Spring 5-14-2022

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Recommended Citation
Klug, Maria, "Improving Palliative Care Education in the Acute Hospital Setting" (2022). *Doctor of Nursing Practice Scholarly Project*. 73.
https://digitalcommons.pittstate.edu/dnp/73

IMPROVING PALLIATIVE CARE EDUCATION IN THE ACUTE HOSPTIAL SETTING

A Scholarly Project Submitted to the Graduate School in Partial Fulfillment of the Requirements of the Degree of Doctor of Nursing Practice

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March 2022

Acknowledgements

I would like to express my greatest appreciation and gratitude to Dr. Barbara McClaskey, Dr. Greg Belcher, and Dr. Trina Larery for their time, their expertise, their commitment to this research project. I would also like to thank the acute care hospital for allowing me to complete my project within their organization and utilizing their education department. Lastly, I would like to thank my family, my friends, and my boyfriend for their support throughout this journey. Their support allowed me to keep going and focus all my attention on this research project.

IMPROVING PALLIATIVE CARE EDUCATION IN THE ACUTE HOSPITAL SETTING

An Abstract of the Scholarly Project by
Maria Klug

As the geriatric population grows rapidly, the importance of utilizing and understanding palliative services continues to rise. Although palliative and hospice care are included in different healthcare courses, misconceptions and lack of knowledge continue to serve as barriers to the utilization of palliative care. The purpose was to assess knowledge, improve palliative care education, and increase understanding of the perspectives of the interdisciplinary team involved in acute patient care. The setting was the telemetry unit in a 300-bed acute care Kansas hospital. A mixed design was utilized with a goal of quality improvement in the use of palliative care. The quantitative portion was a pre-test/post-test to assess participant knowledge before and after the educational intervention. The qualitative portion was an open-ended questionnaire to assess perspectives and intent to use palliative care. The sample included 46 voluntary participants from the interdisciplinary patient care team. After data collection a paired t-test assessed whether there was a statistically significant increase in knowledge following the educational intervention. The open-ended questions were analyzed for common themes. Quantitative results demonstrated a significant 7.8-point increase on the post-test. The qualitative themes emphasized the necessity for hospitals to improve education for the interdisciplinary team, patients, and families. Many participants noted the intent to increase utilization of palliative care in the future but identified a need to better equip staff and increase their confidence with education and assessment tools. Study results emphasized the importance of continuing education in palliative care to ensure more frequent utilization in the hospital setting.

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Introduction

Introduction

In 2014, the World Health Organization (WHO) embarked on a global initiative to increase palliative care services around the world. Before beginning this initiative, the WHO identified significant barriers to improving palliative care:

- national health polices, and systems often do not include palliative care at all.
- training on palliative care for health professionals is often limited or non-existent.
- cultural and social barriers, such as beliefs about death and dying; and
- misconceptions about palliative care, such as that it is only for patients with cancer, or for the last weeks of life ("Palliative Care," 2020).

Unfortunately, the looming misconceptions and the lack of knowledge of palliative care amongst the interdisciplinary team is hindering the increased utilization of palliative care services.

Description of the Clinical Problem

As the geriatric population continues to grow at a rapid rate, the importance of palliative care services continues to rise. Mather et al. (2019) emphasized "the number of Americans ages 65 and older is projected to nearly double from 52 million in 2018 to 95 million by 2060" (para 4). With the growing number of elderlies comes an increase in chronic conditions. Unfortunately, more chronic conditions mean there will be an increase in need for more healthcare services, an increase in hospital admissions, and ultimately an increase in hospital deaths (Burt & Raine, 2006). This alarming rate of growth emphasizes the need for palliative care services. Palliative care services can relieve some of the hospital burden from chronic illnesses while also ensuring patients are maintaining a high quality of life, remaining comfortable, and meeting their goals. Therefore, increasing and improving education about palliative care is the first step in improving the utilization of services.

Background and Significance of the Problem

Although palliative and hospice care are taught in different medical, nursing, and other healthcare educational courses, there are still looming misconceptions that serve as significant barriers to the utilization of palliative care. The largest and most detrimental misconception is that palliative care and hospice care are synonymous due to often being provided by hospice organizations (Jablonski, 2008). This is a misconception held by patients, families, and many health care professionals. According to Jablonski (2008), "Blurring of the differences between hospice and palliative care has led to the notion that only patients nearing the end of life are appropriate candidates for palliative care" (p. 204). This belief that only a dying patient is appropriate for palliative care is true for hospice care, but not palliative care.

With the growing geriatric population comes many chronic conditions, people living longer, and health-related suffering. Morin et al. (2016) emphasized, "As a consequence of this change in mortality patterns, most deaths occur after a period of physical, psychological, and cognitive decline, which negatively impacts the last days, weeks, months and sometimes years of life” (p. 527). Unfortunately, this demonstrates that although patients are living longer with chronic conditions, that does not mean they are living fulfilling lives or have a high quality of life. Therefore, palliative care services need to be utilized early to identify the goals of the patient and improve their quality of life and aid their transitions through care. Improving education is the first step in combating the looming misconceptions and ultimately improving the utilization of palliative care in the hospital setting.

The interdisciplinary team plays an essential role for every patient within the hospital setting, especially those that benefit from palliative care services. According to Finerg et al. (2004), “The multidisciplinary or interdisciplinary approach is central to palliative care, allowing for holistic and comprehensive care within the complex physical, psychosocial, and spiritual patient and family needs” (p. 770). Therefore, educating the entire interdisciplinary team is essential to increasing the number of patients that utilize palliative care.

Specific Aims and Purpose

The purpose of this scholarly project was to improve palliative care education amongst the interdisciplinary team. The improvement of palliative care education would then ultimately lead to the increase in utilization of palliative care services within the acute hospital setting.

Theoretical Framework

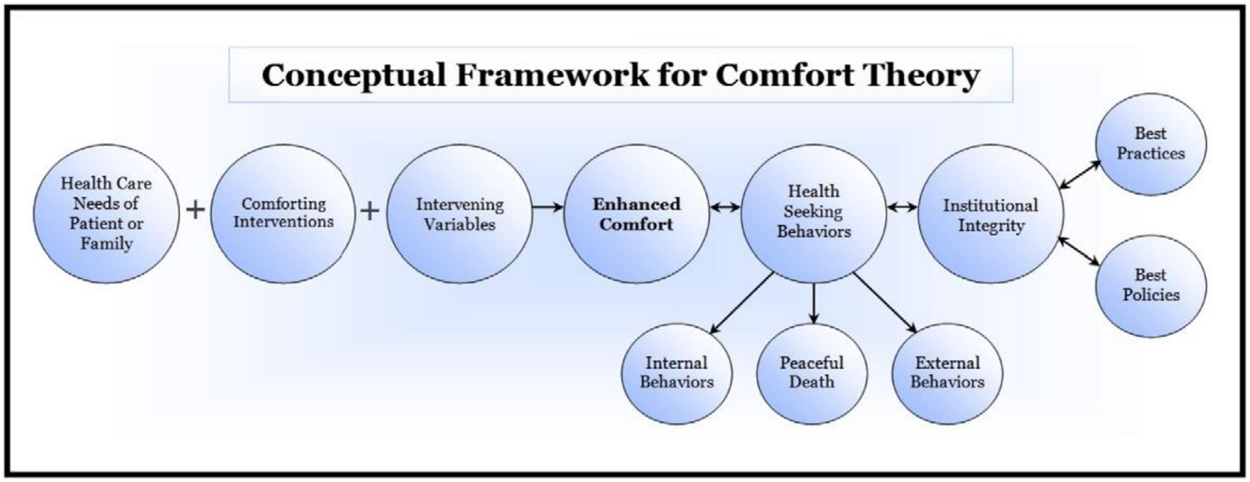
This scholarly project utilized the Kolcaba’s theory of comfort as the theoretical framework to guide this project. This theory revolves around providing holistic care, which results in increased patient comfort and satisfaction (Petirpin, 2019). The primary goal of this theory is to demonstrate and emphasize how every nursing encounter should focus on holistic care and comfort which is demonstrated in the model below (Figure 1). The theory itself describes three types of comfort. The first comfort is ease, which refers to easing one's anxiety, pain or worry. The second comfort is relief, which refers to relieving pain with pain medication, offering services to relieve caregiver burden, and relieving the spiritual struggles of the patient. The last comfort is transcendence. Transcendence refers to allowing the patient to be so comfortable that they can rise above their challenges and succeed further. Holistically caring for the patient and increasing their comfort improves the patient overall quality of life.

