Connor et al., 2019). Palliative care should be the standard of care in both life-limiting and chronic disease. Still, despite the focus on early and high-quality care, palliative care continues to be reactionary and fragmented (Monterosso et al., 2016). Palliative care is a specialty that focuses on the improvement of the quality of life and the prevention and relief of suffering by addressing physical, emotional, and spiritual needs of patients and families (Maddocks et al., 2017). Wolf et al. (2019) found that only 6.1% of nurses perceived that palliative care was always consulted when indicated and that although most reported that palliative care competency is of high importance, few felt highly competent in palliative care. Lack of training of medical professionals, a perceived dichotomy between aggressive care and palliative care, and the reluctance of provider referrals are often noted to be barriers to earlier palliative care referrals (O’Connor et al., 2019). The purpose of this doctoral project was to develop palliative care clinical practice guidelines to ensure appropriate care based on the best available evidence, reduce variability in practice, provide a rationale for a referral to the palliative care team, focus on education, and promote efficient use of palliative care resources.

Palliative care positively affects clinical outcomes, including quality of life, patient satisfaction, and survival (Hui et al., 2017; Maddocks et al., 2017). Palliative care focuses on expert assessment and management of symptoms and coordination of care and specializes in addressing symptom burden concerns, communication, and decision-making needs (Hui et al., 2017; National Consensus Project, 2019). The local gap in practice is the lack of consistent, timely referrals to palliative care. According to the HPNA (2013), all patients with serious or life-threatening illnesses should have access to high-quality palliative care. Nurses are essential to implementing healthcare reform measures that provide high-quality care that improve healthcare outcomes for all patients with serious illnesses. The World Health Organization released a statement suggesting the broadening of the palliative care scope of practice to include patients with chronic illnesses as well as life-threatening illnesses as these patients may also have palliative care needs (Monterosso et al., 2016).

Clinical practice guidelines are needed to reduce the variability of palliative care referral, direct appropriate care for patients with serious illnesses and promote efficient use of resources necessary to meet the patients' palliative needs. Therefore, the practice-focused question was: What current evidence-based practice would facilitate high-quality nursing practice to identify and address patients with unmet palliative care needs?

Nature of the Doctoral Project

This doctoral project focused on developing palliative-care-related clinical practice guidelines for healthcare providers who care for patients with serious illnesses.

The project was guided by the Walden University Clinical Practice Guideline Manual. The source of evidence-based interventions included in the clinical practice guidelines were primary sources published in the literature, government websites, and professional references. I obtained the literature reviewed for this project from common electronic nursing and allied health science databases including MEDLINE, CINAHL, PubMed, Embase, ProQuest, and Joanna Briggs Institute EBP Database. The literature was all peer reviewed and met strict inclusion criteria. Additional evidence came from official government websites, The Center to Advance Palliative Care (CAPC), and the National Consensus Project for Quality Palliative Care. Both CAPC and the National Consensus Project for Quality Palliative Care are leading organizations for palliative care. The National Consensus Project for Quality Palliative Care (2019) developed some basic clinical practice guidelines that set a standard for palliative care programs. I reviewed the standards developed by these two organizations in conjunction with peer-reviewed research and other publicly disseminated reports to outline a clinical practice guideline to (a) ensure appropriate palliative care based on the best available evidence, (b) reduce variability in practice, (c) provide a rationale for referral, (d) focus on education, and (e) promote efficient use of palliative care resources.

The goal of this DNP project was to identify current evidence-based practices and develop clinical guidelines that are determined to be appropriate for use in this setting. The project closed the gap-in-practice at the project location by aligning practices with leading organization recommendations on the use of palliative care referrals practices, directing appropriate care for patients with serious illnesses, and promoting efficient use of palliative care resources. I developed the guidelines from best practices identified in the literature review. An expert panel was used to review current evidence-based practices and evaluate the strength of the resulting clinical practice guidelines using the AGREE II tool. The clinical practice guidelines provided healthcare providers with an opportunity to utilize evidence-based practices and expand their knowledge of seriously ill patients' palliative care needs. The expert panel included two nurse practitioners, two physicians, a palliative care chaplain, and an ethicist for review, recommendations, and identification of anticipated barriers to implementation. The DNP project raised awareness of existing recommendations for this patient population.

Significance

This doctoral project was executed in an acute care hospital and involved developing and presenting the clinical practice guidelines to standardize patient care. The clinical practice guidelines provided healthcare providers an opportunity to utilize evidence-based practices and expand their knowledge on the palliative care needs of seriously ill patients. Currently, the palliative care team consists of two nurse practitioners, two physicians, an ethicist, and a palliative care chaplain. Each provider is board certified in hospice and palliative medicine and was involved as a stakeholder in the evaluation of the clinical practice guidelines. The palliative care service is a consulting service used for symptom management and goals of care conversations. The palliative care team was supportive of this project and has been working to promote earlier involvement of palliative care for those with serious illnesses.

Healthcare in the United States is focused on disease-specific management rather than on the whole person and their family, which has resulted in unnecessary suffering as well as fragmented, burdensome, and often futile care that is costly and results in unmanaged symptoms, frequent hospitalizations, and caregiver burnout (CAPC, 2019). Palliative care is a resource for patients and families experiencing a life-threatening illness and can be received in conjunction with aggressive treatments and align treatments with patient and family goals and preferences (WHO, 2019). Palliative care is comprehensive care that addresses the physical, emotional, and spiritual needs to provide comfort and relief of suffering (NIH, 2019). Studies show that palliative care involvement is associated with improvement in symptom burden, improvement in the quality of life, and a consistent reduction of reduced health-care use (Maddocks et al., 2017; Sharp et al., 2018). Not only does this project have the potential to benefit patients and their families at this local site, but the project will serve as a model for healthcare providers and healthcare organizations to align with a palliative care team to provide more holistic and interdisciplinary care. Society as a whole may benefit from more efficient use of palliative care services. Globally, an estimated 14% of people who need palliative care receive it, with a significant barrier to access being a lack of training and awareness amongst healthcare providers (WHO, 2019). Despite the growth in popularity, it is estimated that only 2%-20% of patients with advanced diseases who are receiving long-term treatments or have been admitted to the hospital have accessed palliative care services (Maddocks et al., 2017). Compared to late referrals, early palliative care referrals, considered to be more than 3 months before death, were associated with significantly lower emergency room visits, admissions, and deaths within the last 30 days of life (Hui et al., 2017). Several studies report that causes of delay in palliative care referral include communication barriers, challenges with prognostication, and the provider perception and attitudes towards palliative care (Lee et al., 2019; O'Connor et al., 2019). Appropriate involvement of palliative care specialists has been shown to improve patient outcomes, quality of life, symptom control, and patient satisfaction (Hui et al., 2017).

Summary

Palliative care is a growing specialty that provides care to patients with serious illnesses and can be provided in conjunction with active treatments. Despite the growth of this specialty, palliative care is often fragmented, and referrals remain variable. The gap in practice is the lack of consistent, timely referrals to palliative care. Palliative care has been shown to improve the quality of life of patients and improve patient outcomes. In the local setting, it is often late in the trajectory of the disease or, on average, 96 hours into a subsequent admission that the palliative care referral is placed. This doctoral project resulted in palliative-care-related clinical practice guidelines to (a) ensure appropriate care based on the best available evidence, (b) reduce variability in practice, (c) provide a rationale for referral, (d) focus on education, and (e) promote efficient use of resources. The clinical practice guidelines were developed and presented to the expert panel for review and recommendations. In Section 2, the concepts, models and theories, relevance to nursing practice, local background and context, the role of the DNP student, and the role of the project team are presented.

