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Integrating Early Palliative Care for Patients with Heart Failure

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Leigh Hinson

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Walden University

2026

Executive Summary: Staff Education Project
Integrating Early Palliative Care for Patients with Heart Failure

by

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MS, Walden University, 2022

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Executive Summary Submitted in Partial Fulfillment
of the Requirements for the Degree of
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Summary

Heart failure (HF) is a leading cause of hospital readmissions. At the project site, early palliative care was inconsistently integrated despite strong evidence of benefit, suggesting that limited staff knowledge, lack of standardized referral processes, and uncertainty regarding referral timing contributed to this practice gap. The guiding practice-focused question was, Does educating staff on early palliative care integration for HF patients improve knowledge as measured by pre- and post-education surveys? The Johns Hopkins evidence-based practice (JHEBP) model and the ADDIE instructional design model guided project development and implementation. A comprehensive literature search was conducted using MEDLINE/PubMed, CINAHL Complete, ProQuest, and the Cochrane Library. Of 30 sources identified, 11 high-quality research and non-research articles informed project design. Expert consensus statements and clinical guidelines supported development of an educational intervention focused on early palliative care principles, referral criteria, and interdisciplinary collaboration. The intervention consisted of two structured, in-person educational sessions for 12 participants including cardiology and interdisciplinary palliative care staff, supported by a PowerPoint presentation and pre- and post-education surveys. Results demonstrated a significant improvement in staff knowledge and confidence related to early palliative care integration, with mean scores increasing by 39.99%. This project is significant to nursing practice by strengthening nurses' knowledge and confidence in early palliative care, supporting timely symptom management, effective care coordination, and improved care transitions for patients with HF.

Background

HF is a chronic, progressive condition associated with significant symptom burden, frequent hospitalizations, and increased mortality. In the United States, HF remains a leading cause of hospital admissions and 30-day readmissions, placing substantial strain on patients, families, and healthcare systems (Heidenreich et al., 2022). Despite advances in guideline-directed medical therapy (GDMT), many individuals continue to experience persistent symptoms, reduced quality of life, and recurrent healthcare utilization.

At the project site, HF readmissions were recognized as a persistent and potentially preventable challenge, often driven by suboptimal symptom management, limited care coordination, insufficient advance care planning, and gaps in post discharge support. Evidence demonstrates that early integration of palliative care can address these contributors by improving symptom control, supporting shared decision-making, and strengthening interdisciplinary communication across the heart failure disease trajectory (Chuzi et al., 2023; Wong et al., 2020). However, palliative care in HF is frequently underutilized or misperceived as end-of-life care rather than a complementary approach delivered alongside disease-directed therapies, highlighting the need for targeted staff education and practice change at the site.

National guidelines emphasize early incorporation of palliative care into HF management. The American Heart Association (AHA), American College of Cardiology (ACC), and Heart Failure Society of America (HFSA) recommend integrating palliative and supportive care to improve quality of life, align treatment with patient goals, and

reduce unnecessary healthcare utilization (Heidenreich et al., 2022). The HFSA further highlights the importance of developing primary palliative care competencies and standardized referral processes to ensure timely consultation (Chuzi et al., 2023). The practice-focused question guiding this evidence-based project was “Does educating staff on early palliative care integration for patients with heart failure improve knowledge, as measured by pre- and post-education surveys?”

Staff Education Project Development

This Doctor of Nursing Practice (DNP) staff education project employed the ADDIE instructional design model, which includes analysis, design, development, implementation, and evaluation, in conjunction with the JHEBP model to guide systematic project development and implementation (Zardosht et al., 2022). The project followed the structured timeline outlined in the Walden University DNP Project Process Guide and the Walden University Staff Education Manual, ensuring methodological rigor and alignment with academic and institutional standards (Walden University, 2022). This structured approach supported the translation of evidence into clinically relevant educational content designed to address identified knowledge gaps and improve staff readiness to initiate early palliative care referrals in HF management.

