EVALUATION OF THE KNOWLEDGE BASE AND PERCEPTIONS OF ACUTE CARE NURSE PRACTITIONERS REGARDING PALLIATIVE CARE REFERRALS

By

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STATEMENT BY AUTHOR

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DEDICATION

I would like to dedicate this master’s project to all the acute care nurses and providers who are at the bedside struggling to provide patients with quality end of life care and a dignified death.
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The Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT) substantiated the fact that dying in the hospital is associated with increased mechanical support, pain, and a prolonged dying process by surveying almost 10,000 patients at the end of life (The SUPPORT Principal Investigators [SUPPORT], 1995). Palliative care is defined as:

A healthcare approach that improves the quality of life for patients and their families facing the problems 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 [WHO], 2008).

Acute Care Nurse Practitioners (ACNPs) are trained to provide comprehensive holistic care to acute and chronically ill hospitalized patients and their families, which makes their role in identifying those who will benefit from hospital based palliative care essential.

The purpose of this project was to review the current literature available about the relationship between palliative care and ACNPs. The literature synthesis revealed an extensive knowledge gap in regard to ACNPs’ general understanding and perception about palliative care. Thus, a survey was developed to better assess the knowledge and perceptions of ACNPs regarding palliative care for future implementation. The hope of
this author is that the survey will help to one day promote palliative care referrals in the acute care setting by ACNPs.
CHAPTER 1

Significance

“Demographic tidal wave” is the term being used to describe the sudden surge of those over the age of 65 by the year 2030, who will account for nearly 20% of the American population by this time (Merck Institute of Aging and Health [MIAH], 2004). These numbers are impressive, but not nearly as significant as the impact this large aging population will have on the delivery of health care in the United States (US). The “tidal wave” is attributed to improved sanitation, public health, clinical medicine, and increased use of preventive medicine (MIAH, 2004; SUPPORT, 1995). Medical technology has afforded Americans longer and more productive lives, but has not protected them from progressive illnesses (Rao et al., 2002).

It is postulated that each one of these 71 million elderly Americans creating this tidal wave, will suffer from at least one chronic illness (MIAH, 2004). The reality is that most elderly Americans suffer from an average of “three chronic conditions and use five different prescription drugs” (MIAH, 2004). The Agency for Healthcare Research and Quality, a division of the U.S. Department of Health and Human Services, convened a 2001 Medical Expenditure Panel which found that 83% of the nation’s medical costs are spent on those with chronic conditions and additional studies have shown that 1 in 5 people in the US utilize intensive care services the last 3 days of life (Lubkin & Larson, 2006; Ferrell et al., 2007). The Centers for Medicare and Medicaid (2003) estimate that Medicare expenditures in the last month of life is twenty times higher than average
monthly expenditures which they attribute to a significant increase in the use of intensive inpatient hospital services. These progressive chronic illnesses result in prolonged death, wrought with significant emotional and financial expense (Rao et al., 2002).

The chronic conditions from which the aging population suffers cause “years of pain, disability, loss of function and independence before resulting in death” (MIAH, 2004). There is significant concern that as chronic conditions worsen the hospital structure fails to provide alternatives when it becomes clear that cure is no longer a realistic goal (Manfredi et al., 2000). Many would argue that this is why 1 in 5 people end up in the intensive care unit the last days of life and 65% of adults die in the hospital. The health care community has been so focused on curative therapies and technologies in an effort to eradicate illness and disease that it has shifted the focus away from quality end of life care (Lofmark et al., 2005).

Problem Statement

There is a real perception by family members of those dying in health care institutions that their loved ones do not receive sufficient symptom control, such as pain and dyspnea relief, during their death experience (Imhof et al., 2007). This is not just a family perspective, the Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT) substantiated the fact that dying in the hospital is associated with increased mechanical support, pain, and a prolonged dying process by surveying almost 10,000 patients at the end of life (SUPPORT, 1995). Family perceptions are a reality proven by the SUPPORT study.
Unfortunately, despite its importance, few hospitals make end-of-life (EOL) care a part of their quality improvement process (Luhrs et al., 2005). The barriers to quality end of life care in the acute care setting are attributed to the “fast-paced environment, discord among team members regarding goals of care, communication barriers between professionals, patients, and family members, as well as a lack of research regarding methods to improve care of the dying in critical care” (Ferrell et al., 2007, p. 207). The importance of quality EOL care is being made a priority for hospitals by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). JCAHO released a new standard in 2006 that mandates hospitals have a framework for withdrawing life support and withholding resuscitative services (National Hospice and Palliative Care Organization [NHPCO], 2008). Interdisciplinary hospital based palliative care teams are being established to meet the growing demand for high quality end of life care in acute care facilities (Chong et al., 2004).

Palliative care is defined as a healthcare “approach that improves the quality of life for patients and their families facing the problems 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” (WHO, 2008). One of the first acute care hospital based palliative care medicine programs began in 1994 at the Cleveland Clinic (Lagman et al., 2008). The Cleveland Clinic Model was utilized as a frontline acute care medical specialty, separate from hospice care. The significance of this model is that palliative care is offered earlier in the disease process which establishes a continuity of care until death (Lagman et al.,
2008). Lagman et al. (2008) emphasizes the point that hospital based palliative care needs to be fully integrated into the acute care system in order to get involved earlier in the disease process to provide continuous services until hospice care is desired. The goal of hospital based palliative care is to: “create a balance between disease intervention and modalities that promote wellness, support the patient and family while they learn to cope with advancing illness and/or severity of treatment, and promote quality of life, regardless of the reality of a cure” (Twaddle et al., 2007, p.87).

As discussed above, JCAHO has been the impetus for an emerging standard for hospitals to provide palliative care in an effort to improve the quality of EOL care. Hospital administrations concerned about fiscal viability support this move because hospital based palliative care has proven over the last decade to protect the bottom line. The Center to Advance Palliative Care (CAPC) (2009) is a “national organization dedicated to increasing the availability of quality palliative care services for people facing serious illness by providing health care professionals with the tools, training and technical assistance necessary to start and sustain successful palliative care programs in hospitals and other health care settings”. CAPC has made it very convenient for those wishing to implement a palliative care program to estimate cost savings with their impact calculators free to the public on their website. The two variables that are most commonly assessed when evaluating cost benefits of palliative care programs are shorter length of stay (LOS) and lower cost per day. Two recent studies have evaluated the cost savings of their hospital based palliative care programs and found very persuading numbers (Stephens, 2008; Morrison et al., 2008).
Cabell Huntington Hospital in Huntington West Virginia, an academic 322 bed medical center, implemented a palliative care team to assess the impact on the bottom line. This team made a significant impact by shortening the length of hospital stays and decreasing the use of intensive care services over the first quarter (Stephens, 2008). These changes resulted in an estimated $227,040 to $693,600 in savings (Stephens, 2008, p. 145). Conservatively, this equates to a savings of $1 million dollars a year (Stephens, 2008, p. 145).

Another study conducted by Morrison et al. (2008) assessed cost savings of two palliative care patient groups; one was those who survived to discharge and the other died prior to discharge. The palliative care patients who were discharged alive had a total savings of $1975, this included significant reductions in laboratory and intensive care unit costs compared with non palliative care patients (Morrison et al., 2008). The palliative care patients who died had a total net savings of $5282, this also included significant reductions in pharmacy, laboratory, and intensive care unit costs compared with non palliative care patients (Morrison et al., 2008). These studies illustrate that hospital based palliative care is a very viable solution to providing quality EOL care to the future 71 million elderly Americans suffering from chronic illnesses and eminent death while protecting the bottom line.

Purpose of this Project

As the pendulum begins to swing away from the curative paradigm, health care providers are making a serious effort to find a balance between technologies based life
sustaining and/or prolonging efforts and quality EOL care. Interdisciplinary hospital based palliative care teams provide a structured approach to help those suffering from exacerbations of symptoms related to advanced diseases make this transition. Often hospital based palliative care is ‘too little too late’ because the distinction between the seriously ill who will recover and those who will not recover is so blurred making recognizing terminal conditions early is nearly impossible (Stephens, 2008, p. 143). Obviously, this creates a need to identify patients who will benefit from hospital based palliative care team interventions sooner.

One very important member of the hospital team (palliative care or otherwise) is the Acute Care Nurse Practitioner (ACNP). ACNPs are on the front line of managing acute exacerbations of chronic /advanced disease. ACNPs are trained to provide comprehensive holistic care to acute and chronically ill hospitalized patients and their families, which makes their role in identifying those who will benefit from hospital based palliative care essential. According to Volpe & Malonry (2004), ACNP’s elite skill set consist of the following:

1) a consistent and compassionate approach to the care of families, 2) expert knowledge of pain and symptom management, 3) leadership within the organization, 4) education of the patient, family, public, and other healthcare professionals, and 5) the dissemination of knowledge regarding palliative care through presentations research, and publications that promote the advancement of
the spiritual, psychosocial, and physical needs of those dying and their families (p. 258).