Section 2: Background and Context

As palliative care has expanded throughout the nation, studies show that healthcare providers feel unskilled in identifying patients with palliative care needs and are unsure when to refer their patients to palliative care specialties (Monterosso et al., 2016; Nevin et al., 2020). The inconsistencies of palliative care referral criteria, along with the lack of confidence in provider knowledge and skill, often cause palliative care to be fragmented and less than optimal (Monterosso et al., 2016). The purpose of this doctoral project was to develop clinical practice guidelines related to palliative care to (a) ensure appropriate care based on the best available evidence, (b) reduce variability in practice, (c) provide a rationale for referral, (d) focus on education, and (e) promote efficient use of palliative care resources.

Evidence shows that earlier palliative care involvement, in conjunction with aggressive management of serious illness, is associated with improved quality of life, reduced symptom burden, improved patient and caregiver satisfaction, and improved survival (Hui et al., 2017). In the following sections, I discuss concepts, models, and theories; relevance to nursing practice; local background and context; the role of the DNP student; and the role of the project team.

Concepts, Models, and Theories

Mishel’s uncertainty in illness theory (1988) and the proposed theory for peaceful end of life by Ruland and Moore (1998) provided a framework for the development of clinical practice guidelines for palliative care that (a) direct appropriate care based on evidence-based practices, (b) reduce variability in practice, (c) provide a rationale for referral, (d) address education, and (e) promote efficient use of palliative care resources. Mishel’s uncertainty in illness theory, introduced in 1988, consisted of four major components of antecedents: generating uncertainty, appraisal of uncertainty, coping with uncertainty, and adaptation (Zhang, 2017). The impact of uncertainty is a component of the illness experience and is likely to increase the burden of serious illnesses (Giammanco et al., 2015). Antecedents generating uncertainty include symptom patterns, event familiarity, event congruency, cognitive capacities, and structure providers and will serve as the variations in palliative care practices and need for clinical practice guidelines (Zhang, 2017). Appraisal of uncertainty is the process of assessing the degree of the patient’s uncertainty and their availability to cope with resources (Miller, 2015; Zhang, 2017). Patients with serious illnesses need support to increase autonomy and self-efficacy in treatment to cope with the emotional uncertainties and lifestyle derailments (Giammanco et al., 2015). Coping with uncertainty encompasses actions to take direct action, seek information, maintain vigilance, and sustain emotional support (Zhang, 2017). The adaption to the illness occurs when a new balance is achieved and coping strategies are effective (Zhang, 2017). The theory was designed to explain that when healthcare providers offer information regarding the trajectory and course of disease and address patient-specific concerns, a patient may be more comfortable dealing with the symptoms of their illness and making autonomous decisions about their care, thus reducing uncertainty and improving their quality of life (Suzuki, 2012; Zhang, 2017).

Antecedents generating uncertainty align with the need to standardize care and reduce variability with the development of clinical practice guidelines. The appraisal of uncertainty and coping with uncertainty will be the process of using the guidelines to direct appropriate evidence-based, high-quality palliative care. An expected patient outcome of using the clinical practice guidelines will be improved patient adaptation to their illness. The desired healthcare provider outcome is the adaption of practices, including the standardization of high-quality palliative care.

The peaceful end of life theory is designed to empower the patients and families to participate in decision making, control symptoms, build confidence that they are receiving the best possible care, and inform them about treatment preferences (Ruland & Moore, 1998). The peaceful end of life theory is appropriate for the patient and family experiencing a serious or life-threatening illness (Ruland & Moore, 1998). The theory outlines the importance of improving the quality of life and reducing suffering.

The peaceful end of life theory by Ruland and Moore (1998) supports the need for standardized palliative care and reduced variation in palliative care practices. Palliative care strives to improve quality of life, reduce suffering, and control symptoms related to serious illness (Sharp et al., 2018). The theory also highlights the importance of nursing care in creating a peaceful end of life as nurses assess and interpret patient experiences to intervene appropriately (Ruland & Moore, 1998).

Relevance to Nursing Practice

According to the HPNA (2013), all patients with serious or life-threatening illnesses should have access to high-quality palliative care. Nurses are essential to implementing healthcare reform measures that provide high-quality care that improves the health outcomes for all patients with serious or life-threatening illnesses (HPNA, 2013). Nurses have been identified as key palliative care providers; however, knowledge gaps regarding palliative care delivery, communication, and training continue to be obstacles in addressing palliative care needs (Houlihan & Paice, 2020). As the population ages, the challenge of access to adequate palliative care is expected to continue due to increasing demand from the aging population with multiple comorbidities and the limited supply of competent clinicians to provide palliative services (Arora et al., 2017).

The importance of palliative care has expanded recently. In 2006, The American Board of Medical Specialties (2020) approved Hospice and Palliative Medicine as a specialty (American Academy of Hospice and Palliative Medicine, 2020). Palliative care focuses on the alleviation of suffering and living well by enhancing the quality of life of seriously ill patients and families (Wolf et al., 2019). Palliative care is recognized as an essential competency for all clinicians; however, insufficient education and training for physicians and nurses remain barriers to appropriate evidence-based practices (Wolf et al., 2019).

The number of palliative care programs across the nation have almost tripled in the last 20 years. The growth in palliative care programs has been a result of an effort to improve access to palliative care, improve the quality of life of patients and families, and improve patient outcomes (Szekendi et al., 2016). Healthcare professionals' competency is an essential element required to achieve high-quality palliative care (Shen et al., 2019). Palliative care services have become a practice standard in high-performing organizations, and efforts to expand palliative care through new care delivery models continue to evolve (Szekendi et al., 2016). Potential barriers to palliative care services are the lack of communication between providers and varied perceptions and understanding of palliative care and what it offers (Szekendi et al., 2016). Palliative care competencies reflect nurses' ability to respond to the holistic needs of patients and families, deal with ethical issues, recognize palliative care needs, and develop communication and interpersonal collaboration (Shen et al., 2019).

The state-wide Palliative Care and Quality of Life Advisory Council for the state where the project site is located is composed of nine members, including The House of Health and Human Services chair, Senate Health and Human Services chair, two members appointed by the Speaker of the House, two members appointed by the Lieutenant Governor, and three members appointed by the Governor (State Department of Community Health, 2017). This appointed council advises the Department of Community Health (DCH) on the establishment, operations, and outcomes evaluations of palliative care initiatives within the state (State Department of Community Health, 2017). In 2017, the Palliative Care and Quality of Life Advisory Council reported that the locally identified gap in palliative care exists because this service is often confused with hospice (State Department of Community Health, 2017). The council also recommended the development of a community stakeholders' group to inform the Council and DCH on important palliative care issues, which would include but not be limited to [state] Hospice and Palliative Care Organization, [state] Healthcare Alliance, and [state] Hospital Association (State Department of Community Health, 2017).

This DNP project will advance the nursing profession and empower nurses as frontline healthcare providers to identify patients with palliative care needs and provide a higher quality of care. The clinical practice guidelines are grounded in evidence-based practice and advance the nursing practice by bridging the knowledge and practice gap. The involvement of palliative care, when appropriate, can improve care outcomes and care transitions. This project addressed the local gap in practice by developing clinical practice guidelines related to palliative care to (a) ensure appropriate care based on the best available evidence, (b) reduce variability in practice, (c) provide a rationale for palliative care referral, (d) focus on education, and (e) promote efficient use of palliative care resources.