There are four major assumptions this theory relies upon. First, humans have a complex holistic response to complex stimuli (Petirpin, 2019). Due to this complex response, humans have a physical, emotional, spiritual, and social response to stress and stimuli. Therefore, the interdisciplinary team needs to attend to all patient needs to ensure comfort. The second assumption is comfort is a holistic outcome of nursing care (Petirpin, 2019). The last two assumptions are the most important. Human beings have a basic need for comfort and will seek it out is the third assumption of this theory (Petirpin, 2019). Once a patient reaches comfort, they are strengthened, happier, and live a better quality of life. Lastly, nurses can assess, design, and provide comfort to their patients to aide in reaching the optimal quality of life is the fourth and final assumption (Petirpin, 2019).

The Kolcaba's theory of comfort guided the creation of the educational intervention and improved current educational practices regarding palliative care. This theory demonstrated how identifying goals and the needs of the patient can ultimately increase the patient’s quality of life and satisfaction with care. Providing education emphasizing the importance of comfort, goal of care, and a holistic approach should always be the primary focus of palliative care education.

Figure 1

Conceptual Framework for Comfort Theory



Note: taken from Krinsky et al., 2014

The Practice Problem

Currently, in the hospital setting, there is an underutilization of palliative care services. This stems from the general lack of knowledge amongst healthcare workers and the public about palliative care. Due to the misconception associated with palliative care and the lack of awareness of how palliative care can make a beneficial impact, palliative care teams are often not consulted, and services are not utilized.

Project Hypothesis and Questions

This project aimed to improve the education amongst the interdisciplinary team regarding palliative care. Ideally, improving palliative care education would increase knowledge of palliative care benefits, decrease misconceptions, improve confidence in usage of palliative care services, and increase plans amongst healthcare professionals to utilize palliative care services.

To improve the strength of this scholarly project, questions were identified:

1) What are the current misconceptions and knowledge levels regarding palliative care amongst the interdisciplinary team?

2) After the intervention, what are the subjects' misconceptions and knowledge level regarding palliative care?

3) Is there a difference between the pre and post measure of misconceptions and knowledge level regarding palliative care?

4) How many healthcare professionals plan on utilizing or consulting palliative care services in the future after the educational intervention?

5) What do members of the interdisciplinary team identify as barriers to consulting palliative care?

6) Who do members of the interdisciplinary team believe to be primarily responsible for consulting palliative care?

7) Why do members of the interdisciplinary team believe palliative care is underutilized in the acute hospital setting?

8) How do members of the interdisciplinary team feel like they can improve the consult process to palliative care?

Definitions of Key Terms

The following terms were defined due to their complexity, need for understanding, and use throughout the following scholarly project.

Education: “formal efforts to provide information and experience and develop new skills and competencies among students or practicing healthcare professionals” (Greiner & Knebel, 2003)

Hospice: “provided for a person who is recognized as having a terminal illness that physicians believe give the survivor 6 months or less to life if the illness runs it natural course” (Stephen, 2020, p. 3).

Interdisciplinary Team: “health care teams which include a range of health service workers, both professionals and non-professionals, with the majority being from professional groups” (O’Reilly et al., 2017).

Palliative Care: “An interdisciplinary approach for people with chronic conditions to provide relief from the symptoms, pain, physical stress, and mental stress at any stage of the illness…can be provided in tandem with curative treatment and can begin at any time of diagnosis with the goal to improve the quality of life” (Stephen, 2020, p. 3)

