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Palliative Care Integration in the Intensive Care Unit

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This is to certify that the doctoral study by

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Abstract

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by

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MS, The Johns Hopkins University School of Nursing, 1998

BS, Graceland University, 1996

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Palliative health care is offered to any patient experiencing a life limiting or life changing illness. The palliative approach includes goals of care, expert symptom management, and advance care planning in order to reduce patient suffering. Complex care can be provided by palliative care specialists while primary palliative care can be given by educated staff nurses. However, according to the literature, intensive care unit (ICU) nurses have demonstrated a lack of knowledge in the provision of primary care as well as experiencing moral distress from that lack of knowledge. In this doctor of nursing practice staff education project, the problem of ICU nurses' lack of knowledge was addressed. Framed within Rosswurm and Larrabee's model for evidence-based practice, the purpose of this project was to develop an evidence-based staff education plan. The outcomes included a literature review matrix, an educational curriculum plan, and a pretest and posttest of questions based on the evidence in the curriculum plan. A physician and a master's prepared social worker, both certified in palliative care, and a hospital nurse educator served as content experts. They evaluated the curriculum plan using a dichotomous 6-item format and concluded that the items met the intent of the objectives. They also conducted content validation on each of the pretest/posttest items using a Likert-type scale ranging from 1 (*not relevant*) to 4 (*very relevant*). The content validation index was 0.82 indicating that test items were relevant to the educational curriculum objectives. Primary palliative care by educated ICU nurses can result in positive social change by facilitating empowerment of patients and their families in personal goal-directed care and reduction of suffering.

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Dedication

This work is dedicated to my family. First and foremost, I would like to thank my husband, David, and daughter, Rachel, who spent much of their time without me over the past four years while I worked. I would also like to thank my sons, Jeffrey and Ryan, for their continued encouragement and willingness to travel to see me when my schedule was tight.

I would also like to dedicate this work to my mother, Alice. During my doctoral journey, my mother was diagnosed with pancreatic cancer. When I was ready to put my work on hold, my mother encouraged me to continue pushing forward to the point that I worked by her bedside while she underwent chemotherapy and a Whipple procedure. She has been an example to me all of my life and when I started this project, I had no idea how close this work would come to home.

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I would like to acknowledge God without whom I would not have the opportunity or ability to follow my passions and to, hopefully, make a change in this world to his Glory. I would like to thank my family, who has supported me throughout this journey, particularly my husband who was always available to help with computer issues as they arose.

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Section 1: Introduction

Introduction

Palliative care is an approach that health care practitioners use to prevent and relieve suffering of patients and families facing life-threatening illnesses through early identification, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems (World Health Organization, 2015). Palliative care was developed as an expansion of hospice care and has evolved alongside that discipline since the 1960s (Clark, 2007).

While hospice care is delivered in support of patients who are expected to pass away within 6 months, palliative care is a service offered to any person who is experiencing a potentially life-limiting or chronic illness (Aslakson, Randall, & Nelson, 2014; Broglio & Walsh, 2017). Palliative care services in the critical care setting assist patients, families, and staff in understanding the current medical situation, focusing on long-term goals, completing advance directives, managing distressing symptoms, and delivering appropriate care. While evidence-based literature supports integration of palliative care in critical care units, there is often resistance and discomfort expressed by intensive care unit (ICU) staff (Aslakson et al., 2012; Gibbs, Mahon, Truss, & Eyring, 2015; Love & Liversage, 2014; Seaman, 2013). For ICU clinicians trained to support, prolong, and save lives, it is difficult to look away from the monitors and data to see the person in the ICU bed.

With palliative care integration, critical care patients have a shorter ICU length of stay, shorter overall hospital stay, reduced 30-day readmission rate, and increased patient

and family satisfaction scores (Morgan, 2011; Nelson et al., 2013). ICU and hospital length of stay have both shortened in the project site hospital since triggers for palliative care involvement were implemented in the ICU. By delivering care that is patient-centered and individualized, the cost of care is also minimized, saving the health care system unnecessary cost burden (Morgan, 2011; Morrison et al., 2008).

In 2006, the American Board of Medical Specialties recognized Hospice and Palliative Medicine as a subspecialty of medicine, offering certification (American Board of Medical Specialties, 2017). Registered nurses and advance practice nurses can earn specialty certification through an examination offered by the Hospice and Palliative Credentialing Center (2016). However, there remains a shortage of specialist providers, which limits access to palliative care for all critically ill patients (Hua & Wunsch, 2014).

Primary palliative care is a skill that can be taught to staff nurses. In a recent call to action, the American Nurses Association in conjunction with the Hospice and Palliative Nursing Association (HPNA) recommended that primary palliative care components adopted from the End of Life Nursing Education Consortium (ELNEC) be incorporated and taught in nursing curriculums (American Nurses Association, 2016). Along with this recommendation came another supporting incorporation of primary palliative nursing as part of the American Nurses Credentialing Center Magnet Recognition Program and the American Association of Critical Care Nurses Beacon Award for Excellence.

The literature has shown that palliative care can be of value in the ICU. Positive social change can result from integration of the palliative care team into the ICU. This

doctor of nursing practice project falls under The Essentials for Doctoral Education for Advanced Nursing Practice III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice (AACN, 2006). In the project, I used the scholarship of application by designing an evidence-based intervention for quality improvement.

The hospital for which I designed this doctorate of nursing practice (DNP) staff education project is a 185-bed, suburban community hospital on the East Coast of the United States. There are 14 beds in the ICU, which is the only critical care unit in the hospital. The hospital has a palliative care team whose functions are to facilitate goals of care discussions, assist in the completion of advance directives, and aid in the management of distressing symptoms. Palliative care involvement in the ICU is initiated through consultation ordered by either the ICU intensivist physician or advance practice nurse.

As an initial plan to increase involvement of the palliative care team in the ICU at my project site, a trigger-based system was developed to prompt timely consultation of the palliative care team for patients at highest risk of morbidity and mortality. According to the Center to Advance Palliative Care (CAPC), triggers are recommended in the hospital setting because needs of the hospitalized patient are great and diverse (Weismann & Meier, 2011).

Practitioners at the study site collected internal data that showed the need for increased involvement of the palliative care team in the ICU. A retrospective review of 28 randomly selected ICU patients during the fall and winter of 2014 through 2015 showed that over half of the patients who met standard triggers passed away, while the

majority of those who survived experienced permanent debility with tracheostomy and PEG tubes.

Triggers were developed as a result of collaboration between the palliative care and ICU teams. I reviewed the current evidence of recommended triggers for palliative care involvement in critical care areas. Triggers implemented at the project hospital site included (a) out of hospital arrest, (b) 7 day ICU stay, (c) 10 day hospital stay, or (d) 30-day readmission to ICU. After 2 years, palliative care presence has become commonplace in the project site ICU with a decrease in ICU and overall hospital length of stay for those patients with palliative care involvement. However, there remained a gap in the delivery of evidence-based primary palliative care when the specialist team was unavailable.

While the implementation of evidence-based triggers was successful in prompting timely involvement of the palliative care team, there remained a gap in the timing and role of follow-up conversations and care. There was evident confusion and an expectation of the ICU team that the palliative care team would take over the majority of follow-up goals of care conversations. With a shortage of palliative care providers in the project site hospital system and nationwide, it is not possible for specialty palliative care teams to take over every follow up conversation, all symptom management, and all advanced care planning. There is a need to fill these gaps in care by educating ICU staff on the role of primary palliative care versus specialty palliative care.

For those patients who have had extensive conversations and wish to talk further, or for those patients who do not meet triggers, a general practice clinician or bedside nurse can provide basic palliative care interventions. Basic palliative care interventions

are also known as primary palliative care. Primary palliative care includes goals of care conversations, basic symptom management, and advance care planning. While the specialist palliative care team provides these same interventions, specialist team consultations should be reserved for those patients with hard to control symptoms, difficult social situations, and families who are conflicted about goals of care.

ICU team members at my project site have expressed discomfort in providing primary palliative care, which is consistent with what researchers have found in the palliative care literature (Anderson et al., 2016; Autor, Storey, & Ziemba-Davis, 2013; Moir, Roberts, Martz, Perry, & Tivis, 2015; White, Roczen, Coyne, & Wiencek, 2014). As researchers have shown, ICU staff could be trained to facilitate goals of care conversations and provide primary palliative interventions (Grossman, 2013; Mirel & Hartjes, 2013). Thus, I developed an evidence-based staff education program specifically for ICU nurses with a focus on providing primary palliative care to fill the gap between the ANA recommendations and the current lack of provision of primary palliative care by the nursing staff at my project site.

Background

In my review of the literature, I found evidence that supports the integration of palliative care in the ICU setting. According to Hua and Wunsch (2014), palliative care in the ICU is a priority. Walker, Mayo, Camire, and Kearney (2013) reported that collaboration between ICU and palliative medicine is a best practice. O'Mahony et al. (2010) report that palliative care integration into critical care areas is beneficial to families and clinicians.

Palliative care integration allows for more precise focus on a patient's unique goals of care with the alleviation of distressing symptoms. In addition to increased patient and family satisfaction, documented benefits include shorter ICU and hospital length of stays and reduced 30-day readmission rates (Morgan, 2011; Nelson et. al 2013). Further, researchers have reported smoother transitions of care, improved symptom management, and cost savings (Center to Advance Palliative Care, 2015; Morgan, 2011; Morrison et al., 2008). In addition to the immediate needs of symptom management and goals of care, palliative intervention assists in preparing those patients who survive the ICU for life after discharge (Aslakson et al., 2014).

The State of Maryland mandated the presence of a palliative care team in every hospital with over 50 beds by the end of 2016 (Gibbs, Mahon, Truss, & Eyring, 2015). According to a survey distributed by Gibbs et al (2015), over 80% of hospitals responding reported having some sort of multidisciplinary palliative team on site. However, which disciplines were involved and whether these were full-time teams versus part-time staff members were not assessed. The functions of these teams are also not well described or outlined and vary from site to site, although standards are forthcoming by the end of 2017. The confusion and lack of standardization lend to the lack of knowledge of ICU staff regarding provision of primary palliative care tenets.

There are not enough specialist palliative care providers to offer these services to every critical care patient (Hua & Wunsch, 2014). This shortage of providers requires strategies to ensure that these specialists are brought in for the highest risk patients. In the project hospital site ICU, implementation of evidence-based triggers has increased

palliative care involvement for those patients at highest risk of morbidity and mortality. ICU and hospital length of stay have both shortened since palliative care triggers for involvement have been implemented. Primary palliative care services should be made available for the rest of the critically ill at my project site.

Informal conversations with ICU staff at the DNP project site confirmed feelings of discomfort in the provision of end of life care, which is consistent with findings in the literature I reviewed. Also, staff identified concerns with understanding legality and the role of surrogates and forms such as advance directives and Maryland Order for Life Sustaining Treatment (MOLST) forms. This discomfort prevents the ICU staff from continuing or initiating goals of care conversations. By designing an evidence-based educational program geared toward filling these gaps in knowledge, I sought to empower critical care nurses to engage in goals of care conversations and feel comfortable providing quality end of life care (Austin, 2013; Milic et al., 2015).

Problem Statement

The problem I addressed in this DNP staff education project was ICU nurses' lack of knowledge about the provision of primary palliative care. The palliative care team at my project site cannot see every ICU patient due to the small size of the specialty team. According to Schulz and Novick (2013), true integration of palliative care into the ICU can only be realized by educating ICU staff members.

There is confusion surrounding the difference between primary palliative care, which the ICU team can provide, and specialist palliative care, which is best provided by a palliative care specialist. In addition, critical care nurses have expressed discomfort in

providing palliative care interventions. Thus, when the palliative care team is off site or unavailable, goals of care conversations and interventions are put on hold. For example, there is an extensive goals of care conversation when a family is considering terminal extubation versus tracheostomy. The primary team, including the bedside nurse, can have a follow up conversation. Often, the primary team will wait for the palliative team to continue this conversation or only to document the decision before any further plans occur. This practice can effectively cause a delay in the plan of care that could be avoided through the provision of primary palliative care by the ICU team.

When ICU team members are equipped with primary palliative skills through evidence-based education, all patients in the ICU will have access to basic palliative care services. The potential for the same benefits then exists for all patients without the need to overburden the specialty team.

Purpose

The purpose of this DNP project was to develop an evidence-based staff education plan for ICU nurses that would facilitate primary palliative care access for all patients and families in the ICU. With this evidence-based project, I worked to bridge the gap between current nursing practice and the evidence-based research guiding care delivery (Austin, 2013; Milic et al., 2015; Montagnini, Smith, & Balistrieri, 2012).

Project Goal and Outcomes

My goal for this project was to provide all patients in the ICU access to palliative care. By completing this DNP project, I met the following outcomes:

- Outcome 1. Literature Review Matrix

- Outcome 2. Educational Curriculum Plan
- Outcome 3. Pretest and Posttest

Framework

I used Rosswurm and Larrabee's model for evidence-based practice change (Rosswurm & Larrabee, 1999) as the theoretical model for this DNP project. This model consists of six steps, the first four of which I used to design the project. The steps are as follows: Step 1, assessing the need for practice change; Step 2, linking the problem with interventions and outcomes; Step 3, synthesizing the best evidence; and Step 4, designing a change in practice. The final two steps, implementing and evaluating the change in practice (Step 5), and integrating and maintaining the change in practice (Step 6), will take place following my graduation from Walden University.

Definitions

I use the following definitions of terms throughout this project:

Intensive care unit: A place where critical care helps people with life-threatening injuries and illnesses. ICU specially trained health care provider teams might treat problems such as complications from surgery, accidents, infections, and severe breathing problems and involves close, constant attention (MedlinePlus, 2015).

Palliative care: An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (World Health Organization, 2015).

Intensivist: A physician who specializes in the care of critically ill patients, usually in an ICU (MedicineNet.com, 2015).

Primary palliative care: Skills that every frontline clinician should be capable of providing to patients with serious illness. This includes symptom management, initial discussions about goals of care and treatment options, and preliminary advance care planning (Center to Advance Palliative Care, 2017).

Specialist palliative care: Expert skills utilized for those patients with serious illness whose cases are complex or severe including difficult to control symptoms, conflicts or concerns about goals of care, difficult psychosocial situations, and unclear or unrealistic wishes (Center to Advance Palliative Care, 2017; MJHS, 2017).

Assumptions

Assumptions are those things accepted as true without question or proof (Cambridge Dictionary, 2015). In this project, I assumed that (a) members of the hospital staff wish to give the best care using the best evidence available, (b) patients and their families wish to receive the best care using the best evidence available, and (c) patients and their advocates wish to have a voice in the direction of care goals.

Scope and Delimitations

I developed this project because of the need for increased understanding of basic palliative care components in delineating goals of care and managing symptoms for critically ill patients. Palliative care integration is not yet standard of care in critical care units, but earlier, and increased, involvement of the palliative care team has occurred for

the most critically ill patients. The population for this project is the nursing staff caring for patients in the ICU.

Limitations

Limitations or restrictions of a project may reduce its generalizability for other populations (Grove, Burns, & Gray, 2013). This project was limited by the fact that I drew data from only one ICU in a suburban community hospital that had integrated palliative care. Populations of urban and rural ICU's may differ. Further, this project was limited by the fact that each ICU, regardless of location, differs in culture, needs, and available resources.

Significance

According to Alspach (2016), nurses tend to believe that physicians handle goals of care conversations. Alspach emphasized that nurses absolutely have a role to play in having these conversations with patients and their families and should not expect or depend on physicians to solely handle this responsibility. The provision of primary palliative care by critical care nurses with a focus on goals of care lends a clear focus to the plan of care. With clear goals delineated, nurses can concentrate efforts on the patient and family's needs and values. According to nursing theorist Sister Callista Roy, health and illness are expected as a part of life. How one adapts is based on a person's individual beliefs, values, and opinions. Nursing plays an important role in facilitating adaptation (Fawcett, 2002). Adaptation is key for those patients who are facing critical illness, particularly when the illness is potentially life limiting.

Managing discomforting symptoms in patients who are critically ill and nearing the end of life is also a significant part of the nurse's role. Researchers have shown that discomfort and lack of empowerment are barriers to ICU nurses providing evidence-based palliative care (Austin, 2013; Holms, Milligan, & Kydd, 2014). When faced with these uncomfortable situations repeatedly, nurses have a higher chance of experiencing burnout (Mirel & Hartjes, 2013). By learning the evidence base supporting symptom management, nurses gain an arsenal of both medicinal and non-medicinal interventions to improve comfort for their patients and for themselves when providing care.

The promotion of palliative care based on current evidence is also significant to nursing practice. The literature supports palliative care team integration in the ICU. While the specialty palliative care team can see the most critically ill, there remain other patients in the ICU who could benefit from this type of discussion and delineation of goals as well as improved symptom management. Clearly defined goals of care give a patient and family a voice in the plan of care. With clearly defined goals, a person remains in control of the direction the plan of care will take, and the ethical principle of autonomy is upheld.

Further, plans of care that are individualized, rather than testing and intervention driven, lead to cost savings for the health care system. According to Pasternak (2013), Medicare spends 28% of health care dollars in patients final 6 months of life. This totals $170 billion dollars annually.

Summary

Palliative care is a service offered to any person who is experiencing a potentially life-limiting or chronic illness (Aslakson, Randall, & Nelson, 2014; Broglio & Walsh, 2017). Palliative care services in the critical care setting assist patients, families, and staff in understanding the current medical situation, focusing on long-term goals, completing advance directives, managing distressing symptoms, and delivering appropriate care.

The evidence-based literature has shown the effectiveness of integrating palliative care in critical care units (Aslakson et al., 2012; Gibbs et al., 2015; Love & Liversage, 2014; Seaman, 2013). With palliative care integration, critical care patients have a shorter ICU length of stay, shorter overall hospital stay, reduced 30-day readmission rate, increased patient and family satisfaction scores, and a reduced cost of care (Morgan, 2011; Morrison et al., 2008; Nelson et al., 2013).

Because of the shortage of specialist palliative care providers throughout the health care system, involvement of the palliative care team is reserved for only those patients at the highest risk of morbidity and mortality and those with the most complex cases. However, all critically ill patients should have access to basic palliative care with goal directed care and management of discomforting symptoms. According to Schulz and Novick (2013), true integration of palliative care into the ICU can only be realized through education of ICU staff. Providing palliative care education for ICU nurses facilitates true integration of palliative care at the bedside.

In Section 2, I discuss Rosswurm and Larrabee's model for evidence-based practice change along with the current literature on palliative care. I also describe the site

for this DNP project and explain the link between the project site's strategic goals and mission and this project.

Section 2: Background and Context

Introduction

Palliative care is a discipline beneficial to critically ill patients in the ICU. The problem I addressed in this DNP staff education project was ICU nurses' lack of knowledge about the provision of primary palliative care. The purpose of this DNP project was to develop an evidence-based staff education plan for ICU nurses that would facilitate primary palliative care access for all patients and families in the ICU. The outcomes included a literature review matrix, educational curriculum plan, and pre- and posttests.

Researchers have shown that the integration of palliative care into the ICU setting is a best practice (Hua & Wunsch, 2014; Walker et al., 2013). O'Mahony et al. (2010) reported that palliative care clinicians' integration into the operations of critical care units was of benefit to both clinicians and patients. To truly integrate palliative care into an ICU, inclusion, empowerment, and education of the critical care staff must be part of the integration plan (Schulz & Novik, 2013). A palliative care specialty team can be helpful for the sickest and most complicated patients. However, for the general population of the critical care unit, access to primary palliative care interventions such as goals of care conversations, effective symptom management, and advance care planning should be standard of care (American Nurses Association, 2016).

Framed within Rosswurm and Larrabee's (1999) model for evidence-based practice change, I used a team approach to design the project. Specifically, I used the first four steps of the model when designing the project, including (a) assessing the need for

practice change (Step 1), (b) linking the problem with interventions and outcomes (Step 2), (c) synthesizing the best evidence (Step 3), and (d) designing a change in practice (Step 4). The final two steps including implementing and evaluating the change in practice, and integrating and maintaining the change in practice will take place following my graduation from Walden University.