The purpose of this project is to review the current literature available about the relationship between palliative care and ACNPs. This review is necessary to accurately assess how ACNPs can help to promote the utilization of hospital based palliative care in an effort to improve EOL care for acutely ill hospitalized adults.
CHAPTER 2

Introduction

The discussion of theory and conceptual frameworks gives the reader a greater understanding of the assumptions and values that create the foundation for this project (Willis & McEwen, 2007). The underpinnings of this project are based on two major theories/conceptual frameworks. The first, importantly, are the core elements of palliative care developed by the 2004 National Consensus Project. Specifically to nursing, Watson’s theory of human caring illustrates the nursing framework utilized in this project. These two theories/conceptual frameworks provide the reader with a comprehensive understanding of this project’s foundation.

Theoretical and Conceptual Frameworks

National Consensus Project

In an effort to denote benchmarks of high-quality palliative care and strive for national programmatic standards, five major US palliative care organizations came together to create clinical practice guidelines which were published in 2004 (National Consensus Project [NCP], 2004). The National Consensus Project for Quality Palliative Care (NCP, 2004) developed “12 Key Elements of Palliative Care”. These 12 elements are discussed in great detail within the 67 page consensus report. Appendix A gives a detailed description of each of the elements.
When applying each of these elements to this project there are some key concepts to remember. First, palliative care in general can be applied to patients of all ages, but for this project the ACNP will only be evaluating patients who are 17 years of age or older due to the constraints of the ACNP licensure and training. Palliative care is applied in situations of debilitating chronic illness, life-threatening, or acute illness (NCP, 2004). For this project the ACNP will be evaluating both patients who are experiencing chronic, acute, and acute on chronic conditions. Thus, the population that will be assessed in this project will be adults who are experiencing chronic, acute, and/or acute on chronic conditions.

The next key concept of palliative care is patient and family centered care. The importance of this concept cannot be overemphasized. For this project, the patient and family are recognized as a whole, one cannot be addressed without the other. The term ‘family’ is defined by the patient, and may or may not be blood relatives, but are significant supporters in the patient’s life (NCP, 2004). Each patient and family is treasured for their uniqueness and idiosyncrasies (NCP, 2004). It is firmly believed that decisions are made by the patient and family with the support and guidance of the health care team (NCP, 2004).

The third key concept is the timing of palliative care. Some may think that palliative care is only applied when a cure is no longer feasible and all that can be done is supportive care. A common misconception is that palliative care is only applicable during the last days of one’s life and is usually associated with hospice care. This is not the
belief of palliative care by the NCP or the author of this project. Palliative care should begin at the time of initial diagnosis, through curative successes and failures, support the patient through death, and finally help to nurse the family through their bereavement period (NCP, 2004). This means that palliative care is based on continuity of care across settings- hospitals, emergency departments, nursing homes, home care, assisted living facilities, outpatient facilities and nontraditional environments such as schools (NCP, 2004). To successfully coordinate this care from beginning to end of the disease process across a multitude of settings requires a team approach.

It is the belief of the National Consensus Project and this project that comprehensive care is best provided by a multidisciplinary team (NCP, 2004). All aspects of healing and suffering are continually assessed and provided for by all team members. The palliative care team’s top priorities for assessment and care include the patient and families’ physical, psychological, social, and spiritual needs (NCP, 2004). These needs are provided for by a core group of specially trained individuals from multiple disciplines which include medicine, nursing, social work, chaplains, psychologists, pharmacists, nursing assistants, home attendants, dieticians, physical-, occupational-, art-, music-therapists, case managers, trained volunteers and volunteer coordinators (NCP, 2004). It is the team’s responsibility to continually assess and reassess the patient’s and families’ needs in an effort to assist them in understanding what is happening throughout the disease process and what to expect in the future while supporting their decisions and goals (NCP, 2004).
It is the belief of the NPC and this project that the relief of suffering through comprehensive symptom management is the focus of quality EOL care (NCP, 2004). Disease and treatments bring about a multitude of physical, psychological, social, and spiritual symptoms that can cause suffering. It is the goal of palliative care to prevent and treat all symptoms of suffering timely and efficiently in order to improve quality EOL care (NCP, 2004). As discussed above, this is best achieved with expertise of the multidisciplinary team because of the multiple modalities that can cause suffering at the EOL. Effective communication is the foundation for successful team management in situations such as these. Highly effective communication skills are a must for palliative care providers in order to accurately assess and meet the needs of the patient and family. These communication skills include appropriate and effective information sharing and active listening in an effort to help determine goals and preferences while assisting with medical decision making (NCP, 2004).

One objective of this project is to facilitate equitable access to palliative care by assessing how ACNPs can help to promote the utilization of hospital based palliative care by identifying those patients who will benefit from this service as early as possible in an effort to improve EOL care for acutely ill hospitalized adults. The objective is congruent with the NPC’s goal of equitable access to palliative care by “patients across all patient populations, all diagnostic categories, and all health care settings, regardless of race, ethnicity, sexual preference or financial situation” (NCP, 2004, p. 7).
The final key element of the consensus project is quality improvement. As discussed in the first chapter of this paper, the improvement of EOL care for acutely ill hospitalized adults is the main focus of this project. ACNPs are committed to the same goal through the pursuit of excellence and high quality care. It is the belief of this project that the NCP’s 12 Key Elements are a necessity for ensuring success at not only improving EOL care but more importantly at excelling at providing the highest quality EOL possible.

_Watson’s Theory of Caring_

Caring is the moral ideal and fundamental value for nursing (Nelson-Marten et al., 1998). Specifically for this project, it is believed that caring is the core value to nursing and is inherent to the foundation of this project because the ACNP is first and foremost a nurse whose theoretical framework is based on Watson’s Theory of Caring. One of the concerns discussed in Chapter One of this paper is that unnecessary suffering is endured by patients due to the lack of quality EOL care when palliative care is not provided. As balance is sought between curative medicine and quality EOL care, Watson reminds us that caring is possible across the continuum. Watson emphasizes that “caring must be present as much when curing has failed or when cure is possible” (Nelson-Marten et al., 1998, p. 71). Watson’s beliefs about caring are parallel with the NCP’s belief that caring is delivered from diagnosis through bereavement while focusing on effective symptom management during curative treatments until death. Watson’s 10 “carative factors” are listed and described in Appendix B (Nelson-Marten et al., 1998).
The first “carative factor” discussed by Watson is the “humanistic-altruistic system of values” which makes up the nursing professional caring ethic (Nelson-Marten et al., 1998). In agreement with Watson, this project believes that humanistic values include kindness, empathy, concern and love for self and others (Nelson-Marten et al., 1998). The drive for this project is based on the altruistic value of caring described by Watson. The ACNP is driven to provide quality EOL care because she receives satisfaction from providing quality care while engaged in meaningful relationships with others (Nelson-Marten et al., 1998).

While engaged in meaningful relationships with others, Watson discusses human needs assistance as a fundamental role of nursing. She defines this “carative factor” as the nurse’s role in helping the patient with activities of daily living while also facilitating growth and development (Nelson-Marten et al., 1998, p.72). Human needs assistance is the broad objective of the ACNP within this project. The ACNP accomplishes this by accurately assessing the needs of the hospitalized adult and making a determination if those needs would be met best with the assistance of the palliative care team. It is the belief of Watson and this project that it is the ACNP’s responsibility to assist the patient and family in identifying their unique needs while facilitating growth and development (Nelson-Marten et al., 1998).

To accurately assess the patient’s needs one must be sensitive to self and others. Watson discusses sensitivity to self and others as a factor of caring. This factor was not highlighted in the National Consensus Project, but from a nursing perspective it is
believed that to prevent judgment one must look within. The journey into one’s self leads to self-acceptance and psychological and spiritual growth, while at the same time it is believed to create sensitivity and acceptance of others (Nelson-Marten et al., 1998). While dealing with diverse patient populations one must be sensitive and accepting of others, which means that one must put aside personal bias’ and opinions in order to provide equity of access to palliative care.

Watson’s helping-trusting human caring relationship is in alignment with the National Consensus Project’s belief that palliative care is centered on the patient and family and is dependent upon effective communication. The multidisciplinary team is engaged in a human caring relationship where each team member enters into the experience of the patient and the patient enters into the team member’s experience (Nelson-Marten et al., 1998). The success of the relationship is based on the principals of highly effective communication outlined in the prior section.

Watson emphasizes the importance of feeling expression which could be nurtured by the use of psychiatry and/or psychology within the multidisciplinary team, which is a unique idea not included in the NPC’s recommendations. Watson emphasizes the expression of both positive and negative feelings as a “carative factor”. Watson believes that feelings alter thoughts, behavior, actions, and experiences of each individual and they must be acknowledged (Nelson-Martenet al., 1998). This is important for both the provider and the patient. Provider and patient must take the time to acknowledge all of his/her feelings in an effort to make the most clear and appropriate decisions. This
activity is a personal and professional responsibility of each multidisciplinary team member in an attempt to minimize bias. The use of psychiatry and/or psychology within the multidisciplinary approach gives the patient and family the professional support needed for appropriate expressions to foster positive relationships.