Local Background and Context

Palliative care continues to grow within the local organization, but referral practices have varied from provider to provider, resulting in delays in palliative care and underutilization of palliative services. The local setting is an inpatient hospital specializing in oncology, cardiac, neurologic, and pulmonology care. The hospital has 514 inpatient beds, including an inpatient rehab unit and subacute unit. According to the institution's website, the mission is: "Rooted in God's love, we treat illness and promote wellness for all people," and the vision is, "Our vision is to set the standards of excellence in the delivery of health care throughout the regions we serve." The palliative care team has been in place for approximately 7 years. The palliative care consult is physician driven and has not been guided by a clinical practice guideline previously, but by physician judgment, leading to variability in palliative care consultation and involvement. For example, two patients, both with advanced Stage IV cancer and high-symptom burden were admitted to the hospital. One patient received a palliative care consult and the other did not. Consults are inconsistently ordered, and the reasons for ordering consults are unclear. Clinical practice guidelines were needed at the project site to provide consistency and encourage clinical decision making based on evidence-based practice.

Role of the DNP Student

My role as a DNP student was to identify the local knowledge practice gap and develop clinical practice guidelines to bridge the gap. I established an expert panel to assist in the development and approval of the clinical practice guidelines. I then performed a literature review and presented pertinent information to the expert panel for approval. Using the recommendations, reviews, and input from the expert panel, I developed the clinical practice guidelines and presented the final clinical practice guidelines.

My motivations for this doctoral project were that the patients, families, and providers I encountered did not understand palliative care and confused it with hospice care. Multiple times each day, I had to explain palliative care and its value, clarify misperception, and still encounter healthcare providers who were improperly educated on the subject. The misperceptions and lack of knowledge illustrated the knowledge practice gap and the need for clinical guideline development. There were no discernable issues of bias in the project design during implementation of the DNP project. To prevent any potential biases, an expert panel was used to ensure interprofessional approval of the evidence-based guidelines and recommendations.

Role of the Project Team

A project team, referred to as an expert panel, was used to develop, evaluate, and review the evidence-based clinical practice guidelines. A PowerPoint accompanied the oral presentation and addressed the background information, evidence, and review of the guidelines using the AGREE II tool and the results. The AGREE II tool was reviewed to ensure the expert panel invariably used the tool.

Each expert panel member had an opportunity to submit applicable evidence and insight relative to the doctoral project. The expert team's insight and expertise were assessed for relevance and validity to determine if the evidence was applicable and needed to be included in the project. The meetings for the expert panel included four one-hour meetings that included the review of the clinical practice guidelines and presentation of literature. The panel then had seven days to review the clinical practice guidelines and return any additional concerns. The project team was used to develop, evaluate, and determine the quality of the developed clinical practice guidelines using the AGREE II tool. They also provided recommendations for any needed changes to assure its effectiveness and success for clinical guidelines implementation.

Summary

There is a knowledge practice gap in palliative care referral practices that often results in delayed and fragmented care. The purpose of this doctoral project was to develop palliative care clinical practice guidelines to (a) ensure appropriate care based on the best available evidence, (b) reduce variability in practice, (c) provide a rationale for a referral to the palliative care team, (d) focus on education, and (e) promote efficient use of palliative care resources. Nurses are essential players in promoting high-quality palliative care and healthcare reforms. Current legislation within the state were developed to address access to palliative care and promote national campaigns to improve awareness but no laws have been passed to date. The [state] Palliative Care and Quality of Life Advisory Council has worked with the DCH and reported a common barrier to palliative care remains the common misperception that palliative care is hospice care.

Section 3: Collection and Analysis of Evidence

Palliative care referral practices are variable and often result in delayed consult and variable involvement of the palliative care service. Clinical guidelines need to be put into practice to standardize care and reduce practice variability. I aimed to develop clinical practice guidelines related to palliative care that ensure appropriate care based on the best available evidence, reduce variability in practice, provide a rationale for referral, focus on education, and promote efficient use of resources. Palliative care improves the quality of life of patients and families and can be provided with aggressive treatments for serious illnesses. In the following sections, I restate the practice question, provide detail on the current evidence available on palliative care referral practices, and analyze and synthesize how this evidence can be applied.

Practice-Focused Question

Palliative care referrals are based primarily on clinician judgment, leading to variable practices among healthcare providers (Hui et al., 2017). Clinician judgment for palliative care referral requires the healthcare provider to be skilled in identifying patients with palliative care needs. Often, the delay for palliative care referral has been related to misperceptions of palliative care and confusion with hospice care (Reynolds et al., 2019; Tehrani et al., 2016). The gap in local practice has been the lack of consistent, timely referrals to palliative care.

The practice-focused question was: What current evidence-based practice would facilitate high-quality nursing practice to identify and address patients with unmet palliative care needs? The expert panel utilized the AGREE II tool to evaluate the clinical practice guidelines and determine the quality of the evidence used to develop the clinical practice guidelines and then provided recommendations for any needed changes to assure its effectiveness and success for clinical guideline implementation.

Sources of Evidence

To develop the clinical practice guidelines, I used evidence-based information located in electronic nursing and allied health databases. Additional evidence came from official government websites, The CAPC, and the National Consensus Project. The evidence found from the National Consensus Project for Quality Palliative Care and the CAPC was supported with peer-reviewed evidence found through online library searches and aligned with this doctoral project's purpose.

Published Outcomes and Research

The following electronic nursing and allied health databases were used to collect evidence: MEDLINE, CINAHL, PubMed, Embase, ProQuest, and Joanna Briggs Institute EBP Database. I used key search terms including *palliative care, clinical practice guidelines, palliative care referrals, palliative care triggers, palliative care competencies, palliative care roles, palliative care education,* and *patient outcomes.* Additionally, data from the National Project Consensus and Centers for Advanced Palliative Care were utilized as long as the data were supported by peer-reviewed evidence. All data were required to answer the clinical practice question: What current evidence-based practice would facilitate high-quality nursing practice to identify and address patients with unmet palliative care needs? Studies were excluded if they were determined to have a low level of evidence or if their study identified bias or was inconclusive.

Evidence Generated for the Doctorial Project

Evidence-based practices were obtained from scholarly literature and used to formulate the clinical practice guidelines. Data pertinent to this doctoral project were collected from the expert panel in their review of the clinical practice guidelines. An Excel spreadsheet was used to organize the data and develop the clinical guidelines. The data received from the expert panel were then analyzed and reported.

Participants

The expert panel included the palliative care team consisting of two nurse practitioners, one medical director, one physician, one chaplain, and an ethicist. This panel used the AGREE II tool to evaluate the evidence-based practices used to formulate the clinical practice guidelines to determine the quality of the guidelines and provide recommendations and identify any anticipated barrier to implementation. The panel also offered feedback on the willingness to accept the clinical practice guidelines for use in the acute care setting.

Procedures

The clinical practice recommendations were developed, and the expert panel was scheduled to meet biweekly until the guidelines were completed. The clinical practice guidelines were then presented using an algorithm accompanied by an oral presentation and a PowerPoint highlighting the gap in practice and supporting information for the clinical practice guidelines. An Excel spreadsheet was the primary tool used for data collection. The AGREE II tool was used to assist the expert panel as they evaluated the reliability, validity, and usability of clinical practice guidelines addressing six domains.

Protections

This project followed the guidelines in the Walden University Clinical Practice Guideline Manual. No human subjects participated in this project. I obtained approval from the acute care organization, and then submitted the permission for exemption to the Walden University Institutional Review Board which was accepted, approval number 10-30-20-0419149.

Analysis and Synthesis

Data were collected from the expert panel's open discussions about the review, recommendations, acceptance, and possible barriers to implementation of the clinical practice guideline. A Likert scale was used to collect quantitative data in a post-presentation survey that addressed the AGREE II tool domains to capture the expert panel's feedback. These data were then analyzed and reported as a percentage rating for each domain.

Summary

The development of the clinical practice guidelines related to palliative care ensured appropriate care based on the best available evidence, reduced variability in practice, provided a rationale for referral, focused on education, and promoted efficient use of palliative care resources. The purpose of the doctoral project was to develop clinical practice guidelines with the assistance of an expert panel. The clinical practice guidelines were presented in an algorithm during an oral presentation accompanied by a

PowerPoint presentation. Data were collected from the expert panel to include qualitative and quantitative data using open discussion and the AGREE II tool.