As I described in Section 1, my project site developed a program using evidence-based triggers to integrate the specialty palliative care team into the ICU. While this program was successful in increasing the involvement of the specialty palliative team into the ICU structure, a new problem emerged. Nursing staff members were uncomfortable continuing goals of care conversations, assisting with advance care planning, and managing distressing end of life symptoms.

In the following sections, I discuss the strategy I used for the literature search. In addition, the first three steps of Rosswurm and Larrabee's model for evidence-based practice change are described. Further, I discuss literature I used to support the approach and framework for this project and provide a summary of the current literature on palliative care specific to the ICU. Finally, I specify my role in the project.

Literature Search Strategy

I completed the literature search for this project using Google Scholar and scholarly databases that I accessed via the Walden University Library including the Cumulative Index to Nursing and Allied Health (CINAHL), Medline, and ProQuest. Inclusion criteria for articles included full text, English language, scholarly, peer-reviewed journals with dates of publication ranging from 2009-2017. Search terms

included *palliative, intensive care unit, critical care unit, integration, trigger, primary palliative care, nursing* with variations of *and* and *or* combinations. I also reviewed web sites including those of the Center to Advance Palliative Care (CAPC), The Institute of Medicine (IOM), and the World Health Organization (WHO). A total of 52 articles were used for the core of this paper.

Framework

Rosswurm and Larrabee's Model for Evidence-Based Practice Change

I framed this DNP project using Rosswurm and Larrabee's (1999) model for evidence-based practice change, which consists of six steps. The first two steps of assessing the need for practice change and linking the problem with interventions and outcomes were partially addressed in Section 1 and will be expanded upon in this section. In this section I also discuss Step 3, synthesizing the best evidence. I will discuss Step 4, designing a change in practice, in Section 3. Step 5, implementing and evaluating the change in practice, and Step 6, integrating and maintaining the change in practice, will take place following my graduation.

Other researchers have successfully used Rosswurm and Larrabee's (1999) model for evidence-based practice change in their evidence-based projects. Examples include operationalizing a self-management strategy of breathing retraining for chronic obstructive pulmonary disease patients (Facchiano, Hoffman Snyder, & Nunez, 2011) and developing a larger model to guide nurses on how to use evidence-based practice in their careers (Reavy & Tavernier, 2008). Rosswurm and Larrabee's model was also used to frame a doctoral dissertation (Jones, 2008) on osteoporosis screening in high-risk men.

Of particular interest was Shifrin's (2016) recent use of Rosswurm and Larrabee's model to frame an educational program for ICU nurses focused on end of life care. Shifrin developed a 3.5-hour classroom-style educational program; 46 ICU nurse participants showed statistically significant improvements between pretest and posttest scores.

Rosswurm and Larrabee Model for Evidence-Based Change: Step One

I implemented the first step of assessing the need for practice change at the request of the project site leadership team. This team approached me at the outset of pursuing my DNP degree and asked me to develop and implement a program to increase the involvement of the palliative care team in the critical care setting.

The project site leadership team had been focusing on improving patient satisfaction scores. The site had yielded scores below benchmark in patient satisfaction as it pertained to physician and provider communication. Because palliative goals of care discussions include a thorough and in-depth discussion as to the current state of the patient's medical condition with the patient and family, improvement in satisfaction scores would be expected as a result of these meetings.

Aside from nursing, other stakeholders included in this assessment of the need for practice change included intensivists, rehabilitation therapists, social workers, and chaplains. All verbally supported the increased presence, involvement, and integration of palliative care in the critical care setting and supported an evidence-based approach moving forward.

While there was success with the implementation of evidence-based triggers increasing the involvement of palliative care specialists in the ICU, the ICU staff expressed discomfort operationalizing the goal-directed plan once established, providing end of life care, understanding the legalities of paperwork, and continuing conversations regarding goals of care.

My findings aligned with those in the literature that showed critical care nurses do not often feel comfortable or empowered providing basic palliative or end of life care (Austin, 2013; Holms et al, 2014). Critical care nurses have expressed a need and desire to increase their knowledge base when providing palliative care in the ICU setting in order to feel comfortable caring for these very sick patients, particularly when there is no hope of recovery (American Nurses Association, 2016; Holms et al., 2014; Montagnini et al., 2012). To meet these needs and address this gap in care, I developed an educational curriculum focused on general palliative information, symptom management, goals of care meetings, communication techniques, documentation, and legal issues.

Rosswurm and Larrabee: Step Two

The second step of Rosswurm and Larrabee's (1999) model for evidence-based practice is linking the problem interventions and outcomes. The problem was ICU nurses' lack of knowledge of the provision of primary palliative care. In the literature, researchers have recommended education for critical care staff as an intervention to increase both knowledge and comfort in providing quality primary palliative and end of life care (Austin, 2013; Holms et al., 2014; Montagnini, et al., 2012; Schulz & Novick, 2013; Wittenberg, Goldsmith, Ferrell, & Platt, 2015). Thus, I developed an educational

program for nurses to increase their knowledge, promote competence, and empower them to deliver primary palliative care. Outcomes of this project included a literature review matrix, an educational curriculum plan, and a pretest and posttest.

Rosswurm and Larrabee: Step Three

Step 3 of Rosswurm and Larrabee's model is to synthesize the best evidence. In the following section, I review the literature, including an overview and benefits of palliative care. I also discuss palliative care teams and the underuse of palliative care components, include a review of literature specific to palliative care in the ICU and critical care nurses. I added articles to the literature review throughout the process of project development.

Literature Review on Palliative Care

Palliative care is a recognized subspecialty of medicine (American Board of Medical Specialties, 2017). Over the past several decades the discipline has grown from the recognition that while hospice provides comfort care at end of life, there was a gap in care for symptom management and advance care planning for those patients who do not yet qualify for hospice, are not interested in hospice, or are pursuing aggressive therapies that are hoped to be curative in nature.

Palliative care specialists assist patients and families with managing current distressing symptoms and in determining goals of care (Aslakson et al., 2014; Broglio & Walsh, 2017). These specialists are able to communicate effectively and honestly about a patient's current illness and trajectory, taking into account psychosocial aspects of the patient's life.

Benefits of palliative care intervention documented in the literature include reduced 30-day readmission rates, increased patient satisfaction, and decreased length of stay (Campbell, Weissman, & Nelson, 2012; Morgan, 2011; Nelson et. al 2013). Symptom management is improved through provision of palliative care (Center to Advance Palliative Care, 2015). In addition, increased numbers of advance directives are completed, increased numbers of do not resuscitate orders are established, and increased referrals to hospice are noted when palliative care components are included in a patient's plan of care (Center to Advance Palliative Care, 2015; Cook et al., 2015).

By delivering care that is patient-centered and individualized through palliative care involvement, the cost of care is also affected (Center to Advance Palliative Care, 2015). In a retrospective review, Morrison et al. (2008) compared 4,908 patients who received palliative care consultation to over 20,000 matched patients who did not receive a palliative consultation. Cost savings were significant. For each of those patients discharged alive, the researchers found a total savings of $2,642 per admission. For those patients who passed away in the hospital, the total savings was $6,896 per admission. Direct savings consisted of significant reductions in pharmacy costs, laboratory costs, and days spent in the ICU.

Of note, the average cost of an inpatient stay per day in the state of Maryland is $2,512 (Becker's Hospital Review, 2015). An ICU stay per day is much more expensive at $5,000 to $7,000 (Cleveland Clinic, 2016; University Hospitals, 2017). The potential cost savings impact of palliative care integration in critical care units is astounding.

Palliative Care Teams

Palliative care teams are teams made up of multidisciplinary members with an interest and, often, national certification in palliative care. These palliative care team members can include physicians, advance practice nurses, social workers, registered nurses, pharmacists, and chaplains. There is not a standard for palliative care teams as to how many or which disciplines must be on each team.

In Maryland, specialist palliative care teams are now a mandatory presence in every hospital with over 50 beds (Gibbs et al., 2015). The regulations that these teams must meet are being developed and are to be published this year. With regulatory guidance, standardization will be increased across hospital systems.

Besides their presence in hospitals, some palliative care teams work in the community setting. These teams work in outpatient clinics and some teams will visit patients in their homes. This push for community embracement of palliative care is growing. Meeting patients, planning for care needs and goals in advance, and attempting to aid in management of distressing symptoms are the ambitions of these teams.

Benefits of Palliative Care Involvement

The benefit of palliative care involvement in critical care units is supported in the literature. According to O'Mahony et al. (2010), over half of Americans who die in a hospital spend time in the ICU during their last three days of life and 20% of deaths in the United States occur during or shortly after an ICU stay. The current literature shows the benefit of palliative care involvement through increasing patient satisfaction, decreasing 30-day readmission rates, decreasing length of stay, decreasing cost, and decreasing

hospital mortality by half for those patients who receive palliative care consultation (Center to Advance Palliative Care, 2015).

O'Mahony et al. (2010) performed a descriptive review of 157 patients seen by the palliative team in the Bronx, New York. Do not resuscitate orders increased from 33% before palliative involvement to 83.4% after goals of care discussion with the palliative team. Over half of the patients required symptom management, particularly pain management. Laboratory and radiology testing were also significantly reduced in the group of patients who received palliative involvement reducing the overall cost of care.

The Three Wishes Project (Cook et al., 2015) was a project undertaken in a 21-bed medical-surgical ICU. Patients near end of life and their families were offered assistance in fulfilling wishes that were important to them at this transitional time. In most cases, families were the ones with wishes as the patients were unable to communicate. Wishes such as pet visitation, organ donation, communication with an estranged loved one and sharing one's life story were examples of wishes requested. Almost 90% of families completed the Quality of End of Life Care- 10 after the project and rated the quality of end of life care as high. The authors cite this intervention as a core component of palliative care.

Underuse of Palliative Care

The challenge lies in increasing the involvement of palliative care into the critical care unit. According to Walker et al. (2013), the collaboration between the ICU and palliative medicine is a best practice but comes with significant challenges. At the DNP project site, leadership identified this issue as a practice problem and requested my

assistance to develop an evidence-based intervention to increase palliative involvement in the ICU. For the project site specifically, the palliative care specialty team is no longer underutilized in the ICU. However, the discomfort of the primary nurses to provide primary palliative care results in underuse of palliative care in the unit as a whole.

Walker et al. (2013) conducted a retrospective review of ICU patients using a palliative care screening tool. Of 201 patients who qualified for palliative involvement, only 92 were referred to palliative care. Interestingly, the patients who were referred to palliative care had a shorter length of ICU stay with seven versus 11 days. There was no significant difference in hospital mortality between the referred and non-referred patients. Many of the referred patients were admitted to hospice care. Following this review, palliative care was integrated into the ICU with the number of patients seen and benefitting from palliative involvement almost doubling.

According to Walker et al. (2013), institutional culture change is needed to improve palliative services. The authors report that as ICU providers become familiar with palliative medicine, referrals for critically ill patients to the palliative care team increase. Collaboration between the two services in launching the integration is vital. However, the specialty team cannot see every critically ill patient. To truly integrate, the critical care nurse will need to be able to provide primary palliative care.

According to Schulz & Novick (2013), advanced training is needed to learn and provide the principles of palliative care. Communication techniques, as well as the ability to improve patient and family understanding of complex health situations, are part of the palliative specialty. The researchers reported that integration of palliative care into the

surgical intensive care unit (SICU) was considered a benefit by interdisciplinary staff, including the surgeons. In particular, the authors noted a benefit in that the palliative team was able to help resolve conflicts between the surgeons and critical care staff regarding the aggressiveness of care.

While the benefits of palliative care integration into critical care units are well documented, there exists a shortage of palliative care specialists (Hua & Wunsch, 2014). In order for all critically ill patients to have access to primary palliative care and to further improve the quality of patient care, plans, symptom management and outcomes, ICU staff will need to be taught the basics of the palliative specialty along with the grounding components.

Palliative Care in the ICU

Palliative care in the ICU is becoming more commonplace. The ICU culture is one of high technology, high stress, and curative treatments. However, the patients in the ICU are critically ill many with chronic conditions that will progress with time. Many of these patients are experiencing setbacks that will change their lives forever. Others are at the end stage of their lives and are struggling with acceptance.

The role of palliative care teams in the ICU is the same as in other settings. Goals of care discussions, advance care planning, and symptom management are top priorities for the team. Because of the aggressive and curative nature of the ICU setting, palliative care teams are not always welcomed (Aslakson et al., 2012; Gibbs et al., 2015; Love & Liversage, 2014; Seaman, 2013). One particular barrier is the misunderstanding critical care staff holds that palliative care is equivalent to hospice care or withdrawal of care.

In addition, to truly integrate into the ICU, the culture must be changed to embrace and understand palliative care as a type of care beneficial to all critically ill patients. Integration can only occur with buy in from critical care nurses who are at the bedside and hold the trust of these critically ill patients and their families (Schulz & Novik, 2013).

Primary Palliative Care for Critical Care Nurses

According to the literature, critical care nurses have expressed discomfort with their knowledge base when it comes to their ability to provide palliative and quality end of life care (Austin, 2013; Holms et al., 2014; Montagnini et al., 2012). Areas where nurses specifically felt uncomfortable included communication techniques, education, training, and decision-making processes (Holms et al., 2014; Montagnini et al., 2012). The culture of an ICU has been documented as an area of discomfort for ICU nurses providing end of life care (National Institute for Nursing Research, 2009; Seaman, 2013). The technology and institutional feel of the ICU do not promote a feeling of warmth and comfort.

Primary palliative care education is recommended to be included in nursing programs as well as for established nursing staff of critical care units (American Nurses Association, 2017). The literature supports that nurses gain knowledge and feel empowered to care for patients with critical illness after receiving this education (Grossman, 2013; Mirel & Hartjes, 2013).

Background and Context

Integration of palliative care in the ICU supports the Institute of Medicine's six aims listed in *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001). These six aims include safe, effective, patient-centered, timely, efficient, and equitable practice. Palliative intervention allows for patients to delineate clearly individualized goals of care based on his/her current medical situation and prognosis. In addition, palliative care components support relief of distressing symptoms with chronic illness and at end of life.

While the process of consultative practice supports the six aims, the palliative team is not on site 24 hours per day. In order to provide palliative support to all patients in a timely and equitable fashion, ICU staff must feel comfortable and empowered to deliver the care required.

In addition, if palliative involvement does not occur in a timely fashion, then efficiency is hindered. When patient goals are not clarified early, more aggressive therapies and procedures may continue longer into the hospital course then the patient may have wanted. Through the integration of palliative care components into the critical care unit processes, palliative involvement occurs thus improving our commitment to these aims.

Project Site

The hospital where this DNP project took place is a185-bed, suburban community hospital on the east coast of the United States (U.S.) with a 14-bed ICU. The hospital is

part of a health care system consisting of ten total hospitals throughout the state of Maryland.

The mission statement of this hospital is “dedication to maintaining and improving the health of the people in its communities through an integrated health delivery system that provides high quality care to all. We are committed to service excellence as it offers a broad range of health care services, technology, and facilities. We do and will continue to work collaboratively with our communities and other health organizations to serve as a resource for health promotion and education”. The vision is “to become the preferred, integrated health care system creating the healthiest community in Maryland”. Values include excellence, compassion, integrity, respect, responsibility, and trust.

My role in this project has been one of leadership and collaboration. My relationship to the project site is one of DNP student but also as an employed nurse practitioner on the palliative care team. This project was identified by the leadership administration of this institution as a priority and a project that would be supported administratively.

The project team consisted of the palliative care physician director, two palliative care nurse practitioners, a high-risk case manager, a palliative care social worker, an acute care (ICU) nurse practitioner, an ICU nurse, and a representative from education. Team tasks included regular meetings with a review of the literature. With input from all stakeholders, all of the outcomes were developed.

Summary and Conclusion

The major themes in the literature presented in this section include the push for palliative care to become integrated into ICU's as the standard of care, the benefits of such palliative care integration, and support of education of ICU staff as a vehicle to aid integration. With palliative care integration, patients and families have a more realistic view of the current medical picture, can glimpse the future, and can plan and express those things that are most important to them. Thus, unnecessary tests, hospitalizations, and discomfort can be avoided when one is edging closer to the end of life. Palliative care intervention at its' core is about adapting to a new way of living, and sometimes, dying.

Palliative care was underutilized at the project site. The development of a program to institute ICU triggers that would prompt a referral to the palliative care team was an initial attempt at palliative care integration. While implementation of these triggers was successful in increasing involvement of the specialty palliative care team, there remained confusion and discomfort among the ICU staff in continuing goals of care discussions, understanding legalities surrounding palliative care, and provision of end of life care when the palliative care team was not on site. Thus, it was clear that true integration of palliative care into the ICU would not occur without a change in the culture and knowledge base of the ICU staff.

Framed using Rosswurm and Larrabee's model for evidence-based practice change (Rosswurm & Larrabee, 1999), I formed a multidisciplinary team to review the literature and develop an educational curriculum with pretest and posttest to support this

project. In section 3, I will further elaborate and describe the approach and methods utilized in developing the project.

Section 3: Approach, Methods, and Rationale

Introduction

The problem I addressed in this DNP staff education project was ICU nurses' lack of knowledge about the provision of primary palliative care. The purpose of this DNP project was to develop an evidence-based staff education plan for ICU nurses that would facilitate primary palliative care access for all patients and families in the ICU.

Because of the recent implementation of evidence-based triggers, involvement of the palliative care specialty team increased in the ICU at my project site. However, ICU staff members have expressed discomfort in continuing goals of care discussions, understanding legalities surrounding palliative care, and providing end of life care when the palliative care team was not on site. As a result of this evidence-based educational program, ICU nurses will gain the knowledge needed in order to be more able and empowered to provide primary palliative care.

Provision of primary palliative care is a change in practice for the ICU nursing staff. With palliative care integration, patients and their families will have access to a service that assists them in focusing on goals of care and managing distressing symptoms, and facilitates connection to care resources following hospitalization. Because ICU staff will be trained to deliver primary palliative care, patients and their families will have access to palliative care at all hours of the day and night. There will no longer be a gap in services when the palliative care specialist team is off site.

In Section 2, I discussed the first three steps of Rosswurm and Larrabee's (1999) model for evidence-based change. In this section I discuss Step 4, designing a change in

practice. I also discuss my approach and rationale for this change in practice of ICU nurses, and identify specific steps of the process including the development and role of a multidisciplinary team. Also included are budget considerations, ethical considerations, and an evaluation plan for the project.

Approach and Rationale

I chose Rosswurm and Larrabee's (1999) model for evidence-based practice change as the framework for this project because the model supports the process of bridging the gap between researcher and practitioner in implementing evidence-based practice changes. The model is based on change theory, and researchers have shown it to be effective in both theoretical and research literature on evidence-based practice (Rosswurm & Larrabee, 1999). This project fits perfectly into Rosswurm and Larrabee's framework because the project is evidence-based and prompts a change in nursing practice.

Steps 1, 2, and 3 of Rosswurm and Larrabee's model were discussed in Section 2. In Step 1, I assessed the need for practice change. Provision of primary palliative care in the ICU is a recommended standard of care (American Nurses Association, 2016). The provision of primary palliative care in the ICU at my project site is lacking because of discomfort and a knowledge deficiency of ICU staff members.

Step 2 involved linking the problem with interventions and outcomes. A robust review of the literature showed that education of ICU staff members increases their knowledge and empowerment to provide primary palliative care. Outcomes of this

project include a literature review matrix, an educational curriculum plan, and a pretest and posttest.

Step 3 of Rosswurm and Larrabee's (1999) model is to synthesize the best evidence. I conducted an exhaustive review of the literature including not only palliative care as it relates to the critical care setting, but also the components that an educational program should contain for critical care nurses. Step 4 of Rosswurm and Larrabee's model is to design a change in practice. In the following sections, I describe the project process including the overall plan, multidisciplinary team meetings, development of the outcomes, and outcome evaluations.