Watson emphasizes the importance of creative problem-solving caring process. This process is based on the caring relationship already discussed. Within the nursing process Watson believes that all knowledge is valuable (Nelson-Marten et al., 1998). As Watson discusses this within the nursing process, it is the belief of this project that this is also true when applied to the multidisciplinary team. Thus, the knowledge that each team member attributes to the plan of care is considered valuable.

For the patient and family to make appropriate decisions in regard to their plan of care there is a significant amount of teaching and learning that takes place. Watson discusses transpersonal teaching-learning as a “carative factor” which she believes is more than just receiving information. Transpersonal teaching-learning is based on the provider’s ability to put themselves in the patient’s shoes to fully understand the patient’s perceptions, feelings, concerns, and understandings (Nelson-Marten et al., 1998). This ability allows the provider to relay the information within the patient’s frame of reference which allows for greater understanding and decision making that is true to his/her personal beliefs and feelings.

Another unique idea presented by Watson that is not included in the NCP’s recommendations is the spiritual element of palliative care. Watson believes that
throughout the care continuum faith and hope are major factors of care. She emphasizes the nurse’s role in nurturing a patient’s faith and hope in something or someone beyond himself (Nelson-Marten et al., 1998). The multidisciplinary approach through palliative care ensures that a patient and family’s faith and hope needs are not only assessed but fully nurtured.

All of Watson’s “carative factors” discussed are intended to create an environment of health and healing. An environment is not defined as the four walls that care is provided in; environment includes the mental, physical, societal, and spiritual space the patient resides in (Nelson-Marten et al., 1998). This is why the multidisciplinary team is such an invaluable part of this project and the core of the palliative care theory. It takes many disciplines to accurately assess and provide care within the patient’s environment. It is Watson’s belief and the belief of this project that it is the responsibility of the ACNP and all team members to strengthen the patient’s self-concept and self-worth by accurately assessing the patient’s environment and providing quality care within that environment (Nelson-Marten et al., 1998).

Summary of Chapter 2

The 12 Key Elements of Palliative Care and Watson’s Theory of Caring support the values and assumptions of the ACNP. The National Consensus Project provides the ACNP in this project with a clear outline of palliative care’s fundamental core values and objectives, while Watson’s Theory of Caring ensures that the core values of nursing are acknowledged and utilized within the framework of the National Consensus Project’s key
elements. While Watson’s Theory of Caring encompassed nearly each key element of the National Consensus project, she provides a broader sense of the foundation of nursing within her framework. These two conceptual frameworks clearly illustrate the core values, assumptions, and beliefs of this project.
CHAPTER 3

Introduction

The literature synthesis component of this project is a comprehensive critique of four selected articles written within the last five years. These articles were selected to assess the current issues surrounding palliative care referral in the acute care setting, the tools used for referral, and the knowledge base and utilization of those tools by ACNPs. As discussed in Chapters one and two, the goal of this project is to improve EOL care by improving the ACNP’s ability to identify those patients who would benefit from palliative care services as early as possible. In order to accomplish this goal the current knowledge base must be assessed and knowledge gaps must be identified.

Literature Search

I worked with Mary Riordan, one of the librarians at the Arizona Health Sciences Library, to enhance my research capabilities. The databases utilized to review the current literature were CINAHL, Medline, Web of Science, PubMed and Health and Psychological Instruments. Key words chosen for the search include “acute care”, “critical care”, “palliative care”, “nurse practitioner”, “acute care nurse practitioner”, “end of life care”, “referral tools”, “tools”, “knowledge base”, “utilization”, and “perception”. These key words were used independently and combined in an effort to obtain the most relevant literature available for this project. The results were abundant in regard to generalized palliative care research (18,070 results) which was independently combined with each of the terms noted above which narrowed down results significantly, palliative care combined with acute/critical care (70 results), and generalized end of life
care (2,533 results). The final search combined palliative care with nurse practitioners within each of the search engines which resulted in approximately 75 articles. Abstracts were reviewed and articles selected as a framework to represent the overall research and literature trends available about this topic.

The four articles selected are intended to provide an overview about the current knowledge base and utilization of palliative care in the acute care setting by ACNPs. The first article was chosen to help illustrate palliative care perceptions and utilization in the acute care setting. The second article was chosen to discuss identifying those patients who need palliative care consults. The third was chosen to give an overview of multiple palliative referral tools available for utilization. Finally, the last article was specifically chosen to address nurse practitioners and palliative care.

Gaps in Literature

There are few articles that discuss the knowledge base of nurse practitioners, let alone ACNPs, regarding palliative care. Instead, the few articles that were located (Meier et al., 2006; Quaglietti et al., 2004; Ryan-Wooley et al., 2007; Scharf, 2000) discussed advance practice nurse’s role as a member of the palliative care team or as the sole palliative care provider. These were not research studies, but literature review articles. This literature search did not provide any evidence of research that evaluated nurse practitioner’s knowledge assessment or utilization of palliative care. The last article chosen to be included in this synthesis was chosen to exemplify the lack of literature available in regard to nurse practitioners and palliative care.
Rodriguez, Barnato, and Arnold (2007) conducted a qualitative study to assess the “Perceptions and Utilization of Palliative Care Services in Acute Care Hospitals” that was published in the *Journal of Palliative Medicine*. Dr. Keri Rodriguez has her PhD and is employed at the Center for Health Equity Research and Promotion within the Pittsburgh Healthcare System’s Veteran’s Administration. She worked with Doctors Amber Barnato and Robert Arnold who practice as Internal Medical physicians at the University of Pittsburgh, School of Medicine. Dr. Barnato also has a master’s degree in public health and is affiliated with the Department of Health Policy and Management within the Graduate School of Public Health at the University of Pittsburgh. Dr. Arnold is affiliated with the section of Palliative Care and Medical Ethics along with the Institute to Enhance Palliative Care at the University of Pittsburgh in Pennsylvania. The information discussed about each of the authors was not presented within the research article, they were purely foot notes. Based on their education backgrounds and current affiliations, all three primary investigators have extensive qualifications to conduct this study. The issues that arise due to the lack of a discussion about the authors are their personal stakes in any of the study or personal bias that may exist that could affect the findings.

The title of the research article, “Perceptions and Utilization of Palliative Care Services in Acute Care Hospitals”, accurately represents what the reader will encounter while reading this study. The title does not clearly define what type of study this is; the
word “perceptions” suggests it is a qualitative study, while the term utilization leads the reader to believe that there could be quantitative data obtained. The title describes the setting of the research (Acute Care Hospitals), but does not indicate who the participants are. The reader is left asking, “Whose perceptions and utilization of palliative care services?”

The abstract is well organized and easy to read. It clearly defines the purpose of the study and highlights the research design as qualitative, utilizing interviews with health care providers who participate in decision making or discharge planning within Pennsylvania hospitals as the method for gathering research. The results and conclusions are clearly stated within the abstract giving the reader realistic expectations of the study’s findings. The body of the article follows suite in regard to logical organization and standard formatting for research reporting, minus a conclusion. The authors’ choice not to include a conclusion to the body of the report leaves the reader without a sense of finality. Each section of the paper is clearly titled and subcategories are also clearly identified. Overall the body of the research article is concise, clearly presented, and logically organized.

The introduction of this research article presents a clear description of the history of palliative care and the gap in knowledge that this research is attempting to fulfill. The authors have identified that in order to facilitate palliative care referrals earlier in the disease process rather than just at the end of life, one must find out how physicians and other health care providers perceive and utilize palliative care services. Neither the
Introduction nor the discussion presents the author’s assumptions, biases or predispositions, specific philosophy that this research is based on, the ethical implications, or a formal literature review.

The authors are detailed in their description of their research process. They accurately described how the 11 hospitals in Pennsylvania where the two-day site visits took place in only the intensive care unit (ICU) were chosen out of a larger research study that investigated variations in EOL treatment intensity. The Institutional Review Board approved both studies and written informed consent was obtained, thus upholding ethical rigor. They also included a brief overview with whom the 129 semi-structured interviews were conducted; “chief nursing officer, director of case management, physician director of the emergency department, physician director of the ICU, the ICU nurse manager, the chief of surgery, two “high volume” physicians, a bedside ICU nurse, an ICU social worker, and oncology social worker, director of pastoral care, the director of palliative care (if applicable), and the chair of the ethics committee” (Rodriguez et al., 2007, p. 101). They then discussed how the data was collected.

The data collection process was very clear and gives the reader such an accurate description, that one feels as if they were experiencing rounds along with the investigators. The demographics information gathered was standardized for each participant. Then the interview began with a standardized interview protocol with a specific sequencing of questions. The conversation begins with an open ended request to “describe his/her involvement in a recent case of the death of a patient in the hospital that
was over the age of 65” (Rodriquez et al., 2007, p.101). From the case presented, inquiries were made about decisions made in regard to “ICU admission, intubation, dialysis, enteral or parental nutrition, transfusions, and cardiovascular support” (Rodriquez et al., 2007, p.101). The investigators also asked about the factors that affected those decisions; such as “the patient, patient’s family members, community, health care providers, and organizational policies, procedures, and resources” (Rodriguez et al., 2007, p.101). Each of these interviews were audio taped from which transcripts were made and the investigators took notes; from these a coding criteria was developed and tested to ensure the date was accurate and representative of the data as a whole.

