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## **Advancing Palliative Care Competency Through an Evidence- Based Educational Intervention for Healthcare Providers**

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# Walden University

College of Nursing

This is to certify that the doctoral study by

Lauren E. Griffin

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.

Review Committee

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Walden University  
2025

Executive Summary: Staff Education Project  
Advancing Palliative Care Competency Through an Evidence-Based Educational  
Intervention for Healthcare Providers

by

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Executive Summary Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Nursing Practice

Walden University

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## Summary

A major gap in acute care is the delayed initiation of palliative consultations. Although over 58 million people worldwide could benefit, only 14% receive such care. Despite evidence that early involvement improves outcomes, providers often overlook their value, leading to late referrals, typically after repeated hospitalizations or near end-of-life, when hospice may be more appropriate.

This Doctor of Nursing Practice (DNP) educational intervention addressed a critical practice-focused question to enhance healthcare providers' understanding of palliative care improve hospital-based patient outcomes. The intervention aimed to demonstrate a  $\geq 20\%$  knowledge gain from pretest to posttest scores related to distinguishing palliative care from hospice, understanding the benefits of palliative care, and identifying optimal referral timing. Results for 28 interdisciplinary providers exceeded the goal of  $>20\%$ , with a knowledge gain of 70.5%, 54.8% in the benefits of palliative care, 94.4% in optimizing referral timing, and 73.7% in the distinction between palliative care from hospice. By equipping healthcare professionals with foundational knowledge, the project supports earlier, more effective integration of palliative care. This promotes patient centered care and improves the quality of life for individuals with serious illnesses. This project has the potential to improve nursing practice by enhancing provider competency in early, culturally responsive palliative care. It also advanced equity by promoting timely, inclusive care and fostering interdisciplinary collaboration for better patient outcomes.

## **Background**

This doctoral educational project addressed an organizational gap regarding variable provider knowledge, inconsistent referral practices, and limited confidence in goals-of-care communication having constrained implementation and impact for palliative care for patients. Within an aging, clinically complex patient population, these gaps translated into delayed symptom relief, fragmented decision-making, and avoidable utilization, all of which undermine quality, equity, and patient- and family-centered outcomes. The project proposed a structured educational intervention that integrated current evidence on palliative care knowledge, comprehensive symptom assessment and management, serious-illness communication, and culturally responsive care of the organization. Through educational reinforcement, the project aimed to increase by a minimum of 20% (a) distinguishing palliative care from hospice management, (b) understanding the benefits of palliative care, and (c) identifying optimal referral timing. Anticipated benefits included improved provider knowledge, earlier alignment of care with patient values, enhanced patient-reported outcomes, and progress toward institutional quality and safety priorities. These could potentially operationalize the organization's palliative care initiative into measurable, sustainable practice change.

The literature search was done using major search engines for nursing and allied health. Both research and nonresearch articles resulted through a concentrated search focused on palliative care and education as a foundational technique for this project. The search revealed that there was strong and growing evidence that palliative care remained underrepresented in the formal education of both medical and nursing students. As a

result, many healthcare providers were not adequately prepared to initiate primary palliative care conversations or recognize when a referral to specialty palliative care is appropriate (Curtis et al., 2022). Healthcare providers across critical care, surgery, and geriatrics faced persistent challenges in delivering effective end-of-life and goals-of-care communication due to limited training, low confidence, and systemic barriers, often reserving the use of palliative care for end-of-life (Haines et al., 2021). Studies by Bakke et al. (2018) and Rajdev et al. (2020) highlighted the need for structured, evidence-based training to improve provider preparedness. This widespread knowledge deficit contributed to late or absent palliative care involvement, which negatively impacted patient outcomes. However, a robust body of literature consistently demonstrated that early palliative interventions improved symptom management, enhanced quality of life (Pavish et al., 2020), increase patient and family satisfaction (Helgeson et al., 2023), and reduce both hospital length of stay (Barkley et al., 2019) and overall healthcare costs (Cox et al., 2020). Emiloju et al. (2020) found that early goals of care discussions had a positive correlation with length of stay. Moreover, when physicians are prompted to initiate timely palliative referrals, patients experience better outcomes, including reduced time on life support, shorter hospital stays, and even prolonged life expectancy (Iguina et al., 2023).

In summary, the strength of the evidence was strong. It validated that educational interventions were an evidence-based mechanism to address this palliative care project.

### **Staff Education Project Development**

This educational initiative engaged multidisciplinary team members of palliative care professionals, including physicians, nurse practitioners, social workers, and family therapists. Team members were selected based on their clinical expertise, experience in educational delivery, and collaborative skills. Their input was instrumental during the project's design phase, where they served as consultants to ensure relevance and effectiveness. Structured brainstorming sessions were conducted to assess the current state of palliative education and identify key areas for improvement.