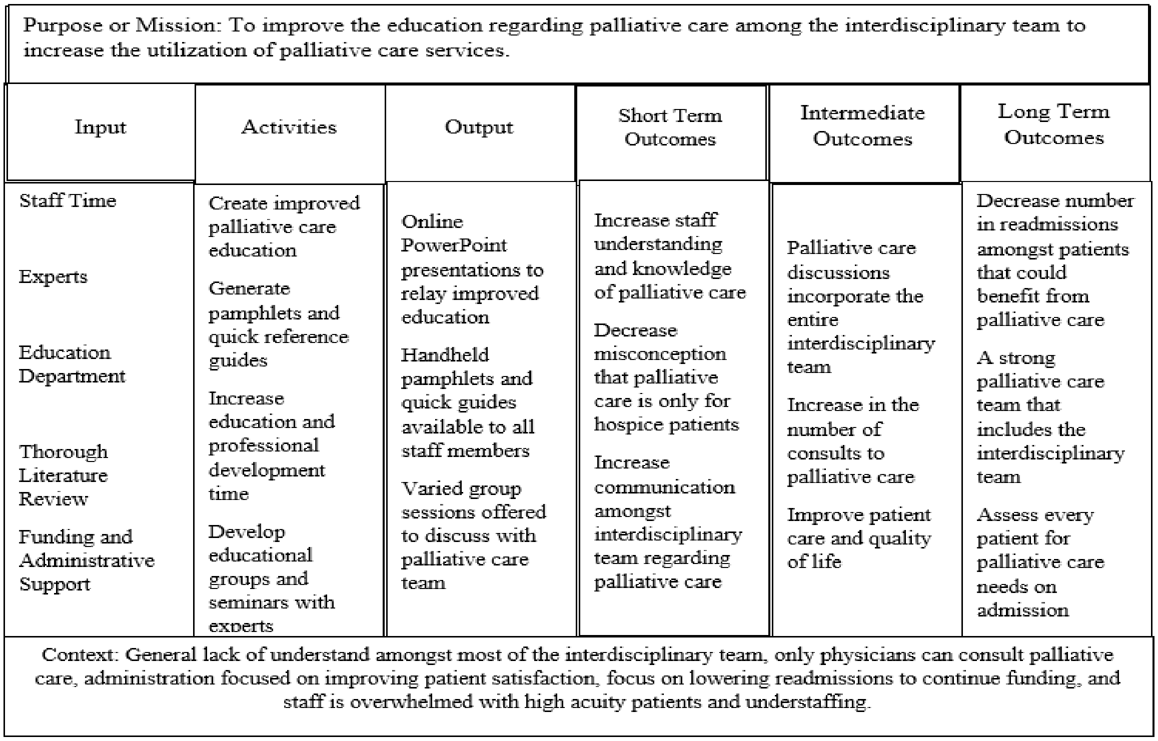
Logic Model

The following model (Figure 2) demonstrated the logic model for the improvement of palliative care education amongst the interdisciplinary team. This logic model offers a visual aid of how improving palliative care education amongst the interdisciplinary team will an impact on the association. The purpose of this change was to improve palliative care education that would then increase the utilization of palliative care services. Unfortunately, the condition of the environment was not completely suitable for implementing this change. There were two evident condition barriers. The first was that only physicians can consult palliative care. Secondly, due to understaffing and high acuity patients, staff was overwhelmed and lacked time for professional development and education. On the other hand, there were environmental factors that did aid this change. There was a general lack of knowledge amongst the interdisciplinary team regarding palliative care, and administrators were focused on improving patient satisfaction scores and decreasing readmission rates. This intervention had the ability to positively impact both these environmental factors significantly.

To implement affective change, the inputs had to work together to develop evidence-based educational opportunities for staff. This included PowerPoint presentations, quick guides, and pamphlets that were easily accessible. By effectively implementing these activities and seeing them through to successful outputs, one could expect significant short-term, intermediate, and long-term outcomes. Overall, the intervention increased palliative care knowledge among staff, encouraged interdisciplinary efforts in assessing each patient for palliative care needs, increased patient satisfaction, and in the future would help aid in decreasing hospital readmissions.

Figure 2

Logic Model for the Improvement of Palliative Care Education Amongst the Interdisciplinary Team



Purpose or Mission: To improve the education regarding palliative care among the interdisciplinary team to increase the utilization of palliative care services.

Input	Activities	Output	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
Staff Time Experts Education Department Thorough Literature Review Funding and Administrative Support	Create improved palliative care education Generate pamphlets and quick reference guides Increase education and professional development time Develop educational groups and seminars with experts	Online PowerPoint presentations to relay improved education Handheld pamphlets and quick guides available to all staff members Varied group sessions offered to discuss with palliative care team	Increase staff understanding and knowledge of palliative care Decrease misconception that palliative care is only for hospice patients Increase communication amongst interdisciplinary team regarding palliative care	Palliative care discussions incorporate the entire interdisciplinary team Increase in the number of consults to palliative care Improve patient care and quality of life	Decrease number in readmissions amongst patients that could benefit from palliative care A strong palliative care team that includes the interdisciplinary team Assess every patient for palliative care needs on admission

Context: General lack of understand amongst most of the interdisciplinary team, only physicians can consult palliative care, administration focused on improving patient satisfaction, focus on lowering readmissions to continue funding, and staff is overwhelmed with high acuity patients and understaffing.

Summary

With the growing need for palliative care, it is important to improve palliative care education amongst healthcare professionals. This is the first step in increasing the utilization of palliative care services. Without proper education, misconceptions and inexperience deter providers and healthcare professionals from offering palliative care to patients in need. Therefore, understanding the impact of improved palliative care education and training is increasingly important.

This project utilized the Kolcaba’s theory of comfort to create educational PowerPoints and pamphlets to increase and improve palliative care education amongst healthcare professionals. A mixed method design was used to evaluate the effectiveness of the educational intervention with pre-test/post-test questionnaires and an open-ended questionnaire postintervention. Increasing education and ensuring healthcare professionals understand the benefits of palliative care would ideally increase the utilization of palliative care services. An increase in palliative care services would, in the end, decrease hospital admissions, increase of patient satisfaction, and most importantly increase the quality of life of each patient.

Chapter II

Review of Literature

Introduction

Due to the complexity of palliative care services, an in-depth literature review was essential to providing a better understanding of the clinical problem. The purpose of this review was to examine the benefits of early palliative care intervention, assess the current misconceptions among healthcare professionals, evaluate the effectiveness of current educational practices, assess the benefits of improving palliative care education, and assess the need for specific palliative care education. To ensure diverse literature collection multiple databases were used to complete the following literature review. The following databases were utilized: Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest Nursing and Allied Health Journals, PubMed, and MEDLINE. Research articles were retrieved from peer-reviewed medical journals and evaluated for their merits and values. Key words and phrases used to search for pertinent articles included palliative education, understanding of palliative care, early palliative care intervention, barriers to palliative care, and need for palliative care.

` Palliative care encompasses a variety of services to aid the patient in achieving their best quality of life. They focus on assessing and treating the symptoms, helping the patient and the family understand the disease and treatment options, aid in the usage of community resources, and help with the patient transition through the medical care system (Kelley & Meier, 2010). The utilization of these services can often decrease patient and family dissatisfaction with medical care. Unfortunately, there is still a staggering underutilization of palliative care. It is estimated that out of the 1 million hospice deaths in 2011, 63% of those patients utilized hospice care for less than a month and 36% of those patients were admitted to hospice within seven days of dying, which ultimately demonstrates the lack of hospice and palliative care intervention (McAteer & Wellbery, 2013). Early palliative care intervention ensures patients are transitioning to the appropriate level of care in a timely matter to improve their quality of life and ease the transition for themselves and their families.

Benefits of Early Palliative Care Intervention

Recognizing the need for palliative care interventions early provides a wide variety of benefits to the patient, the family, and the healthcare system. The patient is the one that primarily benefits from early palliative care interventions. One study demonstrated, “Overall quality of life 12 weeks after baseline was significantly improved in patients receiving early and systematic palliative care compared to standard care” (Vanbutsele et al., 2018). The patients that received early palliative care interventions also demonstrated improved cognition, holistic wellbeing, physical functioning, and a decrease in fatigue and suffering (Vanbutsele et al., 2018). Ensuring medical care is aligned with goals of care is the first step in improving patient perception of treatment and quality of life. This often includes focusing on patient symptoms. Unfortunately, curative treatment without palliative care intervention does not encompass symptom management as the primary goal. Salins et al. (2016) demonstrated that early intervention "improved pain, nausea and vomiting, constipation, breathlessness, restless, and overall patient satisfaction" (p. 263). The patient not only sees an improvement in quality of life but has a significant decrease in symptoms and suffering.

Although the patient is the primary focus of care, family members and caregivers play an essential role in caring for the patient. Often, they are faced with difficult decisions, psychological distress, and caregiver burden. Specifically, early intervention caregivers reported "lower depression symptoms, as well as less anxiety in the months closer to the patients' death compared with caregivers of patients assigned to usual care" (El-Jawahri et al., 2017, p. 1529). This distress is often reduced because palliative care helps the family make difficult healthcare decisions while also easing the transition through the healthcare system. It was found that early palliative care intervention increased symptom management, holistic support for patients and caregivers, assistance with navigating medical decision, and increased patient and caregiver comfort with future plans (Hannon et al., 2016). Caring for the patient and the caregiver with a holistic palliative care approach lends to improve patient and family satisfaction.