Section 4: Findings and Recommendations

Palliative care is an interdisciplinary service specialty that may be provided in conjunction with aggressive treatments for serious, life-limiting illnesses and aims to improve patients' quality of life. Primary care teams can initiate palliative care by addressing basic symptom management, facilitating routine discussions about goals of care and advanced care planning, and addressing care transitions to hospice care (Ernecoff et al., 2019). Specialty palliative care is provided by a specialty service certified in palliative care and should be considered for more complex or refractory problems related to serious illness (Quill & Abernethy, 2013). Studies show that early palliative care involvement improves patient outcomes, quality of life, symptom control, and patient satisfaction (Hui et al., 2017; Reynolds et al., 2019). The gap in practice identified for this project was the inconsistent and fragmented palliative care provided in a local setting and the lack of knowledge of healthcare providers related to the assessment of palliative care needs, resulting in unmet palliative care needs and delayed palliative care referrals.

The practice-focused question was: What current evidence-based practice would facilitate high-quality nursing practice to identify and address unmet palliative care needs? Therefore, the purpose of this evidence-based project was to develop clinical practice guidelines on palliative care to outline a process of screening patients for unmet palliative care needs, determine appropriateness of primary palliative care or a specialty palliative care consult, outline consultation triaging process to meet patient needs, and ensure consistent care based on best available evidence. I anticipated that these guidelines would reduce variability in practice, provide a rational for referral, address palliative care education, and promote efficient use of resources.

The evidence used to create the clinical practice guidelines included current recommendations from the CAPC and the National Project Consensus. I conducted a literature review via MEDLINE, CINAHL, PubMed, Embase, ProQuest, and Joanna Briggs Institute EBP Database. The Fineout-Overholt ranking tool was used to rank the level of evidence for this project. The ranking tool assured the highest levels of evidence were used to create the clinical practice guidelines. In the following sections, I discuss the findings and implications, recommendations, contribution of the doctoral expert team, and the project's strengths and limitations.

Findings and Implications

For this project, I developed clinical practice guidelines to standardize palliative care and bridge a knowledge practice gap in the local setting. The clinical practice guidelines provided a step-by-step process to screen acute care adult patients for unmet palliative care needs on admission and then daily. The guidelines provide options for addressing these needs by considering a primary palliative care intervention versus consideration for a specialty palliative care consultation. The guidelines address appropriate resource utilization by identifying a process for triaging specialty palliative care consults. Lastly, the guidelines address annual palliative care education topics for health care providers to ensure competency. The primary goal was to use an expert panel to review high-quality, evidence-based practices and develop guidelines that would promote high-quality practices. The expert panel was used to evaluate evidence-based literature, review recommendations, and determine the resulting guidelines' quality.

Contributions of the Doctoral Project Team

Fourteen peer-reviewed scholarly sources were identified as useful for the development of the guidelines. I presented these sources to the expert panel in a series of meetings that allowed for discussion related to the appropriateness of the findings for the local setting.

The expert panel included two nurse practitioners, two physicians, one chaplain, and an ethicist, who are all board certified in palliative care. The levels of evidence were mixed and provided the recommendations that were used to develop the guidelines. I then collected the agreed-upon recommendations in an Excel spreadsheet and turned it into a literature review matrix (see Appendix A). I presented a PowerPoint at a final meeting, highlighting the gap in practice and reviewing the literature review matrix and the final clinical practice guidelines (see Appendix D). The AGREE II tool was reviewed and used to evaluate the scope and purpose, stakeholder involvement, the rigor of development, clarity of presentation, applicability, and editorial independence of the set of guidelines (see Table 1).

The AGREE II tool includes the six domains identified above and addresses 23 key items. The first domain, scope and practice, evaluates the overall objectives, health questions covered by the guideline, and applicable populations. The expert panel strongly agreed with 100% that the guideline's objectives, scope, and purpose were identified and easy to understand.

The second domain, stakeholder involvement, evaluates the relevant professionals included in the development, the consideration of views and preferences, and identification of target users. The experts used to review the evidence and generate the guideline were all certified in palliative care. It was discussed that the specialty palliative care service was well represented but that the primary palliative care providers were lacking. The expert members scored the second domain as 96.8%.

The third domain, the rigor of development, evaluates the methods used to search for and select evidence to formulate recommendations. The questions in this section addressed the inclusion and exclusion criteria, the strengths and limitations of the evidence, the consideration of health benefits and risks in formulating recommendations, and the link between the recommendations and the supporting evidence. The total score for this domain from the expert panel was 98.2%.

The fourth domain, clarity of presentation, addresses the format and ease of the guidelines. The questions in this section ensure that recommendations are specific and unambiguous. Different options for primary palliative care versus specialty palliative care are presented, and the identification of key recommendations is easily identifiable. The expert panel gave a total score for this domain of 100%.

The fifth domain, applicability, evaluates the ability to implement the guidelines and the possible impacts. The questions in this section addressed the facilitators and barriers to application, the tool or screening process to identify unmet palliative care needs, the resource implications or triage process outlined, and guideline monitoring. The total score for applicability was 91%. Monitoring compliance with the guidelines was determined to be an area requiring further development.

The sixth domain, editorial independence, pertains to the developing body's potential bias—the questions in this section address conflict of interest. The total score for the expert panel was 80.95%. The majority of appraisers were neutral in scoring their views of the funding body's influence on the guideline's content as they are all certified in palliative care.

The final item of the AGREE II tool addresses the overall quality of the guidelines. The expert panel approved the final product with a score of 94.5%. Each appraiser agreed to a biannual review to ensure continued high-quality rigor and applicability.

Table 1

Collective Domain Scores From the AGREE II Tool

Domain	Item	Total panel score	%
Domain 1			
	1	42	
	2	42	
	3	42	
	Total	126/126	100%
Domain 2			
	4	42	
	5	40	
	6	40	
	Total	122/126	96.8%
Domain 3			
	7	42	
	8	42	
	9	42	
	10	38	
	11	41	
	12	41	
	13	42	
	14	42	
	Total	330/336	98.2%
Domain 4			
	15	42	
	16	42	
	17	42	
	Total	126/126	100%
Domain 5			
	18	42	
	19	41	
	20	41	
	21	29	
	Total	153/168	91%
Domain 6			
	22	31	
	23	37	
	Total	68/84	81%

Average of 6 Domains: 94.5%

Limitations and Implications

During open discussion, while reviewing literature, the expert team determined that most scholarly research available provides evidence of low level with no random controlled trials. because of the nature of the studies of palliative care. Certainly, the lower levels of evidence can cause concern about validity and strength of recommendations. Some of the foreseeable barriers to implementation included the difficulty in building a screening tool in the electronic medical record for unmet palliative care needs. Also, nonspecialty palliative care practitioners did not agree with addressing primary palliative care needs. Another concern was the method by which the annual palliative care education would be presented and tracked. Computer-based modules are currently used for annual education, and this has a system in place to track compliance. This method was determined to be successful with other major education and was recommended for the palliative care education.

The expert panel felt the project was well designed and bridged a knowledge practice gap for palliative care practices. The benefits of the guidelines were identified by the panel as standardization for care to ensure patients with unmet palliative care needs are identified and healthcare providers have treatment options, including primary palliative care versus specialty palliative care. The guidelines address the limited resources of the specialty palliative care consulting services and provide a process for triaging consults. The guidelines also ensure annual education on palliative care that will promote healthcare professionals' palliative care competencies.