An Organizational Readiness Tool was initiated to support the implementation of palliative care education. This tool was a quick, reliable, and valid method for measuring an organization's readiness for change (Shea et al., 2014). The tool concluded that the organization was "somewhat ready" for an educational intervention that addressed palliative care, knowledge, distinction between services and timing of intervention initiation.

A comprehensive stakeholder analysis was conducted using the Stakeholder Analysis and Communication Tool. This process identified key individuals whose influence and engagement were critical to the success of the initiative. These stakeholders included the palliative program manager and palliative medical director, who provided clinical leadership and strategic direction; representatives from Quality and the Ethics Committee, who ensured alignment with institutional standards and ethical considerations; the administration physician advisor, responsible for throughput and operational efficiency; and interdisciplinary representatives from the hospitalist and

intensive care unit (ICU) departments, along with nursing administrators, who were essential for frontline engagement and integration into clinical workflows. Each stakeholder's level of influence and interest was assessed to determine appropriate communication and engagement strategies. High-influence stakeholders such as the medical director and physician advisor were engaged through strategic planning meetings and regular updates to ensure alignment with institutional goals. Interdisciplinary clinical representatives were engaged through collaborative discussions and feedback loops to foster ownership and relevance of the educational content. Nursing administrators were provided with tailored communication and scheduling flexibility to support staff participation.

A strengths, weaknesses, opportunities, and threats (SWOT) analysis revealed that late palliative care consultations in the acute care setting stemmed from educational and communication gaps among providers. Strengths included an existing palliative care unit and evidence that early involvement improves patient outcomes, satisfaction, and hospital efficiency. Weaknesses involved delayed consultations, poor interdisciplinary communication, and lack of palliative presence during rounds. Opportunities lie in educating staff to advocate for timely referrals, especially during end-of-life discussions. Threats included inappropriate use of palliative pathways without consultation and potential barriers from a recent health system merger. Internal and external benchmarking can support efforts to improve palliative integration.

The educational session was designed as a drop-in, self-paced format to maximize accessibility and accommodate varying schedules. This format encouraged broader

participation and allowed learners to engage with the material at their own pace. While the education was primarily directed at healthcare providers, including nurses, advanced practice providers (APPs), and physicians, the actual participants represented a broader interdisciplinary group. Attendees included 24 nurses, APPs, physicians, physical therapists, speech-language pathologists, and marriage and family therapy interns.

A PowerPoint presentation was developed to present introductory and foundational information on palliative care, clinical applications and impact of palliative care and legal tools, and advance care planning used in palliative care (see Appendix A). Additional educational tools were provided after all education sessions were completed for quick reference for the information provided. These additional tools included a pocket card (see Appendix B) and a palliative care tip sheet (see Appendix C). These tools contribute to the sustainability of the education.

Educational session effectiveness was evaluated by using quantitative data obtained using pretests (see Appendix D) and posttests (see Appendix E). Both tests included 14 multiple choice questions. Anonymity and confidentiality were maintained by having the participant identify a unique six-digit number which was used for identification on both the pretest and posttests for data tracking purposes. The assessments focused on three core areas: distinguishing palliative care from hospice care, understanding the benefits of palliative care, and identifying the optimal timing for a palliative consultation. The normalized gain formula was used to measure learning outcomes. This method provided a standardized measure of knowledge improvement across participants and offered evidence of the session's impact.

The post education evaluation (see Appendix F) was designed to assess the effectiveness of the session and guide future improvements. Participants completed a brief, anonymous questionnaire that included both a Likert-type rating scale and open-ended questions. The evaluation assessed the clarity of objectives, relevance of content, quality of materials, and effectiveness of the presenter. The participants were encouraged to reflect on takeaways from the session that will impact their practice and rated their knowledge of palliative care before and after the session. This combination of quantitative and qualitative feedback helped ensure future palliative education sessions remain relevant, engaging, and impactful for healthcare providers.

Data were analyzed using the Excel program that included means for all areas. The normalized gain was then calculated to identify gains in knowledge for distinguishing palliative care from hospice care, understanding the benefits of palliative care, and identifying the optimal timing for a palliative consultation.

### **Results**

This project had 28 multidisciplinary participants which included nurses, APPs, physicians, physical therapists, speech-language pathologists, and marriage and family therapy interns. They were engaged in the entire delivery process. The pretests and posttest questions fell into one of three categories: the difference between palliative care and hospice care (Questions 1, 2, 7, 13, and 14), understanding the benefits of palliative care (Questions 3, 4, 6, 8, and 11), and optimal timing of a palliative care referrals (Questions 5, 9, 10, and 12). The mean score for understanding the benefits of palliative care in the pretest was 77.9 (min = 40; max = 100). The mean score for understanding the

benefits of palliative care in the posttest was 90 (min = 60; max = 100). The knowledge gain for understanding the benefits of palliative care was 54.8% (min = 77.9; max = 90). The mean score for optimal timing of a palliative care referrals in the pretest was 83.9% (min = 50; max = 100). The mean score for the optimal timing of palliative care referrals in the posttest was 99.1% (min = 75; max = 100). The knowledge gain for optimal timing of palliative care referrals was 94.4% (min = 83.9; max = 99.1). The mean score for the difference between palliative care and hospice care in the pretest was 86.4 (min = 40; max = 100). The mean score for the difference between palliative care and hospice in the posttest was 96.4 (min = 60; max = 100). The knowledge gain for the difference between palliative care and hospice care was 73.7% (min = 86.4; max = 96.4). The objective of a 20% gain was exceeded.