Increasing patient and family satisfaction is a benefit of early palliative care. According to Chen et al. (2018), "Patient satisfaction data have increasingly been used by patients and payor both in the United States and abroad as a metric to assess hospital quality and rate hospital performance" (p. 202). After recognizing the need for palliative care, early intervention allows symptoms and suffering to be managed effectively quicker which improves patient satisfaction of care. It was found that the early palliative care intervention group within one study was significantly higher in perception of quality of care and caregiver satisfaction than the other two patient groups (Sandsdalen et al., 2019, p. 910). Palliative care also helps decrease hospital readmissions and costs related to readmissions. It was estimated that palliative care “may decrease hospital expenditures by 9-25% by decreasing hospital readmissions” (Wiskar et al., 2018, p. 446). Unfortunately, early palliative care intervention cannot be introduced without the help of dedicated providers and a strong interdisciplinary team.

Misconceptions Among Healthcare Professionals

Currently within the acute hospital setting, the primary healthcare provider must decide to consult palliative care to initiate the assessment and palliative interventions. However, due to misconceptions and the lack of understanding among healthcare professionals there is a low number of palliative care consultations. A study of non-palliative care providers demonstrated that a majority of providers associated palliative care as solely end of life care (McDarby & Carpenter, 2018). This is one of the most detrimental misunderstandings and fosters the underutilization of palliative care services. In fact, it was found that the average hospitalist physician does not recognize when palliative care is needed unless a patient is near the end of life (Nevin et al., 2020), again contributing to late referrals and decreased quality of life for the patient.

Unfortunately, there are no clear assessment tools or protocols to guide providers to know when to begin involving palliative care. According to Kavalieratos et al. (2014), “non-palliative care providers often reported criteria associated with Medicare Hospice Benefit (<6 months expected survival, suspending life-prolonging treatments) as those for nonhospice palliative care.” Although the Medicate Hospice Benefit is meant to evaluate patients for hospice, it is not meant to evaluate patients and their need for palliative care services. Instead, assessing for palliative care needs should involve assessment of the diagnosis severity, severity of symptoms, and the predictive rate of functional decline (ElMokhallati et al., 2020, p. 1003). Unfortunately, many primary care providers and hospitalists lack the skills and education needed to recognize patient needs that would benefit from palliative care.

Without a formal assessment tool, providers are often forced to make difficult decisions with little experience and expertise. One study demonstrated that providers perceive the most difficult barrier to be “the concern that the patient and family will think the primary provider was giving up on the treatment of the patient” (Buckley de Meritens et al., 2017). This barrier often stems from poor communication with patients and families regarding diagnosis, treatment options, and quality of life. Many providers admitted continuing treatment was easier than stopping treatment and having those high-level difficult discussions (Willmott et al., 2016, p. 500). Underutilization of palliative care also stems from physician inability to recognize the benefits of palliative care within certain patient populations. In order to improve palliative care, clinicians will need to be able to diagnose the dying, improve communication skills, recognize the difference between hospice and palliative care, and to address patient treatment goals (Buckley de Meritens et al., 2017). Therefore, to increase the utilization of palliative care, increasing and improving education regarding palliative care is the first step.

Current Educational Practices

To better understand the benefits of improving palliative care education, current palliative care education must be evaluated. An overwhelming theme among the research is the overall inadequacy of current palliative care education. According to Nevin et al.

(2020), “The need for education in palliative care was largely advocated by healthcare providers, and a lack of specific training opportunities in palliative care was highlighted” (p. 615). Unfortunately, this lack of knowledge leads to a lack of confidence. This lack of confidence often means palliative care needs are not recognized and therefore not addressed. It was identified that non-palliative care specialists have a lack of confidence in addressing symptom management, psychological issues, the difference between palliative care and hospice, and effective communication (Carey et al., 2019, p. 1140). All the research exemplifies the need to improve palliative care education.

Benefits of Improving Palliative Care Education

Palliative care is an essential part of medicine. One study emphasized “palliative care referral for patients may be suboptimal due to limited provider knowledge and misperception” (Kavalieratos et al., 2014). Enhancing palliative care knowledge improves confidence and increases knowledge. After a palliative care education intervention, there was a significant improvement in all 16 domains of confidence and knowledge (Artioli et al., 2019). There are a variety of ways to enhance palliative care knowledge. Classes, flyers, PowerPoints, simulations, and many more can be used in the acute hospital setting. Harden et al. (2017) found, “a significant increase in knowledge, attitudes, and behaviors among those participating in a palliative care educational program” (para 19).

Many other articles focused on the benefit of introducing palliative care education to a number of chronic illnesses. According to Verymylen et al. (2015), “Palliative care increases focus on symptom management, advance care planning, and support for patients as part of comprehensive COPD care” (para 27). Another chronic illness that is being extensively studied is heart failure. Palliative care is utilized more with proper education in heart failure patients, which also increases symptom management like depression, anxiety, pain, spiritual distress, and family stress (Goodlin, 2009). Unfortunately, these studies are extremely limited due to the fact there are not many studies that have been done on palliative care with chronic illnesses other than cancer. In fact, much of the research, establishes that incorporating palliative care education in different fellowships like cardiology would significantly improve care. Crousillat et al. (2018) stresses, “Palliative care will enable cardiologist to better integrate high quality symptom management and advance care planning techniques” (p.1394). Incorporating effective palliative care education in the hospital setting presents the opportunity to reach a variety of healthcare professionals.

Necessary Palliative Care Education

Palliative care uses a team approach when assessing and treating an individual. Therefore, it is extremely important for palliative care education to be presented to every member of the interdisciplinary team like physicians, nursing staff, case managers, social workers, etc. Important educational topics include disease management, holistic care, assessment for need, end-of-life care, and grief (Harris et al., 2007). Including palliative care core competencies increase healthcare professional confidence and expertise. Harris et al. (2007) enacted the comprehensive advanced palliative care education program (CAPCE) and not only discovered an improvement in palliative care within the studied hospital setting but also discovered the hospital system enacted improved palliative care policies and creating patient-centered palliative care meetings (p. 268).

Although understanding palliative care is essential, possessing the adequate skills to deliver effective palliative care is equally as important. Palliative care education needs to give healthcare professionals the opportunity to build communication skills, understand psychological and social needs, and provide hands-on experience (Negrete & Tariman, 2019, p.568). Providing these educational opportunities allows providers to improve their skills. Improving skills and knowledge ensures strong communications with patients and families, effective management, and treatment, and helps maintain positive attitudes that decrease burnout (Negrete & Tariman, 2019, p. 568). Burnout is unfortunately a serious issue that plagues the healthcare community. This often arises from either lack of confidence, difficult patient encounters, ethical dilemmas, or difficult work environments. Unfortunately, palliative care patients are often those difficult patient encounters that encompass ethical dilemmas. Due to the lack of knowledge or hands-on experience, these encounters can single handedly burnout healthcare professionals.