From the coding process the investigators were able to assemble characteristics of the hospitals and the individual participants that are presented in Table 2 of the research article. They were also able to develop four major themes related to palliative care; “perceptions of palliative care, current utilization of palliative care, barriers to utilization of palliative care, and suggestions for increasing palliative care consults” (Rodriguez et al., 2007, p. 103). The results were presented in a narrative format that was easy to read and offered great detail and many examples. The highlights of each of the themes are discussed below;

- Perceptions of palliative care
  - Focuses on terminal pain and symptom management
  - Facilitates decisions to stop life sustaining treatments
  - Only for those who are “terminal” or “actively dying”
Necessity is based on timing of disease process rather than the services that are provided.

Viewed as “pulling the plug” or “doing nothing”.

Nurses identified the role of palliative care as a supportive service that can be utilized 6-12 months prior to the death process. They also feel that it can help to facilitate discussions and decisions about goals of care and quality of life issues.

Physicians feel that palliative care consults are “lateral consults”; they can perform the same service.

Role in conflict resolution concerning care goals and decision making during the last days of life.

- Current utilization of palliative care
  - Appropriate when
    - Aggressive care is futile
    - EOL preferences are not met
    - Disputes over goals and course of care
      - Concerns about high-intensity treatment especially in the elderly.
  - Most institutions require physician to formally make the consult
  - Palliative Care admissions are usually those where death is imminent

- Barriers to utilization of palliative care
  - Barriers to early use
    - Narrow view of palliative care’s range of services
- Palliative care providers once consulted would change the goals of care prior to the attending physician being ready to do so, thus a feeling of losing their autonomy.
- Culture of high-intensity treatment
- Concern over reputations and lawsuits
- Belief and perception of patients that palliative care is the same as hospice care
- Beliefs experience and medical specialty of the individual physicians
- Economic constrains that affect hospital practices and staffing

- Suggestions for increasing palliative care consults
  - Arranging negotiations involving hospital administrators, chaplains, ethics committee members, and nursing units
  - Providing workforce development, education, and training about palliative care
  - Increasing the number of staff involved in palliative care
  - Improving financial reimbursement and sustainability for palliative care
  - Raising community awareness
  - Changing the normative hospital culture
  - Incorporating palliative care providers into care teams for high risk patients
  - Mandating palliative care consults for all medical ICU unit admissions
- Role modeling
- Physician collegiality
- Changing the description of the service, one suggestion “pain and symptom management consult service” or “chronic diseases management”

The authors clearly presented the integrated findings and the gaps in knowledge these findings identified. The authors also discuss the ways that their results support prior research findings in regard to palliative care and they also highlight new findings. One of the main points discussed is that the results illustrate that palliative care services are not identified as necessary for managing many symptoms of life-limiting illnesses outside of the actively dying, the authors attribute this to the misunderstanding about how hospice and palliative care differ (Rodriquez et al., 2007). They deduct that this is a major reason why palliative care’s role in the acute care setting has been underutilized. Palliative care services were acknowledge as necessary earlier in the process, but only when it was felt that the aggressive life-sustaining treatment should have ended much earlier (Rodriguez et al., 2007). When earlier consultation was discussed, it was done so through a cost-effective benefit as opposed to a clinical benefit (Rodriguez et al., 2007). Nurses were found to be the most aware of appropriate palliative care utilization and were trying to effect change through educating new nurses, and informally initiating consults by families, residents, or other physicians (Rodriguez et al., 2007). The authors suggest the perception that palliative care is primarily the practice of symptom management may be the reason why physicians feel that it is a “lateral consult” (Rodriguez et al, 2007, p.104).
From their research results Rodriguez et al. (2007) suggest that education is a primary intervention in changing palliative care perceptions and utilization. They recommend that education has to address advance care planning and hospital staff education about palliative care consultation benefits and goals. The authors close by recommending that palliative care providers market their benefits to patients and providers focusing on their “unique skill set and compatibility with parallel treatment plans that do not threaten the autonomy of the referring provider” (Rodriguez et al., 2007, p. 109).

Within the discussion the authors did identify two limitations to their research. The first being the integration of palliative care and hospice care maybe a result of the opening interview question focusing on the death of a patient. The authors identify that a direct question about palliative care may have produced a better assessment of the role of palliative care in the practice. The limitation identified also could be considered a threat to procedural rigor considering the opening question for the interview may have made the direct link between palliative care and EOL. The second limitation identified was the small hospital base utilized, only ICU setting, and only in one state. The authors identify that this limits this study’s ability to be generalized.

Overall, this research project gives the reader a well rounded perspective of how palliative care is utilized and perceived in the acute care setting. The major strength of this project is the multiple perspectives that are obtained about palliative care within the ICU setting. The way in which those perspectives were obtained is in question because
of the opening question that was utilized as a conversation starter, as discussed in the prior paragraph. Another strength to this project is the insight that it delivers to the readers about the lack of knowledge health care providers have about the unique services that palliative care can offer early in the disease process. Knowing so little about the author’s bias, philosophical, and theoretical stance, possibly weakens the argument.

Nonetheless, this study provides very important information for ACNPs. First and foremost, this study educates the reader about the diverse services of palliative care. Palliative care is not all about ending life sustaining interventions nor is it just appropriate when there is no longer a curative treatment. Secondly, this study illustrates to ACNPs the lack of utilization in the acute care setting, and gives rise to the question of how ACNPs can be instrumental in that change. Lastly, this study gives the ACNP a realistic picture of the uphill battle that she will face while trying to change perceptions about palliative care and improve utilization of its services. Fortunately, the authors provide suggestions in regard to education and training, advocating for improved financial reimbursement, and being a change agent within the hospital culture.

*Article Two*

The second article to discuss in this literature synthesis is authored by Dr. Marissa Salven, Nancy Wylie R.N., B.H.ScN., M.H.S.M, Beryl Fitzgerald R.N., Nancy Henderson, and Susan Taylor B.Sc.N., M.B.A., titled “Who Needs a Palliative Care Consult?: The Hamilton Chart Audit Tool” published in the *Journal of Palliative Medicine* in November 2007. As in the first article critiqued in this project, there is little
information disclosed about the authors, minor foot notes are provided that inform the reader that Dr. Slaven works in the Department of Palliative Care at McMaster University Hamilton, Ontario, Canada. The other co-authors and researchers also are associated with Hamilton Health Services departments of Nursing and Clinical Appropriateness and Efficiency. This leaves little knowledge about their qualifications such as research expertise, clinical expertise, and education preparation. As stated in the prior article critique, with such little information known about the authors there is no knowledge of the authors’ bias, assumptions, or personal stakes in this research process.

The title of the article is clear that there is a tool being utilized to assess a population who may need a palliative care consult, but is ambiguous about what population is being assessed for the need or where this assessment is taking place. Because the title of the article incorporates a chart audit tool one is lead to believe that this is a quantitative study. The abstract does not clarify what specific population is being assessed for a palliative care need, but does make a case for why identification of those in need of palliative care is of utmost importance. The abstract lacks formatting of the research article and does not include any information on the methods, results, or conclusions of the research. Overall the title is weak and the abstract is of very poor quality due to its lack of appropriate formatting and lack of coinciding information.

This article lacks any discussion of its theoretical perspective or framework utilized during the research process, but does state a clear purpose which is found at the end of the introduction which states that, “the objective of this study was to better
understand how many more patients our consult service could/should be seeing” (Slaven et al., 2007, p.305). The problem identified by the authors is significant to nursing from a needs assessment perspective. The authors make a strong case for the number of patients who are in need of palliative care and may not be even considered candidates. They do so without a formal literature review. All of the references were current in last ten years except one. None of the 16 studies were utilized to perform a formal literature review, thus they did not provide the reader with a complete summary of the current knowledge.

As noted above, the authors did clearly state their objective. They also identified the variables measured by the audit tool, but did not describe them in detail; (1) caregiver/family stress/support, (2) alteration in mental status, (3) goals of care, (4) pain, (5) dyspnea, (6) patient stress/support, (7) nausea/vomiting, (8) other symptoms (Slaven et al., 2007, p.305). The variables chosen are very significant to nursing in regard to needs assessment, as stated above. They did not discuss the acquisition of primary diagnosis or demographics of those patients, but this data was also included in the results; the primary diagnosis being heart disease (Slaven et al., 2007). They also stated in the introduction the research design as a retrospective audit of 222 patients that expired in the authors’ institution in Canada (Slaven et al., 2007). The intervention implemented is the Hamilton Chart Audit tool. There was not a sample of the tool provided in the research article. The reader is left to assume that this is the pilot study for this tool because there is a lack of information about the tool’s previously tested reliability and validity. There was a description of the sample inclusion criteria; charts were chosen of patients who died in a specific 8 month period which 983 patients were identified. From that large group,
exclusion criteria were utilized to choose those charts not to audit; death within 48 hrs of admission, neonates, and those with palliative care consults. The Hamilton Chart Audit tool was then briefly described, in regard to its application to this sample. The tool was implemented by a palliative care registered nurse who assessed the 24hr period occurring 72 hours prior to the patient’s demise (Slaven et al., 2007). The article lacks any description of the statistical analysis utilized to formulate the results.