The impact on the organization that resulted from the staff education project was a positive effect on the way palliative care was educated throughout the organization. Palliative clinicians were now a part of the onboarding process for new nurses with a specific time for a palliative nurse or nurse practitioner to present during every new nurse orientation session. New ICU nurses now participate in a four-hour shadowing experience with palliative clinicians and counselors during their ICU orientation process. Second year family medicine residents are now rotating through the palliative service to actively work with palliative clinicians to gain experience with serious illness conversations. There are conversations taking place to also have internal medicine residents rotate through the palliative service as an elective rotation. Finally, measures are

being taken to reimplement a fellowship program to train physicians in palliative and hospice care.

Despite the strengths of the palliative care education initiative, several limitations should be acknowledged. First, the small sample size limits the generalizability of the findings and may not fully represent the broader healthcare provider population. Additionally, the pretest and posttest questions were not equally distributed across all content categories, which may affect the accuracy of knowledge assessment. Lastly, physician participation was limited, which may have reduced the overall impact of the program, particularly in interdisciplinary care settings where physician engagement was critical.

While this palliative care education project was implemented at an organizational Level 1 trauma center, its significance extends well beyond this organization. This facility was one of three hospitals within the same regional healthcare system. Unlike the trauma center, the other two hospitals are smaller community-based facilities that currently do not offer dedicated palliative care services. By demonstrating the value and impact of palliative care through this educational initiative, this project has the potential to serve as a model for system-wide adoption. The goal is that the evidence and outcomes generated here will support the expansion of palliative care education and services to the other hospitals in the network, ultimately improving care for patients across the entire system.

## Conclusions

This DNP project addressed a critical gap in acute care: the delayed initiation of palliative services. Despite its global importance, many patients only learn about palliative care during hospitalization, often when their condition has significantly declined. Delays stemmed from limited provider education and confidence in initiating early conversations or referrals. The project has already driven institutional changes, including integration of palliative care into nurse orientation, ICU shadowing, and resident rotations. Plans are underway to expand these efforts and reintroduce a palliative fellowship program, reflecting a growing commitment to early, compassionate, patient-centered care.

This initiative emphasized the vital role of nurses in identifying palliative needs and advocating for timely interventions. By equipping nurses to initiate conversations, it strengthens interdisciplinary collaboration and improves care quality. Expanding access promotes dignity, comfort, and autonomy for patients and families. Early integration reduces unnecessary interventions, enhances quality of life, and supports equitable care, especially for vulnerable populations. The project also advances diversity, equity, and inclusion by ensuring all patients receive appropriate care regardless of background. Educational efforts focus on culturally sensitive communication and inclusive planning, helping providers address diverse values and needs at the end of life. Ultimately, this initiative served as a model for expanding palliative education and services across hospital networks, improving outcomes and advancing compassionate, equitable care.

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## Appendix A: Educational PowerPoint



# Palliative Care

Presented by: Lauren Griffin, NP

## Learning Objectives

By the end of this session, attendees will be able to:

- Describe the goals and scope of Palliative Care as a multidisciplinary approach to serious illness.
- Identify patient populations who benefit from Palliative Care interventions.
- Compare and contrast Palliative Care and Hospice Care, including timing, eligibility, and focus of treatment.
- Recognize the importance of communication in goals-of-care conversations and end-of-life planning.
- Understand code status options, including Full Code, DNR, DNI, and Comfort Care.
- Identify legal decision makers for medical decisions and procedures, according to Georgia's 2024 legal framework.
- Explain the purpose and use of the POLST and Advance Directives, including who can authorize them.
- Describe the role of a dedicated Palliative Care Unit, including staffing and patient services.