Recommendations

The primary focus of this project was to the close the gap in practice of caring for patient with serious progressive illness by developing clinical practice guidelines to ensure consistent, timely referrals to palliative care. The next steps would be implementation of the clinical practice guidelines and frequent audits, coaching, and evaluation over the next year. A palliative care committee should be developed to facilitate ongoing education and quality improvement. This committee would be responsible for biannual review and updating of the clinical practice guidelines. It is recommended that future projects focus on the development of quality measures to measure to patient care outcomes of early consistent palliative care referrals. Future research should replicate this project to provide more evidence to support the standardization of palliative care.

Strengths and Limitations of the Project

Clinical practice guidelines are used to improve the quality of care, reduce variability in care practices, and promote efficient use of resources. Palliative care is an interdisciplinary specialty that focuses on the improvement of the quality of life and prevention of suffering (Sharp et al., 2018). Palliative care has been shown to improve the symptom burden of serious illnesses, reduce unplanned hospitalizations, minimize aggressive end-of-life care, and empower patients to make choices about treatment preferences (Bennett et al., 2016; Hui et al., 2017).

One strength of this project was the use of an expert panel that has experience working in the adult acute care setting and possess certification in palliative care. The palliative care specialists have been working to improve their established palliative care program which has been in place for over 7 years. These experts identified areas for improvement and understand the knowledge gap of palliative care services in the local setting. The expert panel had insight into the need to identify patients with unmet palliative care needs, the importance of addressing appropriate resource utilization, and the need for education surrounding palliative care competencies. The project addressed many processes to improve patient care and standardize practices.

Potential limitations of the doctoral project were identified include the challenge of building the screening tool into the admission navigator of the electronic record and the daily screening process for nursing staff. The information technology department will have to build the tool and the nursing staff will have to be educated before implementation. The nursing staff completing the screening tool must be trained on the use of the tool to ensure consistency in screening practices. Nurses' daily charting with limited resources during the pandemic was discussed as another potential barrier to implementation.

A solution to the identified limitations was to develop the education while information technology was completing the build. The roll out would be done on select units to determine nurse acceptance of the clinical practices guidelines. Nurses are resilient and working hard during the pandemic. Monitoring feedback in the units would ensure acceptance and positive response to palliative care services and allow for negative feedback to be utilized to tailor processes.

Summary

The DNP project was to bridge the knowledge practice gap identified in the local setting and to identify a process to improve patient care. The expert panel was used to develop clinical practice guidelines to improve and standardize palliative care practices provided to adults in the acute care setting. The project has the potential to provide positive social change. Section 5 will discuss the dissemination plan.

Section 5: Dissemination Plan

The developed guidelines outline a method to identify patients with unmet palliative care needs, determine the role of primary palliative care versus specialty palliative care, outline a process for triaging palliative care consults, and standardize annual palliative care education to ensure high-quality palliative care. The expert panel will disseminate the guidelines within the local setting. The guidelines will be shared with the local setting for implementation, which has the potential to reach all primary and specialty healthcare professionals within the local setting. The guidelines will also be shared with other medical professionals within the community who provide palliative care. Additional means for dissemination to consider include abstract and poster presentation at the HPNA conference. The project will be published in ProQuest and available to others who search the database for palliative care clinical practice guidelines.

Analysis of Self

In this section, I provide an analysis of myself in the role of practitioner, scholar, and project manager. I discuss the project experience, present state, and long-term professional goals. I also address the challenges, solutions, and insights gained in this scholarly journey.

Practitioner

Advanced-practice registered nurses possess the skill and education to supplement the workforce shortages and provide high-quality health care to patients and improve health outcomes (Gentry & Dahlin, 2020). HPNA (2013) stated that nursing leadership is imperative to high-quality palliative care as palliative care nursing improves health outcomes, improves overall health, and lowers care costs. The DNP project pushed me to grow and develop my professional skills.

I began this journey by performing a self-evaluation of my goals, knowledge, and current skills. I spent the time to identify a local knowledge practice gap that aligned with my goals and interests. I obtained board certification in hospice and palliative care in 2018 when I began this DNP journey, and this certification influenced my interest in this project. I have been working on a small palliative care team in the local community, which has minimal palliative care resources and faces many challenges in patient care. Coincidentally, another local facility was working to develop a palliative care program, which allowed me to network with other professional within my field for the local community. Through these networking opportunities, I identified similar challenges throughout the community. As I began the literature review and establishment of the expert panel, I realized that the standardization of palliative care services had the potential to develop the local palliative care services into a high-quality, more efficient service that would have a positive social impact on the community. I reviewed the current National Consensus Project's palliative care clinical practice guidelines and determined how to add to and complement these existing guidelines. I spent a great deal of time performing the literature review, reviewing, analyzing, and selecting the most up-to-date and highest quality evidence to include in the clinical practice guidelines development.

Scholar

As a scholar, I spent countless hours on this DNP project and learned a great deal about myself and my studies from my mentors and my project committee. I had one goal:

to improve palliative care practices within the local setting. Walden University focuses on social change. Through the completion of this project, I was able to see how my education and training can improve my local community. As an advanced practice registered nurse, I am trained and skilled in bringing new evidence to practice improving the health of patients and practice of the nursing profession. This project allowed me the opportunity to utilize my skills in research, communication, leadership, and quality improvement.

I have always enjoyed research and learning and have been excited to embark on this journey to a terminal nursing degree. This process was challenging, and as the project comes to a close, I can reflect and appreciate my professional and personal growth. The project forced me out of my comfort zone and into the role of project manager with a group of professionals who challenged me with expert opinions and conversations on implementing evidence-based practices and improving the local health care community.

Project Manager

As a project manager, I was responsible for providing the expert panel with all necessary objectives and resources and managing the timeline to ensure the project was efficient and complete. The information and resources I provided to the expert panel included the identified knowledge practice gap, the literature selection process, and the evidence-based research that met inclusion criteria. I also provided objectives for each meeting to ensure the project stayed on task. During the meetings, I collected the resulting recommendations from the evidence presented and recorded the evidence's ratings. Between meetings, I organized the recommendations and compiled them to form the clinical practice guidelines. The AGREE II tool was reviewed to ensure consistent use by the expert panel. I then provided the tool to the panel along with the guidelines. Once the scoring was completed, I calculated the results and summarized the AGREE II data.

Long-Term Professional Goals

My long-term professional goals include continuing to provide palliative care for the local community. I will continue to head quality improvement projects and provide education on palliative care services to other healthcare providers. Another goal I have is to present an abstract and poster at a palliative care conference. The DNP project allowed me to work with local leaders, and I have been offered an opportunity to develop a manuscript for the *Journal for Palliative Care and Symptom Management*.

Challenges, Solutions, and Insight of Project Completion

The biggest challenge of this project was the timing of the pandemic. The pandemic made gathering and extra work difficult for the expert panel and me. Zoom and email became the primary means for communication and meetings and, as the project manager, I had to restructure my agenda and expectations for the biweekly meetings. There were some delays in the scheduling because of those who were unavailable due to health issues. With those being out and others already feeling burnt out, it was challenging to get the expert panel to complete tasks promptly. To overcome these challenges, I stayed committed to the goal. I sent out the agenda, objectives, and literature before the meetings to allow the group to review on their own before holding the group discussions and identifying recommendations. The final project completion was accomplished with the dedication of the expert panel. We overcame all the challenges during this process and developed the final clinical practice guidelines recommended for use in the local setting.