In the results section, the authors briefly summarize their findings beginning with the demographics findings; the average age of those evaluated was 70.5 years old, 55% of males, and as stated earlier the primary diagnosis (30.6%) being heart disease (Slaven et al., 2007, p.305). The result of the Hamilton Chart Audit Tool was that 69% of those charts assessed were considered missed consults (Slaven et al., 2007, p.306). The number one variable scored was a need for caregiver/family support and education (22.9%) (Slaven et al., 2007, p306). Since there was not a formal discussion about the anticipated demographic results it is impossible to assess if the results were or were not expected. Based on the introduction, the authors expect a large population of missed consults. This expectation is congruent with the findings.

In the discussion, the authors do address the applicability of the Hamilton Chart Audit Tool and its ability to be utilized by those with minimal research experience in a relatively short amount of time, 15minutes (Slaven et al., 2007, p. 306). The discussion also includes the authors’ opinions about possible weaknesses of the tool. The first weakness identified is the infrequent symptoms that may not have been included in the
assessment tool (Slaven et al., 2007). They also discussed the lack of a spiritual domain assessment because the authors’ experience is that spiritual issues are not usually documented in the chart (Slaven et al., 2006). In that same light, the authors acknowledge that because the results are dependent upon a chart audit tool, the results are limited to the medical record which can contain a high variability of information (Slaven et al., 2007). Finally, they acknowledge that because the inclusion criteria included only those who had died, there is potentially a large population who would benefit from palliative care consult who had not died, thus leaving another group of patients to be assessed (Slaven et al., 2007).

Overall, this study did give an overview of how the Hamilton Chart Audit Tool was utilized to perform the retrospective study in an attempt to assess if there is a greater need for palliative care consults at the end of life. Since the study provided the reader with such limited information and did not provide a sample of the actual tool, one could not replicate the study based on the authors’ methods description. This study does illustrate to the ACNP that there is a large patient population who does not receive palliative care consult in the last days of life in the acute care setting. Based on the weaknesses discussed above, the ACNP may lack confidence in this study’s findings and the applicability of the Hamilton Chart Audit Tool. If one accurately assesses the weaknesses presented, one would identify that the tool may underestimate the number of missed consults. Thus, even though the study leaves the reader questioning its strength, this study proves that there are missed palliative care consults. This study substantiates the prior study’s stance on poor utilization of palliative care services in the acute care
setting. The ACNP can confidently acknowledge that palliative care consultation utilization is of great concern.

Article Three

“Finding the Way to a Better Death; An Evaluation of Palliative Care Referral Tools” by Dr. Sara Imhof and Dr. Brian Kaskie, with the assistance of research assistant Matthew Wyatt took place at the University of Iowa and was published in the Journal of Gerontological Nursing in June 2007. The abstract and beginning of the article present a strong case for a standardized inpatient assessment tool to assist health care providers in making appropriate palliative care referrals. The title is clear about the purpose and content of the study. The abstract is clear and concise, but lacks formal formatting. The beginning of the article is not labeled as the introduction, but the authors do utilize appropriate formatting beginning on the second page with the title “Barriers to Palliative Care” followed by standardized presentation of the research process (Imhof et al., 2007). The references are alphabetized as anticipated, all but three are current within the last ten years of this articles publication date, but the 37 references are not numbered (Imhof et al., 2007). Overall the organization of the article is uniform and assists the reader in comprehending the depth of information provided.

The information that is provided about the authors is located after the reference section. Dr. Imhof is a Senior Analyst in Washington D.C. with the Government Accountability Office. Dr. Kaskie is an assistant professor at the University of Iowa, College of Public Health within the Department of Health Management and Policy. Mr.
Wyatt, at the time of publication, was a graduate research assistant with Dr. Kaskie at the University of Iowa. This research was supported by a pilot grant from the Geriatric Nursing Interventions Research Center at the University of Iowa, College of Nursing. Little else is known about the author’s qualifications such as research expertise, clinical expertise, or educational preparation. The authors are not discussed in the body of the research article; therefore there is no knowledge of their personal bias, assumptions, or personal stakes in the research process.

This research study has three primary objectives clearly stated in bullet format; (1) compare the six tools and determine how well they incorporate the 16 clinical referral triggers defined by palliative care specialists, (2) evaluate how much empirical evidence supports their application, (3) assess how easy the tools were to apply across institutional health care settings (Imhof et al., 2007, p. 42). The authors do not formally discuss their research framework or design, but the reader is able to deduce that this is a quantitative research study because the authors utilize a correlational design for the study in order to gain knowledge by making comparisons. The authors present the way in which the data was obtained to identify the tools for assessment, which included a formal literature search. This involved a database search, which was described, but a formal literature review was not presented by the authors.

The methods of the research study were generally discussed. The greatest detail was given to the description of the six tools chosen for comparison and the 16 referral triggers developed by palliative care physicians and nurses described by the CAPC
(Imhof et al., 2007). A brief overview was given to the research performed by the palliative care team in implementing the tools in order to assess their applicability at the bedside, but no details were given as to how the assessment was performed or evaluated. Basically the authors stated that the team had three criteria in which they assessed the tools; (1) the length of time the tool took to be administered, (2) what the demand on the patient was to provide information, (3) how quickly and easily the results could be interpreted (Imhof et al., 2007, p. 43). Finally, the authors gave mention to the acquisition of knowledge in regard to the prior empirical research performed on each tool to test its reliability and validity, but the formal literature review process was not given any mention. The authors chose not to belittle the methods discussion with many details which gives the reader slight concern about the study’s ability to be replicated.

The results are organized very clearly by headings within the body of the article and each tool is discussed in the same format, which gives the reader a real sense of the strengths and weaknesses of each tool and provides a better understanding of its applicability. Table 2 in the article gives the reader a comprehensive overview of the comparison of each of the tools inclusion of the 16 referral triggers. The discussion section does a comprehensive job of describing the results, but leaves the reader disappointed with the stance that an ideal tool with the ability to be applied universally does not exist in this group and the reality of such a tool maybe imprudent to develop due to the variability of institutions and their palliative care programs (Imhof et al., 2007). The conclusion of the article was short and to the point. The take home message from the authors was that even though their research did not support one tool to be used
universally, they feel that any tool that facilitates a conversation between the provider and the patient about palliative care is of great value to any organization (Imhof et al., 2007). The authors chose to highlight the key points of this research article with a box on the last page, which is of value to the reader due to the length of the article.

This article has a great significance to nursing and to this project. The first being that throughout this article the authors emphasize the importance of nursing in initiating palliative care requests, facilitating palliative care conversations, and providing EOL care (Imhof et al., 2007). By highlighting the 16 referral triggers established by the Center to Advance Palliative Care, the reader is educated about what any tool should include. The six referral tools provide a broad knowledge base which highlights issues for researchers to consider during further tool development and evaluation. This study provides the ACNP with an outline for evaluating any tool that she maybe considering incorporating into her practice; the tool needs to include a majority of the 16 referral triggers, empirical evaluation, and the tool has to be tested for validity and reliability. Finally, the greatest point this study makes to the reader is the value that every tool has in stimulating conversations about palliative care between patients and the ACNP. Specifically, it is very important that the patient’s goals of care are discussed and how the palliative care specialist can help meet those goals.

*Article Four*

This final article was included in this literature synthesis as an example of the results of this project’s literature search for information about ACNPs and palliative care.
Due to the lack of results, this search was generalized to nurse practitioners and palliative care. The broadened search resulted in multiple articles that discussed the role of the advanced practice nurse as a provider of palliative care dating from the late 1990s. This final article was chosen because it provides a summary of the education process and multiple ways the advanced practice nurse functions as a provider of palliative care medicine.

“Advanced Practice Nurses in Palliative Care: A Pivotal Role and Perspective” by Dr. Diane E. Meier and Larry Beresford was published in the *Journal of Palliative Medicine* in November 2006. Footnotes to this article list Dr. Meier’s processional roles as: (1) the director of the Center to Advance Palliative Care at Mount Sinai School of Medicine, (2) the director of The Lillian and Benjamin Hertzberg Palliative Care Institute (3) professor of geriatrics and internal medicine at Mount Sinai School of Medicine, and (4) Catherine Gaisman professor of medical ethics at Mount Sinai School of medicine. Larry Beresford is described as a freelance health care journalist and serves as a consultant to the Center to Advance Palliative Care in New York. This is all the information that is provided about the author’s educational and professional backgrounds.