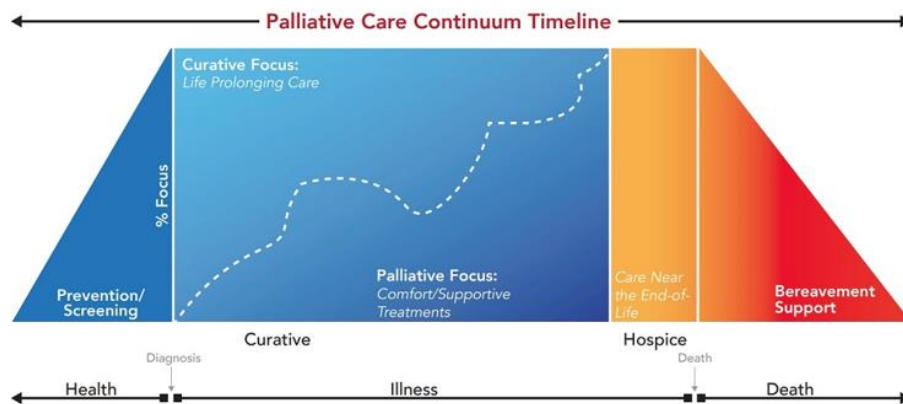
## Palliative Care

- A subspecialty that provides an alternative to viewing death as something to be feared.

- Create a care plan that improves patient and family satisfaction, improves quality of care, and reduces costs.

- Healthcare strategy that offers a comprehensive, multidisciplinary package to patients and families with professionals who are experts at symptom management and problems that often arise in advanced stages of disease.

## Palliative Care/Hospice Continuum Timeline



- Retrieved from Joyner, N. (n.d.) About palliative care. Retrieved July 14, 2025 from <https://www.nancvjoyner.com/palliative-care/>

## Who Benefits from Palliative Care

- Patients with life-limiting or life-threatening illnesses
- Severe Heart Failure
- Advanced COPD
- Advanced Dementia
- Cancer (stages III or IV, high symptom burden)
- Advanced Liver Disease
- Advanced Renal Disease ~~HIV~~ with Advanced AIDS
- Progressive Neurological Diseases
- Multiorgan Dysfunction Syndrome
- Traumatic Brain Injury or devastating Stroke
- Cardiac Arrest
- Adult frailty with decisions for PEG, Tracheostomy, re-intubation and/or diverting colostomy
- Any adult on ECMO, prolonged support, or CRRT
- Prior or current hospice enrollee
- Multiple hospitalizations for similar condition
- ICU stay  $\geq 7$  days or documented poor prognosis

## Palliative vs Hospice Care

### • Palliative Care:

Available at any stage of a serious illness, the earlier the better

Focuses on relieving symptoms and improving quality of life

Is offered in conjunction with curative treatment

Involves a multidisciplinary team, including doctors, nurses, and social workers.

### Hospice Care:

For terminal patients with a life expectancy of less than 6 months

Focuses on comfort and quality of life rather than curative treatment.

Usually provided in the patient's home or a hospice facility.

Emphasizes support for both the patient and their family during the end-of-life process.

Both types of care prioritize patient comfort and support, but the key difference lies in the timing and intent of the care provided.



## Resuscitation/Code Status

Resuscitation Status Orders  
Making Health Care Decisions

Types of Resuscitation Status Orders

**Full Scope of Treatment**  
You will get the medical care you need. This may include life support like CPR and/or a breathing tube (mechanical ventilation).

**Do Not Attempt Resuscitation-Total Scope Treatment**  
You will get the medical care you need, but doctors won't try CPR if your heart stops beating. They may talk about other treatments that could help. This may include using a breathing tube and machine to help you breathe.

**Do Not Attempt Resuscitation-Limited Scope of Treatment**  
You will get the medical care you need, but doctors won't try CPR or put you on a breathing machine if your heart stops or you stop breathing. You or someone you trust can decide to not do other treatments like feeding tubes, dialysis, or artificial fluids. It's important to make these decisions if you can't make them for yourself.

**DNAR – Comfort Care Scope of Treatment**  
If your heart or breathing stops, doctors won't try CPR. Instead, your health care team will make sure you are comfortable and treat you with dignity. You and your loved ones will decide how you want to spend the rest of your life. You might be moved from the Intensive Care Unit to a regular hospital room or to a special unit called the Palliative Care Unit. You will be allowed a natural death. Hospice care can be involved at home, nursing home or in a special facility for those needing extra care.

Full Code

DNR

DNR/DNI  
+ any additional limitations

Comfort Care

## Resuscitation/Code Status

Order History
Future Output

**DNAR / Limited Scope of**

Process Instructions:

- DO NOT use anti-arrhythmic drips
- DO NOT give antibiotics
- DO NOT give blood products
- DO NOT implant cardiac pacemaker
- DO NOT perform dialysis
- DO NOT implant cardiac defibrillator (AICD)
- DO NOT give IV fluids
- DO NOT perform labs and/or imaging tests
- DO NOT provide non-invasive vent. support (NIPPV)
- DO NOT place PEG tube
- DO NOT give TPN/PPN

Authorization determined by:

- DO NOT perform tracheostomy
- DO NOT give tube feedings (DHT/NG)
- DO NOT use vasoactive drips
- Other (see comments)

Additional Treatment Limitations:

+ Add

Code Status Comments: [+ Add Code Status Comments](#)