Analysis

This DNP educational project began with identification of a practice gap related to inconsistent integration of early palliative care for patients with HF. A focused practice question was developed using the JHEBP model to guide evidence review and project design. With support from a Walden University librarian, a comprehensive literature

search was conducted using MEDLINE/PubMed, CINAHL Complete/EBSCO, ProQuest, and the Cochrane Library. Search terms included *heart failure, palliative care, early palliative care integration, symptom management, interdisciplinary care, and hospital readmissions*. Of 30 relevant articles identified, 11 were selected for rigorous appraisal using JHEBP research and non-research tools. Evidence spanning Levels I–V consistently supported early palliative care integration as an effective strategy to improve symptom management, enhance patient-centered care, and reduce hospital readmissions.

The synthesized evidence informed the development of a targeted staff education intervention to improve staff knowledge, confidence, and readiness to identify eligible patients and initiate early palliative care referrals. Organizational readiness was assessed using the JHEBP Organizational Readiness Tool, along with SWOT and stakeholder analyses. Findings confirm leadership support, resource availability, and interdisciplinary engagement, supporting the feasibility and appropriateness of implementing the educational intervention

Design and Development

The design and development phases of this DNP project were guided by synthesized findings from the JHEBP model, including the Individual Evidence Summary, SWOT analysis, Organizational Readiness Tool, and stakeholder analysis. Using the JHEBP Translation and Action Planning Tool, the project progressed systematically from evidence synthesis to development of a targeted staff education intervention addressing identified knowledge gaps related to early palliative care integration for patients with heart failure.

Evidence appraisal identified content areas with strong empirical support for improving staff knowledge and readiness regarding early palliative care referral, symptom management, goals-of-care discussions, and interdisciplinary collaboration in heart failure care (Dang et al., 2021). Following DNP committee approval, the educational content, implementation strategy, and evaluation plan were developed. Baseline assessment and evidence synthesis informed development of pre- and post-intervention survey instruments (Appendix A) and an evidence-based educational PowerPoint presentation (Appendix B). Instrument reliability and content validity were supported through alignment with the JHEBP Individual Evidence Summary and adherence to clinical site policies.

Two content experts reviewed the educational materials to ensure quality and clinical relevance. A nurse educator with more than 10 years of experience in curriculum development and evidence-based practice provided instructional design and content validation, while an advanced practice nurse with over 7 years of cardiovascular experience contributed clinical insight into HF and palliative care integration. Both experts completed structured evaluation forms (Appendix C), confirming clarity, relevance, and effectiveness of the materials. Stakeholder feedback was incorporated prior to implementation. An action plan kickoff meeting was subsequently held with the faculty advisor and preceptor to review and align on next steps.

Implementation

Prior to implementation, completion of the Walden University ethics pledge was verified in accordance with institutional requirements. This DNP staff education project

on early palliative care integration for patients with heart failure was implemented following approval from the Walden University DNP committee, faculty advisor, and project site preceptor. To accommodate staff schedules, two in-person educational sessions were offered within one week. There were 12 participants, one physician, four nurse practitioners, and seven registered nurses. Participation was voluntary and confidential, with no impact on employment status. Staff were informed that no personal identifiers would be collected. The staff education sessions were held in at the palliative care center. Sessions took place on December 11th and December 12th, 2025, during lunch hours with lunch provided to maximize attendance.

Pre- and post-intervention surveys were administered on paper, with the initial page providing consent and participation instructions. Participants were assigned unique three-character identifiers to ensure anonymity while allowing pre- and post-survey comparison. The pre-intervention survey consisted of 10 multiple-choice questions assessing baseline knowledge of early palliative care principles, referral timing, and integration into heart failure care. Following the pretest, participants reviewed an evidence-based PowerPoint presentation. The post-intervention survey contained the same 10 questions, enabling direct comparison to evaluate the effectiveness of the educational intervention.

Evaluation

The final phase of the ADDIE model, evaluation, focused on assessing the effectiveness of the staff education intervention and disseminating project findings in accordance with the Walden University DNP Project Process Guide (Walden University,

2022). The evaluation of the educational intervention employed a pre- and post-survey design to assess changes in staff knowledge regarding early palliative care integration for patients with heart failure.