Planning and Development

Following are the major steps in planning and development:

1. Once I identified the problem, the multidisciplinary team composed of stakeholders was formed and the need for the project confirmed.
2. I performed an analysis and synthesis of the literature, which I presented to the team.
3. I developed the educational curriculum, including the pretest and posttest, which were reviewed by the whole team. After their recommendations were incorporated into the project, the outcomes were presented to the content experts.
4. The content experts evaluated the project outcomes.
5. The team members completed the summative evaluations.
6. After graduation from Walden University, I will implement the project.

Team Tasks and Meetings

Congruent with Rosswurm and Larrabee's (1999) model for evidence-based practice change, I was the leader of the multidisciplinary team that developed the project. The multidisciplinary team consisted of the palliative care director who is a palliative care physician, two palliative care nurse practitioners including myself, a high risk case manager, a palliative care social worker, an acute care nurse practitioner practicing in the ICU, an ICU nurse, and a representative from education.

According to Pigeon and Khan (2015), effective meetings are organized and meeting leaders use an agenda to guide the discussion. Meetings start and end on time with each agenda item given a time limit. Prior to ending, debriefing is necessary to review what has been discussed and to clarify which team members will be working on which tasks prior to the next meeting. In our multidisciplinary team's case, meetings were accomplished in small groups or on an individual basis based on group availability.

Once the team was formed, I shared and discussed baseline data from the retrospective review showing improvement in ICU length of stay after triggers were established. Team members also discussed the discomfort that ICU staff expressed when providing palliative care at times when the specialty palliative team is unavailable. I shared the literature review, which was discussed. The literature review was expanded through a multidisciplinary team based approach. The goal of increasing palliative involvement and integration through an educational program for nurses became the common focus of team members.

Initially, meetings were to be held twice monthly and last no longer than 30 minutes with an agenda distributed by me at least 72 hours in advance. Many of the stakeholders have limited time in their schedules and were not be able to devote extended periods of time at one sitting. As the leader, I decided to have a less formal approach to the development of this project, and meetings took place at times with fewer members with much work done over e-mail, phone, and individual or small group conversations.

Educational Curriculum Development

An educational curriculum contains a guide or outline of the content that will be taught to the learner (McEwen & Wills, 2011). In addition, the process by which the content will be taught is also described in an educational curriculum. The purpose of the education described in the curriculum may be to gain knowledge, develop skills, and/or alter attitudes about a subject. The educational curriculum for this project consists of learning goals and objectives with associated modules of education including

1. A palliative care overview,
2. Palliative care integration and how this aligns with the "triple aim" of the parent organization,
3. Components and value of goals of care discussions,
4. Explanations as well as comparing and contrasting of legal forms,
5. Identification of and interventions for distressing symptoms, and
6. Therapeutic communication techniques.

I developed a pretest and posttest based on the educational curriculum to document staff members' improvement in knowledge.

Three experts, two from palliative care and one from education, reviewed the literature review matrix, educational curriculum plan, pretest, and posttest items. A Ph.D. expert in assessment reviewed the content items of the pretest and posttest.

Budget

There was no need to establish a budget for this QI project. Facility leaders requested that I initiate this project, which required the time and talents of team members during the regular workday.

Ethical Considerations

I sought approval for this QI project from Walden University's Institutional Review Board (IRB). Walden's IRB approved the application (approval number 10-06-16-0466049). I also obtained approval from my study site's IRB because data was collected with their oversight.

Evaluation Plan

According to Zaccagnini and White (2011), evaluation of a project should be thoughtfully designed and unique to the particular project. Ongoing process and formative evaluation occurred in meetings. Three members of the committee who are experts in palliative care or education reviewed the contents of the curriculum and pre- and posttests. The evaluations included both quantitative scoring and recommendations for improvement of the outcome products. A Ph.D. with expertise in assessment reviewed items on the pretest and posttest. A summary evaluation of the entire project was completed by the team members at the end of the project, which looked at the project, process, and my leadership.

Summary

In summary, integration of palliative care into the ICU setting results in a culture shift. This QI project was framed using Rosswurm and Larabee's (1999) model for evidence-based practice change. Effective team meetings with teams consisting of multidisciplinary stakeholders were the foundations of this QI project. Outcomes included a literature review matrix, educational curriculum plan, and pretest and posttest for critical care staff members focused on primary palliative care.

In Section 4, I briefly discuss evidence-based triggers, which were initially established to increase involvement of the palliative care team in the ICU at my project site. Following this discussion of triggers, I discuss the need for nursing education regarding primary palliative care and then turn to the outcomes. I then discuss the outcome products including the extensive literature review, educational curriculum plan, and pre- and posttest. Experts' evaluation of the outcome products is also covered in Section 4.

Section 4: Findings and Recommendations

Introduction

The purpose of this DNP project was to develop an evidence-based staff education plan for ICU nurses that would facilitate primary palliative care access for all patients and families in the ICU. My goal for this project was to provide all patients in the ICU access to palliative care. The outcomes of this project included a literature review matrix, an educational curriculum plan for primary palliative education of ICU nurses, and a pre- and posttest based on the educational curriculum plan. Three experts evaluated the educational curriculum plan and validated the content of the pre- and posttest. At the completion of the project, the multidisciplinary team members completed a summative evaluation.

In Section 4, I outline the evaluation and findings of this project. This section contains a review of the outcomes and products as well as the implications, strengths, and limitations of the project. Finally, this section concludes with an analysis of myself as a scholar, leader, and practitioner.

Evaluation/ Findings and Discussion

Throughout the development of the educational curriculum plan that outlined the educational program for ICU nurses, the culture of the ICU changed from one of separation of palliative care to one of palliative care being a part of the critical care patient experience. This culture change has occurred over 2 years and is continuing to evolve. Much of the culture change that has thus far taken place can be attributed to the evidence-based triggers implemented 2 years ago, which prompted increased specialty

palliative care team involvement and presence. ICU staff members now possess an understanding of the purpose of palliative care in a critical care unit. ICU staff members understand this purpose to be far more than withdrawal of life sustaining measures and hospice.

However, there was still discomfort and a lack of knowledge regarding the delivery of primary palliative care. The time was ripe for true integration of palliative care through a solid foundation in primary palliative care education for the staff. Primary palliative care provided by the ICU team would then augment rather than be dependent on the specialty palliative care team. This integration was catalyzed by this DNP QI project, which is based on the current evidence base on primary palliative care as delivered by the ICU nurse.

I used Rosswurm and Larrabee's (1999) model for evidence-based practice change to frame this DNP project. An extensive literature review contributed to the development of the project site's own triggers as well as the educational component of this project. As the literature review matrix grew and discussions continued with ICU staff, the educational curriculum plan took shape. Nurses expressed a desire to learn more about the legality of certain forms such as advance directives, MOLST, and surrogacy. They also expressed discomfort regarding distressing symptom management and communication with patients and families when discerning goals of care. The literature has also shown that nurses feel uncomfortable in providing primary palliative care and express the desire for education in palliative care provision (Anderson et al., 2016; Autor et al., 2013; Moir et al., 2015; White et al., 2014).

In the following sections, I address the outcome evaluations of this project including the literature review matrix, educational curriculum plan, and pre- and posttest. I also discuss the multidisciplinary team's qualitative summative evaluation completed at the end of the project.

Expert Evaluation and Content Validation of the Product

After reviewing the literature and discussing needs with the ICU team, I developed an educational curriculum plan and a pre- and posttest which were reviewed by the multidisciplinary team. Two content experts and one educational expert evaluated the curriculum and provided content validation for the pretest and posttest items. A Ph.D. in educational psychology with specialty in assessment and statistics reviewed the test item construction.

One of the content experts is the physician for the palliative care team and holds certifications in both internal medicine and palliative care. The other content expert serves as the social worker for the palliative care team. She holds a bachelor's degree in social work and a master's degree in psychology. Additionally, she is certified in palliative care. The educational expert is a nurse working in the education department of the hospital where this project will be implemented. At the completion of the project, I asked all multidisciplinary team members to complete a qualitative evaluation of the project.

Outcome I: Literature Review Matrix (See Appendix A)

Discussion. I initially constructed the literature review matrix to show the need for integration of palliative care into the ICU and implementation of standard triggers for

palliative involvement. As the project further developed, evidence was added to the review supporting the need for education of the ICU bedside nurses (American Association of Critical Care Nurses, 2016; Austin, 2013; Holms et al., 2014; Milic et al., 2015). This further evidence became the foundation of the content included in the curriculum as well as the pretest and posttest.

Evaluation. All members of the multidisciplinary team reviewed the literature review matrix. None had concerns or requested further review of the literature to support the project.

Data. There were no data associated with the literature review matrix.

Recommendation. The multidisciplinary team deemed that the literature review matrix contained sufficient evidence to support the project purpose, goal, and outcomes.

Outcome II: Educational Curriculum Plan (See Appendix B)

Discussion. I developed the educational curriculum to meet the needs of ICU nurses working at the bedside of critically ill patients. The curriculum was developed based on the literature review and expressed needs of the ICU nurses. The literature review guided the main topics covered as well as the actual content included in the instruction.

Evaluation. Two content experts and one educational expert formally reviewed the curriculum plan using the Content Expert Evaluation Form (see Appendix C). The evaluation form includes six items and the reviewer designated whether each item was *met* or *not met*. The two content experts included a physician and social worker both certified in the specialty of palliative care.

Data. Data for this outcome were associated with reviewers content evaluation summaries. The reviewers agreed that the content contained in the curriculum was relevant and supported by the literature review (See Appendix D).

Recommendation. One member of the multidisciplinary team recommended rewording the objectives using Bloom's taxonomy (Armstrong, 2017). I reworded some objectives to better incorporate Bloom's taxonomy into the curriculum, although the objectives remain knowledge based.

Outcome III: Pretest and Posttest (See Appendix E)

Discussion. A Ph.D. in educational psychology with expertise in assessment reviewed the pretest and posttest construction. The pre- and posttest consisted of eight multiple-choice questions and 12 true/false questions. The pre- and posttest was distributed to the entire multidisciplinary team to review. A physician and social worker certified in the specialty of palliative care, as well as an educational expert, completed content validation for the items.

Evaluation. The three content validation experts completed a 20-item content validation form, which detailed each item. A four-point Likert-type rating scale was used with options ranging from *not relevant= 1* to *highly relevant = 4* (See Appendix F).

Data. The content validation index score calculates to 0.82 out of a scale from 0 to 1 (See Appendix G).

Recommendation. A recommendation was made to make all multiple-choice questions with four possible answers rather than one that had three options and rewording of two true/false questions for clarity. I incorporated all recommendations.

Summative Evaluation (See Appendix H)

At the completion of the project, a summative evaluation consisting of a seven-item open-ended questionnaire was distributed to all seven of the multidisciplinary team members via inter-office mail. These questionnaires were to be completed and returned anonymously. Four of the seven questionnaires were returned. Several themes emerged from these evaluations. These included my being forthcoming, flexible, and clearly outlining what was coming ahead of time for the team to prepare. In general, the team reported feeling that their input was appropriate but minimal in that I did most of the work and they spent more time reviewing material and helping with revisions. In the future, I would engage a team earlier in the project to help with development from the ground up. Two of the four respondents mentioned that they wished to continue on the team to assist with implementation of the project.

Implications

This evidence-based educational curriculum will result in the empowerment of nurses to meet the basic palliative care needs of all patients and families in the ICU. With this new knowledge and arsenal of interventions to relieve suffering, critical care nurses will have the preparation and confidence to deliver appropriate care to patients throughout the spectrum of life.

Policy

Integration of palliative care in the ICU is considered to be a priority and best practice according to the literature (Center to Advance Palliative Care, 2015; Hua & Wunsch, 2014; O'Mahony et al., 2010; Walker et al., 2013). In the state of Maryland,

palliative care teams are now mandatory in hospitals over 50 beds **(**Gibbs et al., 2015). Nationally, palliative care integration into the ICU supports the Institute of Medicine's six aims including safe, effective, patient-centered, timely, efficient, and equitable practice (Institute of Medicine, 2001).

The implications of this project on policy are two-fold. First, the project supported the worldwide, national, state, and local push supporting palliative care integration at many levels of the health care system, including critical care units. Second, the project supported the use of triggers and an educational curriculum that can be shared and disseminated among the other hospitals in the project site's health care system.

Practice

Critical care nurses are the bridge between the patient/family and the rest of the health care team. These nurses spend 24 hours of every day at the bedside of the patients who the health care team is committed to helping. Rated as the most ethical professionals according to a Gallup poll for the 15th straight year (Norman, 2016), nurses are sought out by patients and their families for information, advice, and solace. Critical care nurses have expressed a lack of comfort with palliative care components and how to incorporate these components into their practice. With education that is geared to the interest and practice of critical care nurses, there will be an increased comfort level lending empowerment to incorporate palliative care components into nursing practice.

Research in Practice

Future research implications include those for both nursing and patient/family outcomes after integration of palliative care into critical care units. Long-term outcomes

such as patient satisfaction, length of stay, and symptom management effectiveness are a few patient-related outcomes that could be measured. For nursing, job satisfaction and retention could be areas to investigate.

Social Change

Primary palliative care in the ICU can lead to social change by facilitating empowerment of patients and their families in personal goal-directed care as expressed in patient/family satisfaction surveys and reduced readmission rates.

Strengths and Limitations of the Project

The strengths of this project include having the full support of the administration of the project site. Implementation of triggers for palliative care consults was a request of administrators, while my development of an educational curriculum for ICU nurses was met with the same enthusiasm and support. Another strength includes the dual role I serve as a DNP student and as an employee of this hospital system. This dual relationship allowed for time outside of practicum hours to continue to build relationships with ICU staff and further explain the DNP project goals. The literature review was robust and fully showed the need to integrate palliative care into the ICU. The literature review continued to grow as the curriculum was developed and added a foundation for palliative care educational needs for ICU nurses.

A limitation of this project is my background as primarily a clinician and not as an educator. Learning curriculum development and test item development was time consuming. A second limitation of this project is that the implementation of the educational portion of this project will take place after graduation. Thus, I will not know

the effectiveness of the education on outcomes such as increasing nursing comfort level, empowerment, length of stay, and patient satisfaction prior to this publication.

Analysis of Self

In the following sections, I discuss my growth and development throughout the process of the DNP project as a scholar, practitioner, and project developer. Also discussed is the contribution of this project to my longer-term goals in my professional development.

As Scholar

As a scholar, I have grown considerably throughout this project. I learned to properly search the literature for answers to practice problems. I not only learned basic things such as which databases to use, but also more advanced processes such as how to grade evidence. Synthesizing literature and summarizing evidence and then applying that evidence to a practice problem in my own workplace is a massive area of growth that has occurred, and will serve as a foundation for my career as a DNP.

As Practitioner

Prior to this project and program, I would tend to practice the way things had always been done rather than searching out the "why" behind the decisions I made for any patient problem. In addition to being able to search and synthesize evidence on system practice problems, I am now comfortable searching evidence to support my practice as a clinician. Further, my literature search for this project contained a wealth of information. I use this information on an everyday basis in my practice and am able to explain to patients why I choose one intervention over another based on the evidence.

As Project Developer

As a project developer, I have learned two very important lessons. First, I learned that input from all stakeholders when developing a project is mandatory. Different perspectives and different agendas are necessary for buy-in and important to an end product that will meet the goals. In addition, I learned how to be flexible. In working with my multidisciplinary team members, formal meetings were difficult to arrange. Therefore, much communication occurred informally over email, by telephone, and in smaller groups. This worked well for our multidisciplinary group. My idea of how this would take place was adjusted to a more realistic, yet very effective, plan.

Project Contribution to My Professional Development

As a result of the growth I have experienced throughout the process of completing this DNP project, I have gained skills and confidence to go forward in my career as a DNP. During the program, I wrote an article entitled "Palliative Care in the Acute Care Setting" which was published in the *American Journal of Nursing* in September. I also applied and was appointed by the governor of Maryland to the State Board of Nursing Home Administrators for a 4-year term. I joined, and have continued to sit on, the legislative committee for the Nurse Practitioners Association of Maryland. Also, while in school, I wrote and submitted a grant to the Cambia Foundation to fund a program to expand palliative care education to long-term care facilities. Unfortunately, the grant was not funded. However, per my follow up discussion with Cambia representatives, the topic is one in which they would support and encouraged my reapplication once my DNP degree was completed.

The Walden DNP program, my professors along the way, my practicum mentor, and my advisor have offered not only the educational pieces, but the tools, motivation, and support to push forward through each day and each obstacle. Going forward, I look forward to seeking additional training in education as I have found I enjoy teaching.

Summary

In Section 4, I discussed the outcome products and evaluation of those products including the literature review matrix, educational curriculum plan, and pre- and posttest. A multidisciplinary team including three content experts evaluated and helped to shape the final outcome products. All products were found to meet standards, and the content validation index for the pre- and posttest was 0.82. Further, I discussed strengths and limitations of the project, which led into a discussion of my own growth as a scholar, leader, and practitioner. I have grown in all areas and fully expect to continue this growth after graduation. In Section 5, I present my dissemination plan consisting of a continuing education presentation for hospital nurses.

Section 5: Scholarly Project Dissemination

In addition to providing education to ICU nurses on primary palliative nursing in the critical care unit, I will develop a continuing education presentation for all nurses throughout the hospital system. This hour-long continuing education presentation will provide information on the most commonly asked questions encountered by the palliative care team. In the presentation, I will give specific attention to surrogacy law, legal forms, and symptom management.

I am in the process of submitting an application and paperwork to the Maryland Nurses Association by request of the project site's educational department for approval of 1 continuing education credit hour (See Appendix I). Please note that any facility identifying pages have been removed from the application in the appendix. The American Nurses Credentialing Center Commission on Accreditation accredits the Maryland Nurses Association as an approver of continuing nursing education.