Order Title

DO NOT use anti-arrhythmic drips

DO NOT give antibiotics

DO NOT give blood products

DO NOT implant cardiac pacemaker

DO NOT perform dialysis

DO NOT implant cardiac defibrillator (AICD)

DO NOT give IV fluids

DO NOT perform labs and/or imaging tests

DO NOT provide non-invasive vent. support (NIPPV)

DO NOT place PEG tube

DO NOT give TPN/PPN

DO NOT perform tracheostomy

DO NOT give tube feedings (DHT/NG)

DO NOT use vasoactive drips

Other (see comments)

+ Add

Code Status Comments: [+ Add Code Status Comments](#)

Next Required
Link Order
Accept
Cancel

## Medical Decision Makers

### Who Can Make Decisions for Code Status Change?

As of 2024, the order for Georgia legal next of kin is:

- Health Care Agent
- Spouse
- Guardian, 18 years or older
- Any adult child, 18 years or older (multiple children have equal decision-making power)
- Any parent
- Any brother or sister, sibling 18 years or older (multiple siblings have equal decision-making power)

\*\*In the absence of LNOK, two doctors may change code status after consulting Ethics.

### Who Can Make Decisions for Procedures?

- Healthcare Agent
- Spouse
- Guardian, 18 years or older
- Any adult child, 18 years or older (multiple children have equal decision-making power)
- Any parent
- Any brother or sister, sibling 18 years or older (multiple siblings have equal decision-making power)
- Any grandparent
- Any adult grandchild
- Any adult niece, nephew, aunt, or uncle of the patient who is related to the patient in the first degree
- Upon the absence of any person to consent, an adult friend of the patient

## Physician Orders For Life-Sustaining Treatment (POLST)

What is the POLST?

- ❖ Physician Orders for Life-Sustaining Treatment (POLST).
- ❖ Converts treatment preferences into written physician orders.
- ❖ Travels with the patient across care settings.
- ❖ Other states may use a MOLST, or Medical Orders for Life-Sustaining Treatment.



# POLST

**PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)**

Patient's Name: \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last)

Date of Birth: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)      Gender: Male  Female

---

**A**      **CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.**  
**CODE STATUS**  
 Attempt Resuscitation (CPR).  
 Allow Natural Death (AND) - Do Not Attempt Resuscitation.  
 Check One      \*\* Signature of a consenting physician is needed for this section to be valid. If this form is signed by an Authorized Person who is not the Health Care Agent, see additional guidance under III on back of form.

**B**      **MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.**  
 Check One       Comfort Measures. Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment.  
 Limited Additional Interventions. In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. Transfer to hospital if indicated. Generally avoid intensive care unit.  
 Full Treatment. In addition to treatment and care described above, use intubation, mechanical ventilation, and cardiopulmonary resuscitation as indicated. Transfer to hospital and/or intensive care unit if indicated. Additional Orders (e.g. dialysis): \_\_\_\_\_

**C**      **ANTIBIOTICS**  
 Check One       No antibiotics. Use other measures to relieve symptoms.  
 Determine use or limitation of antibiotics when infection occurs.  
 Use antibiotics if life can be prolonged.  
 Additional Orders: \_\_\_\_\_

**D**      **ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS**  
 Check One      **Where indicated, always offer food or fluids by mouth if feasible**  
 In Each       No artificial nutrition by tube.       No IV fluids.  
 Column       Trial period of artificial nutrition by tube.       Trial period of IV fluids.  
 Long-term artificial nutrition by tube.       Long-term IV fluids.  
 Additional Orders: \_\_\_\_\_

**DISCUSSION AND SIGNATURES**

The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name: _____	Physician Signature: _____	Date: _____
License No.: _____ State: _____		Phone: _____
Concurring Physician Name (if needed, see III. on back of form): _____	Concurring Physician Signature (if needed): _____	Date: _____
License No.: _____ State: _____		Phone: _____
Patient or Authorized Person Name: _____ **Authorized person may NOT sign if patient has decision-making capacity.	Patient or Authorized Person Signature: _____	Date: _____
		Phone: _____

Relationship to Patient (check all that apply):  
 Self     Health Care Agent     Spouse     Court-Appointed Guardian     Son or Daughter     Parent     Brother or Sister

Must be signed by the patient, a Healthcare Agent, or patient's LNOK.

Must be signed by 2 physicians if the patient is unable or a Healthcare Agent is not appointed.

# Advance Directive

Region: Southeast	Market Entry: All Newcent Medical Group	Dept: Palliative Care
Open Date: 07/02/2018	Effective Date: 07/02/2018	

**A102 Advanced Directive for Healthcare**  
 GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

By: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 (Print Name) (Month/Day/Year)

**PART ONE**      **HEALTH CARE AGENT** This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and disposition of your body. You should talk to your health care agent about this important role.