Data analysis utilized a data analysis chart to calculate percentage changes and mean score differences between pre- and post-intervention results. Descriptive statistics summarized correct responses for each survey item before and after the intervention. IBM SPSS Statistics (Version 24) was used to calculate means and standard deviations for total pretest and post test scores. A paired *t* test was conducted to determine statistical significance and evaluate the effectiveness of the intervention by comparing overall knowledge scores before and after the intervention.

Results

Content Experts

The results of the staff education project demonstrated a measurable improvement in nursing knowledge following implementation of the educational intervention. Content expert evaluations confirmed that the educational materials were clear, relevant, and appropriate for supporting early palliative care integration in heart failure management. Reviewers identified referral criteria and workflow integration as key strengths and recommended incorporating brief visual aids, real-world clinical examples, and enhanced emphasis on interdisciplinary communication. All recommendations were incorporated prior to implementation.

Pre- and Post-Survey

Table 1 and Figure 1 illustrate a clear and clinically meaningful improvement in

participant knowledge following the educational intervention. Prior to the intervention, the mean pre-test score was 6.8 correct responses ($SD = 1.40$), corresponding to 56.67%, indicating moderate baseline knowledge with notable variability among participants. This variability suggests inconsistent understanding of palliative care concepts across disciplines and roles within the care team.

Item-level analysis of pre-test responses revealed that participants more consistently answered questions related to the general definition of palliative care and its ability to be provided concurrently with disease-directed therapy. These findings suggest that staff possessed foundational awareness of palliative care as a concept. However, questions addressing the appropriate timing of palliative care referral in heart failure and core components of palliative care beyond end-of-life care including symptom management, interdisciplinary collaboration, and integration of goals-of-care discussions were answered correctly less frequently. These results highlight gaps in applying palliative care principles operationally within routine heart-failure management rather than a lack of basic familiarity.

Following the educational intervention, the mean post-test score increased substantially to 11.6 correct responses ($SD = 0.49$), representing 96.68%, with markedly reduced variability among participants. This reduction in score dispersion reflects not only improved knowledge acquisition but also greater consistency in understanding across the interdisciplinary team. The most pronounced post-intervention gains were observed in questions related to early referral timing and identification of appropriate candidates for palliative care, indicating that the educational content effectively targeted

and corrected the most clinically relevant misconceptions. Overall, the 39.99% absolute increase in mean correct responses demonstrates a substantial improvement in staff knowledge.

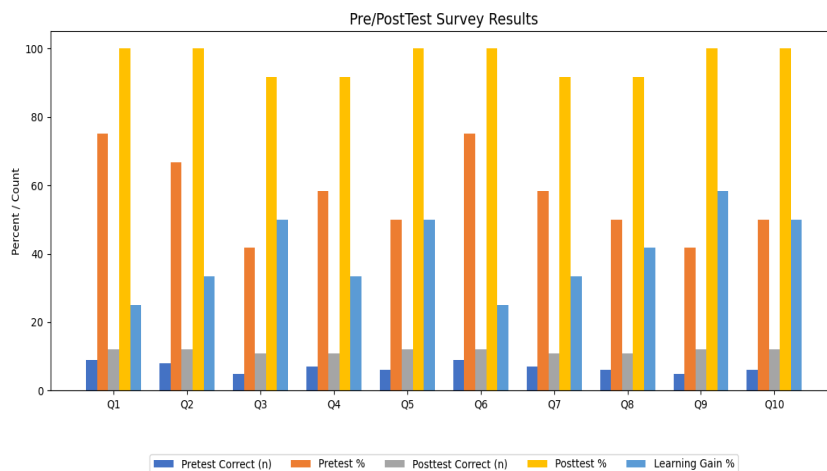
Table 1

Number and Percentage of Correct Responses Before and After the Educational Intervention