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Appendix A: Literature Review Matrix

Johns Hopkins Rating Scale Used with Permission

Palliative Care Integration in the Intensive Care Unit

Full Reference	**Theoretical / Conceptual Framework**	**Research Question(s) / Hypotheses**	**Research Methodology**	**Analysis & Results**	**Conclusions**	**Grading the Evidence**
Alspach, J. (2016). When it's your time, will it be your way? *Critical Care Nurse, 36*(1), 10-13.	Descriptive	Aggregate and discussion of purpose/ use of Advance Directives	EBP support	Describes use of and purpose of Advance Directives giving guidance to critical care nurses on the same	Encourages nurses to ask for, interpret and follow Advance Directives	IV
American Association of Colleges of Nursing. (2006). The essentials of doctoral education for advance practice nursing. Retrieved from http://www.aacn.nche.edu/publications/position/DNPEssentials.pdf					Used for the DNP Essentials	IV
American Association of		Plethora of information	Website		Will be used to	IV

Critical Care Nurses. (2016). Palliative and end of life care. Retrieved from http://www.aacn.org/wd/practice/content/palliative-and-end-of-life-care.content?menu=practice		for critical care nurses with classes, resources and EBP tools.			review curriculum/ educational plan to ensure it is all inclusive of necessary elements	
American Board of Medical Specialties. (2017). Specialty and subspecialty certificates. Retrieved from http://www.abms.org/member-boards/specialty-subspecialty-certificates/	Informational		Website		Used to verify palliative care as a medical subspecialty	IV
American Nurses Association. (2016). Call for action: Nurses lead and transform palliative care. Retrieved	Call to Action	Recommendations from ANA/ HPNA to integrate palliative care and improve delivery of	Expert Consensus	Supports integration of palliative care into specialties; supports education in nursing programs		IV

from http://nursingworld.org/CallforAction-NursesLeadTransformPalliativeCare		palliative care through nursing				
Anderson, W. G., Puntillo, K., Boyle, D., Borbour, S., Turner, K., Cimino, J.,…Pantilat, S. (2016). ICU bedside nurses' involvement in palliative care communication: A multi-center survey. *Journal of Pain and Symptom Management, 51*(3), 589-596.	Quantitative		Survey	-46 item survey emailed to critical care nurses at the medical centers of the University of CA -1791 nurses responded -88% believed palliative care conversations were important to quality of patient care -66% wanted more training -43%reported emotional toll being a barrier -45% reported rarely being involved in the goals of care discussion	-nurses need education and the opportunity to practice what they learn -successful and sustained integration of palliative care into the ICU requires active engagement of bedside nurses	III
Armstrong, P. (2017). Bloom's Taxonomy. Retrieved from https://cft.vanderbilt.edu/guides-sub-		Description of and image of Bloom's Taxonomy	Website			V

pages/blooms-taxonomy/						
Aslakson, R. A., Randall, C. J., & Nelson, J. E. (2014). The changing role of palliative care in the ICU. *Critical Care Medicine, 42*(11),2418-2428**.**		-Review evidence of opportunities to improve palliative care for critically ill adults, -Summarize strategies for ICU palliative care improvement, - Identify resources to support implementation.	Systematic Review	Synthesis of peer-reviewed articles, consensus statements and guidelines were grouped into four themes. Conclusions list those pertinent to this DNP project.	Palliative care is becoming an essential part of the care for critically ill patients, regardless of diagnosis or prognosis. - Palliative care can help prepare and support patients and families for challenges after ICU discharge - Further research is needed to inform efforts to integrate palliative care with intensive care more effectively and efficiently	IV
Aslakson, R. A., Wyskiel,	Grounded theory	- explore the barriers to	Qualitative	-4 focus groups of nurses in 3	-Nurses providing	III

R., Thornton, I, Copley, C., Shaffer, D., Dauryne, Z.,… Pronovost, P. J. (2012). Nurse-perceived barriers to effective communication regarding prognosis and optimal end-of-life care for surgical ICU patients: A qualitative exploration. *Journal of Palliative Medicine, 15*(8), 910-915.		optimal communication and end-of-life care in SICUs as perceived by the bedside nurses.		ICU's - content analysis technique revealed 4 themes: logistics, clinician discomfort with discussing prognosis, inadequate skill and training, and fear of conflict. - Also, 24 barriers to end of life care were identified	bedside care in SICUs identify barriers in several domains that may impede optimal discussions of prognoses and end-of-life care for patients with surgical critical illness. - Consideration of these perceived barriers and the underlying SICU culture is relevant for designing interventions to improve palliative care in this setting	
Austin, D. (2013). UC Health helps ICU nurses bring palliative care	Semi-Experimental	-To implement a system wide palliative care program	Quasi-experimental	Pilot study was successful with nurses feeling empowered although no hard data was	Funding had been received ($1 million grant) to expand	II

to patients. Retrieved from http://scienceofcaring.ucsf.edu/future-nursing/uc-health-helps-icu-nurses-bring-palliative-care-patients		empowering bedside ICU nurses to increase integration of palliative care in the ICU		given	program to 5 hospitals in the system	
Autor, S. H., Storey, S. L., Ziemba-Davis, M. (2013). Knowledge of palliative care. *Journal of Hospice and Palliative Care Nursing, 15*(5), 307-315.	Quantitative	- assess nursing knowledge of palliative care	Survey	-143 nurses (43% ICU) -Palliative Care Quiz for Nurses (assesses knowledge and misconceptions) - oncology nurses did the best	-critical care nurses were less comfortable/ knowledgable about palliative care	III
Becker's Hospital Review. (2015). Average cost per inpatient day across 50 states in 2010. Retrieved from http://www.beckershospitalreview.com/lists/average-cost-per-inpatient-day-across-50-states-in-		Not an article; Website with a listing of every state sourced from Kaiser Health Facts				IV

2010.html						
Bernat, J. L. (2005). Medical futility: Definition, determination, and disputes in critical care, *Neurocritical Care, 2(*2), 198-205.	Informative; descriptive; opinion	Discusses the situation and ethical issues surrounding medical futility	Informational	Reviews the definition of medical futility and pitfalls for clinicians	Recommends understanding the outcomes before declaring futility; strongly encourages open and honest communication to avoid disputes	IV
Blinderman, C., & Billings, J. A. (2015). Comfort care for patients dying in the hospital. *The New England Journal of Medicine, 373*(26), 2549-2561.	Descriptive	to provide both generalists and specialists in fields other than palliative care with a practical, evidence-based approach to alleviating these symptoms in patients who are dying in a hospital.	Evidence based consensus	Reviews goals of care meeting components as well as multiple symptom management strategies for in hospital comfort care	Advances that deserve widespread incorporation into the clinical practice of both generalists and specialists	IV
Broglio, K., & Walsh, A. (2017). Referring	Descriptive	Article written for providers describing	Informational		Used to support differences between	IV

patients to hospice or palliative care. *Nurse Practitioner, 42(4)*, 49-55		hospice versus palliative care; includes many statistics			palliative and hospice	
Cambridge Dictionary. (2015). Assumption. Retrieved from http://dictionary.cambridge.org/dictionary/british/assumption					Online dictionary	V
Campbell, M. (2015). Caring for dying patients in the ICU: Managing pain, dyspnea, anxiety, delirium, and death rattle. *Advanced Critical Care, 26*(2), 110-120.	Descriptive	to provide a review of symptom prevalence, prevention, assessment, and treatment for 5 common symptoms experienced by critically ill patients who are dying: pain, dyspnea, anxiety, delirium, and death rattle.	EBP support and guidelines	Pain, dyspnea, anxiety, and delirium are common, distressing symptoms among dying critically ill patients receiving palliative care. Valid, reliable means of assessment include seeking the patient's self-report (pain, dyspnea, anxiety) and using behavioral observation scales specific to the	Gaps in the evidence include knowing the prevalence of distressing symptoms of pain, dyspnea, and anxiety among critically ill patients who cannot self-report as typifies the sickest ICU patients and those who may die.	IV

				symptom. An evidence base for medications and other interventions to reduce these symptoms was described.		
Campbell, M. L., Weissman, D. E., & Nelson, J. E. (2012). Palliative care consultation in the ICU #253. *Journal of Palliative Medicine, 15*(3), 715-716.		- Review of role of palliative care consults in the ICU	-Expert Review	-Multiple bullet points on benefits of palliative care consultation with references to supporting research -Also, bullet points for when to consult palliative care	-"Specialist palliative care consultations, together with integration of palliative care principles into the care of all ICU patients, can improve the patient/family experience, reduce length of stay, improve ICU throughput without increasing mortality, and lower health care costs."	IV

Carson, S. S., Garrett, J., Hanson, L. C., Lanier, J., Govert, J., Brake, M. C.,…Carey, T. S. (2008). A prognostic model for one year mortality in patients requiring prolonged mechanical ventilation. *Critical Care Medicine, 36*(7), 2061-2069.	Quantitative	Objective was to develop and validate a prognostic model for 1-year mortality in patients ventilated for 21 days or more.	Prospective cohort study	300 consecutive medical, surgical, and trauma patients requiring mechanical ventilation for at least 21 days. One-year mortality was 51% in the development set and 58% in the validation set. Independent predictors of mortality included requirement for vasopressors, hemodialysis, platelet count $\leq 150 \times 10^9$/L, and age ≥ 50.	These four predictive variables can be used in a simple prognostic score that clearly identifies low risk patients (no risk factors, 15% mortality) and high risk patients (3 or 4 risk factors, 97% mortality).	II
Center to Advance Palliative Care. (2015). Business case and palliative care. Retrieved from https://www.capc.org/topics/business-case-and-palliative-care/	Expert consensus based on research evidence	What is the business case for palliative care teams in acute care?	Synthesis of available research		Palliative teams: -lower costs -improve transitions of care - reduce symptoms -improve pt/ family satisfaction -increase referrals to hospice	IV

Center to Advance Palliative Care. (2017). Palliative care definitions and delivery models. Retrieved from https://www.capc.org/payers/palliative-care-definitions/	Descriptive; Informational		Website		Used for definition of primary palliative care vs specialty palliative care	IV
Clark, D. (2007). From margins to centre: A review of the history of palliative care in cancer. *Lancet Oncology, 8,* 430-438.	Historical	Describe the history of palliative care across the world	Review		-St Christopher's (1967) UK - In US less focus on cancer like in UK -In 1980's received specialization status as medicine subspecialty -future needs are guidelines and earlier involvement	IV
Cleveland Clinic. (2016). Patient price information list. Retrieved from	Informational	Used for cost of care		List of prices for inpatient stay by unit		IV

https://my.clevelandclinic.org/ccf/media/files/Patients/cleveland-clinic-main-charges.pdf						
Cohen, C., King, A., Lin, C. P., Friedman, C. K., Monroe, K., & Kutny, M. (2015). Protocol for reducing time to antibiotics in pediatric patients presenting to an emergency department with fever and neutropenia: Efficacy and barriers. *Pediatric Emergency Care*, doi: 10.1097/PEC.0000000000000362		Would a protocol reduce TTA for pediatric patients presenting to the ED with febrile neutropenia ?	Prospective cohort study	Protocol reduced TTA administration with significance of P< 0.0001	Protocols for specific conditions can improve process efficiency	II
Cook, D., Swinton, M., Toledo, F., Clarke, F., Rose, T., Hand-Breckenridge, T.,…Heels-Ansdell, D. (2015).	None mentioned	To bring peace to the final days of a patient's life and to ease the grieving process.	Mixed Methods	N- 40 ICU patients with 1 family member for each patient being terminally extubated or with care withdrawal Qual-	The **3 Wishes Project** facilitated personalization of the dying process through explicit integration	III

Personalizing death in the intensive care unit: The 3 wishes project: A mixed-methods study. *Annals of Internal Medicine, 163*(4), 271-279.				interviews Quant- Quality of EOL-10 questionairre & processes of care	of palliative and spiritual **ca re** into critical **care** practi ce.	

(a) Facchiano, L, Hoffman Snyder, C., & Nunez, D. E. (2011). A literature review on breathing retraining as a self-management strategy operationalized through Rosswurm and Larrabee's evidence-based practice model. *Journal of the American Acade*	Rosswurm & Larrabee	-critically appraise and synthesize the literature on breathing retraining as a self-management strategy for individuals with chronic obstructive pulmonary disease (COPD) guided by Rosswurm and Larrabee's evidence-based practice model.	Literature Review	-regularly practiced pursed lip breathing is an effective self-management strategy for individuals with COPD to improve their dyspnea.	-implementation of this non-pharmacological self-management intervention will improve perception of dyspnea, functional performance, and self-efficacy in individuals with COPD.	IV

my of Nurse Practitioners, 23(8), 421-426.						
(b) Fawcett, J. (2002). Scholarly dialogue: The nurse theorists: 21st century updates- Callista Roy. *Nursing Science Quarterly, 15*(4), 308-310.	Roy's Adaption Model	-to publish Sister Callista Roy's basic ideas through interview edited over 2 years time	Qualitative: Interview with theorist	- reiterates adaptation model and this as the foundation of nursing	-hopes for her model to be used in both quantitative and qualitative studies; mentions doctoral level studies	V
Francis, M., Rich, T., Williamson, T., & Peterson, D. (2010). Effect of an emergency department		to evaluate the time to antibiotics for emergency department (ED) patients meeting	Quasi-experimental Retrospective chart review (n=213)	P< 0.001 with median TTA dropping from 163 min. to 79 min	- a guideline based protocol for severe sepsis improved TTA	II

sepsis protocol on time to antibiotics in severe sepsis. *Canadian Journal of Emergency Medicine, 12*(4), 303-310.		criteria for severe sepsis before and after the implementation of an ED sepsis protocol	3 months pre and post sepsis protocol implementation			
Gibbs Jr., K. D., Mahon, M. M., Truss, M., & Eyring, K. (2015). An assessment of hospital-based palliative care in Maryland: Infrastructure, barriers, and opportunities. *Journal of Pain and Symptom Management, 49*(6), 1102-1108.	Descriptive	To assess the PC infrastructure at Maryland's 46 community-based non-specialty hospitals and to describe providers' perspectives on barriers to PC and supports that could enhance PC delivery. -HB 581 passed in 2013	Mixed Methods Survey sent to all 46 hospital CEO's (60.9% response); interviews also conducted	The most common barriers reported to PC delivery were lack of knowledge among patients and/or families and lack of physician buy-in	most hospitals reported that networks and/or conferences to promote best practice sharing in PC would be useful supports.	III
Grossman, S. (2013). Development of the palliative care of dying critically ill patients algorithm:	Quantitative		Pre and post assessment	-50 senior nursing students -End of Life Nursing Educational Consortium Knowledge Assessment	-noted… Preceptors reported not assigning students to dying patients because	III

Implications for critical care nurses. *Journal of Hospice and Palliative Nursing, 15*(6), 355-359.				Test (ELNEC-KAM) -3 simulations; interactive discussion and education -scores doubled after intervention	less technology was in use - reccommended education including practice with therapeutic communication skills, symptom mgt, advance directives, legal issues	
Grove, S. K., Burns, N., & Gray, J. R. (2013). *The practice of nursing research* (7th ed.). St. Louis, Missouri: Elsevier.			Textbook			IV
Holms, M., Milligan, S., & Kydd, A. (2014). A study of the lived experiences of registered nurses who have provided end of life care in an intensive care unit. *International*	Phenomenological	This qualitative study explored the experiences of ICU nurses who had provided EOLC to patients and their families	Qualitative	N=5 nurses from the ICU with semi-structured interviews. The themes identified were; use of integrated care systems, communication, the environment, education and training, staff	The findings suggest that ICU nurses do not feel adequately prepared to give proficient EOLC. Those who felt more confident in EOLC	III

Journal of Palliative Nursing, 20(11), 549-556				distress.	had learned what to do over time. Appropriate training, support and improved communication is necessary for good EOLC in ICUs.	
Hospicare. (2016). Is hospice right for you? Retrieved from http://www.hospicare.org/questions-answered/#11	Informational	Direct answers to frequently asked questions	Website			IV
Hospice and Palliative Credentialing Center. (2016). Certified hospice and palliative nurse. Retrieved from http://hpcc.advancingexpertcare.org/competence/rn-chpn/	Informational		Website		Used to verify nursing certification in palliative care as a specialty	IV
Hua, M. S.,		To estimate	Retrospe	85.4% (of	A trigger	III

Li, G., Blinderman, C. D., & Wunsch, H. (2014). Estimates of the need for palliative care consultation across the United States intensive care units using a trigger-based model. *American Journal of Respiratory and Critical Care Medicine*, *189*(4), 428-436.		the prevalence of ICU admissions who met criteria for palliative care consultation using different sets of triggers.	ctive cohort study of ICU admissions from Project IMPACT for 2001–2008. We assessed the prevalence of ICU admissions meeting one or more primary palliative care triggers, and prevalence meeting any of multiple sets of triggers. - 385,770 in 179 ICU's total	almost 20% who met comprehensive set of triggers) were captured by five triggers: (1) ICU admission after hospital stay greater than or equal to 10 days, (2) multisystem organ failure greater than or equal to three systems, (3) stage IV malignancy, (4) status post cardiac arrest, and (5) intracerebral hemorrhage requiring mechanical ventilation.	based system can identify those patients that could benefit from PC involvement in the ICU - Each ICU may need to develop triggers from a larger evidence based set for their own setting/ culture	
Hua, M., & Wunsch, H. (2014). Integrating	Descriptive	examines the current evidence supporting	Review	Developing a mixed model of palliative care delivery is	Efforts focused on improving integrative	IV

palliative care in the ICU. *Current Opinion in Critical Care*, *20*(6), 673-680.		the different models of palliative care delivery and highlights areas for future study.		necessary to meet the palliative care needs of critically ill patients.	models and appropriately targeting the use of palliative care consultants are needed.	
Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.			Report			IV
Jones, N. (2008). *Osteoporosis screening rates in men with risk factors* (Doctoral Dissertation). Retrieved from ProQuest Dissertations Publishing. (1453243)	Rosswurm and Larrabee's Model for Change to Evidence-Based Practice.	To determine whether men with known risk factors were being screened for osteoporosis	Retrospective Chart Review	Compared the screening rates in four categories: those with predisposing primary disease processes, those with previous fragility fractures, those with independent comorbidities, and those who fall into more than one of these categories. The data was then	This study determined that men are not being screened, although limitations of small study size, make it difficult to generalize these results.	III

				analyzed using either the Fisher's Exact Test or a chi-square.		
Knaus, W. A., Draper, E. A., Wagner, D. P., & Zimmerman, J. E. (1985). APACHE II: A severity of disease classification system. *Critical Care Medicine, 13*(10), 818-829.	Descriptive	presents the form and validation results of APACHE II	Tool validation	Uses a point score based upon initial values of 12 routine physiologic measurements, age, and previous health. An increasing score (range 0 to 71) was closely correlated with the subsequent risk of hospital death for 5815 intensive care admissions from 13 hospitals. This relationship was also found for many common diseases.	When APACHE II scores are combined with an accurate description of disease, they can prognostically stratify acutely ill patients and assist investigators comparing the success of new or differing forms of therapy.	III
Le Gall, J. R., Lemeshow, S., & Saulnier, F. (1993). A new simplified acute physiology score (SAPS	Quantitative	To develop and validate a new Simplified Acute Physiology Score, the SAPS II, from a large	Tool development and validation	137 ICU's in 12 countries; 13,152 patients	The SAPS II, based on a large international sample of patients, provides an estimate of the risk of	II

II) based on a European/ North American multicenter study. *The Journal of the American Medical Association, 271*(17), 1321.		sample of surgical and medical patients, and to provide a method to convert the score to a probability of hospital mortality.			death without having to specify a primary diagnosis.	
Leung, J. G., Nelson, S., & Leloux, M. (2014). Pharmacotherapy during the end of life. *Advanced Critical Care, 25*(2), 79-88.	Descriptive	This column discusses barriers to medication administration and pharmacological agents that can be used to manage actively dying patients.	Review/ EBP recommendations	Review of symptoms/ pharmacological management	Sharing of information regarding symptom mgt can improve care of ICU pts	IV
Love, A. W., & Liversage, L. M. (2014). Barriers to accessing palliative care: A review of the literature. *Progress in Palliative Care, 22*(1), 9-19.	Developed their own conceptual model	review factors affecting patients' access to palliative care	Literature Review	44 articles reviewed -pt/ family may refuse -clinicians tend to overprognosticate and willingly say they lack understanding of PC role	Most studies were small and not replicated -education for families and clinicians regarding PC role	IV
Lynch, M. T. (2014). Palliative care at end of life.	Descriptive	To describe the process of symptom managemen	Descriptive	Reviews assessment for symptoms and holistic	Symptom management is an essential	V

Seminars in Oncology Nursing, 30(4), 368-379.		t in the care of oncology patients with advanced cancer.		approaches to treatment .	component of oncology nursing practice that improves quality of life for patients and families throughout the cancer trajectory.	
McEwen, M., & Wills, E. M. (2011). *Theoretical basis for nursing*. Philadelphia, PA: Lippincott Williams & Wilkins.			Textbook			IV
McGowan, C. M. (2011). Legal aspects of end of life care. *Critical Care Nurse, 31*(5), 64-69.	Descriptive	Discusses legal issues of decision making in critical care	Guideline	Gives step by step process to decision making particularly in end of life	If disagreements, transfer of care may be only option.	IV
MedicineNet.com. (2015). Definition of intensivist. Retrieved from http://www.medicinenet.com/script/main/		Used for definition of intensivist	Website			IV

art.asp?articlekey=23392						
Medlej, K. (2016). APACHE II score. Retrieved from http://www.mdcalc.com/apache-ii-score/#next-steps		Provides online calculator and brief tutorials and definitions for use of APACHE II	Online calculator for APACHE II	For use of mortality prediction in ICU	Links to primary sources	IV
MedlinePlus. (2015). Critical care. Retrieved from http://www.nlm.nih.gov/medlineplus/criticalcare.html		Used for definition of critical care	Website			IV
Milic, M. M., Puntillo, K., Turner, K., Joseph, D., Peters, N., Ryan, R.,…Anderson, W. G. (2015). Communicating with patients' families and physicians about prognosis and goals of care. *American Journal of Critical Care,*	Multi-method	To improve critical care nurses' skills and confidence to engage in discussions with patients' families and physicians about prognosis and goals of care by using a focused educational intervention.	Pre and post surveys; focus groups	8 hr educational workshop which included role play, teaching of communication skills, and assisting in goals of care discussions	Defining roles and providing opportunities for skills practice and reflection can enhance nurses' confidence to engage in discussions about prognosis and goals of care.	III