**PART TWO**      **HEALTH CARE TREATMENT PREFERENCES** This part allows you to state your health care treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your health care treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your health care treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

**PART THREE**      **GUARDIANSHIP** This part allows you to nominate a person to be your guardian should one ever be needed.

**PART FOUR**      **EFFECTIVENESS AND SIGNATURES** This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care or health care proxies may be used in Georgia.



- Part One – Health Care Agent
- Part Two – Health Care Tx Preferences
- Part Three – Guardianship
- Part Four – Effectiveness & Signatures

Advance Care Planning Documents are NOT:



Not to be used as a DNR order and should not be instituted in emergency situations without communicating with decision makers

Questions



**Palliative Care**

## References

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\*All images were created using the paid version of Chat GPT

## Appendix B: Pocket Information Sheet

### ***Advancing Palliative Care Competency Through an Evidence-Based Educational Intervention for Healthcare Providers***

#### **POCKET INFORMATION SHEET**

##### **Withholding & Withdrawing Care - Key Reminders**

###### Confirm Before Withdrawal:

- Resuscitation Status (Status III - Care & Comfort)
- ICD defibrillator deactivated (NOT pacemaker)
  - Notify organ donor agency if indicated
- Notify interdisciplinary team: RT, chaplain, palliative, consultants

###### Medication & Monitoring:

- Wean pain/sedation drips - maintain comfort
- Continue seizure prophylaxis & steroids unless palliative says otherwise
- Discontinue tube feeds  $\geq$ 12-24 hrs. before withdrawal
  - Stop insulin after tube feeds stopped
- Discontinue diagnostic tests, imaging, IM injections
- Discontinue vasoactives before extubation

###### Equipment:

- Remove non-essentials: SCDs, NGT, pumps, telemetry
- Elevate arms PRN for edema

##### **Comfort Measures & Family Support**

###### Family & Environment:

- Lower bed rails
- Support cultural practices
- Honor requests: music, personal items, time alone
  - HOB 30-45 degrees as tolerated
  - Offer pastoral support
- Set bedside monitor to comfort mode

###### Respiratory:

- Oxygen only per family/clinician request
- Ensure paralytics/anesthetics off before extubation
- Document TOF & spontaneous respirations if possible
- Suction lungs & mouth before ETT removal

###### General Comfort:

- Frequent mouth care

## Appendix C: Palliative Care Tip Sheet

### *Advancing Palliative Care Competency Through an Evidence-Based Educational Intervention for Healthcare Providers*

#### PALLIATIVE CARE TIP SHEET

#### Who to consult?

*Clinician: Must be placed by a physician/advanced practice provider (NP/PA)*

- Manage pain/symptoms - provide prognostication- educate on complex disease
- Evaluate for hospice - withdrawal of life support/actively dying

*Counselor: can be placed by nurse “inpatient consult to counselor” without MD order*

- Discuss goals of care/quality of life - resolve conflict/identify decision maker
- Assist with coping /difficult health decision - provide hospice education
- Complete Advance Directive/POLST - assist ordering MD with code status change

#### Contact us

- Counselors: Monday-Friday 0800-1630 (main office ENTER PHONE NUMBER)
- Clinicians: available 24/7 for symptom management and/or questions for patient already being followed by Palliative Care
- Use “on-call finder” in EPIC to identify who is on-call over nights/weekends

#### Resuscitation Status Options

- Full Code: no restrictions to care
- DNAR/Total SOTO: total scope of treatment options with only restriction being no CPR (no ACLS protocol)
- DNAR/Limited SOTO: limited scope of treatment automatically includes no CPR and no intubation but may include other restrictions to care. “Hover to Discover” over the code status in EPIC to identify any other restrictions

#### Symptom management (personalized to patient needs)

- Pain: includes medication and non-pharmacological options; including long- and short-acting opioids. **DO NOT CRUSH** long-acting opioid! Please reach out to Palliative clinician if pain not well controlled
- Dyspnea: continue scheduled breathing treatments (nurses may need to relay this to RRT), provide supplemental O2 for comfort as needed
- Secretions: scopolamine patch, IV Robinul, set up suction at bedside as needed
- Seizures, agitation/restlessness: **DO NOT HOLD ANTIPILEPTICS!** If patient cannot swallow, ask Palliative clinician to change to IV management. Provide PRN meds for agitation, encourage family visitation and provide frequent reorientation
- GI symptoms: nausea/vomiting, diarrhea/constipation, GI bleed are all treated for comfort, continue H2 inhibitors, PPIs, dulcolax, etc

#### Other End-of-Life considerations

- Obtain vitals once per shift to assess for hemodynamic stability of patients for potential transfer to Palliative Care Unit or inpatient hospice
- Continue to turn patients, provide daily baths, and provide frequent mouth care to prevent dry oral mucosa
- “Comfort Feeds” are continued for appropriate patients, tube feeding and TPN are **NOT CONTINUED**
- Offer the family “The Final Journey” booklet to help set expectations for patient’s last days
- Any patient that has transitioned to DNAR/comfort should have a Palliative counselor and clinician consult, please ADVOCATE