Item No.	Question Description	Presurvey (n = 12) No. Correct	Presurvey % Correct	Postsurvey (n = 12) No. Correct	Postsurvey % Correct	% Change
1	What is the primary goal of palliative care in heart failure management?	9	75.0	12	100.0	25.0
2	When should palliative care be introduced for patients with heart failure?	8	66.7	12	100.0	33.3
3	What is one major factor contributing to 30-day readmissions among heart failure patients?	5	41.7	11	91.7	50.0
4	Which of the following best describes interprofessional collaboration in palliative care?	7	58.3	11	91.7	33.3
5	What is the most effective way to ensure patient understanding during education?	6	50.0	12	100.0	50.0
6	Which of the following is a measurable outcome of effective palliative integration in heart failure?	9	75.0	12	100.0	25.0
7	What should staff emphasize when educating patients and families about palliative care?	7	58.3	11	91.7	33.3
8	What is the role of the nurse in palliative care integration for heart failure?	6	50.0	11	91.7	41.7
9	What target blood pressure and LDL level are generally recommended for secondary prevention in heart failure patients?	5	41.7	12	100.0	58.3
10	Which outcome best demonstrates the success of palliative care education for staff?	6	50.0	12	100.0	50.0
Mean			56.72%		96.68%	39.99%

Figure 1

Changes in Correct Answers from Pretest to Posttest



Note. Pretest Score (Mean %): 56.72%, Posttest Score (Mean %): 96.68%, Learning Gain (Mean %): 39.99%

Paired *t* Test

Statistical analysis using a paired *t* test confirmed that the observed improvement in post-intervention scores was statistically significant, $t(9) = 10.84$, $p < .0001$ (Table 2). This finding demonstrates a strong effect of the educational intervention on staff knowledge, with improvements observed consistently among participants. The magnitude of change suggests not only knowledge acquisition but also greater clarity and confidence in applying early palliative care principles within clinical practice. Collectively, these findings indicate that the educational intervention was highly effective in enhancing staff knowledge, particularly in domains essential to the successful integration of early palliative care into HF management.

Table 2*Paired t Test Results Comparing Pretest and Posttest Knowledge Scores*

Measure	M	SD	T	df	Sig. (2-tailed)
Knowledge score difference	4.8	1.40	10.84	9	< .0001

Strengths and Limitations

The findings of this DNP project indicate that a targeted staff education intervention significantly improved medical staff knowledge related to early palliative care integration for patients with HF. Enhanced knowledge supports more proactive, patient-centered care through improved understanding of palliative care principles, appropriate referral timing, symptom management, and interdisciplinary collaboration, with the potential to reduce preventable 30-day hospitalizations.

Several limitations should be acknowledged. The project involved a small sample size and utilized a pretest–posttest design without a control group, limiting generalizability and statistical power. Additionally, the evaluation focused on short-term knowledge gains rather than long-term knowledge retention, practice change, or direct patient outcomes. Future initiatives should evaluate sustained referral behaviors, clinical outcomes, and patient-reported quality-of-life measures.

To build on these findings, the organization may consider periodic refresher education to reinforce learning and maintain alignment with evolving HF and palliative care guidelines. The development of asynchronous education modules could improve accessibility, support staff onboarding, and integrate content into ongoing professional development. Sustaining these efforts will require leadership support, adequate resources,

and continued prioritization of education as a key quality improvement strategy.

Conclusions

The findings of this DNP project underscore the importance of staff education in supporting early palliative care integration for patients with heart failure, as evidenced by a statistically significant improvement in staff knowledge following the educational intervention. Enhanced knowledge improves staff ability to identify appropriate patients, collaborate effectively across disciplines, and support goal-concordant, patient-centered care throughout the HF trajectory. Improved staff preparedness can enhance patient outcomes through timely symptom management, smoother care transitions, and reduced preventable 30-day readmissions. Integrating palliative care education into cardiology practice supports both clinical and financial outcomes while promoting patient-centered, equitable care through earlier identification of palliative needs in individuals with HF.

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Appendix A: Staff Education PowerPoint

HEART FAILURE MANAGEMENT: PREVENTING 30-DAY READMISSIONS

Staff Education Session

LEARNING OBJECTIVES

• Identify common reasons for 30-day readmissions in heart failure.

• Apply evidence-based interventions to prevent readmissions.

• Educate patients and families on daily self-management.

• Coordinate multidisciplinary follow-up and discharge planning.

• Promote continuity of care across all settings.

UNDERSTANDING HEART FAILURE



- Heart failure occurs when the heart cannot pump effectively to meet the body's needs.



- Types: HFrEF – weakened heart muscle. HFpEF – heart muscles is preserved



- Causes: CAD, hypertension, valve disease, arrhythmias.