Many of the research articles emphasized the importance of the National Consensus Project (NCP) for Quality Palliative Care. These are well-known guidelines that emphasize the importance of integrating palliative care into all sections of healthcare. Incorporating strong guidelines with effective processes, educating on the importance of palliative care, building knowledge of the palliative care competencies, and emphasizing end-of-life care are all essential domains to include within palliative care education services (Ferrel et al., 2020). Effective palliative care education will pave the way for providers to begin providing improved patient centered care. Ferrel et al. (2020) found, “Six-month post-course data showed more APRNs participating in family meetings, recommending palliative care consultations, speaking with family members regarding bereavement services, and preparing clinical staff for impending patient deaths" (p. 222). Educating providers and healthcare professionals properly and efficiently has the potential to make a significant impact in palliative care services in the hospital setting.

Summary

According to Meier et al. (2017), "In 2014 the World Health Organization (WHO) called for standardized access to palliative care as a human right" (p. 1265). Palliative care offers services to vulnerable populations that have the ability to improve their quality of life, ease their transition through the healthcare system, and offer support and guidance with difficult medical decisions. Unfortunately, "as of 2017 palliative care remains difficult to access for more than forty million Americans with serious illness and functional dependency" (Meier et al., 2017, p. 1265). This underutilization of palliative care stems from provider misunderstanding, poor education, and lack of strong palliative care skills.

Early palliative care education has demonstrated significant improvements in a variety of areas. With early intervention patients receive patient-goal oriented care that often results in improved quality of life, symptom management, and decreased hospital readmissions. Better perceptions of care turn into improved patient and family satisfaction. A combination of increased satisfaction scores and decreased hospital readmissions leads to improved hospital reimbursement and overall ratings. Unfortunately, to provide adequate palliative care providers must be able to assess and recognize the need for palliative care services. Unfortunately, due to the misconceptions, lack of knowledge, and no evidence-based assessment tool available very few patients see the benefit of early palliative care intervention.

Current educational practices focused on providing palliative care are lacking. According to Meier et al. (2017), “many US health professionals lack training in core palliative care domains: the treatment of pain and other symptoms, communication about care priorities and options, and care coordination” (p 1265). Therefore, improving palliative care education is the first step in improving the utilization of palliative care. Enhancing palliative care education increases confidence of healthcare professionals, improves communication skills, and gives healthcare professionals the opportunity to provide better and adequate palliative care services to vulnerable in-need populations. Palliative care education must focus on palliative care core competencies and skills needed to carry out these competencies. In the end, palliative care is about providing the best patient-centered care to patients and families throughout an illness and in order to do so the current educational practices must evolve to combat the lack of knowledge and looming misconceptions.

Chapter III

Methodology

Introduction

Even with global initiatives to improve the usage of palliative care, misconceptions, and lack of education amongst healthcare professionals hinder the full utilization of palliative care services in the acute hospital setting. The purpose of this project was to assess misconceptions amongst the interdisciplinary team, offer an educational intervention that improved palliative care education, and to increase the intent to refer patients to palliative care. Understanding hinderances and improving education were the first steps to improving the utilization of palliative care.

Design

This project utilized a mixed design with a goal of quality improvement in the use of palliative care. The quantitative portion of this design was a pre-test/post-test to assess the participants knowledge before and after the educational intervention. The pre-test/post-test was a true and false exam. Demographic information was collected during the pre-test. The post-test included questions that are identical to those on the pre-test to allow for easy comparison of data prior to and after the intervention. The qualitative portion of this design was a questionnaire following the post-test. This open-ended questionnaire was utilized to assess the different perspectives, feelings, and intent to use palliative care services in the future. This quality improvement project was available to participants on HealthStream. HealthStream is a software service used by healthcare employers for online education, credentialing, and performance assessment. This scholarly project was completed within an acute hospital that already utilized HealthStream for training and online learning.

Sample/Target Population

Sample Access/Target Population

This quality improvement project focused on an acute telemetry unit within an acute care 300 bed hospital in Kansas. This project focused on members of the interdisciplinary team that were involved in direct patient care on the telemetry unit of the hospital. This included bedside nurses, mid-level providers, physicians, social workers, case managers, dieticians, physical therapists, occupational therapists, nursing assistants, etc. To provide the best care to patients an interdisciplinary approach ensures that patients are being treated holistically (Fineberg et al., 2004). Therefore, educating the entire interdisciplinary team ensured the team was providing the best care and ensured the team is adequately assessing those that would benefit from a palliative care consult within the hospital setting. By including the entire interdisciplinary team, this also increased the power of the sample size. The larger the sample size the better the chances of assessing the effectiveness of the educational intervention.

Sample/Target Population Recruitment

Participants were asked to participate on a voluntary basis. Recruitment of subjects on the telemetry unit was completed through word of mouth, email, newsletters, and bulletin boards. Purposive sampling was utilized in this study. This ensured that all participants were members of the interdisciplinary team involved in direct patient care. It also provided the most reliable participants with a baseline knowledge of the subject being studied. To ensure easy access, the project was available over HealthStream. HealthStream was available to all employees at home or at work.

Inclusion and Exclusion Criteria

To participate in this scholarly project, the participant had to be part of the interdisciplinary team involved in direct patient care. Each participant was an employee of the acute care hospital on the acute/telemetry unit and agreed to participate on a voluntary basis. Participants could have been part time, full-time, or PRN employees. Exclusion criteria included employees under the age of 18, pregnant women, and those that did not consider English to be their first language. Other exclusion factors included employees that were not involved in direct patient care like hospital administration, Sodexo staff, nursing directors, and environmental services employees.

Protection of Human Subjects

Before beginning, benefits and risks of the project were reviewed with each participant. Benefits included improving staff knowledge of palliative care services, increasing palliative care services, and decreasing rehospitalizations in the future. Risks were minimal to participants but included test anxiety, psychological stress, and emotional stress. After reviewing the benefits and risks, an informed consent was obtained. Once consent was obtained, the pre-test then opened. To accurately analyze and compare the pre-test and post-test, a participant identifier was collected at the beginning of the pre-test and post-test. This participant identifier was the participant’s employee number. This was a unique number assigned to each employee of the acute care hospital. This researcher did not have access to the designation of employee numbers; therefore, identify remained confidential. All data was stripped of the participant identifier once data was analyzed and compared. The only demographic information that was collected was the occupation of each participant, age, and gender to ensure they were an interdisciplinary team member involved in direct patient care. All vulnerable populations were excluded from this scholarly project. This researcher ensured the confidentiality of all participants. Lastly, this researcher had completed the Collaborative Instrumental Training Initiative to ensure this researcher understood human research protection.

Instruments

An educational PowerPoint was created after a thorough literature review by this researcher. This educational intervention aimed to inform the interdisciplinary team of the differences between palliative care and hospice, the benefits of palliative care, when to consult palliative care in the acute hospital setting, and how palliative care could benefit the patient, family, and the hospital. The educational PowerPoint is included in Appendix A. To reinforce the information provided in the educational intervention, a palliative care brochure was also created and was distributed around the telemetry unit. This brochure is included in Appendix B.

The first test administered before the educational intervention was the pre-test. This assessed participants knowledge and misconceptions prior to the educational PowerPoint through HealthStream. The pre-test included the demographic questions to assess gender, age, and occupation. This ensured that all inclusion criteria were met which included 18 years of age and older and a member of the interdisciplinary team involved in direct patient care. The post-test was then administered after the educational intervention. The post-test was identical to the pre-test without the demographic questions.