## Appendix D: Educational Pretest

### Pretest: Advancing Palliative Care Competency Through an Evidence-Based Educational Intervention for Healthcare Providers

1. *Purpose*: This questionnaire aims to assess your current knowledge level.
2. *Confidentiality*: Your responses will be kept confidential and anonymous.
3. *Time*: The questionnaire should take approximately 10 minutes to complete.
4. *Identification Number*: Please place a six-digit identification number on this test that you will remember as you will need to use it again following the presentation. Do not use consecutive numbers. Use a unique string of numbers (e.g., 357834). Only place the number on the test – not your name or any other personal information.  
**Six Digit Identification Number:** \_\_\_\_\_
5. *Directions*: Please select the correct response to each of the following items by circling your selection. There is only one correct response for each item.
  1. What is the primary goal of palliative care?
    - A. Cure the underlying disease
    - B. Extend life at all costs
    - C. Relieve suffering and improve quality of life
    - D. Provide financial assistance
  2. Which of the following is NOT a core component of palliative care?
    - A. Pain and symptom management
    - B. Psychological and spiritual support
    - C. Coordination of care
    - D. Ensuring the patient is DNR
  3. Which of the following patients would be appropriate for a Palliative consult:
    - A. A 45-year-old patient with a right hip fracture following an automobile accident that will require home care
    - B. A 78-year-old patient with recurring admissions for heart failure exacerbation failing recommended treatment
    - C. A healthy 80-year-old patient admitted for acute cholecystitis and surgical intervention and subsequent home care
    - D. A 63-year-old patient with admitted for an acute GI bleed

4. According to the WHO pain ladder, which medication is used for moderate to severe pain?
  - A. Ibuprofen
  - B. Paracetamol
  - C. Morphine
  - D. Prednisone
  
5. Which ethical principle supports a patient's right to make their own healthcare decisions?
  - A. Beneficence
  - B. Nonmaleficence
  - C. Autonomy
  - D. Justice
  
6. What is the most reliable indicator of pain in a patient who can communicate?
  - A. Changes in vital signs
  - B. Family member's report
  - C. Behavioral signs
  - D. Patient's self-report
  
7. In palliative care, a patient-centered approach means:
  - A. Reducing healthcare costs
  - B. Aligning care with patient values
  - C. Prioritizing team efficiency
  - D. Treating disease pathology first
  
8. Which of the following is a common side effect of opioid use in palliative care?
  - A. Diarrhea
  - B. Hypertension
  - C. Constipation
  - D. Insomnia
  
9. When should palliative care ideally begin?
  - A. Only in the final days of life
  - B. After all curative treatments fail
  - C. At the time of diagnosis of a serious illness
  - D. Only in hospice settings
  
10. Which communication technique demonstrates active listening?
  - A. Using medical jargon
  - B. Nodding and paraphrasing
  - C. Asking only yes/no questions
  - D. Redirecting emotional topics

11. What is the most important factor in titrating morphine for pain control?
  - A. Respiratory rate
  - B. Strength of the pill
  - C. Pain relief
  - D. Regulatory limits
  
12. In a family meeting about a patient with an advanced disease, what is MOST important to do?
  - A. Reassure the family everything is going to be okay
  - B. Repeat and summarize the plan for care
  - C. Avoid providing prognosis
  - D. Speak using medical terminology
  
13. A family meeting in palliative care is primarily intended to:
  - A. Update on billing and insurance issues related to patient admission
  - B. Clarify prognosis, goals of care, and care preferences
  - C. Schedule follow-up appointments to meet family convenience
  - D. Teach complex medical procedures needed for care
  
14. Spiritual care in palliative practice aims to:
  - A. Convert patients to a specific faith based on organizational values
  - B. Ensure patients receive religious sacraments
  - C. Support patients in finding meaning, hope, and connection
  - D. Diagnose psychiatric disorders

## Appendix E: Educational Posttest

### Posttest: Advancing Palliative Care Competency Through an Evidence-Based Educational Intervention for Healthcare Providers