- Symptoms: dyspnea, fatigue, swelling, weight gain.

WHY READMISSIONS OCCUR

- Lack of understanding about HF and discharge instructions.

- Missed medications or dose errors.

- Excess sodium or fluid intake.

- Missed follow-up appointments.

- Inadequate discharge planning or care coordination.

- Uncontrolled comorbidities (diabetes, COPD, CKD).

DISCHARGE PLANNING ESSENTIALS



- Begin discharge education on admission.



- Review heart failure action plan daily.



- Ensure understanding of medications and follow-up schedule.

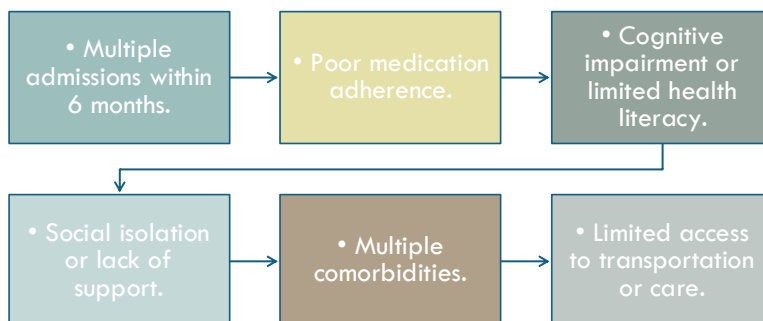


- Confirm prescriptions are filled before discharge.



- Schedule follow-up visit within 7 days.

EARLY IDENTIFICATION OF HIGH -RISK PATIENTS



MEDICATION ADHERENCE STRATEGIES



- Simplify medication regimens.



- Use pill organizers, alarms, or blister packs.



- Explain medication purpose and side effects clearly.



- Avoid harmful interactions (e.g., NSAIDs).



- Reinforce adherence at every encounter.



- Limit sodium intake to ≤ 2 grams/day.



- Avoid canned or processed foods.



- Restrict fluids to 1.5–2 L/day if ordered.



- Teach label reading and meal planning.



- Encourage daily weights to detect retention early.

SODIUM & FLUID MANAGEMENT



• Call early for:



- Weight gain >2 lbs./day or >5 lbs./week.



- Swelling in feet, legs, or abdomen.



- Shortness of breath or new fatigue.



- Persistent cough or dizziness.

RECOGNIZING EARLY WARNING SIGNS

FOLLOW-UP & TRANSITIONAL CARE



• SCHEDULE FOLLOW-UP WITHIN 7 DAYS POST-DISCHARGE.



• FOLLOW-UP CALLS WITHIN 48-72 HOURS.



• USE TELEHEALTH FOR REMOTE MONITORING.



• REFER TO HOME HEALTH WHEN NEEDED.

DAILY SELF - MONITORING



- Weigh daily, same time, same scale.



- Track results in a log or app.