The pre-test and post-test used an adapted version of the Palliative Care Knowledge Scale (PaCKs). This version was used in a research study to assess physician knowledge and misconceptions of palliative care (Biswas et al., 2021). According to Biswas et al. (2021), “A pilot study was done to validate the tool among 50 physicians, which yielded almost the same result (as the PaCKs)” (p. 3). The pre-test/post-test included a 16-item true/false test that assessed knowledge and common misconceptions among healthcare professionals. The original test consisted of 13 true/false questions. This researcher added three questions that directly related to the educational intervention. The true/false questions added were “all palliative care patients need hospice”, “palliative care and hospice care provide the same services”, and “palliative care and hospice care are often covered by insurance, Medicare, and Medicaid”. The pre-test with demographic questions and the post-test with correct answers are located in Appendix C. Higher scores exemplify a better understanding and knowledge of palliative care.

Lastly to assess the perspective and feelings of each interdisciplinary member, a six-question open-ended survey was administered after the post-test. This open-ended questionnaire is included in Appendix D. The development of these open-ended questions was based on a previous study that assessed physician knowledge, attitude, and experience with advanced care planning (Snyder et al., 2012). The questions developed are not identical to the previous study but do mimic the same themes and questions. This open-ended survey focused on healthcare professional perspectives of palliative care including perceived barriers, who is responsible for consulting palliative care, why they believe palliative care is underutilized, and if they foresee themselves initiating more palliative care consults in the future. Lastly, there was a question that asks for any comments or concerns from each participant at the end of the survey.

Procedure

Prior to implementing this quality improvement project, all aspects were reviewed by multiple committees. First, this project was presented to the Corporate Compliance Committee of the acute care hospital. Benefits and risks were reviewed with the hospital committee. After receiving approval, this researcher worked with the palliative care team within the acute hospital setting to ensure their approval and support of the project. After finalizing the project including the educational intervention, the pre-test/post-test, and open-ended questionnaire, this DNP project was then presented to the Institutional Review Board (IRB) at Pittsburg State University.

Once reviewed and approved, this researcher began working with the educational department within the acute care hospital to implement the project and educational intervention within HealthStream. Once the pre-test, educational intervention, post-test, and open-ended questionnaire were available on HealthStream, participants were recruited and allowed to participate. This project was open for participation at the beginning of November through the end of January. Each participant followed the exact same procedure during the study. They were asked to fill out an informed consent prior to the starting and then began the demographic portion of the pre-test, which then led into the rest of the pre-test. Following the pre-test, each participant had access to the educational intervention. They had an unlimited amount of time to review the educational

PowerPoint. They also had the ability to click through the slides at their own speed. After completing the education portion, they were to take the post-test and finally the open-ended questionnaire. There was no time limit on the tests or questionnaire.

Data collected included the demographic information, pre-test results, post-test results, and the open-ended questionnaire answers. No identifying information was collected about the different participants. This ensured the confidentiality of each participant. Access to data was limited to this researcher and the committee members of this DNP project. After completion of the project, results were available to all participants, the acute care hospital, and Pittsburg State University. All data was then locked in a secure cabinet for three years to ensure security and then will be destroyed.

Treatment of Data/Outcomes/Evaluation Plan

Evaluation Measures Linked to Objectives

The purpose of this quality improvement project aimed to evaluate the effectiveness of the palliative care educational intervention in the acute hospital setting. The hope was to improve the knowledge among the interdisciplinary team and increase the utilization of palliative care in the future. Unfortunately, many non-palliative care specialists have identified a lack of confidence and knowledge when addressing symptom management, the difference between palliative care and hospice, and how to effectively treat patients nearing end of life (Carey et al., 2019, p. 1140). Therefore, it was important that the pre-test assessed misconceptions held prior to the educational intervention, while the post-test evaluated how effective the intervention truly was. Improving palliative care knowledge amongst the interdisciplinary team was essential in improving the utilization of palliative care within the hospital setting and improving the quality of care these patients receive. Lastly, to evaluate perceptions and intention of utilizing palliative care services in the future, an open-ended questionnaire was offered after the post-test. This questionnaire evaluated the feelings and attitudes of the interdisciplinary team in terms of utilizing palliative care services. Essentially, this study aimed to prove that improving education among the interdisciplinary team improved knowledge and increased the intention of consulting palliative care.

Methods of analysis for each Measurement

To better understand the effectiveness of the educational intervention, the correct answers of each true/false question were calculated in terms of percentages and then compared. Total scores were also completed on each pre-test and post-test for comparison. Utilizing a paired sample t-test allowed for easy comparison between the results of the pre and post-test and whether the intervention was effective or not.

In regard to the open-ended questionnaire, this researcher examined the data collected for recurring answers and similar concepts. This allowed this researcher to identify common themes about the perceived barriers of palliative care, the intention of involving palliative care in the future, and how each member of the interdisciplinary team hopes to improve the utilization of palliative care.

Evaluation Measures Linked to Objectives

Throughout the project, the evaluation measures correlated with the overall research questions and the overall purpose of the logic model (see Figure 2) established in Chapter I. This project aimed to evaluate the effectiveness of the educational intervention in addressing the short-term outcomes and intermediate outcomes also established in the logic model (see Figure 2). Unfortunately, this scholarly project did not have the ability to address the long-term outcomes established in the logic model (see Figure 2) like decreasing hospital readmissions.

Overall, the evaluation of outcomes shed light on the effectiveness of the intervention. It also determined where solutions and improvements to this research study need to be made and also determined how research in the future can further this topic.

Plan for Sustainability

Improving the utilization of palliative care is an ongoing process and battle. The benefit that palliative care has in reducing hospital readmissions, saving patients and the hospital money, and improving patient care should be significant enough to be prioritized by healthcare. Therefore, constantly evaluating, updating, and improving palliative care education will be a top priority. Therefore, after this project was completed and data was collected, it was important that this project was assessed and evaluated for improvements that could be added to the educational intervention. It was also appropriate to use the information identified in the open-ended questionnaires to encourage conduction of more extensive research in the future. The data and results collected were also presented to the acute hospital educational team to determine if the educational intervention and brochure would be a requirement for the rest of the hospital.

Chapter IV

Evaluation of Results

Purpose

The study aimed to improve the knowledge and increase the intent to utilize palliative care services amongst the interdisciplinary team in the acute hospital setting. A pre-test post-test design was utilized to assess knowledge and misconceptions about palliative care amongst the interdisciplinary team before and after encountering an educational intervention. To assess intent to improve the utilization of palliative care and assess barriers to consulting palliative care, a qualitative open-ended questionnaire was utilized. The project aimed to answer the following questions:

1) What are the current misconceptions and knowledge levels regarding palliative care amongst the interdisciplinary team?

2) After the intervention, what are the subjects’ misconceptions and knowledge level regarding palliative care?

3) Is there a difference between the pre and post measure of misconceptions and knowledge level regarding palliative care?

4) How many healthcare professionals plan on utilizing or consulting palliative care services in the future after the educational intervention?

5) What do members of the interdisciplinary team identify as barriers to consulting palliative care?