Summary

Palliative care is an interdisciplinary specialty that focuses on enhancing the quality of life of patients and families who are experiencing serious illnesses by addressing symptom burden, communication, and decision-making needs (Hui et al., 2017). Although palliative care has been recognized as a specialty care area since 2006, palliative care services remain fragmented, misperceived, and underutilized (Monterosso et al., 2016). The purpose of this DNP project was to develop palliative care clinical practice guidelines to standardize palliative care services, assist health care professionals in identifying patients with unmet palliative care needs, determine the difference between primary palliative care roles and specialty palliative care roles, develop a process to triage specialty consults and utilize appropriate resources, and address palliative care education. The clinical practice guidelines were developed through a rigorous review of the literature and use of an expert panel. HPNA (2013) stated that nursing leadership is transformative and should be encouraged, developed, and recognized. This DNP project provided an opportunity to disseminate high-quality, evidence-based practices, and other quality improvement initiatives. The DNP competencies of (a) scientific underpinning, (b) organizational and systems leadership, (c) quality improvement and systems thinking, (d) clinical scholarship and analytical methods for evidence-based practice, (e) interprofessional collaboration for improving patient and populations health outcomes, (f) clinical prevention and population health for improving the nation’s health, and (g) advanced nursing practice have all been achieved by this DNP project.

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Appendix A: Literature Matrix

Author	Year	Journal	Title	Findings/ recommendation	Level of Evidence
Ahluwalia et al.	2018	Journal of Pain and Symptom Management	A systematic review in support of the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, Fourth Edition.	-Moderate-quality evidence for the impact of comprehensive palliative care team -Spiritual assessment, grief & bereavement support improve outcomes for patients and families	I
Binney, Z., Quest, T., Perkins, M., Grant, G., & Idler, E.	2015	Journal of Pain and Symptom Management	Hospital-based chaplain activities with seriously ill patients and adherence to clinical practice guidelines for spiritual care in palliative care.	-Chaplains address spirituality assessment, existential issues, and assesses religious background and rituals.	VII
Bradway, C., Cotter, V. T., Darrah, N. J., Gibbs, V. D., Hadley, D., Kim, E. H., LaMarra, D., Packel, L., & Westcott, A. M.	2018	The Journal of Nursing Education	An interprofessional education simulation workshop: Health professions learning palliative care communication.	-Palliative care education should focus on Interprofessional collaboration and education on team dynamics and communication, roles and responsibilities, and individual communication skills	VI
Ernecoff, et al.	2019	Journal of Pain and Symptom Management	Specialty vs. primary palliative care in randomized clinical trials: A systematic review (FR420B)	-Primary palliative care interventions may meet some but often not all palliative care needs of seriously ill patients and families	I
Kistler, E. A., Stevens, E., Scott, E., Philpotts, L. L., Greer, J. A., & Greenwald, J. L.	2020	Journal of Pain and Symptom Management	Triggered palliative care consults: A systematic review of interventions for hospitalized and emergency department patients	-Nurse acts as primary operator of trigger tools -triggers must be sensitive enough to identify those with palliative care needs but specific enough to limit prohibitively high numbers of consults that exceed specialty capacity -Most common triggers include advanced disease state or life limiting disease, Goals of care, and characteristics associated with higher resource utilization and worse outcomes, multisystem organ failure, high symptom burden, vent/trach/PEG, and patient and family request. -Positive trigger system Is to identify patient with palliative care needs, not trigger a specialty palliative care consult	V
Powazski, R. D., Walsh, D., & Shrotriya, S.	2015	American Journal of Hospice & Palliative Medicine	A prospective study of the clinical content of palliative medicine interdisciplinary team meetings	-Interdisciplinary team (IDT) meetings address clinical resources and patient and family issues that address (1) clinical services, (2) psychosocial, and (3) care plan. - IDT includes problem identification and intervention	VI
Quill, T. E., & Abernethy, A. P.	2013	New England Journal of Medicine	Generalist plus specialists' palliative	-Primary palliative care: Basic management of symptoms, discuss about prognosis, goals of	VI

			care- Creating a more sustainable model	treatment, suffering and code status -Specialty Palliative Care: complex symptom management, management of complex depression, anxiety, grief, and existential distress, assistance with conflict resolution regarding goals of care and treatment options, complex communication between patients, families, and treatment teams, and assistance in addressing cases of near futility	
Radwany, S., Mason, H., Clarke, J. S., Clough, L., Sims, L., & Albanese, T.	2009	Journal of Pain and Symptom Management	Optimizing the success of a palliative care consult service: How to average over 110 consults per month	-The consulting palliative care service should be tailored to the organization's culture -Developing a successful palliative care consulting service requires planning, education, communication, accessibility, and ongoing evaluation -triage process through palliative NP	VI
Russell, B., Vogrin, S., Philip, J., Hennessy-Anderson, N., Collins, A., Burchell, J., Le, B., Brand, C., Hudson, P., & Sundararajan, V.	2020	Journal of Pain and Symptom Management	Triaging the terminally ill—Development of the responding to urgency of need in palliative care (RUN-PC) triage tool.	-Key determinants of urgent palliative care needs includes (1) physical suffering, (2) psychological suffering, (3) caregiver distress, (4) urgent communication needs, (5) significant discrepancy between needs and care, (6) mismatch between site of care and desired site of care, and (7) imminent dying.	III
Starks, H., Coats, H., Paganelli, T., Mauksch, L., van Schaik, E., Lindhorst, T., Hurd, C., & Doorenbos, A.	2018	American Journal of Hospice & Palliative Medicine	Pilot study of an interprofessional palliative care curriculum: Course content and participant-reported learning gains	-Palliative care education should include patient-centered narrative skills, introducing palliative care and eliciting the patient narrative, identifying and responding to emotion, facilitating family conferences, interprofessional team communication, role identification and functioning, and metrics and systems integration -7 questions to assess impact of illness: Perspective, past illness experience, hopes, concerns, strengths/ spirituality, support/family, and what else?	VI
Thrane, S. E.	2020	Official Journal of the American Association of Colleges of Nursing	Online palliative and end-of-life care education for undergraduate nurses.	- Palliative care competencies include promoting palliative care for seriously ill patients from time of diagnosis, educate and communicate with patients and families about serious illnesses, collaborate with interdisciplinary team to improve palliative care, perform a comprehensive assessment of pain and symptoms, analyze and communicate with IDT in planning and intervening in symptom management, assess	VII

				and address physical, psychosocial, social, and spiritual needs, and recognize and seek consultation for complex patients and families	
Weisenfluh, S. M., & Csikai, E. L.	2013	Journal of Social Work in End-of-Life & Palliative Care	Professional and educational needs of hospice and palliative care social workers	-Initial assessment by nurse and social worker to determine patient needs -Social workers communicate psychosocial needs of patient and family, assess grief and bereavement, facilitate communication, link to resources, educate about palliative care and end of life/ hospice, address advanced care planning, assist with family meetings, and address ethical issues	VI
Weissman, D. E., & Meier, D. E.	2011	Journal of Palliative Medicine	Identifying patients in need of a palliative care assessment in the hospital setting: A consensus report from the Center to Advanced Palliative Care	-Daily care of seriously ill patients is managed by primary palliative care services provided by attendings, nursing staff, social workers, chaplains, and other personnel involved in routine care -Specialty palliative care is reserved for needs beyond primary palliative care capabilities. -Education is essential for better primary palliative care skills - Identifying patients with palliative care needs: Life limiting disease or illness, physical, psychological, social, or spiritual concerns, identifying patient understanding of illness and treatments, identifying patient goals of care -Screen patients at time of admission and during daily rounds	VII
Zalenski, R. J., Jones, S. S., Courage, C., Waselewsky, D. R., Kostaroff, A. S., Kaufman, D., Beemath, A., Brofman, J., Castillo, J. W., Krayem, H., Marinelli, A., Milner, B., Palleschi, M. T., Tareen, M., Testani, S., Soubani, A., Walch, J., Wheeler, J., Wilborn, S., & Granovsky, H.	2017	Journal of Pain & Symptom Management	Impact of palliative care screening and consultation in the ICU: A multihospital quality improvement project	-Patients identified with unmet palliative care needs: Admitted from LTAC, SNF, vent LTC, advanced or life-limiting illness, recent CVA or neurological event, cardiac event, readmission to ICU for same diagnosis, team identifies poor prognosis or complex care needs.	III