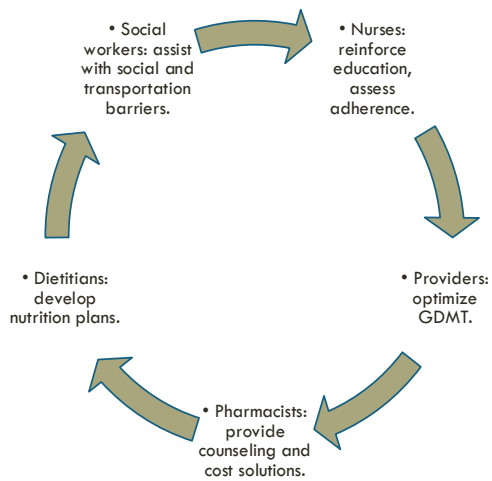


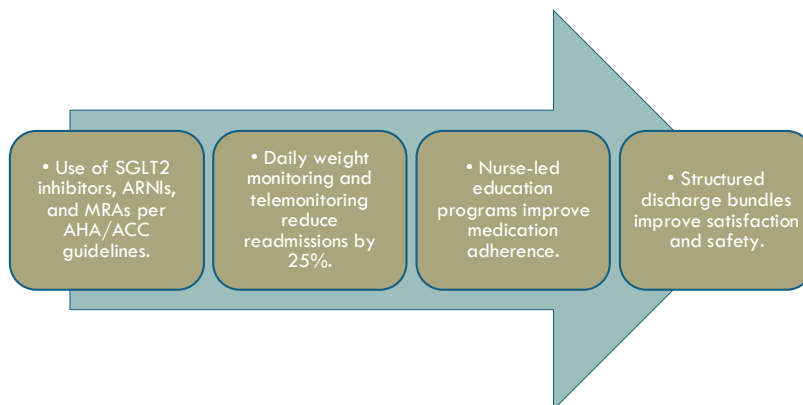
- Monitor blood pressure and heart rate if able.



- Maintain an emergency contact plan.

INTERPROFESSIONAL COLLABORATION





EVIDENCE -BASED PRACTICES



- Include families in teaching and discharge planning.



- Use teach-back to confirm understanding.



- Provide written action plans and phone numbers.



- Encourage shared decision-making about care goals.

PATIENT & FAMILY ENGAGEMENT

WHY INTEGRATE PALLIATIVE CARE?

- Heart failure is chronic and progressive — patients often experience repeated hospitalizations.

- Palliative care helps manage symptoms, clarify goals, and support decision-making.

- Early involvement promotes continuity, reduces crisis admissions, and supports families.

KEY BENEFITS OF PALLIATIVE CARE IN HEART FAILURE



- Improved symptom control (dyspnea, fatigue, anxiety).



- Enhanced communication about care goals and prognosis.



- Increased medication adherence and care coordination.



- Reduced emergency visits and unplanned readmissions.

EARLY PALLIATIVE CARE TRIGGERS



- Frequent readmissions (≥ 2 in 6 months).



- NYHA Class III or IV heart failure.



- Persistent symptoms despite optimal treatment.



- Complex psychosocial or family needs.



- Uncertainty about goals of care or treatment burden.

HOW PALLIATIVE CARE SUPPORTS DISCHARGE PLANNING

- Joint patient and family education sessions.

- Review of medication and symptom management plans.

- Assistance with advance care planning and POLST forms.

- Emotional and social support resources after discharge.

COLLABORATION BETWEEN CARDIOLOGY & PALLIATIVE CARE TEAMS

- Regular interdisciplinary rounds.
- Shared documentation in EHR for continuity.
- Direct communication between inpatient and outpatient teams.
- Ongoing staff education on palliative principles.



KEY TAKEAWAY: INTEGRATED CARE IMPROVES OUTCOMES AND PREVENTS READMISSION

- Integrating palliative care with HF management improves quality of life.

- Early referral = fewer crises, fewer readmissions, and better support.

- Education, empathy, and teamwork are the foundation of sustainable care.

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Appendix B: Pretest/Posttest Survey

1. What is the primary goal of palliative care in heart failure management?

- A. To replace curative treatment
- B. To provide comfort and improve quality of life
- C. To discontinue cardiac medications
- D. To delay advance care planning discussions

Answer: _____

2. When should palliative care be introduced for patients with heart failure?

- A. Only during hospice care
- B. After all treatment options fail
- C. At any stage of illness, concurrent with standard therapy
- D. Within the last 48 hours of life

Answer: _____

3. What is one major factor contributing to 30-day readmissions among heart failure patients?

- A. Overuse of beta-blockers
- B. Poor symptom management and care coordination
- C. Frequent provider visits
- D. Hospital-acquired infections

Answer: _____

4. Which of the following best describes interprofessional collaboration in palliative care?

- A. Physicians make all patient care decisions
- B. Disciplines work independently to avoid overlap
- C. Healthcare team members communicate regularly and share decision-making
- D. Only the primary nurse provides education to patients

Answer: _____

5. What is the most effective way to ensure patient understanding during education?

- A. Provide lengthy written materials
- B. Use medical terminology frequently
- C. Use the teach-back method and confirm comprehension
- D. Ask if they understand without assessment

Answer: _____

6. Which of the following is a measurable outcome of effective palliative integration in heart failure?

- A. Increased emergency department visits
- B. Decreased 30-day hospital readmissions

- C. Increased medication side effects
- D. Longer hospital stays

Answer: _____

7. What should staff emphasize when educating patients and families about palliative care?

- A. It is only for end-of-life care
- B. It focuses on comfort, support, and symptom management
- C. It replaces the cardiology team
- D. It eliminates the need for home health services

Answer: _____

8. What is the role of the nurse in palliative care integration for heart failure?

- A. Identify eligible patients and coordinate referrals
- B. Avoid discussions about goals of care
- C. Manage only medications without communication
- D. Refer all questions to the physician

Answer: _____

9. What target blood pressure and LDL level are generally recommended for secondary prevention in heart failure patients?