6) Who do members of the interdisciplinary team believe to be primarily responsible for consulting palliative care?

7) Why do members of the interdisciplinary team believe palliative care is underutilized in the acute hospital setting?

8) How do members of the interdisciplinary team feel like they can improve the consult process to palliative care?

Description of Sample

This scholarly project was completed by 46 participants who are currently employed on the acute telemetry unit within the acute care hospital. Once approval from Pittsburg State University and the acute hospital quality committee was obtained, the project went live on HealthStream on November 17, 2021, and data collection was completed on January 31, 2022. To participate in the project, participants had to be employees of the acute telemetry unit involved in direct patient care and agree voluntarily to complete the project. Exclusion criteria included employees under the age of 18, pregnant women, and those that did not consider English to be their first language. Other exclusion factors included employees that are not involved in direct patient care like hospital administration, Sodexo food service staff, nursing directors, and environmental services employees.

Table 1. Demographics of Participants (N=46)

Characteristics	N	%
Gender		
• Male	6	13.04%

• Female	40	86.96%
Age		
• Under 18	0	0.00%
• 18-25	10	21.74%
• 26-30	10	21.74%
• 31-35	6	6.52%
• 36-40	6	13.04%
• 41-45	5	10.87%
• 46-50	4	8.70%
• 51-55	3	6.52%
• 55+	5	10.87%
Occupation		
• Registered Nurse	37	80.43%
• Physician	1	2.17%
• Mid-Level Providers	5	10.87%
• Rehab (OT/PT/SLP)	1	2.17%
• Case Management	1	2.17%
• Other Not Listed	1	2.17%

Of the 46 participants, 40 participants were female, and 6 participants were male. A majority of the participants were in the age group 18-25 and 16-30. These two age groups accounted for 43.48% of the participants. The rest of the participants ranged from 31 years of age and older. The data collected involved the entire interdisciplinary team. Of the 46 participants, 37 participants were registered nurses. This accounted for 80.43% of the participants. Other participants included 1 physician, 5 mid-level providers, 1 rehabilitation employee, 1 case manager, and 1 cardiac nurse navigator.

Description of Key Variables

Independent Variable

The independent variable of this project in the quantitative portion was the palliative care education provided after the pre-test and before the post-test. The educational intervention was a PowerPoint that was created after a thorough literature review. An educational brochure was also available throughout the acute telemetry unit. Before the educational intervention, a pre-test was administered to assess knowledge, competency, and misconceptions. The educational intervention was then introduced and was available for participants to go through at their own pace. Immediately after the educational intervention, the post-test was administered to participants.

In the qualitative portion of this project, the open-ended questionnaire was used to gather responses. Each participant was given the opportunity to answer the same open-ended questions. These questions were used to assess barriers to utilizing palliative care and if there was an intent to utilize palliative care more in the future.

Dependent Variable

The dependent variable of the project is the knowledge of the participants after the educational intervention was introduced. This was assessed utilizing the post-test immediately after the educational intervention. To better understand the barriers to palliative care in the acute hospital setting, the open-ended questionnaire was available at the end of the project. The themes identified in the responses varied depending on the opinions of each participant.

Analyses of Project Questions

The pre-test post-test design portion of this project was used to analyze the first three research questions. This part of the project aimed to identify common misconceptions amongst the interdisciplinary staff prior to the intervention, evaluate the misconceptions and knowledge base post-intervention, and measure how effective the education intervention was based on pre-test score versus post-test scores. On the other hand, research questions four through eight were evaluated using a qualitative open-ended questionnaire. Participants were given an open-ended questionnaire to assess their perspectives and ideas about palliative care at the end of the study. This data was then collected and assessed for common themes. The answers to the open-ended questionnaires can be found in Appendix E.

Table 2 Pre-test versus Post-test Scores by Item (N=46)

Questions		Correct Answer	Correct Answer Pre-test (%)	Correct Answer Post-test (%)
1	Palliative care is an interdisciplinary team-based approach.	True	92.16%	100%
2	Palliative care treats the patient holistically: physically, emotionally, spiritually, and psychologically.	True	96.08%	100%
3	Palliative care is exclusively for the last six months of life.	False	90.20%	97.96%
4	Palliative care helps better understanding of the treatment options being offered.	True	88.24%	95.92%
5	To be on palliative care the patient must stop all curative treatment.	False	92.16%	95.92%
6	All palliative care patients need hospice.	False	88.24%	97.96%
7	Palliative care improves patient's daily activities.	True	86.27%	95.92%
8	Palliative care helps manage side effects of other treatments	True	88.24%	100%
9	Palliative care addresses stress from serious illnesses.	True	92.16%	100%
10	Palliative care helps families to cope.	True	92.16%	100%
11	Palliative care and hospice care provide the same resources.	False	72.55%	81.63%
12	Palliative care is only for cancer patients.	False	94.12%	100%
13	Palliative care is only for older adults.	False	96.08%	100%
14	Palliative care is offered in the hospital setting and the outpatient setting.	True	92.16%	95.92%
15	Palliative care stops all consults to other specialties.	False	88.24%	97.96%
16	Palliative care and hospice care are often covered by insurance, Medicare, and Medicaid.	True	90.20%	97.96%

Research Question One.

What are the current misconceptions and knowledge levels regarding palliative care amongst the interdisciplinary team?

Based on the pre-test results, there were six of the true or false questions answered below the 90% mark. The first item identified as a misconception was that a portion of the interdisciplinary team did not understand that palliative care helps patients and family members understand the different treatment options being offered. This was evaluated with question number four on the pre-test. On the pre-test, 88.24% percent of the participants identified the correct answer. Another misconception was that all palliative care patients need hospice. Of the 46 participants, only 88.24% of the participants picked the correct answer on question number 6 that correlated with this idea. Similarly, question seven and eight also identified two more misconceptions amongst the interdisciplinary team. These two questions revealed that a portion of the interdisciplinary team did not understand that palliative care improves quality of life and can manage side effects of other treatments. The highest missed question was number eleven. Only 72.55% of the participants chose the right answer, which identified that a good portion of the interdisciplinary team do not realize that hospice care and palliative care do not offer the exact same resources to patients and their families. The last misconception identified was palliative care stops all consults to other specialties. Only 88.24% of participants got that question correct on the pre-test.

Research Question Two

After the intervention, what are the subjects' misconceptions and knowledge level regarding palliative care?

After the educational intervention, all of the post-test scores raised above 90% except for question number eleven. This was also the most missed question on the pre-test. The post-test score for this question remained below 90% at 81.63%. Although the score did improve, it still demonstrates a misconception amongst the interdisciplinary team that palliative care services and hospice care services offer the same resources. On the other hand, the post-test scores did raise 7% when compared to the pre-test.

Research Question Three

Is there a difference between the pre and post measure of misconceptions and knowledge level regarding palliative care?

To evaluate the effectiveness of the education intervention, a paired sample t-test was performed. According to Gleichmann (2020), “A paired t-test is a statistical test that compares the averages/means and standard deviations of two related groups to determine if there is a significant difference between two groups” (para 4). This type of project design and t-test eliminates the possibility of variation amongst samples because it uses the same sample group. In this project, the educational intervention is the dependent variable and the participant’s knowledge, and misconceptions are the independent variables.