24(4), 56-64.						
Mirel, M., & Hartjes, T. (2013). Bringing palliative care to the surgical ICU. *Critical Care Nurse, 33*(1), 71-74.	Qualitative	-discusses integration of palliative care into the SICU	Discussion	-discussed the finding that nurses were feeling burned out and stressed from not having the tools to provide quality end of life care	-change in the quality of palliative care in the critical care unit improved by both bringing in a palliative team and spearheading the change for nurses from within the unit	III
MJHS. (2017). Specialist palliative care. Retrieved from https://www.mjhspalliativeinstitute.org/specialist-palliative-care/	Infromational		Website		Used for definitions of primary palliative and specialty palliative care	V
Moir, C., Roberts, R., Martz, K., Perry, J., & Tivis, L. J. (2015). Communicating with patients and their families about	Quantitative		Survey	-60 inpatient nurses in Idaho -End of Life Professional Caregiver Survey -increased years of experience correlated with increased	-education for nurses was recommended	III

palliative and end of life care: Comfort and educational needs of nurses. *International Journal of Nursing, 21*(3), 109-112.				comfort r/t end of life -oncology nurses were the most comfortable with end of life care		
Montagnini, M., Smith, H., & Balistrieri, T. (2012). Assessment of self-perceived end-of-life care competencies of intensive care unit providers. *Journal of Palliative Medicine, 15*(1), 29-36.	Descriptive	The purpose of this study is to describe ICU health care providers' self-perceived knowledge, attitudes, and behaviors related to the provision of EOL care as a first step in planning educational interventions for ICU staff	Survey	several deficiencies in self-perceived EOL competencies were identified among staff, particularly in the areas of communication, continuity of care, and decision-making process. Nursing and medical staff also had different perceptions on how certain EOL behaviors were carried out in the ICU	Education for ICU staff on palliative care to be tailored to needs assessment	III
Morgan, L. (2011). Improving communication and cost-effectiveness		clarify what palliative care is and provide direction for clinicians to	Systematic Review	-PC supports autonomy in pt decision making -PC intervention is	-Education needs to be given although there are not studies	IV

in the intensive care unit through palliative care. *Dimensions in Critical Care Nursing, 30*(3), 133-138.		improve the palliative care services that are being provided in the ICU setting.		cost effective and improves communication and pt/ family satisfaction	on how effective this is 1) improved communication with families and patients through the implementation of palliative care and (2) the implementation of palliative care to improve cost-effectiveness of care.	
Morrison, R. S., Penrod, J. D., Cassel, J. B., Caust-Ellenbogen, M., Litke, A., Spragens, L.,… Meier, D. (2008). Cost savings associated with us hospital palliative care consultation programs. *Archives of Internal Medicine,*	Quantitative	This study examined the effect of palliative care teams on hospital costs.	Generalized linear models were estimated for costs per admission and per hospital day.	analyzed administrative data from 8 hospitals with established palliative care programs for the years 2002 through 2004. The palliative care patients who were discharged alive had an adjusted net savings of $1696 in direct costs per admission (P =	Hospital palliative care consultation teams are associated with significant hospital cost savings	III

168(16), 1783-1790.				.004) and $279 in direct costs per day (P < .001) including significant reductions in laboratory and intensive care unit costs compared with usual care patients. The palliative care patients who died had an adjusted net savings of $4908 in direct costs per admission (P = .003) and $374 in direct costs per day (P < .001) including significant reductions in pharmacy, laboratory, and intensive care unit costs compared with usual care patients.		
National Institute of Nursing Research. (2009). Improving palliative care and communication in the ICU.	Descriptive	Overview of nursing role in palliative care ICU integration	Review/ overview	symptom management and communication were a large part of nursing role for palliative care in the ICU; also mentions	Will include focus on symptom management and communication	IV

American Nurse Today, 4(1). Retrieved from https://americannursetoday.com/improving-palliative-care-and-communication-in-the-icu/				the culture of the ICU can affect how much involvement nursing is able to have in discussions with families/ patients		
National POLST Paradigm. (2016). POLST & advance directives. Retrieved from http://polst.org/advance-care-planning/polst-and-advance-directives/	Not research	To educate on use of POLST and Advance Directives	Website	Full of information on POLST and completion of Advance Directives as well as differences between the two	Will be used in educational session for DNP project	IV
Neville, T. H., Wiley, J. F., Yamamoto, M. C., Flitcraft, M., Anderson, B., Curtis, J. R., & Wenger, N. S. (2015). Concordance of nurses and physicians on whether critical care patients are receiving futile	Quantitative	To explore concordance of physicians' and nurses' assessments of futile critical care.	Correlational based on nurse and physician assessments	A focus group of clinicians developed a consensus definition of "futile" critical care. Daily for 3 months, critical care physicians and nurses in a health care system identified patients perceived to be receiving futile	Interprofessional concordance on provision of critical care perceived to be futile is low; however, joint predictions between physicians and nurses were most	III

treatment. *American Journal of Critical Care, 24*(5), 403-410.				treatment. Assessments and patients' survival were compared between nurses and physicians	predictive of patients' outcomes, suggesting value in collaborative decision making	
Norman, J. (2016). Americans rate healthcare providers high on honesty, ethics. Retrieved from http://www.gallup.com/poll/200057/americans-rate-healthcare-providers-high-honesty-ethics.aspx	Descriptive	Review of Gallup poll	survey	Nurses rated most ethical profession for 15 years		IV
Northridge, K. (2015). Difference between health care surrogate and power of attorney. Retrieved from http://www.livestrong.com/article/74409-difference-between-health-care-surrogate/		Website	Informational only	Clarified difference between surrogate and patient appointed medical power of attorney		IV

Nunn, C. (2014). It's not just about pain: Symptom management in palliative care. *Nurse Prescribing, 12*(7), 338-344.	Descriptive	Focuses on four common **sy mptoms** at the end of life: nausea and vomiting, dyspnoea, respiratory secretions—'death rattle', and agitation, restlessness and delirium.	Guidelin es based on evidence ; not research	Principles of prescribing, holistic assessment and communication , together with some pharmacothera py strategies, are considered.		IV
O'Mahony, S., McHenry, J., Blank, A. E., Snow, D., Eti, K. S., Santoro, G.,… Kvetan,V. (2010). Preliminary report of the integration of a palliative care team into an intensive care unit. *Palliative Medicine, 24*(2), 154-165.	Descriptive	This is a descriptive report of a convenience sample of 157 consecutive patients served by a palliative care team which was integrated into the operations of an ICU at Montefiore Medical Center in the Bronx, New York, from August 2005 until August 2007.	Mixed methods : Descript ive report & then case control study last 6 months of the project; intervie ws	Preliminary evidence suggest that such models may be associated with improved quality of life, higher rates of formalization of advance directives and utilization of hospices, as well as lower use of certain non-beneficial life-prolonging treatments for critically ill patients who are at the end of life.	We conclude that the integration of palliative care experts into the operation of critical care units is of benefit to patients, families and critical care clinicians.	II
Pasternak, S.	Information	Blog in	Listed	Brief statement		IV

(2013, June 3). *End of life care constitutes third rail of U.S. health care policy debate*. Retrieved from http://khn.org/morning-breakout/end-of-life-care-17/	al	Medicare Newsgroup	facts	about costs at end of life		
Pigeon, Y., & Khan, O. (2015). *Leadership lesson: Tools for effective team meetings*. Association of American Medical Colleges. Retrieved from https://www.aamc.org/members/gfa/faculty_vitae/148582/team_meetings.html	Informational	This Leadership Lesson presents a discussion of effective meeting practices and member actions that support team productivity.	Checklist/ review for effective meetings; not research	Attention to meeting preparation, facilitation, participation, and evaluation processes is the recommended approach for ensuring productive outcomes. The following meeting practices are well known to support productive team processes: 1. Organize meeting logistics 2. Distribute an agenda	Plan to apply these principles to meetings	V

				before the meeting 3. Start and end on time 4. Open with member check-in 5. Establish and review ground rules 6. Assign administrative roles 7. Summarize decisions and assign action items 8. Debrief: evaluate and plan for improvement 9. Distribute meeting minutes promptly		
Reavy, K., & Tavernier, S. (2008). Nurses reclaiming ownership of their practice: Implementation of an	Evidence Based Practice Model for Staff Nurses	Discussion of a new model for implementing EBP based on the Iowa Model, Stetler and	Pilot study used to test a change using the model	Model emphasizes importance and centrality of the staff nurse as well as emphasizes communication	This model basically puts the staff nurse between the nurse researcher and the patient.	IV

evidence-based practice model and process. *The Journal of Continuing Education in Nursing, 39*(4), 166-172.		Rosswurm & Larrabee			The "nurse researcher" could be a DNP, APN etc. The researcher fosters the staff to drive the changes-	
Rosswurm, M. A., & Larrabee, J. H. (1999). A model to change evidence based practice. *The Journal of Nursing Scholarship, 31*(4), 317-322.	Descriptive	-overview of Rosswurm and Larrabee's Model for Evidence-Based practice	Overview of model			IV
Schulz, V., & Novick, R. J. (2013). The distinct role of palliative care in the surgical intensive care unit. *Seminars in Cardiothoracic and Vascular Anesthesia, 17*(4), 240-248.	Descriptive	Explores palliative care, identifying patients/families who benefit from palliative care services, how palliative care complements SICU care, and opportunities to	Synthesis of literature	Explains roles of surgical and palliative team, conflicts, similarities and how they can work together for best patient outcomes	Palliative care can provide a significant, "value added" contribution to the care of seriously ill SICU patients.	IV

		integrate palliative care into the SICU				
Seaman, J. B. (2013). Improving care at end of life in the ICU: A proposal for early discussion of goals of care. *Journal of Gerontological Nursing, 39*(8), 52-58.	Descriptive	The purpose of this article is to explore several key factors that contribute to the problem of poor EOL care among older adults in the ICU and a proposed solution	Proposal for research to support a new EBP	Although this problem is complex, five distinct factors are highly relevant: 1. The prevailing technological and research imperatives in modern medicine. 2. The lack of explicit informed consent with regard to ongoing treatment provided in the ICU. 3. A lack of clarity about the role of a surrogate. 4. The inadequacy of most advance directives (ADs), when they exist, to provide clear direction on values and preferences. 5. The difficulty of prognostication, especially with	proposed solution: a mandatory review of goals of care conducted at 48 hours after admission--with all ICU patients at high risk of dying or with their surrogates--to address the negative ethical and patient-care sequelae associated with each of these elements.	IV

				nononcological conditions or those that do not follow a predictable trajectory.		
Shifrin, M. M. (2016). An evidence-based approach to end of life nursing education in intensive care units. *Journal of Hospice and Palliative Nursing, 18*(4), 342-348	Quantitative		Pre and post test	-formed an educational program for ICU RN's: EOL care -6 ICU's -46 nurses -3.5 hrs classroom -statistically significant change in pre and post test scores	-nursing education for critical care nurses regarding end of life care	III
Stacy, K. M. (2012). Withdrawal of life sustaining treatment. *Critical Care Nurse, 32*(3), 14-24.	Descriptive	to present the nursing aspects of managing an adult patient undergoing the withdrawal of mechanical ventilation as an end-of-life procedure	Informational	Discusses goals of care conferences and terminal extubation	Having an organized approach can ensure that patients experience a peaceful death and staff experience closure regarding the event	IV
University Hospitals. (2017). Patient pricing	Informational	Used for cost of care		Pricing for stay by unit		IV

information. Retrieved from http://www.uhhospitals.org/rainbow/patients-and-visitors/billing-insurance-and-medical-records/patient-pricing-information						
Vincent, J. L., de Mendonca, A., Cantraine, F., Moreno, R., Takala, J., Suter, P.,…Blecher, S. (1998). Use of the SOFA score to assess the incidence of organ dysfunction/ failure in intensinve care units: Results of a multi-center prospective study. *Critical Care Medicine, 26(*11), 1793-1800.	Quantitative	To evaluate the use of the Sequential Organ Failure Assessment (SOFA) score in assessing the incidence and severity of organ dysfunction in critically ill patients.	Prospective, multicenter study.	The main outcome measures included incidence of dysfunction/failure of different organs and the relationship of this dysfunction with outcome. In this cohort of patients, the median length of ICU stay was 5 days, and the ICU mortality rate was 22%. Multiple organ dysfunction and high SOFA scores for any individual organ were associated with increased mortality	The SOFA score is a simple, but effective method to describe organ dysfunction /failure in critically ill patients. Regular, repeated scoring enables patient condition and disease development to be monitored and better understood.	II

Walker, K. A., Mayo, R. L., Camire, L. M., & Kearney, C. D. (2013). Effectiveness of integration of palliative medicine specialist services into the intensive care unit of a community teaching hospital. *Journal of Palliative Medicine, 16*(10), 1237-1241.	Quantitative ; Descriptive	Assess effectiveness of integrating palliative medicine specialists in the ICU.	Retrospective chart review. Nonrandomized and nonblinded.	Of 201 patients who qualified for palliative consultation using a palliative screening tool, 92 were referred and 109 were not referred for palliative medicine consultation. Palliative medicine consult volume increased significantly compared with preintegration No significant difference in hospital mortality was found. ICU length of stay was significantly shorter in the referred. Referred patients were more frequently enrolled in hospice.	: Integrating palliative medicine specialists into intensive care was associated with a significant increase in use of palliative medicine services and a significant decrease in ICU length of stay for referred patients without a significant increase in mortality. The screening tool effectively identified patients at high risk of death. Given the high mortality rate of the unreferred patients, the criteria could be	III

					more widely adopted by ICU physicians to consider expanding palliative medicine referrals.	
Weissman, D. E., & Meier, D. E. (2011). Identifying patients in need of a palliative care assessment in the hospital setting: A consensus report from the center to advance palliative care. *Journal of Palliative Medicine*, *14*(1), 17-23.		The Center to Advance Palliative Care convened a consensus panel to select criteria by which patients at high risk for unmet palliative care needs can be identified in advance for a palliative care screening assessment.	Consensus panel	developed primary and secondary criteria for two checklists—one to use for screening at the time of admission and one for daily patient rounds	The criteria identified in this report should be viewed as a starting point for discussion within hospitals	IV
White, D.B., Malvar, G, Karr J., Lo, B., & Curtis, J. R. (2010). Expanding the paradigm of the physician's role in	Qualitative	To determine how responsibility is balanced between physicians and surrogates	Multi-centered study of audio-taped clinician –family conferences with a	In the derivation cohort (n = 63 decisions), no clinician inquired about surrogates' preferred role in decision-making.	There is considerable variability in the roles physicians take in decision-making	IV

surrogate decision-making: an empirically derived framework. *Critical Care Medicine, 38*(3), 743-750.		for life support decisions and to empirically develop a framework to describe different models of physician involvement.	derivation and validation cohort.	Physicians took one of four distinct roles: 1) informative role (7 of 63) 2) facilitative role (23 of 63), 3) collaborative role (32 of 63 and 4) directive role (1 of 63)	about life support with surrogates but little negotiation of desired roles. We present an empirically derived framework that provides a more comprehensive view of physicians' possible roles.	
White, K. R., Roczen, M. L., Coyne, P. J., & Wiencek, C. (2014). Acute and critical care nursing: Perceptions of palliative care competencies: A pilot study. *The Journal of Continuing Education in Nursing, 45*(6), 265-277	Quantitiative		Survey	-49 nurses attending a critical care continuing ed. Event + graduate nurses in an acute care NP program -33 item survey -showed a deficit of knowledge and comfort with pall care components even when palliative teams are in	-Noted that palliative care in the ICU as top priority of the IOM, Joint Commission, Crit. Care Societies Collaborative, AACCN, commercial insurers, and others -education recommended for	III

				place -overall lack of understanding of plans of care -variation in knowledge of pall care components noted	nurses specifically in symptom mgt, pain assess/ mgt, communication, Advance Directives, and ethics	
Wittenberg, E., Goldsmith, J., Ferrell, B., & Platt, C. (2015). Enhancing communication related to symptom management through plain language. *Journal of Pain and Symptom Management, 50*(5), 707-711.	Non experimental	Application of the Plain Language Planner for Palliative Care(©), a provider tool for communicating about medication and symptoms using plain language, was tested	Education sessions with Pre and post responses to types of language used to describe symptoms	Approximately 75% of the 155 health care professionals, mostly nurses participated in a before-and-after educational activity about the tool, provided written communication explanations using one of three medication-symptom pairs. A comparison between written responses before and after the education session showed improvement in the use of plain language.	Provider training with the tool produced increased plain language. Use of the tool in provider education shows promise in increasing the health literacy for patients and families regarding symptom management.	III

World Health Organization. (2015). WHO definition of palliative care. Retrieved from http://www.who.int/cancer/palliative/definition/en/		Used for definition of palliative care	Website			IV
Zaccagnini, M. E., & White, K. W. (2011). *The doctor of nursing practice essentials.* Sudbury, MA: Laureate Education Inc.		Core textbook for DNP Essentials both for class and as a reference for practicing DNP's	Textbook		Reference	IV

Appendix B: Educational Curriculum Plan

Problem: The problem I addressed in this DNP staff education project was ICU nurses' lack of knowledge about the provision of primary palliative care.

Purpose: The purpose of this DNP project was to develop an evidence-based staff education plan for ICU nurses that would facilitate primary palliative care access for all patients and families in the ICU.

Goal: The goal of this project is to provide all patients in the ICU access to palliative care.