1. *Purpose*: This questionnaire aims to assess your current knowledge level.
2. *Confidentiality*: Your responses will be kept confidential and anonymous.
3. *Time*: The questionnaire should take approximately 10 minutes to complete.
4. *Identification Number*: Use your six-digit identification number created during pre-test as your identification– not your name or any other personal information.  
**Six Digit Identification Number:** \_\_\_\_\_
5. *Directions*: Please select the correct response to each of the following items by circling your selection. There is only one correct response for each item.
  1. What is the primary goal of palliative care?
    - A. Cure the underlying disease
    - B. Extend life at all costs
    - C. Relieve suffering and improve quality of life
    - D. Provide financial assistance
  2. Which of the following is NOT a core component of palliative care?
    - A. Pain and symptom management
    - B. Psychological and spiritual support
    - C. Coordination of care
    - D. Ensuring the patient is DNR
  3. Which of the following patients would be appropriate for a Palliative consult:
    - A. A 45-year-old patient with a right hip fracture following an automobile accident that will require home care
    - B. A 78-year-old patient with recurring admissions for heart failure exacerbation failing recommended treatment
    - C. A healthy 80-year-old patient admitted for acute cholecystitis and surgical intervention and subsequent home care
    - D. A 63-year-old patient with admitted for an acute GI bleed
  4. According to the WHO pain ladder, which medication is used for moderate to severe pain?
    - A. Ibuprofen
    - B. Paracetamol
    - C. Morphine
    - D. Prednisone

5. Which ethical principle supports a patient's right to make their own healthcare decisions?
  - A. Beneficence
  - B. Nonmaleficence
  - C. Autonomy
  - D. Justice
  
6. What is the most reliable indicator of pain in a patient who can communicate?
  - A. Changes in vital signs
  - B. Family member's report
  - C. Behavioral signs
  - D. Patient's self-report
  
7. In palliative care, a patient-centered approach means:
  - A. Reducing healthcare costs
  - B. Aligning care with patient values
  - C. Prioritizing team efficiency
  - D. Treating disease pathology first
  
8. Which of the following is a common side effect of opioid use in palliative care?
  - A. Diarrhea
  - B. Hypertension
  - C. Constipation
  - D. Insomnia
  
9. When should palliative care ideally begin?
  - A. Only in the final days of life
  - B. After all curative treatments fail
  - C. At the time of diagnosis of a serious illness
  - D. Only in hospice settings
  
10. Which communication technique demonstrates active listening?
  - A. Using medical jargon
  - B. Nodding and paraphrasing
  - C. Asking only yes/no questions
  - D. Redirecting emotional topics
  
11. What is the most important factor in titrating morphine for pain control?
  - A. Respiratory rate
  - B. Strength of the pill
  - C. Pain relief
  - D. Regulatory limits

12. In a family meeting about a patient with an advanced disease, what is MOST important to do?
- A. Reassure the family everything is going to be okay
  - B. Repeat and summarize the plan for care
  - C. Avoid providing prognosis
  - D. Speak using medical terminology
13. A family meeting in palliative care is primarily intended to:
- A. Update on billing and insurance issues related to patient admission
  - B. Clarify prognosis, goals of care, and care preferences
  - C. Schedule follow-up appointments to meet family convenience
  - D. Teach complex medical procedures needed for care
14. Spiritual care in palliative practice aims to:
- A. Convert patients to a specific faith based on organizational values
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  - C. Support patients in finding meaning, hope, and connection
  - D. Diagnose psychiatric disorders

## Appendix F: Educational Evaluation Form

### Advancing Palliative Care Competency Through an Evidence-Based Educational Intervention for Healthcare Providers Program Evaluation

Your responses and comments will help improve future educational programs. Please circle your rating on each item below:

**Strongly Disagree (SD), Disagree (D), Undecided (U), Agree (A), Strongly Agree (SA)**

Criteria	SA	A	U	D	SD
1. Program objectives were clearly defined.	5	4	3	2	1
2. All of the program objectives were met.	5	4	3	2	1
3. The materials were the right level of complexity for my background.	5	4	3	2	1
4. The course materials helped to support the program objectives.	5	4	3	2	1
5. The content was relevant to my needs.	5	4	3	2	1
6. The content and presentation were engaging.	5	4	3	2	1
7. The presentation structure was clear and logical.	5	4	3	2	1
8. The facilitator made the subject understandable.	5	4	3	2	1
9. The presentation slides were clear.	5	4	3	2	1
10. The program content was presented clearly.	5	4	3	2	1
11. The time allowed for this program was right.	5	4	3	2	1
12. The setting was conducive to my learning.	5	4	3	2	1

Please complete the following:

1. To what extent will the content included in this presentation impact your practice?
  - a. Very strongly impact my practice
  - b. Strongly impact my practice
  - c. Moderately impact my practice
  - d. Somewhat impact my practice
  - e. Will not impact my practice
  
2. State one action you will integrate within your practice in the next month:
  
3. Please rate your knowledge of palliative care prior to completing this session:
  - a. Extremely knowledgeable
  - b. Very knowledgeable
  - c. Moderately knowledgeable
  - d. Somewhat knowledgeable
  - e. Not at all knowledgeable
  
4. Please rate your knowledge of palliative care after to completing this session:
  - a. Extremely knowledgeable
  - b. Very knowledgeable
  - c. Moderately knowledgeable
  - d. Somewhat knowledgeable
  - e. Not at all knowledgeable

Thank you for completing this questionnaire. It will assist future education on palliative care.