Appendix B: Fineout-Overholt Ranking Tool

Level of Evidence	Study Design
I	Systematic reviews and meta-analysis of randomized controlled trials (RCT)
II	RCT
III	Non-randomized controlled trails
IV	Case-control or cohort studies
V	Systematic reviews of qualitative or descriptive studies
VI	Qualitative or descriptive studies
VII	Opinions of authorities and/or reports of expert committees

Appendix C: Palliative Care Clinical Practice Guidelines

Palliative Care Clinical Practice Guideline

Objectives:

1. Define palliative care
2. Define the difference between primary palliative care and specialty palliative care
3. Identify patients with unmet palliative care needs
4. Process for completing palliative care screen
    a. Describe the roles of the interprofessional palliative care team
    b. Triaging patients
5. Identify palliative care education topics

Palliative care Defined:

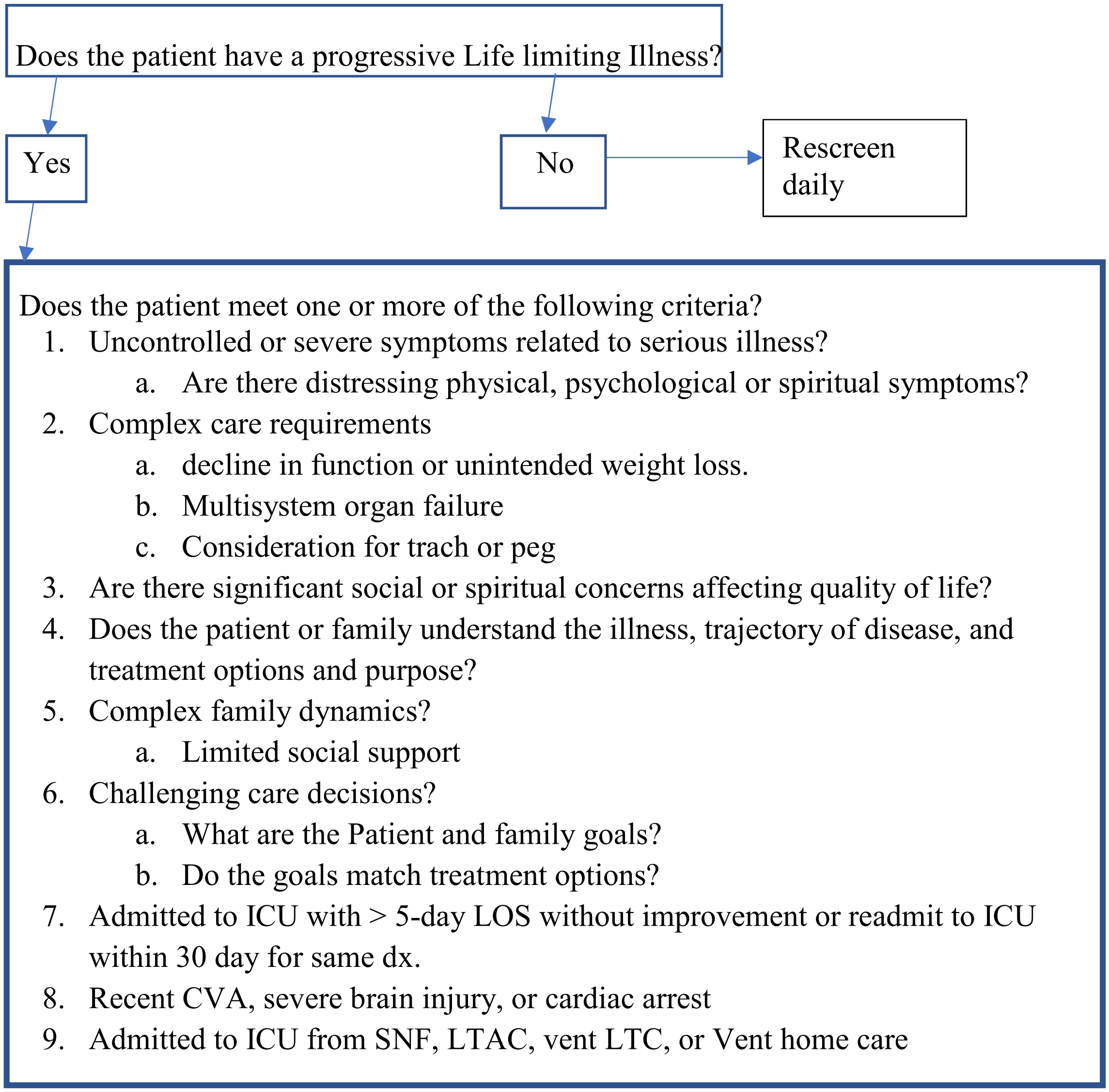
Palliative care is an interprofessional specialty that aims to improve the quality of life of patients with progressive serious illnesses by addressing symptom burden, communication, and decision-making needs (Hui et al., 2017). Palliative care is provided alongside of aggressive treatments for serious illnesses and improves the quality of life of patients and families by addressing specific needs and aligning care with patient and family preferences and goals (National Consensus Project, 2019). Studies show that early palliative care involvement improves patient outcomes, quality of life, symptom control, and patient satisfaction (Hui et al., 2017; Reynolds et al., 2019).

Primary Palliative Care Vs. Specialty Palliative Care

Primary care palliative care is palliative care provided by providers who are not palliative care specialists. Components of primary palliative care include basic symptom management, routine discussions about code status and goals of care, and care transitions to hospice care (Ernecoff et al., 2019). These basic palliative care skills are skills that all clinicians who care for seriously ill patients should have competency with (Ernecoff et al., 2019). Specialty palliative care consultation should be considered for more complex or refractory problems related to serious illness (Quill & Abernethy, 2013).

Determining Patients with Unmet Palliative Care Needs

Patients are screened on admission and daily for unmet palliative care needs.
Screen is completed by RN and prompts consideration for palliative care consultation
Goal: identify patients who have unmet palliative care needs, prompting care beginning with primary palliative care and then progress to specialty palliative care consult if needed.



Does the patient meet one or more of the following criteria?

1. Uncontrolled or severe symptoms related to serious illness?
    a. Are there distressing physical, psychological or spiritual symptoms?
2. Complex care requirements
    a. decline in function or unintended weight loss.
    b. Multisystem organ failure
    c. Consideration for trach or peg
3. Are there significant social or spiritual concerns affecting quality of life?
4. Does the patient or family understand the illness, trajectory of disease, and treatment options and purpose?
5. Complex family dynamics?
    a. Limited social support
6. Challenging care decisions?
    a. What are the Patient and family goals?
    b. Do the goals match treatment options?
7. Admitted to ICU with > 5-day LOS without improvement or readmit to ICU within 30 day for same dx.
8. Recent CVA, severe brain injury, or cardiac arrest
9. Admitted to ICU from SNF, LTAC, vent LTC, or Vent home care

Progressive life-limiting illnesses: Advanced cancer, advanced dementia or central nervous system disease, advanced chronic comorbidities: heart failure, ESRD, end-stage liver disease.

Consideration for Primary Palliative Care or Specialty Palliative Care Consult?