This is not a research article; it serves as an informative piece written to describe the role of the advance practice nurse in palliative care across the United States. This article highlights the intentional use of the term “advance practice nurse” because palliative care nurse practitioners come from a variety of backgrounds. There are many roads that can lead to a certification in advanced practice palliative care offered by the
National Certification of Hospice and Palliative Nurses. The backgrounds specifically discussed are nurse practitioners, clinical nurse specialists, nurse administrators who are master’s prepared, registered nurses who have advanced nursing education at a master’s level or higher in a specialty area (Meier & Beresford, 2006, p. 624). All applicants for the certification exam must provide documentation of 500 clinical hours of palliative care within the year prior to taking the exam (Meier & Beresford, 2006). This means that the certified palliative care nurse practitioner can have prior training ranging across all life spans and areas of expertise. Those who choose to pursue special certification in palliative care have a special interest in EOL and values palliative care as the key to providing quality EOL care for all age and diagnosis groups.

Meier & Beresford (2006) state that 237 advanced practice nurses were certified in hospice and palliative care at the time of publication. These APNs work within a variety of settings and roles which the authors describe in detail by proving examples of specific providers across the United States. While describing each of the roles the authors also introduce the reader to a number of different palliative care programs. These programs range from single providers to members of full interdisciplinary teams, from rural areas to urban areas, from community hospitals to academic hospitals, and outpatient services to inpatient services. The authors note that the number of palliative care nurse practitioners has increased steadily in line with the increase in palliative care programs in the United States and the “demand for nurse practitioners on palliative care services far exceeded the supply” (Meier & Beresford, 2006, p. 626).
The authors conclude this article by highlighting the importance of the nursing framework and philosophy as a provider of palliative care. Nursing is based on a philosophy of holistic care and the framework is based on active listening, being present with the patient in the moment, individualized teaching, and caring (Meier & Beresford, 2006). While the nurse practitioner is capable of prescribing medicine to relieve suffering, this is not what is of utmost importance about her role. The nursing philosophy and attributes that make up the nursing framework are what give the nurse practitioner a unique skill set as a provider on the palliative care team.

While this article does not discuss the specific role of the ACNP in palliative care, nor does it provide research data about the role of any nurse practitioner within palliative care, it does have an important role in this literature synthesis. First of all, it serves as an example of the lack of empirical knowledge that is available about the relationships that exist between nurse practitioners and palliative care. Specifically, the literature search done for this project did not provide any information about the role of the ANCP either as a provider of palliative care or even as a pivotal player for referral services to palliative care services. A major strength of this article is that it introduces the reader to the diverse role of the advance practice nurse as a provider of palliative care. It describes the education necessary to function in this role and it reminds the reader of the importance of nursing within the palliative care team. For this project specifically, this article serves to illustrate the information that is available about nurse practitioners and palliative care.

Summary of Chapter 3
As stated in the introduction of this chapter each of the four articles chosen for this literature synthesis serve to provide the ACNP with a comprehensive knowledge base of the state of palliative care in the acute care setting. This literature synthesis discussed the great misperceptions of palliative care in the acute care setting. Rodriguez et al. (2007) feels that the misperceptions of palliative care are vital to it’s under utilization. Slaven et al. (2007) proved that palliative care is grossly underutilized threatening the quality of end of life care provided in the acute care setting. In hopes of improving utilization, the author of this project thought that a referral tool may prove to help resolve this issue. The research performed by Imhof et al. (2007) did not provide a recommendation for a universally applicable referral tool to improve palliative care utilization. Imhof et al. (2007) did note the importance that any tool would have in facilitating the conversation about palliative care between the ACNP and the patient, thus hoping to improve palliative care utilization in the acute care setting. The last article of this literature synthesis provided evidence that a body of knowledge is missing in regard to ACNPs interaction with palliative care and the referral process utilized by this profession.
CHAPTER 4  

Introduction

The prior literature synthesis concluded that there is a large gap in knowledge in regard to ACNPs knowledge base about referrals to palliative care services. As the article by Rodriguez et al. (2007) summarized, underutilization of palliative care services is a direct result of the perceptions of the provider making the referral. It is the responsibility of this author to assess the knowledge base and perceptions of the ACNP in regard to palliative care referral prior to any other interventions to improve the referral process can be explored. Thus, this chapter discusses the development of a survey to help assess the knowledge base of ACNPs about palliative care and palliative care referrals. The development of this survey is for possible future implementation. The sample of the survey can be found in Appendix C of this paper.

Survey Development

As stated above, the literature synthesis revealed a significant knowledge deficit in regard to hospital based palliative care referrals and ACNPs. Thus, this author has identified an opportunity to investigate the knowledge base and perceptions of ANCPs in regard to palliative care utilizing a survey in hopes of proving more insight on this topic. The survey acts as a descriptive study design, which will allow the author of this paper to identify problems with current practices (Burns & Grove, 2005). For ease and convenience the survey participants will be asked to complete the online survey via an email. This survey will have four sections that will incorporate participant demographics,
perceptions about palliative care referral, and ability to identify the 16 key triggers for palliative referral developed by the CAPC, and the last section will ask opinions about their preparation for making palliative care referrals.

In any survey it is appropriate to know the basic demographics of the group that is being assessed. This helps to ensure that a diverse sample size was utilized and also gives the research team a perspective on what similarities and differences exist within the sample. Thus, basic demographic questions will be the content assessed in the first section of this survey. The questions will be formatted as check boxes to identify the most appropriate response for age, gender, location of practice, and length of practice as ACNP.

The second section will include questions about the ACNP’s perceptions of palliative care services. These questions will be developed from the Rodriguez et al. (2007) article’s discussion of their results. These results are detailed in bullet format in Chapter 3 under article one. The questions will be formatted as fill in the blank with two choices provided, one that is an appropriate perception of palliative care and one that is not.

The third section will assess the ACNPs ability to identify the 16 triggers that the CAPC have developed. These triggers were discussed in Chapter 3, they were the comparison criteria used by Imhof et al. (2007) for the comparison of the six referral tools. The CAPC has developed a handout with both the consult triggers for general referral criteria and intensive care unit criteria, this reference can be found in Appendix
D. This question will be formatted as a check system. The participant will be asked to place a check mark in the box of the palliative care referral trigger.

The final section will ask their personal feelings in regard to their educational preparation for making palliative care service referrals. This will be yes/no response selection. This will help give the researcher an assessment of how well the ACNP feels about how well they are prepared to make palliative care referrals. This may indicate a greater need for palliative care referral education during the ACNPs formal educational process.

Survey Implementation

This survey will provide the researcher with a body of knowledge about the ACNP’s perceptions about palliative care services and her ability to recognize the 16 key referral triggers for palliative care services. This information will identify what (if any) education needs to take place to help ACNPs make appropriate and timely palliative care referrals. As discussed by Rodriguez et al. (2007) in Chapter 3, education is a vital way to change perceptions in an effort to improve utilization of palliative care services. Knowing if the ACNP can accurately identify the majority of referral triggers will provide the researcher an idea of the likely hood that the ACNP recognizes those who are appropriate for palliative care consultation. If the ACNP is unable to recognize the 16 key referral triggers then a referral tool maybe necessary to assist the ACNP in making appropriate referrals for consultation.
Ethical consideration is necessary to include in the implementation of this survey. Approval from the institutional review board (IRB) will be necessary prior to implementation of this survey. It is anticipated due to the nature of this project that it may be expedited or accepted by the IRB. Participation in this survey is completely voluntary and the identity of each participant will remain unknown, which is an inherent benefit to utilizing an online survey.

The greatest challenge to this survey’s implementation is identifying the sample population. There are such few ACNPs in a given area that to ensure that a significant response is received, a request will be made to the University of Arizona, College of Nursing to ask former ACNP graduates to please participate. If the alumni agree to participate they will be asked to log onto the survey website. They will also be asked to please pass the website address onto any other ACNPs that they know. The survey website will remain active for one month after the first survey is completed. If 50 surveys are not completed by the end of the one month period the researcher will send a reminder email to those that agreed to participate and the availability of the website will be reassessed.

The ease of the online survey will provide the participant with the ability to provide quick accurate responses. The formatting of the survey should facilitate ease of use for the participant. This formatting should also aid the researcher in quick and accurate analysis of the results.
Summary of Chapter 4

The purpose of the survey is to assess the knowledge base of the ACNPs in regard to palliative care service referral. The development of this survey relies heavily upon the results of the literature synthesis. This chapter outlined the plan for future survey implementation. Please see Appendix C for the complete descriptive survey proposed for implementation.
CHAPTER 5

Introduction

The final chapter offers the reader a summary of this project. The plans for survey analysis will be described. The strengths and weaknesses of this project will be identified. This chapter will conclude with a discussion about the significance of this project to the profession of ACNPs.

Survey Analysis

The length of this survey’s implementation is going to dependent on the time it takes to obtain a target sample size of 50 completed surveys. One of the benefits of the online survey is that it can be left active for whatever remainder of time the researcher deems necessary. Reminder emails can be sent repeatedly and the survey can easily be shared with colleagues in an effort to meet the goal of 50 completed surveys.