- A. BP <130/80 mmHg and LDL <70 mg/dL
- B. BP <160/90 mmHg and LDL <100 mg/dL
- C. BP <140/90 mmHg and LDL <90 mg/dL
- D. BP <120/60 mmHg and LDL <80 mg/dL

Answer: _____

10. Which outcome best demonstrates the success of palliative care education for staff?

- A. Decreased awareness of care pathways
- B. Improved interdisciplinary communication and early referrals
- C. Fewer patient education sessions
- D. Increased hospice-only referrals

Answer: _____

Appendix C: Content Expert Evaluation

I. Educational Project Overview

This was an educational project designed to improve medical staff knowledge related to early palliative care integration for patients with heart failure, to enhance symptom management, interdisciplinary collaboration, and reducing preventable 30-day hospital readmissions.

a. Describe your feelings about your involvement as a content expert

First Content Expert

My professional confidence in the project's relevance and impact has been further strengthened. The educational content is comprehensive, evidence-based, and directly addresses common gaps in understanding regarding the role and timing of palliative care in heart failure management. The material clearly differentiates palliative care from hospice and emphasizes its value alongside guideline-directed medical therapy.

Second Content Expert

The inclusion of current evidence on heart failure and palliative care, along with practical clinical scenarios, reflects a well-researched and thoughtfully designed educational initiative. As a content expert, I strongly recommend this module because it provides clinically relevant information that can be applied immediately in practice.

b. What aspects of the project do you think require improvement?

First Content Expert

Development of a brief “quick reference” tool or checklist to assist staff in identifying appropriate patients for early palliative care referral would further enhance clinical usability.

Second Content Expert

Identifying a clinical or nursing champion within the cardiology clinic to promote ongoing discussion and reinforcement of early palliative care principles would support sustainability.

II. Pre-/Post-Test Evaluation

a. Were the pre- and post-tests relevant to the content taught?

First Content Expert

Yes. The pre- and post-test questions were directly aligned with the educational content. They effectively measured knowledge related to palliative care principles, referral timing, interdisciplinary roles, and outcomes in heart failure care.

Second Content Expert

The strong alignment between the educational module and the assessment questions reflects a well-designed evaluation strategy focused on measurable knowledge gains related to early palliative care integration.

b. How might you have changed the project?

First Content Expert

While the project effectively measures immediate knowledge gains, discussing strategies to sustain knowledge over time or to reinforce early palliative care integration within routine workflows would strengthen the project's long-term impact.

Second Content Expert

The clinical case scenarios effectively supported the application of knowledge. Adding a brief post-survey item assessing staff confidence or intent to apply palliative care principles in daily practice (e.g., initiating goals-of-care discussions or referrals) could further strengthen evaluation of practice readiness.

III. Role of the Student as a Team Leader**a. Was the student effective in directing the team and meeting the organization's objectives?****First Content Expert**

Yes. The student demonstrated strong leadership by coordinating effectively with interdisciplinary stakeholders, maintaining open communication, and ensuring that the project remained aligned with organizational priorities for quality improvement and patient-centered care.

Second Content Expert

The students showed initiative and professionalism throughout the project. She maintained clear objectives, adhered to timelines, and encouraged collaboration among team members to support successful project implementation.

IV. Suggestions for Improvement**First Content Expert**

The student effectively articulated how her learning aligned with course objectives and Walden University's emphasis on evidence-based practice and leadership development.

Second Content Expert

While the educational intervention successfully improved knowledge, future efforts could explore strategies to evaluate the translation of knowledge into practice, such as self-reported changes in referral behavior or interdisciplinary communication related to early palliative care integration.