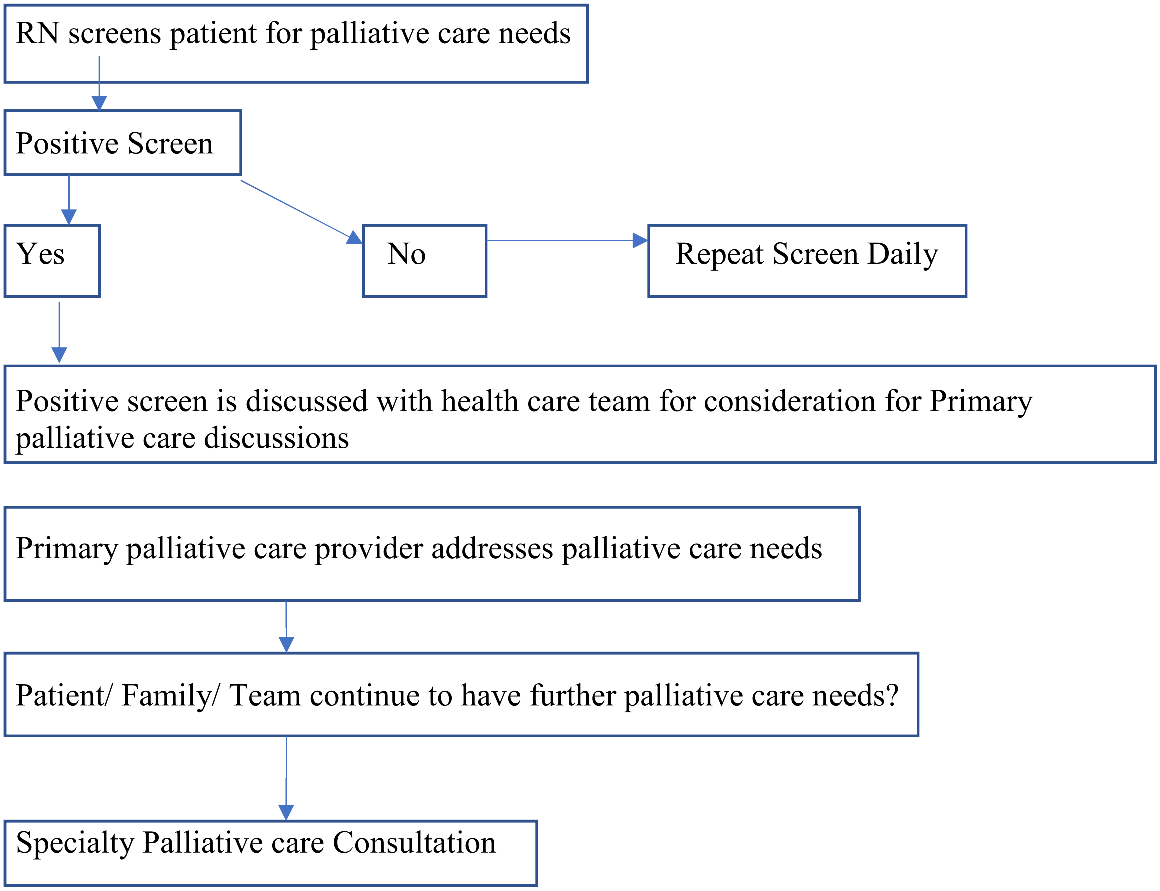
Primary Palliative Care:

1. Discuss diagnosis, treatment options, and illicit patient goals and understanding
2. Address symptoms

Specialty Palliative Care consultation:

1. Complex end of life concerns
2. Clarifying patient/ family goals and support for complex decision making
3. Further discussion on prognosis and helping patient and families understand treatment options
4. Complex symptom management
5. Patient and family request or healthcare team request extra support

Process for initial and daily screening:



Specialty palliative care consult assessment completed by RN and SW to determine needs:
Social Worker: Address psychosocial needs, assess grief, facilitate family and team meetings, address advanced care planning, link patients to available resources
Chaplain: spiritual assessment, assess and address grief
NP/PA: Discuss prognosis, goals of care, assess for and treat complex symptoms, address care transitions
MD: Collaborate and oversee complex patient care management

Patient is discussed in IDT to determine collaborative palliative care plan and further needs

Specialty Consults are Triaged by:

1. Physical suffering
2. Psychological suffering
3. Caregiver distress
4. Unmet communication needs
5. Discrepancy between care needs and care arrangements
6. Mismatch between current site of care needs and care arrangements
7. Imminent dying

Palliative Care Education:
Annual training for nurses and healthcare providers includes training in palliative care that addresses:

1. Patient-centered and narrative communication
    a. Introducing palliative care
    b. Elicit and respond to emotion using NURSE pneumonic (Name, Understand, Respect, Support, Explore)
    c. Elicit a patient’s narrative using the 7 questions to assess illness

Perspective: How do you see your situation?
Past illness: What are your experiences with illness?
Hopes: What are you hopes for the coming days, weeks, and months?
Concerns: What are you most concerned about?
Strengths/ Spirituality: Where do you draw your strengths from?
Support/Family: Who is your support?

What else? What else do we need to know to provide the best care to you?

2. Interprofessional team practice
    a. Define and explain disciplinary roles
    b. Examine team dynamics
3. Metric and systems integration
    a. Identify annual quality metrics to measure palliative clinical outcomes

Appendix D: Overview of PowerPoint Presentation

Objective: Identify knowledge practice gap and review clinical practice guidelines

Nursing Professional Goal: Standardize palliative care practices and improve health care professionals' ability to identify patients with unmet palliative care needs

Patient Goal: Improve access to palliative care and improve adaptation to serious illness

Slide Content	Time spent on slide	
What is Palliative Care?	5"	Hui, D., Mori, M., Meng, Y.-C., Watanabe, S. M., Caraceni, A., Strasser, F., … Bruera, E. (2017). Automatic referral to standardize palliative care access: an international Delphi survey. *Supportive Care in Cancer*, *26*(1), 175–180.
Primary Palliative Care	5"	Ernecoff, N., Check, D., Bannon, M., Hanson, L., Dionne-Odom, J., Corbelli, J., Klein-Fedyshin, M., Schenker, Y., Zimmermann, C., Arnold, R., & Kavalieratos, D. (2019). Specialty vs. primary palliative care in randomized clinical trials: A systematic review (FR420B). J*ournal of Pain and Symptom Management*, *57*(2), 409–410.
Specialty Palliative Care	5"	Quill, T. E., & Abernethy, A. P. (2013). Generalist plus specialists' palliative care- Creating a more sustainable model. *New England Journal of Medicine*, *368*, 1173-1175
Knowledge Practice Gap	3"	Fink R. M. (2015). Review of a study on late referral to a palliative care consultation service: Length of stay and in-hospital mortality outcomes. *Journal of the Advanced Practitioner in Oncology*, *6*(6), 597–601.
Purpose of the Project	2"	
Evidence	10"	See Appendix A
Interdisciplinary Team Roles	5"	Ahluwalia, S. C., Chen, C., Raaen, L., Motala, A., Walling, A. M., Chamberlin, M., O'Hanlon, C., Larkin, J., Lorenz, K., Akinniranye, O., & Hempel, S. (2018). A systematic review in support of the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, Fourth Edition. J*ournal of Pain and Symptom Management*, *56*(6), 831–870. Powazski, R. D., Walsh, D., & Shrotriya, S. (2015). A prospective study of the clinical content of palliative medicine interdisciplinary team meetings. *American Journal of Hospice & Palliative Medicine*, *32*(8), 789–796.
Palliative Care Annual Education	5"	Bradway, C., Cotter, V. T., Darrah, N. J., Gibbs, V. D., Hadley, D., Kim, E. H., LaMarra, D., Packel, L., & Westcott, A. M. (2018). An interprofessional education simulation workshop: Health professions learning palliative care communication. *The Journal of Nursing Education*, *57*(8), 493–497.
Presentation of the CPGs	15"	See Appendix C