Objectives At the conclusion of this educational experience, learners will be able to:	**Content Outline**	**Evidence**	**Method of Presenting**	**Method of Evaluation P/P Item**	**Grade**
I. The learner will be able to identify the project purpose and significance of the curriculum developed to educate ICU nurses about palliative care.	1. Introduction: Definition of palliative care per World Health Organization (2015) is "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and	1. World Health Organization (2015); Center to Advance Palliative Care, (2015); Austin, D. (2013) 2a. Walker, K. A., Mayo, R. L., Camire, L. M., & Kearney, C. D. (2013); (Center to Advance Palliative	Oral and power point; discussion	1,4,5,6,13,14	1. IV, IV, II 2a. III, IV, IV, IV, IV, II 2b. II 2c. IV, IV, III,

	impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"; difference between hospice (expected 6 months or less of life) and palliative care (beneficial for any life limiting or threatening illness even when cure is the goal); The National Board for Certification of Hospice and Palliative Nurses began certifying nurses in 1994, and palliative care was recognized by the American Board of Medical Specialties in 2006. 2. Project Significance a. Nursing With palliative involvement there is documented potential for	Care, (2015); Morgan, (2011); Nelson, J. E., Curtis, J. R., Mulkerin, C., Campbell, M., Lustbader, D. B., Mosenthal, A.C.,… Puntillo, K. (2013); Campbell, M. L., Weissman, D. E., & Nelson, J. E. (2012); Austin, D. (2013) 2b. O'Mahony, S., McHenry, J., Blank, A. E., Snow, D., Eti, K. S., Santoro, G.,… Kvetan,V. (2010). 2c. Morgan, (2011); Nelson et al. (2013); Morrison, R. S., Penrod, J. D., Cassel, J. B., Caust-Ellenbogen, M., Litke, A., Spragens,			IV, II 3a. IV, III, IV 3b. III, IV 3c. IV, IV, II

	shorter ICU length of stay (7 versus 11 days), shorter overall hospital stay, a reduced 30-day readmission rate and increased patient and family satisfaction scores (Morgan, 2011; Nelson et. al 2013); improved transitions of care and symptom management (CAPC, 2015); with a focus on goals of care lends a clear focus to the plan of care; nurses are the most consistent family/ patient involvement in the hospital b. Social: over half of Americans who die in a hospital spend time in	L.,… Meier, D. (2008); Pasternak (2013); O'Mahony et al. (2010) 3a. Schulz & Novick (2013); Montagnini, M., Smith, H., & Balistrieri, T. (2012); Love, A. W., & Liversage, L. M. (2014) 3b. Holms, M., Milligan, S., & Kydd, A. (2014); Milic, M. M., Puntillo, K., Turner, K., Joseph, D., Peters, N., Ryan, R.,…Anderson, W. G. (2015) 3c. Aslakson, Randall & Nelson, (2014); National Institute of Nursing Research. (2009); Hua & Wunsch (2014); Austin, D.			

	an ICU during their last three days of life and 20% of deaths in the United States occur during or shortly after an ICU stay; a person remains in control of the direction the plan of care will take, and the ethical principle of autonomy is upheld c. Financial: Medicare is spending 28% of their health care dollars in the last six months of life ($170 billion); For those patients discharged alive, total savings of $2,642 was documented per admission. For those patients who passed away in the hospital, the total savings	(2013)			

	was $6,896 per admission. Direct savings consisted of significant reductions in pharmacy cost, laboratory cost and days spent in the ICU; 3. Curriculum Purpose a. Increase knowledge: research consistently reflects clinician (and family) misunderstanding of palliative care role and interventions b. Increase confidence in skills: ICU nurses were not confident in end of life care skills/ training and instead, needed to learn these skills over time c. Improve				

	patient care: There is a shortage of palliative care providers. Nursing can help to fill the gap for basic primary palliative care needs.				
II. The learner will be able to identify and express the correlation between the integration of palliative care into the ICU and the "Triple Aim" of the UCH system.	1. Triple Aim: Cost effective care, better health for the patient, greater patient satisfaction (University of Maryland Upper Chesapeake Health, 2016) 2. Palliative Care Integration: a. Palliative care in the ICU is a priority: requires a specialist approach to be most effective; Review of the literature supports the integration of palliative care into the ICU setting. According to Hua and	1. University of Maryland Upper Chesapeake Health, (2015, para. 1 & 2); Gibbs Jr., Mahon, Truss, & Eyring, (2015); University of Maryland Upper Chesapeake Health, 2016) 2a. Hua & Wunsch (2014); Morgan, (2011); Nelson et. al (2013); Walker, Mayo, Camire, and Kearney (2013); O'Mahony et al. (2010)	Oral with power point; discussion	2,3	1. IV, III, IV 2a. IV, IV, IV, III, II 2b. IV, III, II, II, II, II 2c. III, II, IV, III, II

	Wunsch (2014), palliative care in the ICU is a priority. Walker, Mayo, Camire, and Kearney (2013) report that collaboration between ICU and palliative medicine is a best practice. O'Mahony et al. (2010) state that "integration of palliative care clinicians into the operation of critical care units is of benefit to patients, families, and critical care clinicians" (p. 163). b. Use of triggers to identify highest risk patients: Use of screening tools increased palliative care consults in ICU (113% MICU &	2b. Weismann & Meier, (2011); Hua, Li, Blinderman, and Wunsch (2014); Francis, Rich, Williamson, and Peterson (2010); Cohen, C., King, A., Lin, C. P., Friedman, C. K., Monroe, K., & Kutny, M. (2015); Sihra, L., Harris, M., & O'Reardon, C. (2011); Campbell, M. L., Weissman, D. E., & Nelson, J. E. (2012); Austin, D. (2013) 2c. Knaus, W. A., Draper, E. A., Wagner, D. P., & Zimmerman, J. E. (1985); Le Gall, J. R., Lemeshow, S., & Saulnier, F. (1993); Medlej, K. (2016);			

	51% SICU); Statistically significant differences were evident showing increased mortality and morbidity outcomes for the patients that met triggers. (our own retrospective review: only 1/17 patients went home that met triggers) These triggers include: • ICU admission after a hospital stay greater than or equal to 10 days; • Multisystem organ failure greater than or equal to three systems; • Stage IV malignancy; • Status post cardiac arrest; • Intracerebral hemorrhage requiring mechanical ventilation. Consult palliative	Neville, T. H., Wiley, J. F., Yamamoto, M. C., Flitcraft, M., Anderson, B., Curtis, J. R., & Wenger, N. S. (2015); Vincent, J. L., de Mendonca, A., Cantraine, F., Moreno, R., Takala, J., Suter, P.,…Blecher, S. (1998)			

	care for the following scenarios: • Difficult-to-control physical symptoms despite usual treatment approaches. • Patients/surrogates wish to explore non-ICU supportive care options such as hospice services. • Staff has questions about the appropriateness of life-sustaining therapies in the setting of advanced complex illnesses. • There are complex family dynamics impacting decisions about use of life-sustaining treatments. • There are disagreements among staff or between staff and patients/surrogates about prognosis and/or use of life-sustaining treatments. • Patients are being				

	readmitted to the ICU more frequently within a given time frame. c. Prognostication (morbidity and mortality prediction): APACHE II; SAPS; SOFA; nurses and physicians together better predicted futile treatments than either group alone				
III. The learner will be able to identify and discuss the components of and value to conducting a goals of care meeting	1. Value of goals of care meeting a. Encourages health care team and patient/ family to communicate and work toward a common goal b. Allows for open discussion of options from the realm of fully aggressive care to hospice (patient may	1. Alspach, J. (2016); Seaman, J. B. (2013); Stacy, K. M. (2012); Blinderman, C., & Billings, J. A. (2015); McGowan, C. M. (2011); Hospicare, (2016) 2. Milic, M. M., Puntillo, K., Turner, K., Joseph, D., Peters, N., Ryan, R.,…Anderso	Oral with power point; role play with discussion	4,11	1. IV, IV, IV, IV, IV, IV 2. III, II, III, II, IV, II, IV, IV

	be a Full Code on hospice). c. "Correlated with the use of fewer aggressive, life-extending interventions (e.g., mechanical ventilation and resuscitation), as well as with end-of-life care that is consistent with the patient's preferences, fewer deaths in the intensive care unit, and earlier referral to a hospice" (Blinderman, C., & Billings, J. A., 2015, p 2550) d. In a review of 16 studies, surrogates were wrong in assumptions about patient wishes for goals of care 1/3 of the time.	n, W. G. (2015); Carson, S. S., Garrett, J., Hanson, L. C., Lanier, J., Govert, J., Brake, M. C.,…Carey, T. S. (2008); Knaus, W. A., Draper, E. A., Wagner, D. P., & Zimmerman, J. E. (1985); Le Gall, J. R., Lemeshow, S., & Saulnier, F. (1993); Medlej, K. (2016); Vincent, J. L., de Mendonca, A., Cantraine, F., Moreno, R., Takala, J., Suter, P.,…Blecher, S. (1998); Stacy, K. M. (2012); Blinderman, C., & Billings, J. A. (2015).			

	2. Components of goals of care meeting a. Understand and elicit consensus from health care team regarding realistic goals and options b. Pay attention to environment: meet in patient's room if patient is participating; no distractions or interruptions c. Explain role of goals of care meeting d. Establishing what patient and family understand e. Explain the medical situation including prognosticati on and options going forward (do not offer futile interventions) f. Understand the social and				

	spiritual situation g. Ask about and address any misconceptions, anxieties and fears h. Ask about and address any "unacceptable" situations or conditions i. Putting the medical, social, and spiritual situation together j. Establishing a common, realistic goals				
IV: The learner will be able to identify the purpose, similarities, and differences between different legal forms regarding the expression of goals of care.	1. Legal forms frequently used in palliative care a. MOLST/ POLST (Maryland or Physician Orders for Life Sustaining Treatment): DNR orders increased from 33% to 83% after palliative consults b. Advance Directive/ Living Will	1a. O'Mahony et al. (2010); National POLST Paradigm. (2016). 1b. Alspach, J. (2016); Seaman, J. B. (2013); National POLST Paradigm. (2016). 1c. Seaman, J. B. (2013); McGowan, C.	Oral with review of actual forms	9,10,12,20	1a. II, IV 1b. IV, IV; IV 1c. IV, IV, IV 1d. IV, IV, IV 1e.

	(express patient wishes in future conditions usually designated as end stage, terminal, or persistent vegetative state): Only 25-30% of US population has one; surveys of physicians at Hopkins 1960's and Stanford 2014 showed physicians wanted less aggressive care than they give c. Health Care Power of Attorney/ Medical Power of Attorney (adult appointed by patient to make health care decisions either immediately or when no longer competent) d. Surrogate (an	M. (2011); Northridge, K. (2015) 1d. Seaman, J. B. (2013); National POLST Paradigm. (2016); Northridge, K. (2015) 1e. McGowan, C. M. (2011) 1f. Neville, T. H., Wiley, J. F., Yamamoto, M. C., Flitcraft, M., Anderson, B., Curtis, J. R., & Wenger, N. S. (2015); Bernat, J. L., 2005) 1g. McGowan, C. M. (2011) 2. Seaman, J. B. (2013); McGowan, C. M. (2011); National POLST Paradigm. (2016).			IV 1f. III, IV 1g. IV 2. IV, IV, IV

	adult who makes health care decision for a patient who is unable to give consent or make medical decisions for oneself; does not need to be a relative e. Guardianship (court appointed medical guardian of person): State guardianship has same authority for medical decisions as HCPOA. However, decisions may be delayed because of the need to set court dates for decision such as DNR, DNI, comfort care f. Medical Futility ("Medical futility means that the proposed therapy should not be				

	performed because available data show that it will not improve the patient's medical condition" Bernat, J. L., 2005) g. Capacity (the ability to understand the complexities and long term consequences of a decision; medical in our cases) 2. Form purposes, similarities, and differences: Advance Directives are different than a MOLST/ POLST. Advance Directives direct future decisions while a MOLST reflects current wishes. Many of the similarities and differences of the forms and concepts will be discussed with the definitions.				
V: The learner will	1. Common distressing	1a. Campbell, M. (2015);	Power point	7,8,15,16,17, 18,19	1a. IV,

be able to identify common, distressing symptoms associated with life limiting illnesses as well as relieving interventions for these same symptoms.	symptoms (over ½ of patients seen in consult require symptom management- Mahoney, 2010) a. Pain: most feared by patients; 40% last 3 days of life; etiology needs to be determined for best interventions; pre medicate for procedures; acetaminophen/ NSAIDS, opioids if severe (bolus dosing with titration to basal dose/ no toxic ceiling); watch for constipation with opiates; neuroleptics; steroids; antidepressants b. Dyspnea: fear of suffocation; air hunger; most "distressing" symptom; 33-76% (even with mechanical	Leung, J. G., Nelson, S., & Leloux, M. (2014); Blinderman, C., & Billings, J. A. (2015). 1b. Campbell, M. (2015); Leung, J. G., Nelson, S., & Leloux, M. (2014); Nunn, C. (2014); Blinderman, C., & Billings, J. A. (2015). 1c. Campbell, M. (2015); Leung, J. G., Nelson, S., & Leloux, M. (2014); Blinderman, C., & Billings, J. A. (2015). 1d. Campbell, M. (2015); Leung, J. G., Nelson, S., & Leloux, M. (2014); Nunn, C. (2014); Blinderman, C., & Billings, J. A. (2015).	with discussion; Blinderman and Billings article (with chart)		IV 1b. IV, IV, IV 1c. IV, IV 1d. IV, IV, IV 1e. IV, IV 1f. IV, IV, IV 1g. IV 1h. IV 1i. IV 2a. IV, V 2b. IV, V, III, IV

	ventilation); Cheyne-Stokes, intermittent apnea and hyperpnea are not dyspnea; opiates are drug of choice and well studied for in COPD and oncology patients (usually lower doses than for pain); fentanyl and morphine only ones studied; can adjunct with benzodiazepine. c. Anxiety: 58-63%; benzodiazepines; sedative such as propofol in ICU d. Secretions: up to 92%; "death rattle"; generally bothers caregivers more than patient and treatment other than repositioning not	1e. Nunn, C. (2014); Blinderman, C., & Billings, J. A. (2015). 1f. Nunn, C. (2014); Blinderman, C., & Billings, J. A. (2015); Leung, J. G., Nelson, S., & Leloux, M. (2014). 1g. Blinderman, C., & Billings, J. A. (2015) 1h. Blinderman, C., & Billings, J. A. (2015) 1i. Blinderman, C., & Billings, J. A. (2015). 2a. Campbell, M. (2015); Leung, J. G., Nelson, S., & Leloux, M. (2014); Lynch, M. T. (2014);			3. IV, IV, IV 4. IV, IV

	recommended (SE of meds). However, we use scopolamine, levsin, atropine often e. Nausea and vomiting: can be multifactorial and hard to treat (may need more than one drug class); attempt to treat for underlying etiology; bowel obstruction (octreotide; steroids), side effects of medications (varies); increase ICP (steroid), gastroparesis (dopamine receptor antagonisits: reglan, Haldol; avoid mineral oil if aspiration risk and fiber if low fluid intake; Vaseline balls used by hospice),	Blinderman, C., & Billings, J. A. (2015). 2b. Campbell, M. (2015); Leung, J. G., Nelson, S., & Leloux, M. (2014); Lynch, M. T. (2014); Wittenberg, E., Goldsmith, J., Ferrell, B., & Platt, C. (2015); Blinderman, C., & Billings, J. A. (2015) 3. Campbell, M. (2015); Leung, J. G., Nelson, S., & Leloux, M. (2014); Stacy, K. M. (2012); Blinderman, C., & Billings, J. A. (2015) 4. Blinderman, C., & Billings, J. A. (2015); Leung, J. G., Nelson, S., &			

	chemotherapy (serotonin agonists: Zofran), anticipatory nausea (benzodiazepines); cannabinoids (now legal in Maryland) f. Agitation, restlessness and delirium: up to 85% of patients; No high level evidence to base treatment at end of life: haldol, antipsychotics. Benzodiazepines as last resort and can worsen delirium; if patient is calm, no need to medicate g. Cough: 60-100% at end of life; opiates, gabapentin, other anti-tussives h. Anorexia/ cachexia: No evidence to support any medications;	Leloux, M. (2014)			

	Artificially administered fluids are not supported in the evidence to improve comfort and can, instead, promote suffering from overload (Very controversial subject and more studies are needed) i. Fever: neoplasms, medications, infections, neurologic changes: acetaminophen, NSAIDS, steroids (not much evidence for steroids) 2. Relieving interventions a. Medicinal (addressed with each symptom); IV, SQ, rectal (should be avoided in patients with neutropenia, thrombocytopenia,				

	diarrhea, abdominoperineal resection, and anorectal disease),SL (up to 1ml can be used buccal if unable to swallow), oral, TD (absorption affected by body fat), topical (compounded creams and gels can be helpful but it is difficult to know what serum levels will be reached), nebulized routes b. Non-medicinal: cold/ heat packs; positioning; emotional support; skin/ wound care; music (some evidence base but not in critical care); chaplaincy services; discontinuation of				

	uncomfortable or unnecessary interventions (vital signs; statins, etc.); discontinuation of fluids artificially; diet for pleasure; pleurx (or thoracentesis/ paracentesis); oxygen; fans; open window; humidified air; elevated head of bed; suctioning (rarely) 3. Terminal Extubation: Karen Ann Quinlan 1976; no evidence-based guidelines on procedure; 2 types: terminal wean versus immediate withdrawal; Emotional support needed; prophylactic doses of opiates and benzodiazepines if death expected quickly; dexamethasone 4 mg q6h for 24				

	hours prior if stridor anticipated 4. Palliative Sedation: not the same as physician assisted suicide; used only when all other efforts have failed in providing comfort to a dying patient; midazolam, ketamine, propofol				
VI: The learner will be able to identify and express therapeutic communication techniques when interacting with ICU patients.	1. Importance of communication: Allows for common goals to be set (goals cannot be set without an understanding of the medical situation); improves patient/ family satisfaction 2. Communication barriers: logistics, clinician discomfort with discussing prognosis, inadequate skill and training, and fear of conflict.	1.Schulz & Novick (2013); Lynch, M. T. (2014); Blinderman, C., & Billings, J. A. (2015) 2. Aslakson, R. A., Wyskiel, R., Thornton, I, Copley, C., Shaffer, D., Dauryne, Z.,… Pronovost, P. J. (2012) 4. Milic, M. M., Puntill	Oral with power point; role playing	4	1. IV, V, IV 2. III 3. III, IV, IV, III, IV, IV

	3. Communication techniques: simple, clear jargon free language; open ended questions can be helpful; it is acceptable to recommend a plan consistent with patients values and wishes; allow patient and family time to consider and discuss options among themselves unless decision is urgent	o, K., Turner, K., Joseph, D., Peters, N., Ryan, R.,… Anderson, W. G. (2015); National Institute of Nursing Research. (2009); White, D.B., Malvar, G, Karr J., Lo, B., & Curtis, J. R. (2010); Wittenberg, E., Goldsmith, J., Ferrell, B., & Platt,			

		C. (2015); Blinderman, C., & Billings, J. A. (2015); Stacy, K. M. (2012)			
Summary	Integration and triggers need to be tailored to individual ICU	Nelson et al., (2013); CAPC, (2015); Hua, M., & Wunsch, H. (2014).			IV, IV, IV

Appendix C: Content Expert Evaluation of the Curriculum Plan

Title of Project: Palliative Care Integration in the ICU
Student: Jennifer Goldsborough
Date:
Name of Reviewer:

Products for review: Curriculum Plan, Complete Curriculum Content, Literature review Matrix

Instructions Please review each objective related to the curriculum plan, content and matrix. The answer will be a "yes" or "no" with comments if there is a problem understanding the content or if the content does not speak to the objective.

Objective 1: The learner will be able to identify the project purpose and significance of the curriculum developed to educate ICU nurses about palliative care.

Met Not Met

Comments:

Objective 2: The learner will be able to identify and express the correlation between the integration of palliative care into the ICU and the "Triple Aim**"** of the UCH system.

Met Not Met

Comments:

Objective 3: The learner will be able to identify and discuss the components of and value to conducting a goals of care meeting.

Met Not Met

Comments:

Objective 4 The learner will be able to identify the purpose, similarities, and differences between different legal forms regarding the expression of goals of care.