Section one of the surveys will be analyzed easily based on simple mathematical equations to develop percentages for the demographics assessed. Section two provided the participant with a right and wrong choice; therefore this section will be “graded”. The grade of each survey will be averaged to illustrate whether or not ACNPs have an appropriate perception of palliative care services, the lower the score the more inappropriate the perception of those evaluated. A score lower that 75% would indicate a need for generalized palliative care service education to ACNPs.
In section three the participants were instructed to identify all the triggers for palliative care referral. All the options were appropriate triggers for palliative care developed by CAPC, therefore this section will be “graded” like section two. Each one is worth one point; each trigger not marked will result in the loss of a point. The grades from all the participants surveys will be averaged, the grade will indicate the ACNP's knowledge of key triggers for palliative care referral. A score less than 75% indicate that a formal referral tool would benefit the ACNP.

Finally, section four indicates how well the ACNP feels her education program prepared her for making appropriate palliative care referrals. A ‘yes’ response to either of the questions indicates a positive feeling. A ‘no’ response indicates a negative feeling that may indicate a need for greater palliative care referral content in the formalized ACNP education program. The positive and negative results will be averaged to indicate the overall feeling of the alumni. This information will be shared with the director of the ACNP program at the University of Arizona in order to make appropriate curriculum changes if needed.

Strengths of this Project

This master’s project has a number of strengths. The first will be the personal interest and attributes of the author that contributes to this project’s development. Next will be the strong argument presented in Chapter One for the necessity of palliative care to improve EOL care. The Imhof et al. (2007) article critiqued in the literature synthesis gave this project direction. And finally, the conclusion of the literature synthesis keeps
this project focused on the appropriate steps that need to take place to best influence future change.

The topic for this project was decided upon by this author as a result of her professional experience as an intensive care nurse and educational development as an ACNP student. As an ICU nurse there is a great concern about quality of EOL care. As an ACNP student, one is educated about how palliative care ensures that quality EOL care is provided. Thus, the author’s professional and educational experience provide for a complete and comprehensive perspective of how necessary the relationship between ACNPs and palliative care referrals are.

Another major strength of this project is the knowledge base that the literature review presented in Chapter One of this project provides to the reader about the importance of palliative care. This literature is clear that palliative care services are necessary to improve EOL care. Thus, when the literature synthesis concludes that palliative care perceptions and utilization are less than desirable the reader is able to understand the importance that this survey has in facilitating change for better referrals by ACNPs.

Another strength of this project is the Imhof et al. (2007) research results presented in the literature synthesis. These results illustrated the 16 key triggers for palliative care referral which is a valuable assessment tool for the ACNP. Without this knowledge this project would have lacked direction and an essential part to the assessment process.
Finally, without the conclusion of the literature synthesis the need for ACNP knowledge base assessment would not have been the focus of this project. The literature synthesis truly informed this author that more information gathering needs to be done prior to a referral tool development. This survey will provide a better understanding of the ACNPs perceptions of palliative care, her knowledge of the referral triggers, and her overall feeling about the preparation of her education for making referral decisions. From this knowledge the appropriate intervention can be selected for further research.

Project Limitations

There are number of limitations in this project that need to be recognized. The first is the lack of data about the relationship between ACNPs and palliative care. The other limitations are specific to the design and implementation of the study. These limitations will be discussed in the following paragraphs.

It was very difficult for the author of this project to adequately assess the knowledge base or perception of palliative care services by ACNPs. Many of the relationships suggested were made from generalized assumptions about acute care providers or nurse practitioners. There is limited literature available discussing the role of the ACNP, let alone the specific role in association with palliative care. This gap in knowledge does present another opportunity for further research and also creates a barrier for this project to substantiate relationships.

In 2005, it was estimated that there were approximately 3,500 certified ACNPs in the United States (Kleinpell, 2005). The largest barrier to implementing this survey is a
lack of available contact information for all the ACNPs in the United States. The success of this study is dependent upon word of mouth by the alumni at the University of Arizona. This may limit the ability of the survey results to be generalized due to the participants’ possible homogeneity. Since this is an online program that allows alumni to be from all over the United States it is anticipated that the participants will not be limited to Arizona, this may help to decrease the homogeneity of the survey results.

The survey itself is a limitation because the participants are only asked about certain information. If interviews were conducted then the researcher could gather more information by making inquires outside of the survey set. Thus, the survey as the tool for this project limits the information that this project will acquire.

Significance to the ACNP

This project presented a clear case in chapter one about the crisis that is occurring in regard to quality EOL, especially in the acute care setting. Chapter one also made a strong case for palliative care as change agent in that crisis and stressed the role of the ACNP as a primary player in ensuring palliative care is utilized to solve this crisis. The connections made in chapter one about the unique skill set of the ACNP and palliative care provides a fresh perspective on yet another role of the ACNP in the acute care setting.

Chapter 2 discusses two very appropriate theories/frameworks that reminds the ACNP of the value systems that nursing and palliative care are grounded upon. The discussion of each of these is of importance to the ACNP in order to make the project a
true part of the profession. By exemplifying the ways in which Watson’s Theory of Caring and the NCP’s key elements meet the same goals, it is as though palliative care is as inherent to nursing as caring. This connection provides the ANCP with a real belief and understanding of the need to advocate for palliative care as the solution for quality EOL care.

Finally, as discussed above in the strengths of this project, the literature synthesis made it clear that a large gap in knowledge exists in regard to the role of the ACNP in palliative care utilization. This gap in knowledge has created many opportunities for further research studies. Many of these opportunities were discussed in the end of Chapter 3 and highlighted again in Chapter 4. Knowing that there is a need for further research gives the ACNP profession further opportunities for growth and development. Although this project did come up with many ideas for further research opportunities, it is the hope of this author that this survey can be implemented and the results applied toward an appropriate intervention to improve palliative care referrals by ACNPs.
### National Consensus Project 12 Key Elements of Palliative Care

<table>
<thead>
<tr>
<th><strong>Key Element</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Population</td>
<td>Population served includes all patients of all ages experiencing a debilitation chronic or life-threatening illness, condition, or injury.</td>
</tr>
<tr>
<td>Patient-family centered care</td>
<td>The uniqueness of each patient and family is respected, and the patient and family (as defined by the patient) constituted the unit of care.</td>
</tr>
<tr>
<td>Timing of palliative care</td>
<td>Ideally, palliative care begins at the time of diagnosis with a life-threatening or debilitation condition and continues through cure or until death and into a family’s bereavement period.</td>
</tr>
<tr>
<td>Comprehensive Care</td>
<td>Palliative care uses a multidimensional assessment to identify and relieve suffering through the prevention of or alleviation of physical, psychological, social, and spiritual distress. Palliative care requires the regular and formal clinical process of assessment, diagnosis, planning, interventions, monitoring and follow-up.</td>
</tr>
<tr>
<td>Interdisciplinary Team</td>
<td>Palliative care presupposes indication for care provided by an interdisciplinary team that includes a core group of professionals from medicine, nursing, social work, and may include (but is not limited to) chaplains, bereavement counselors, pharmacists, case managers, trained volunteers, and physical, occupational, and music therapists.</td>
</tr>
<tr>
<td>Attention to relief of suffering</td>
<td>The primary goal of palliative care is to prevent and relieve the burdens imposed by disease and its treatments and consequent suffering, including pain and symptom distress.</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Effective communication skills are a hallmark of quality palliative care.</td>
</tr>
<tr>
<td>Skill in care of the dying and bereaved</td>
<td>Palliative care specialist teams must be knowledgeable about all aspects of care of the dying, including prognostication, signs of imminent death, and the associated care</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
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<tr>
<td>Continuity of care across settings</td>
<td>Palliative care integral to all healthcare settings, and palliative care teams collaborate with professional and informal caregivers in each of these settings to ensure care coordination, communication, and continuity of palliative care across institutional and home care settings.</td>
</tr>
<tr>
<td>Equitable access</td>
<td>Palliative care teams should strive to provide equitable access to palliative care for patients of all ages, diagnoses, and healthcare settings, regardless of race, ethnicity, sexual orientation, or ability to pay.</td>
</tr>
<tr>
<td>Addressing regulatory barriers</td>
<td>Palliative care professionals should collaborate with policy makers, law enforcement, and regulators to achieve a balance and positive regulatory environment for pain management and palliative care.</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>Palliative care should be committed to the provision of the highest quality care, and palliative care teams should participate in regular and systematic evaluation of the processes of care and measurement of outcomes data using validated instruments.</td>
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</table>