Met Not Met

Comments:

Objective 5: The learner will be able to identify common, distressing symptoms associated with life limiting illnesses as well as relieving interventions for these same symptoms. Met Not Met

Comments:

Objective 6: The learner will be able to identify and express therapeutic communication techniques when interacting with ICU patients.
Met Not Met

Comments:

Appendix D: Content Expert Evaluation of the Curriculum Plan Summary

Not Met = 1 Met = 2

At the conclusion of this educational experience, learners will be able to:

Objective Number	Evaluator 1	Evaluator 2	Evaluator 3	Average Score
1. Identify the project purpose and significance of the curriculum developed to educate ICU nurses about palliative care.	2	2	2	2
2. Identify and express the correlation between the integration of palliative care into the ICU and the "Triple Aim" of the UCH system.	2	2	2	2
3. Identify and discuss the components of and value to conducting a goals of care meeting.	2	2	2	2
4. Identify the purpose, similarities, and differences between different legal forms	2	2	2	2

regarding the expression of goals of care.				
5. Identify common, distressing symptoms associated with life limiting illnesses as well as relieving interventions for these same symptoms.	2	2	2	2
6. Identify and express therapeutic communication techniques when interacting with ICU patients.	2	2	2	2

Appendix E: Pretest Posttest Questionnaire

Pre-Test/ Post-Test: Palliative Care Integration in the Intensive Care Unit

Name:
Date:

1. **What percent of patients in the United States spend time in the ICU at end of life?** (O' Mahoney et al., 2010)

    a. **10%**
    b. **20% ***
    c. **30%**
    d. **40%**

2. **Hua et al. (2014) applied the most standard triggers retrospectively to patients in the ICU. Twenty percent of these patients met criteria for palliative involvement. What were these triggers? (Circle all that apply)**

    a. **Stage III lung cancer**
    b. **Cardiac arrest ***
    c. **Longstanding COPD**
    d. **History of intubation**
    e. **Multi system organ failure ***
    f. **Brain metastasis ***

3. **Specialist palliative care involvement is recommended in which cases: (Circle all that apply):** (Campbell, 2012- all 5 options)

    a. **Difficult-to-control physical symptoms despite usual treatment approaches. ***
    b. **Patients/surrogates wish to explore non-ICU supportive care options such as hospice services. ***
    c. **Questions about the appropriateness of life-sustaining therapies in the setting of advanced complex illnesses. ***
    d. **Complex family dynamics impacting decisions about use of life-sustaining treatments. ***
    e. **Disagreements among staff or between staff and patients/surrogates about prognosis and/or use of life-sustaining treatments. ***

4. **In the literature, patients with palliative team involvement in the ICU have outcomes that include: Circle all that apply.**

a. **Lower 30 day readmission rates *** (Campbell, 2012)
b. **Improved symptom management *** (CAPC, 2015)
c. **Improved patient satisfaction *** (Campbell, 2012)
d. **Increased ICU mortality statistics** (Campbell- no change)
e. **Decreased cost of care *** (Campbell, 2012)
f. **Increased completion of Advance Directives *** (O'Mahony et al., 2010)

5. **What percentage of their health care dollars is Medicare is spending in the last six months of life?** (Pasternak, 2013)

   a. **8%**
   b. **18%**
   c. **28% ***
   d. **38%**

6. **Direct cost savings occurred for ICU patients who received a palliative care consultation compared to ICU patients who did not receive consultation:** (Morrison et al., 2008)

   a. **When patients were discharged home**
   b. **When patients died in the hospital**
   c. **Both a and b ***
   d. **Neither a or b**

7. **Which of the following medications is a first line medication for delirium?** (Blinderman & Billings, 2015)

   a. **Ativan**
   b. **Haldol ***
   c. **Morphine**
   d. **Both A & B**

8. **How many milliliters can be given buccally when one is unable to swallow?** (Leung & Leloux, 2014)

   a. **0.5 ml**
   b. **1 ml ***
   c. **1.5 ml**
   d. **2 ml**

<u>TRUE or FALSE</u>

9. **True or False: When surveyed, more physicians requested aggressive care at end of life versus focus on comfort.** (Alspach,, 2016)

    a. **True**
    b. **False ***

10. **True or False: Capacity to make decisions and patient competence are often used interchangeably because they have the same meaning. (**McGowan, 2011)

    a. **True**
    b. **False ***

11. **True or False: Hospice care will accept and admit patients with a Maryland Order for Life Sustaining Treatment form (MOLST) indicating FULL CODE.** (Hospicare, 2016)

    a. **True ***
    b. **False**

12. **True or False: A MOLST is equivalent to an Advance Directive.** (National POLST Paradigm, 2016)

    a. **True**
    b. **False ***

13. **True or False: There is a shortage of palliative care specialists in the United States.** (Hua & Wunsch, 2014)

    a. **True ***
    b. **False**

14. **True or False: Direct cost savings resulting from palliative care consultations were due to savings in laboratory costs, pharmacy costs, and less days spent in the ICU.** (Morrison et al., 2008)

    a. **True ***
    b. **False**

15. **True or False: The evidence base supports treatment of oral secretions (death rattle) at end of life with medication (scopolamine) for patient comfort.** (Blinderman & Billings, 2015)

a. **True**
b. **False ***

16. **True or False: Evidence supports that artificially administered fluids at end of life can cause suffering.** (Lynch, M. T., 2014)

a. **True ***
b. **False**

17. **True or False: Palliative sedation is the same as physician assisted suicide.** (Blinderman & Billings, 2015)

a. **True**
b. **False ***

18. **True or False: Compounded creams can be used topically as they are known to achieve therapeutic and predictable serum levels of the drugs they contain.** (Leung, Nelson, & Leloux, 2014)

a. **True**
b. **False ***

19. **True or False: Morphine has been studied for efficacy in treating dyspnea.** (Campbell, 2015)

a. **True ***
b. **False**

20. **True or False: Surrogate decision makers must be related to the patient.** (Northridge, 2015)

a. **True**
b. **False ***

Total of 34 points possible- 1 point for true/ false or single answer questions; 1 point for each answer either circled or NOT circled correctly in the 'circle all that apply' questions

Appendix F: Pretest/Posttest Expert Content Validation

PRETEST/POSTTEST EXPERT CONTENT VALIDATION

TITLE OF PROJECT: Palliative Care Integration in the Intensive Care Unit

Date: 1/7/17 **Student Name: Jennifer Goldsborough**

Reviewer's Name:

Packet: Curriculum Plan, Pretest/Posttest with answers

INSTRUCTIONS: **Please check each item to see if the question is representative of the course objective and the correct answer is reflected in the course content. Circle the relevance level.**

Test Item #

1. What percent of patients in the United States spend time in the ICU at end of life? (O' Mahoney et al., 2010)

c. 10%
d. 20% *
e. 30%
f. 40%

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

2. Hua et al. (2014) applied the most standard triggers retrospectively to patients in the ICU. Twenty percent of these patients met criteria for palliative involvement. What were these triggers? (Circle all that apply)

a. Stage I lung cancer
b. Cardiac arrest *
c. COPD
d. History of intubation

e. Multi system organ failure *
f. Brain metastasis *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

3. In what cases is a palliative care consult recommended for specialist involvement (Circle all that apply): (Campbell, 2012- all 5 options)

a. Difficult-to-control physical symptoms despite usual treatment approaches. *
b. Patients/surrogates wish to explore non-ICU supportive care options such as hospice services. *
c. Questions about the appropriateness of life-sustaining therapies in the setting of advanced complex illnesses. *
d. Complex family dynamics impacting decisions about use of life-sustaining treatments. *
e. Disagreements among staff or between staff and patients/surrogates about prognosis and/or use of life-sustaining treatments. *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

4. Outcomes documented in the literature of patients with palliative team involvement in the ICU include: Circle all that apply.

a. Lower 30 day readmission rates * (Campbell, 2012)
b. Improved symptom management * (CAPC, 2015)
c. Improved patient satisfaction * (Campbell, 2012)
d. Increased ICU mortality statistics (Campbell- no change)
e. Decreased cost of care * (Campbell, 2012)
f. Increased completion of Advance Directives * (O'Mahony et al., 2010)

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

5. What percentage of their health care dollars is Medicare is spending in the last six months of life? (Pasternak, 2013)

    a. 8%
    b. 18%
    c. 28% *
    d. 38%

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

6. Direct cost savings occurred for ICU patients who received a palliative care consultation compared to ICU patients who did not receive consultation: (Morrison et al., 2008)

    a. When patients were discharged home
    b. When patients died in the hospital
    c. Both a and b *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

7. Which of the following is a first line medication for delirium? (Blinderman & Billings, 2015)

    a. Ativan
    b. Haldol *
    c. Morphine
    d. A & B

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

8. How many milliliters can be given buccally when one is unable to swallow? (Leung & Leloux, 2014)

    a. 0.5 ml
    b. 1 ml *
    c. 1.5 ml
    d. 2 ml

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

9. True or False: When surveyed, more physicians requested aggressive care at end of life versus focus on comfort. (Alspach,, 2016)

    a. True
    b. False *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

10. True or False: Capacity to make decisions and patient competence are often used interchangeably because they have the same meaning. (McGowan, 2011)

    a. True
    b. False *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

11. True or False: Hospice care will accept and admit patients with a Maryland Order for Life Sustaining Treatment form (MOLST) indicating FULL CODE. (Hospicare, 2016)

    a. True *
    b. False

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

12. True or False: A MOLST is equivalent to an Advance Directive. (National POLST Paradigm, 2016)

    a. True
    b. False *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

13. True or False: There is a shortage of palliative care specialists in the United States. (Hua & Wunsch, 2014)

    a. True *
    b. False

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

14. True or False: Direct cost savings resulting from palliative care consultations were due to savings in laboratory costs, pharmacy costs, and less days spent in the ICU. (Morrison et al., 2008)

    a. True *
    b. False

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

15. True or False: The evidence base supports treatment of oral secretions (death rattle) at end of life with medication (scopolamine) for patient comfort. (Blinderman & Billings, 2015)

    - True

- False *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

16. True or False: Evidence supports that artificially administered fluids at end of life can cause suffering. (Lynch, M. T., 2014)

    a. True *
    b. False

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

17. True or False: Palliative sedation is the same as physician assisted suicide. (Blinderman & Billings, 2015)

    a. True
    b. False *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

18. True or False: Compounded creams can be used topically as they are known to achieve therapeutic and predictable serum levels of the drugs they contain. (Leung, Nelson, & Leloux, 2014)

    a. True
    b. False *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

19. True or False: All opiates have been studied for efficacy in treating dyspnea. (Campbell, 2015)

a. True
b. False *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

20. True or False: Surrogate decision makers must be related to the patient. (Northridge, 2015)

a. True
b. False *

Not Relevant Somewhat Relevant Relevant Very Relevant

Comments:

Appendix G: Summary of Content Expert Validation of Pretest Posttest Items

Not Relevant = 1, Somewhat Relevant = 2, Relevant = 3, Very Relevant = 4

Test Item	Eval 1	Eval 2	Eval 3	Average Score
1. What percent of patients in the United States spend time in the ICU at end of life? (O' Mahoney et al., 2010) a. 10% b. 20% * c. 30% d. 40%	4	4	4	4
2. Hua et al. (2014) applied the most standard triggers retrospectively to patients in the ICU. Twenty percent of these patients met criteria for palliative involvement. What were these triggers? (Circle all that apply) a. Stage I lung cancer b. Cardiac arrest * c. COPD d. History of intubation e. Multi system organ failure * f. Brain metastasis *	4	4	4	4
3. In what cases is a palliative care consult recommended for specialist involvement (Circle all that apply): (Campbell, 2012- all 5 options) a. Difficult-to-control physical symptoms despite usual treatment approaches. * b. Patients/surrogates wish to explore non-ICU supportive care options such as hospice services. * c. Questions about the	3	4	4	3.7

appropriateness of life-sustaining therapies in the setting of advanced complex illnesses. * d. Complex family dynamics impacting decisions about use of life-sustaining treatments. * e. Disagreements among staff or between staff and patients/surrogates about prognosis and/or use of life-sustaining treatments. *				
4. Outcomes documented in the literature of patients with palliative team involvement in the ICU include: Circle all that apply. a.Lower 30 day readmission rates * (Campbell, 2012) b.Improved symptom management * (CAPC, 2015) c. Improved patient satisfaction * (Campbell, 2012) d. Increased ICU mortality statistics (Campbell-no change) e. Decreased cost of care * (Campbell, 2012) f. Increased completion of Advance Directives * (O'Mahony et al., 2010)	3	4	4	4
5. What percentage of their health care dollars is Medicare is spending in the last six months of life? (Pasternak, 2013) e. 8% f. 18% g. 28% * h. 38%	3	3	4	4
6. Direct cost savings occurred for ICU patients who received a palliative care consultation compared to ICU patients who did not receive consultation:	3	4	4	4

(Morrison et al., 2008) a. When patients were discharged home b. When patients died in the hospital c. Both a and b *				
7. Which of the following is a first line medication for delirium? (Blinderman & Billings, 2015) a. Ativan b. Haldol * c. Morphine d. A & B	3	4	4	3.7
8. How many milliliters can be given buccally when one is unable to swallow? (Leung & Leloux, 2014) a. 0.5 ml b. 1 ml * c. 1.5 ml d. 2 ml	3	4	4	3.7
9. True or False: When surveyed, more physicians requested aggressive care at end of life versus focus on comfort. (Alspach,, 2016) a. True b. False *	4	4	4	4
10. True or False: Capacity to make decisions and patient competence are often used interchangeably because they have the same meaning. (McGowan, 2011) a. True b. False *	4	4	4	4
11. True or False: Hospice care will accept and admit patients with a Maryland Order for Life Sustaining Treatment form (MOLST) indicating FULL CODE.	3	4	4	3.7

(Hospicare, 2016) a. True * b. False				
12. True or False: A MOLST is equivalent to an Advance Directive. (National POLST Paradigm, 2016) a. True b. False *	3	4	4	3.7
13. True or False: There is a shortage of palliative care specialists in the United States. (Hua & Wunsch, 2014) a. True * c. False	3	4	4	3.7
14. True or False: Direct cost savings resulting from palliative care consultations were due to savings in laboratory costs, pharmacy costs, and less days spent in the ICU. (Morrison et al., 2008) a. True * b. False	3	4	4	3.7
15. True or False: The evidence base supports treatment of oral secretions (death rattle) at end of life with medication (scopolamine) for patient comfort. (Blinderman & Billings, 2015) • True • False *	3	4	4	3.7
16. True or False: Evidence supports that artificially administered fluids at end of life can cause suffering. (Lynch, M. T., 2014) a. True * b. False	3	4	4	3.7

17. True or False: Palliative sedation is the same as physician assisted suicide. (Blinderman & Billings, 2015) a. True b. False *	4	4	4	4
18. True or False: Compounded creams can be used topically as they are known to achieve therapeutic and predictable serum levels of the drugs they contain. (Leung, Nelson, & Leloux, 2014) a. True b. False *	3	4	4	3.7
19. True or False: All opiates have been studied for efficacy in treating dyspnea. (Campbell, 2015) a. True b. False *	3	4	4	3.7
20. True or False: Surrogate decision makers must be related to the patient. (Northridge, 2015) a. True b. False *	3	4	4	3.7

Content Validation Index: 0.82

Appendix H: Summative Evaluation

Summative Evaluation Stakeholders/Committee Members

TITLE OF PROJECT
Student: Jennifer Goldsborough
Thank you for completing the Summative Evaluation on my project. Please complete and send anonymously via interoffice mail to:

A. This project was a team approach with the student as the team leader.

1. Please describe the effectiveness (or not) of this project as a team approach related to meetings, communication, and desired outcomes etc.

Responses included

- Jennifer provided frequent and updated communication via email, written, and verbal.
- We had virtual meetings and email communication that allowed us time and space.
- Jennifer was very well organized and did an exhaustive search of the literature before forming her team. This made her extremely knowledgeable about her subject matter, showed her commitment to her project, and demonstrated a superb preparation methodology. Her communication was exemplary and she met and exceeded all of her objectives. The input that was received from multiple disciplines certainly played a role in creating such a well-rounded, well-done final project.
- Jen communicates clearly her goals and the teams' role in this project.

2. **How do you feel about your involvement as a stakeholder/committee member?**
    - Appropriate level
    - I felt my opinions were heard
    - I felt that my input was valued and included in Jennifer's project. I felt honored to be included in such an important project and was very pleased to see the outcomes.
    - I was minimally involved.
3. **What aspects of the committee process would you like to see improved?**
    - N/A
    - No improvement necessary
    - None
    - Outline of what's ahead

B. There were outcome products involved in this project including an educational curriculum for ICU nurses and pre/ posttest.

1. Describe your involvement in participating in the development/approval of the products.

- My involvement was in reviewing the research and content outline of Jennifer's curriculum. I also assisted in the formation of objectives and providing a second look to make sure that the content outline for each objective was appropriate for the overall goal/ purposes of the project.

- I was asked to review these things.
- Reviewed education/ test
- I reviewed the tests and offered suggestions.

2. **Share how you might have liked to have participated in another way in developing the products.**
    - None
    - In an ideal world, I'd like to be able to participate in this when piloted in the ICU
    - At some point in the future, I hope to be part of an ICU that gets to implement the suggestions of this phenomenal presentation.
    - None

C. The role of the student was to be the team leader.

1. As a team leader how did the student direct the team to meet the project goals?

- Jen was clear on the goals and our roles and allowed us to give suggestions
- Jennifer was an excellent team leader. She was persistent in her follow up and open to receiving feedback in order to make sure that her project included input from multiple disciplines. Jennifer was well organized.
- She was instructive with plans and available as needed.

- She did most of the work and met goals.

3. **How did the leader support the team members in meeting the project goals?**

    - Jennifer provided full access to her project for each stage of planning, development, and final edits. She maintained open, direct communication channels and methods of contact. It was a pleasure to work with such a natural and effective leader.
    - She was forthcoming with information and objectives.
    - Left blank
    - Jen was available for any questions or concerns about this project.

D. Please offer suggestions for improvement. None offered

Appendix I: Continuing Education Hour Documentation

If yes, please provide the following information:
Date: Action: Denial Suspension Revocation
Brief description:

- A currently licensed registered nurse with baccalaureate degree or higher in nursing is actively involved, as the nurse planner, in the planning, implementing and evaluation process of this continuing education activity. ✓ Yes ____ No

Please list the name and credentials of the nurse involved/responsible for this educational activity:

Nurse Planner's Name	Credentials
Jennifer Goldsbaragh	RN, MSN, CRNP

Section 2: Commercial Interest

The following section is intended to collect information about the applicant's corporate structure.

Below are some applicant types that are *automatically* exempt from ANCC's definition of a commercial interest. If your type is listed below please identify with an "X":

	Non-Profit 501(c)(3) organization
	Blood banks
	Diagnostic laboratories
	Constituent Member Associations
	National nurses organizations based outside the United States
	Federal Nursing Services
	Specialty Nursing Organizations
	A provider of clinical services directly to patients, including but not limited to hospitals, healthcare agencies and independent health care practitioners
X	Acute care hospitals (for profit and not for profit)
	Nursing homes (for profit and not for profit)
	Rehabilitation centers (for profit and not for profit)
	Group medical practices
	Government organizations
	Health insurance providers
	Liability insurance providers
	Non-health care related companies whose primary mission is not producing, marketing or selling or distributing health care goods or services consumed by or used on patients.
	An entity the sole purpose of which is to improve or support the delivery of health care to patients, including but not limited to providers or developers of electronic health information systems, database systems, and quality improvement systems
	A single focused organization*devoted to offering continuing nursing education (exists for the single purpose of providing CNE)
	Other: Identify the applicant's exemption type **if not listed above** in section 2**:**

(The single-focused organization exists for the single purpose of providing CNE)*

NOTE: 501c applicants are not *automatically* exempt. The ANCC Accreditation Program requires 501c applicants to be screened for eligibility.

__X__ **An "X" on this line identifies the applicant as exempt from ANCC's definition of a commercial interest.**

If you checked the box above, then you have completed this questionnaire, proceed to Section 5.

Section 3 - Only complete this section if applicant organization is not exempt

____ **An "X" on this line identifies the applicant as not exempt from the ANCC Accreditation Program's definition of a commercial interest.** The following questions must be answered, so the Maryland Nurses Association can assess the applicant's eligibility.

- Does the applicant produce, market, re-sell, or distribute health care goods or services consumed by, or used on, patients?
  ____ Yes **If yes**, the applicant is **not** eligible for approval of Individual Educational Activities.
  ____ No **If no**, complete the next bulleted question

- Is the applicant owned or controlled by a multi-focused organization (MFO*) that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?
  ____ Yes **If yes,** complete the next bulleted question
  ____ No **If no, this section of the questionnaire is complete, proceed to Section 5.**

- Is the applicant a separate and distinct entity from the MFO*?

  ____Yes - **If yes,** continue to section 4
  ____ No - **If no,** the applicant is **not** a separate and distinct entity from the MFO* then the applicant is **not** eligible for approval of Individual Education Activities.

> * Multi-Focused Organization (MFO) is an organization that exists for more than providing continuing nursing education.

Section 4: Commercial Interest Evaluation - Continued

- Does the multi-focused organization that owns the applicant have a 501-C Non-profit Status?
  ____ Yes ____ No **If no**, complete the next bulleted question

  If yes, does the company that owns the applicant advocate for a commercial interest (as defined by the ANCC Accreditation Program?)
  ____ Yes **If yes**, or not sure, please describe the relationship the company that the applicant has with a commercial interest and the types of work the company that owns the applicant does for or on behalf of a commercial interest that might be considered advocacy. ____
  ____ No

- Is any component of the multi-focused organization an entity that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?