APPENDIX B
## Watson’s 10 Carative Factors

<table>
<thead>
<tr>
<th>Carative Factor</th>
<th>Description</th>
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<tbody>
<tr>
<td>Humanistic-Altruistic System of Values</td>
<td>Caring is grounded in a set of universal humanistic and altruistic values. Humanistic values include kindness, empathy, concern, and love for self and others. Altruistic values arise from commitments to and satisfaction from receiving through giving. They bring meaning to one’s life through relationships with other people. Both values provide a basis for human caring and promote the professional care ethic.</td>
</tr>
<tr>
<td>Instilling faith-hope</td>
<td>Patient’s beliefs and personal meaning are encouraged and respected as significant influences in promoting and maintaining health. Even when there is nothing left to do medically, the nurse can nurture a patient’s faith and hope in something or someone beyond himself or herself. This factor honors the spiritual dimensions of nursing and health care.</td>
</tr>
<tr>
<td>Sensitivity to self and others</td>
<td>Sensitivity to self is the recognition and acknowledgement of feelings—painful as well as happy ones. It is cultivated by looking into oneself and willingness to explore one’s own feelings. Sensitivity to self not only leads to self-acceptance and psychological and spiritual growth, but also to sensitivity and acceptance of others.</td>
</tr>
<tr>
<td>Helping-trusting human care relationship</td>
<td>The human caring relationship is central to professional health care. In the transpersonal human caring relationship, the nurse enters into the experience of another person, and another can enter into the nurse’s experiences. A helping-trusting human caring relationship evolves from a certain quality of communication.</td>
</tr>
<tr>
<td>Expressing positive and negative feelings</td>
<td>Because feelings alter thoughts, behavior, actions, and experiences, they need to be acknowledged and considered in the human</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
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<tr>
<td>Creative problem-solving caring process</td>
<td>Within the nursing processes of assessing, planning, intervening, and evaluating are the full use of self and all domains of knowledge, including empirical, aesthetic, intuitive, affective, and ethical knowledge. All knowledge is valuable and accessed within the caring process. The process calls on creative imagination, clinical judgment, and a grasping of the whole within the context of a caring relationship.</td>
</tr>
<tr>
<td>Transpersonal teaching-learning</td>
<td>Health teaching is one of nursing’s main functions. Learning is more than the receiving of information. It also depends on the nurse’s ability to assess accurately another’s perceptions, feelings, concerns, and understandings. This factor requires staying with another’s frame of reference and attending to the meaning the situation holds for him or her.</td>
</tr>
<tr>
<td>Supportive, protective, and/or corrective mental, physical, societal, and spiritual environment</td>
<td>The goal of this carative factor is to strengthen self-concept and self-worth through attention to environment to promote health and healing.</td>
</tr>
<tr>
<td>Human needs assistance</td>
<td>Assisting with the gratification of human needs is important to nursing’s role of helping individuals in their daily activities as well as facilitating growth and development. Needs operate independently and demand that the nurse respond to the other as a unique individual, allowing one cared for to assist in the identification of his or her most important needs.</td>
</tr>
<tr>
<td>Existential-phenomenological-spiritual forces</td>
<td>Existential, phenomenological, and spiritual dimensions are closely related in that they all support a subjective appreciation of the inner world of the experiencing person and the meaning he or she finds in life. The clinical application of existential concepts is based on the assumption that each person must find his or her own meaning and solution to the</td>
</tr>
</tbody>
</table>
problems of existence. A phenomenological orientation to nursing emphasizes understanding people from their frame of reference. Awareness of oneself and others as existential-phenomenological and spiritual beings opens up infinite possibilities for growth, both interpersonal and transpersonal.

Palliative Care Referral Survey

Prepared by: Kristy L. Keating, ACNP-S

Purpose:

The purpose of this survey is to assess the perceptions and knowledge base of ACNPs in regard to palliative care referral in acute care settings. This survey is intended for ACNPs who practice in acute care settings and evaluate patients for referral for palliative care services. The results of this survey will be analyzed for educational needs and possible development of a referral tool. Please complete the survey online at www.keatingsurvey.com. It will take less than 15 minutes to complete this survey. Thank you for your time and service!

The survey is divided into the following four sections:

1. Demographics
2. Perceptions of Palliative Care Services
3. Triggers for Palliative Care Services
4. Perceptions of Educational Preparation
Section 1

Demographics

1. Indicate your age range
   - O 20-30
   - O 31-40
   - O 41-50
   - O 51-60
   - O ≥61

2. What is your gender?
   - O Male
   - O Female

3. How long have you been an ACNP?
   - O 0-5 yrs
   - O 6-10 yrs
   - O 11-15 yrs
   - O ≥15 yrs

4. Are you Board Certified?
   - O Yes
   - O No

5. Are you currently practicing?
   - O Yes
   - O No
   - If not, what year did you stop practicing? ______

6. Are you currently working Full time or Part time?
   - O Full Time (>36 hrs a week)
   - O Part time (20-35 hrs a week)

7. Where is your practice located in the United States?
   - O Alabama
   - O Alaska
   - O Arizona
   - O Arkansas
   - O California
   - O Colorado
   - O Connecticut
   - O Delaware
   - O Florida
   - O Georgia
   - O Hawaii
   - O Idaho
8. What setting are you currently working in (Hospital, Long Term Care, Rehabilitation, etc)?

__________________________________

9. What patient population do you primarily provide care for? (Medical, Cardiac, Trauma, etc)?

__________________________________

Section 2

Perceptions of Palliative Care Services

Choose the most appropriate choice to fill in the blank

1. Palliative care focuses on
   O holistic pain and symptom management across the illness trajectory
   O patients who are actively dying

2. When is the right time for a palliative care referral?
   O when the patient is actively dying
   O when the services are needed by the patient and family

3. Palliative care is
   O a unique set of skills that is ideally provided by a trained multidisciplinary team
O symptom management provided by a generalist

4. Palliative care referral is necessary when
   O a patient is diagnosed with cancer
   O when any disease process leaves a patient with a poor prognosis

**Section 3**

Triggers for Palliative Care Services

Please check which items you feel should be triggers for a palliative care consult:

- O New diagnosis of life-limiting illness for symptom control, patient/family support.
- O Declining ability to complete activities of daily living
- O Weight loss
- O Progressive metastatic cancer
- O Admission from long-term care facility
- O Two or more hospitalizations for the same illness w/in three months
- O Difficult to control physical or emotional symptoms
- O Patient, family or physician uncertainty regarding prognosis
- O Patient, family or physician uncertainty regarding appropriateness of treatment options
- O Patient or family requests for futile care
- O DNR order conflicts
- O Conflicts regarding the use of non-oral feeding/hydration in cognitively impaired, seriously ill, or dying patients
- O Limited social support in setting of a serious illness (e.g., homeless, chronic mental illness)
- O Patient, family or physician request for information regarding hospice appropriateness
- O Patient or family psychological or spiritual distress

**Section 4**

Perceptions of Educational Preparation

Please Indicate Yes/No about your personal education experiences
1. Did your undergraduate program provide any education about palliative care?
   O Yes
   O No

2. If yes about how many hours?
   _______________________

3. Did your graduate program provide any education about palliative care?
   O Yes
   O No

4. If so, about how many hours?
   _______________________

5. I feel like my educational programs prepared me to accurately identify candidates for palliative care referral.
   O Yes
   O No

6. I feel like my education program taught me the importance of palliative care referral in my practice.
   O Yes
   O No
Palliative Care Referral Criteria
Source: Center to Advance Palliative Care

The following criteria have been suggested, or are in actual use, at leading palliative care centers for initiating a palliative care referral. Some hospitals use these criteria for internal marketing, while others have established these as defining criteria for automatic consultations.

General Referral Criteria

*Presence of a serious illness and one or more of the following.*
- New diagnosis of life-limiting illness for symptom control, patient/family support.
- Declining ability to complete activities of daily living
- Weight loss
- Progressive metastatic cancer
- Admission from long-term care facility
- Two or more hospitalizations illness w/in three months
- Difficult to control physical or emotional symptoms
- Patient, family or physician uncertainty regarding prognosis
- Patient, family or physician uncertainty regarding appropriateness of treatment options
- Patient or family requests for futile care
- DNR order conflicts
- Conflicts regarding the use of non-oral feeding/hydration in cognitively impaired, seriously ill, or dying patients
- Limited social support in setting of a serious illness (e.g., homeless, chronic mental illness)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual distress

Intensive Care Unit Criteria

- Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g. dementia)
- Two or more ICU admissions within the same hospitalization
- Prolonged or failed attempt to wean from ventilator
- Multi-organ failure
Consideration of ventilator withdrawal with expected death
- Metastatic cancer
- Anoxic encephalopathy
- Consideration of patient transfer to a long-term ventilator facility
- Family distress impairing surrogate decision-making

Cancer Criteria
- Metastatic or locally advanced cancer progressing despite systemic treatments
- Karnofsky < 50 or ECOG > 3
- Brain metastases, spinal cord compression, or neoplastic meningitis
- Malignant hypocalcaemia
- Progressive pleural/peritoneal or pericardial effusions

Neurological Criteria
- Folstein Mini Mental score <20
- Feeding tube is being considered for any neurological condition
- Status Epilepticus > 24 hrs
- ALS or other neuromuscular disease considering mechanical ventilation
- Any recurrent brain neoplasm
- Parkinson’s disease with poor functional status or dementia

References