____ Yes **If yes**, please describe the health care good or service consumed by or used on patients and the role of the entity in producing, marketing, re-selling or distributing those healthcare goods or services. ____

____ No **If no, this section of the questionnaire is complete, proceed to Section 5.**

If **yes**, please complete and submit the ***Individual Activity Eligibility Commercial Interest Addendum*** with this Form.

Section 5: Statement of Understanding

I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, compliance with all eligibility requirements and approval criteria throughout the entire approval period, and that the Maryland Nurses Association will be notified promptly if, for any reason compliance is not maintained while this application is pending or during any approval period. I understand that any misstatement of material fact submitted on, with or in furtherance of this application for activity approval shall be sufficient cause for the Maryland Nurses Association to deny, suspend or approval of this individual activity and to take other appropriate action.

(Eligibility Verification forms received without a signature incur a delay in processing which will cause a delay in the review of the individual education activity application.)

An "X" in the box below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information contained.

☐ **Electronic Signature (Required)** **Date** 7/4/17

Jennifer Goldstein RN MSN

Completed By: Name and Title

B. Evidence to validate the professional practice gap (check all methods/types of data that apply)

☐ Survey data from stakeholders, target audience members, subject matter experts or similar
☑ Input from stakeholders such as learners, managers, or subject matter experts
☐ Evidence from quality studies and/or performance improvement activities to identify opportunities for improvement
☐ Evaluation data from previous education activities
☑ Trends in literature, law and health care
☑ Direct observation
☐ Other—Describe: _____

Please provide a brief summary of data gathered that validates the need for this activity: ***(DO NOT list resources. Provide a summary of the information received in the evidence checked above in Letter B)***

Palliative care is recommended as standard of care through integration. Specialty teams cannot see every patient due to limited number of Specialty providers. Bedside nurses express discomfort in providing primary palliative care. Education is suppcted as an effective catalyst to integration.

Educational need that underlies the professional practice gap ***Indicate the knowledge, skill and/or practice needed:***

1. Primary Palliative care

C. Description of the target audience. (You can identify more than one target audience)

1. Acute care bedside nurses
2.
3.
4.

D. Desired learning outcome(s) ***(What will the outcome be as a result of participation in this activity?)***

① Increase in knowledge
② Increase in comfort level

Area of impact (check all that apply):

☑ Nursing Professional Development ☐ Patient Outcome
☐ Other- Describe: _____

E. Outcome Measure(s) ***(A quantitative statement as to how the outcome will be measured/ What measure did you incorporate to determine the participants learned the outcomes stated for this activity):***

pretest post test

Content of activity: A description of the content with supporting references or resources

- ☑ See Educational Planning Table OR
- ☐ Describe content and include time calculation for content: Click here to enter text.

Content for this educational activity was chosen from

- ☑ Information available from the following organization/web site (organization/web site must use current available evidence within past 5 - 7 years as resource for readers; may be published or unpublished content; examples – Agency for Healthcare Research and Quality, Centers for Disease Control, National Institutes of Health): CDC
- ☑ Information available through peer-reviewed journal/resource (reference should be within past 5 – 7 years): Journal of Hospice & Palliative Nursing.
- ☐ Clinical guidelines (example - www.guidelines.gov): _____
- ☑ Expert resource (individual, organization, educational institution) (book, article, web site): DNP project RIT palliative integration
- ☐ Textbook reference: _____
- ☐ Other: _____

F. Learner engagement strategies

- ☑ See Educational Planning Table OR
- ☐ Integrating opportunities for dialogue or question/answer
- ☐ Including time for self-check or reflection
- ☐ Analyzing case studies
- ☐ Providing opportunities for problem-based learning
- ☐ Other: _____

G. Criteria for Awarding Contact Hours

Criteria for awarding contact hours for live and enduring material activities include:
(Check all that apply)

- ☑ Attendance for a specified period of time (e.g., 100% of activity, or miss no more than 10 minutes of activity)
- ☐ Credit awarded commensurate with participation
- ☐ Attendance at 1 or more sessions
- ☑ Completion/submission of evaluation form

- ☐ Successful completion of a post-test (e.g., attendee must score _____% or higher)
- ☐ Successful completion of a return demonstration
- ☐ Other - Describe: _____

H. Description of evaluation method: Evidence that change in knowledge, skills and/or practices of target audience was assessed

pre test post test
intent to change practice

I. Short-term evaluation options:

- ☑ Intent to change practice
- ☐ Active participation in learning activity
- ☑ Post-test
- ☐ Return demonstration
- ☐ Case study analysis
- ☐ Role-play
- ☐ Other – Describe: _____

J. Long-term evaluation options:

- ☑ Self-reported change in practice
- ☐ Change in quality outcome measure
- ☐ Return on Investment (ROI)
- ☐ Observation of performance
- ☐ Other – Describe: _____

JOINT PROVIDER INFORMATION

Will this activity be Joint Provided?

☐ Yes ☑ No

If yes, list the organization(s) joint providership of this activity has been arranged with:

_____

If yes, make sure:

- All joint providers, including your organization's name as the provider, will be prominently listed in advertising.
- Joint provider information is disclosed to learners prior to the start of the activity

BLENDED OR ENDURING ACTIVITY INFORMATION

Complete the following if this is a blended activity or an independent study whereby the learner completes learning independently, from a live presentation.

A. Enduring Activity Plan/Process

Describe the elements of the independent study (an outline of all activities of the learner):

- ☐ Article(s): Title(s)_____
- ☐ Audiotape: Title(s)_____
- ☐ Videotape/DVD: Title(s)_____
- ☐ On-line Program
- ☐ Registration Form
- ☐ Post-Test N/A
- ☐ Other – Describe: _____

B. What method will participants use to get assistance with resources or interact with the provider of the independent study/enduring portion of activity?

_____

_____ N/A

_____

C. Contact Hour Calculation for enduring portion of activity

a. What is the estimated time it should take for a participant to complete enduring this activity?_____

b. Explain the method used to determine the time it will take to complete this enduring activity:

_____

_____ N/A

_____

_____

ADDITIONAL IMPORTANT APPLICATION INFORMATION

FOR ACTIVITIES REQUESTING MORE THAN 3 CONTACT HOURS
Submitting Presenter BIOS/COIS, Evaluation forms and Planning Tables

For your presenter documentation, if your activity is requesting more than 3 contact hours, choose 3 hours of educational activity receiving contact hours from your activity, and the submit the Bio's/Coi's, Evaluation Forms and Educational Planning Tables for the presenters that fit in that 3 hours of activity for review with your application. Therefore if you have an activity requesting 30 contact hours for approval, you only need to choose 3 hours of presenter content to submit with your application for the reviewer to review your activity for approval. Although, the Bio's/Coi's, Evaluation Forms and Educational Planning Tables for the presenters in the remaining portions of the activity do not need to be submitted for approval, they must be kept with your educational activity file. **Please note this does not apply to the overall activity documents only the presenter documents.** The activity application, activity brochure, activity agenda and contact hour calculation sheet will need to reflect the entire activity from registration to closing.
Therefore if you submit an activity requesting 30 contact hours you would submit the activity brochure, activity agenda and contact hour calculation sheet showing the full 30 contact hours for reviewer to validate the amount of contact requested is accurate.

How to determine if a Conflict of Interest exists in your activity

Conflict of Interest occurs when:
Individual has ability to control content of activity and has a financial relationship with a commercial interest and/or the products or services of the commercial interest are relevant to the topic of the educational activity

Commercial Interest is any entity producing marketing, reselling or distributing healthcare goods or services consumed by or used on patients. Could also be any entity owned or controlled by such an entity.

Note: Person or organization that is "making or selling" things that are consumed by or used on patients is considered a commercial interest. If you are "providing" patient care or services done in the course of taking care of patients is not a commercial interest

Examples of non-commercial entities
Hospitals, providers of clinical services, government entities, liability insurance providers, health insurance providers and diagnostic laboratories.

Section 4: Conflict of Interest

The potential for conflicts of interest exists when an individual has the ability to control or influence the content of an educational activity **and** has a financial relationship with a *commercial interest*,* the products or services of which are pertinent to the content of the educational activity. The Nurse Planner is responsible for evaluating the presence or absence of conflicts of interest and resolving any identified actual or potential conflicts of interest during the planning and implementation phases of an educational activity. If the Nurse Planner has an actual or potential conflict of interest, he or she should recuse himself or herself from the role as Nurse Planner for the educational activity.

****Commercial interest***, as defined by ANCC, is any entity producing, marketing, reselling, or distributing healthcare goods or services consumed by or used on patients, or an entity that is owned or controlled by an entity that produces, markets, resells, or distributes healthcare goods or services consumed by or used on patients.

Commercial Interest Organizations are ***ineligible*** for accreditation.

An organization is NOT a Commercial Interest Organization* if it is:

- A government entity;
- A non-profit (503(c)) organization;
- A provider of clinical services directly to patients, including but not limited to hospitals, health care agencies and independent health care practitioners;
- An entity the sole purpose of which is to improve or support the delivery of health care to patients, including but not limited to providers or developers of electronic health information systems, database systems, and quality improvement systems;
- A non-healthcare related entity whose primary mission is not producing, marketing or selling or distributing health care goods or services consumed by or used on patients.
- Liability insurance providers
- Health insurance providers
- Group medical practices
- Acute care hospitals (for profit and not for profit)
- Rehabilitation centers (for profit and not for profit)
- Nursing homes (for profit and not for profit)
- Blood banks
- Diagnostic laboratories

(*Reference: Accreditation Council for Continuing Medical Education (ACCME) Standards of Commercial Support, August 2007 (www.accme.org) - ANCC's definition is intended to ensure compliance with Food and Drug Administration Guidance on Industry-Supported Scientific and Educational Activities and consistency with the ACCME definition)

All individuals who have the ability to control or influence the content of an educational activity must disclose all ***relevant relationships**** with any commercial interest, including but not limited to members of the Planning Committee, speakers, presenters, authors, and/or content reviewers. Relevant relationships must be disclosed to the learners during the time when the relationship is in effect and for 12 months afterward. All information disclosed must be shared with the participants/learners prior to the start of the educational activity.

Relevant relationships, as defined by ANCC, are relationships with a commercial interest if the products or services of the commercial interest are related to the content of the educational activity.

- Relationships with any commercial interest of the individual's spouse/partner may be relevant relationships and must be reported, evaluated, and resolved.
- Evidence of a relevant relationship with a commercial interest may include but is not limited to receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (stock and stock options, excluding diversified mutual funds), grants, contracts, or other financial benefit directly or indirectly from the commercial interest.
- Financial benefits may be associated with employment, management positions, independent contractor relationships, other contractual relationships, consulting, speaking, teaching, membership on an advisory committee or review panel, board membership, and other activities from which remuneration is received or expected from the commercial interest.

Is there an actual, potential or perceived conflict of interest for yourself or spouse/partner?

_____ Yes ✓ No

If yes, complete the table below for all actual, potential or perceived conflicts of interest**:

Check all that apply	Category	Description
	Salary	
	Royalty	
	Stock	
	Speakers Bureau	
	Consultant	
	Other	

** All conflicts of interest, including potential ones, must be resolved prior to the planning, implementation, or evaluation of the continuing nursing education activity.

Section 5: Statement of Understanding

Completion of the line below serves as the electronic signature of the individual completing this Biographical/Conflict of Interest Form and attests to the accuracy of the information given above.

CRP — 7/9/17

Typed or Electronic Signature: Name and Credentials (Required) **Date**

Section 6: Conflict Resolution (to be completed by Nurse Planner)

A. Procedures used to resolve conflict of interest or potential bias if applicable for this activity: (Check all that apply)

- ✓ Not applicable since no conflict of interest.
- ____ Removed individual with conflict of interest from participating in all parts of the educational activity.
- ____ Revised the role of the individual with conflict of interest so that the relationship is no longer relevant to the educational activity.
- ____ Not awarding contact hours for a portion or all of the educational activity.
- ____ Undertaking review of the educational activity by a content reviewer to evaluate for potential bias, balance in presentation, evidence-based content or other indicators of integrity, and absence of bias, AND monitoring the educational activity to evaluate for commercial bias in the presentation.
- ____ Undertaking review of the educational activity by a content reviewer to evaluate for potential bias, balance in presentation, evidence-based content or other indicators of integrity, and absence of bias, AND reviewing participant feedback to evaluate for commercial bias in the activity.
- ____ Other - Describe: ____

Nurse Planner Signature (* If form is for the activity Nurse Planner, an individual other than the Nurse Planner must review and sign the form).

Completion of the line below serves as the electronic signature of the Nurse Planner reviewing the content of this Conflict of Interest Form

CRP — 7/9/17

Typed or Electronic Signature: Name and Credentials (Required) **Date**

Certificate of Successful Completion of
An Approved Continuing Nursing Education Activity

*Name*_____ *Address*_____

(First, Middle, Last) (Street)

_____

(City, State, Zip)

Successfully Completed

TITLE: _____

CODE NUMBER:_____ **CONTACT HOUR(S)**_____ **PRESENTATION DATE(S)** _____

PRESENTATION LOCATION _____

City State

Name/Address of Provider: _____

Name

_____

Address City State Zip

_____

Provider's Signature

This continuing nursing education activity was approved by the Maryland Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation

Maryland Nurses Association
6 Park Center Court, Suite 212
Owings Mills, MD 21117
Telephone (443) 334-5110 Fax: (443) 334-5109

MNA Continuing Education-Activity Attendance Record

APPLICANT ORGANIZATION: _____

ADDRESS: _____

ACTIVITY TITLE: _____

_____	_____	_____
ACTIVITY CODE NUMBER	**CONTACT HOURS**	**VALID THROUGH (Date)**

LOCATION OF PRESENTATION: _____

THE FOLLOWING NURSES ATTENDED:

Name	**Address**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

_____

Authorized Signature Activity Date

Please return this form within four weeks to the MNA with your evaluation summaries. You may reproduce as many copies as you need.

Participants may be contacted directly by MNA for quality assurance reasons

Maryland Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's COA.

Name of Organization

Educational Planning Table – Live/Enduring Material

Title of Activity: Primary Palliative Care: Understanding Documentation & Managing Symptoms

Identified Gap(s): Knowledge & comfort deficit for bedside nurses

Description of current state: Specialty palliative team provides most of palliative care

Description of desired/achievable state: Full integration of palliative care with bedside nurses able to provide primary palliative care

Gap to be addressed by this activity: ✓ Knowledge ____ Skills ____ Practice ____ Other: Describe ____

Learner Outcome (s) ① Increased knowledge as evidenced by improved post test scores
② Intent to change practice

Select all that apply: ☑ Nursing Professional Development ☐ Patient Outcome ☐ Other: Describe ____

CONTENT (List/Summarize the discussion topics)	TIME FRAME (if live)	PRESENTER/ AUTHOR	TEACHING METHODS/LEARNER ENGAGEMENT STRATEGIES
Provide an outline of the content	Approximate time required for content	List the Author	List the learner engagement strategies to be used by Faculty, Presenters, Authors
Intro + Documentation / Legal forms	20	J Goldsborough	Power point lecture / Q+A
Symptom management: Assessing + interventions	25	J Goldsborough	Power point lecture / Q+A
Pretest post test	15	J. Goldsborough	

List the evidence-based references used for developing this educational activity **(Year and Author information required)**:

If Live:

Note: Time spent evaluating the learning activity may be included in the total time when calculating contact hours.

Total Minutes 60 **divided by 60 =** 1 **contact hour(s)**

If Enduring:

Method of calculating contact hours:

____ **Pilot Study** ____ **Historical Data** ____ **Complexity of Content** ____ **Other: Describe** ____

Estimated Number of Contact Hours to be awarded: 1

CRP

Completed By: Name and Credentials

7/9/17

Date

Activity Title	Primary Palliative Care: Understanding Documentation & Managing Symptoms
Activity Presentation Date(s)	2/7/18

ACTIVITY DISCLOSURES

For Activity Participants to review **prior to start** of educational activity

1. **ANCC Accreditation Statement**
   This continuing nursing education activity was approved by the Maryland Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

2. **Activity Purpose and/or Learning Outcomes**

   _____

   _____

   _____

3. **Successful Completion of this Continuing Nursing Education Activity**
   In order to successfully complete this activity and receive full contact-hour credit for this CNE activity, you must:
   1. _____
   2. _____
   3. _____
   4. _____

4. **Conflicts of Interest**
   (Choose A or B)

   A. There is **no conflict of interest** for any planner or presenter of this activity

   OR TO DISCLOSE ANY CONFLICTS OF INTEREST

   B. There is no conflict of interest for any planner or presenter of this activity **except for**
   1. Who has the conflict of interest
   2. What the coi/financial relationship is
   3. Name of the commercial interest

4. **Commercial Company Support**
   This CNE activity is supported by an unrestricted educational grant from _____

   AND/OR

   This CNE activity is supported by an in-kind donation of *(refreshments, meal, or other)* from: _____

Adopted 10/15

Maryland Nurses Association
Provider Responsibility Agreement
(Provider/Learner Paced)

Providers must comply with the following policies and procedures. Failure to do so can jeopardize maintenance of approval of an activity and/or review of future continuing education applications.

1. **MNA APPROVED PUBLICITY**: The applicant may publish the following statement: "This continuing nursing education activity was approved by the Maryland Nurses Association an accredited approver by the American Nurses' Credentialing Center's Commission on Accreditation." This statement must be disclosed to learners before the start of the educational activity. New

2. **CERTIFICATE OF SUCCESSFUL COMPLETION**: The applicant is required to distribute a certificate of completion to each registered nurse who completes the Provider-paced or Learner-paced activity in its entirety and returns a completed evaluation form. If an applicant chooses to use his/her own certificate a copy must have been approved with the application. New

3. **EVALUATION FORMS:** Evaluation should ask participants to confirm the receipt of activity disclosures and how the activity will improve their performance in their nursing profession. The applicant is required to include the approved evaluation form(s) in all Provider-paced and Learner-paced participant packets and receive a completed evaluation form from the participant prior to presenting a certificate of completion. The applicant is required to summarize all participant evaluations for each Provider-paced and Learner-paced activity. The applicant is required to retain the accessible summarized evaluations for six years.

4. **RECORDKEEPING SYSTEM**: The applicant must retain full records of the educational activity for six years after completion of the last session of the activity. This includes a completed application packet as approved, a list of all presentation dates with names and addresses of facilities where the activity was held, a copy of the attendance roster for each presentation date, and a copy of the summarized evaluations for each presentation date. These records should only be available to authorized individuals.

Reminder: Providers must provide a description of the particular recordkeeping they will maintain for the activity in the body of the application. Signature on the provider responsibility statement is not sufficient to meet this requirement.

5. **QUALITY ASSURANCE**: The MNA review mechanism includes an evaluation procedure which requires additional provider cooperation. For Learner Directed activities, the evaluation consists of direct mail evaluation of activity participants. The provider will be asked to submit to MNA a roster of nurses who completed the selected activity, with names and mailing addresses. No additional assistance is required of providers. The MNA will contact participants directly. Any educational activity may selected for a site visit or online review. The selected provider is expected to permit the gratis attendance onsite or online of a peer reviewer from the MNA Continuing Education Approver Committee and to reimburse the MNA for mileage at the current US rate, to a maximum of 50 miles. Providers will be notified in advance if an educational activity has been selected for a site visit. Providers may request a postponement of a site visit by providing an appropriate justification in writing to MNA, but postponement is not guaranteed.

6. **PROVIDER REPORTS TO MNA**
Providers need to summarize the evaluation data and send this summary with attendance rosters to MNA-CEAC within 30 days following the activity. For learner-paced or "enduring" presentations, this data may be submitted every 6 months during the approval process.

I have read the above policies and procedures and agree to comply:

Provider Signature

7/9/17
Date