Table 3 Paired Sample T-test (N=46)

Mean Pre-test	**SD Pre-test**	**Mean Post-test**	**SD Post-test**
89.70	18.30	97.50	4.29
Mean difference between the Pre and Post Test = 7.8			
t = 2.8694, p = .0062			
Decision: The probability (.0062) calculated with the test statistic (t = 2.8694) is less than alpha (.05), so the Ho is rejected. There was a significant difference between the pre and post-test. Subjects in this study averaged 7.8 points higher on the post-test than they did on the pre-test.			

As documented in Table 3, the paired sample t-test revealed a significant difference between the pre-test and post-test scores. The analysis demonstrated a p value of .0062 which is less than alpha (0.5). This means the null hypothesis can be rejected. This also demonstrates the difference between the means of the pre-test and the post-test are statistically significant with a t value of 2.8694. In the end, participants scored 7.8 points higher on the post-test than on the pre-test after the educational intervention. Overall, the sample paired t-test analysis demonstrates the effectiveness that the education intervention improves knowledge and decreases misconceptions amongst the interdisciplinary team in the acute hospital setting.

Research Question Four

How many healthcare professionals plan on utilizing or consulting palliative care services in the future after the educational intervention?

This research question was assessed in the open-ended questionnaire. Each participant was asked if they foresaw themselves initiating or pursuing consults to palliative care in the future. All 46 of the participants answered the question. Of the 46, 36 participants answered yes that they would utilize and push for more palliative care consults in the future. Three of the participants identified that they believe they already utilize palliative care now. Five of the participants believed they would bring the discussion to the interdisciplinary team like the physician or case manager more frequently now that they understand what palliative care is. Lastly, two individuals answered no that they would not pursue palliative care resources more for their patients.

Research Question Five

What do members of the interdisciplinary team identify as barriers to consulting palliative care?

Participants were asked to discuss what barriers they felt limited their referrals to palliative care in the acute hospital setting. An overwhelming number of participants identified the family and patient’s misconceptions and lack of knowledge about palliative care often limits the referral to palliative care services. They identified that a patient or family that is not knowledgeable about palliative care often rejects or turns down the referral. Another common theme among participants was that many feel there is no assessment tool or good time to consult palliative care. They identified that physicians and nurses do not always see eye to eye on when to consult palliative care services and there is no tool to aide in this process. Lastly, there was a number of participants that identified the acute hospital palliative care is small and often overwhelmed by consults, especially in the middle of the COVID-19 pandemic.

Research Question Six

Who do members of the interdisciplinary team believe to be primarily responsible for consulting palliative care?

To evaluate the responsibility of palliative care referrals, participants were asked who they thought was primarily responsible for consulting palliative care services. Of the 46 participants, 30 of them identified the primary care physician or hospitalist seeing the patient as the person primarily responsible. Many of the participants also included that it is the job of the nurse to bring up these concerns to the rounding physicians. Another common theme was mentioning that the interdisciplinary team including the social workers and case managers should all be on board with the same plan to ensure the patient and the family is receiving the support they need.

Research Question Seven

Why do members of the interdisciplinary team believe palliative care is underutilized in the acute hospital setting?

Participants were asked to discuss why they believed palliative care was underutilized in the acute hospital setting. Many identified that lack of teaching to patients and families was the number one reason palliative care was underutilized. They identified that it was difficult to bring up to patients because they feared the patient or family getting angry because of the association between palliative care and hospice care. Another common theme was identifying that physicians and nurses did not want to be responsible for initiating palliative care and making the patient feel like they are giving up on them. Many also mentioned the lack of education amongst staff to consult palliative care early rather than just at the end of life. Lastly, another common theme was a lack of communication amongst the interdisciplinary team. Participants identified that not everyone on the care team was always on the same page on whether or not palliative care should be consulted or not consulted.

Research Question Eight

How do members of the interdisciplinary team feel like they can improve the consult process to palliative care?

Lastly, participants were encouraged to discuss how they felt like they could improve the consult to palliative care process. One large theme amongst the answers was teaching families and patients the difference between palliative care and hospice care in an open and supportive manner. Another overall theme amongst the data was that nursing staff should make assessments and recommendations to physicians about palliative care in a timely manner. They identified the earlier in the admission it is mentioned the higher the likelihood that palliative care will get involved. Many also identified that nurses are the strongest advocates for their patients and that should include advocating for palliative care when it is needed. Lastly, many mentioned improving their knowledge about the subject to be more confident when conversing with patients, families, and members of the interdisciplinary team.

Summary

This study aimed to answer eight research questions using a quantitative and qualitative portion. The quantitative portion of this design was a pre-test post-test design that focused on identifying the misconceptions and knowledge base before and after the education intervention. A sample paired t-test was also utilized to measure the significance and the effectiveness of the intervention. The values of the sample paired t-test identified a statistically significant improvement in knowledge after the education intervention with a p value of .0062 and a t value of 2.8694. This overall demonstrated the effectiveness of the palliative care educational intervention.

Lastly, an open-ended questionnaire was utilized for the qualitative portion of this study. The open-ended questionnaire was used to assess the perspectives, feelings, and thoughts about palliative care amongst the interdisciplinary team. Answers were then evaluated. After evaluation, the answers were compared, and common themes were identified to answer research question four through eight.

Chapter V

Discussion

Purpose

The purpose of this scholarly project was multifaceted. A pre-test was utilized to better understand the current knowledge base in regard to palliative care amongst the interdisciplinary team on the acute telemetry unit. This study also aimed to understand the effectiveness of a palliative education intervention and assess knowledge post-intervention. Lastly, this study evaluated the perceptions of the interdisciplinary team through open-ended questionnaires to better understand perceived barriers to consulting palliative care, if palliative care would be utilized more in the future, and what improvements could be made to improve palliative care consults.

Relationship of Outcomes to Research

Through a mixed design, this scholarly project focused on answering eight research questions. The first three questions were answered by the quantitative pre-test post-test design. The first question focused on evaluating the current misconceptions and knowledge base of the interdisciplinary team. This question was answered by evaluating the pre-test scores on each true and false question. It was determined that an average below 90% on a question was a knowledge deficit or a poor performance. Once the pre-test scores were analyzed, six areas were identified as areas of concern. These areas included palliative care can help patients and families understand different treatment options, not all palliative care patients need hospice, palliative care can improve quality of life, palliative care be used to treat symptoms, that palliative care and hospice care can offer different resources, and that consults to other specialties do not stop because someone is utilizing palliative care services. The need for improving knowledge was expected prior to the educational intervention. Although the findings from question one was consistent with poor knowledge in certain areas, the scores of the pre-test were still relatively high. The only question that averaged below an 80% was true or false question number eleven that focused on the concept that palliative care and hospice care do not provide the same resources. Although the findings indicate there were knowledge deficits present amongst the interdisciplinary team, the scores were still relatively high which was apparent with an overall average of 90% on the pre-test.

The second research question evaluated the knowledge and misconceptions of the interdisciplinary team post-intervention by analyzing the scores of the post-test. The goal of the project was to see an improvement in knowledge in regard to palliative care post-intervention. After the educational intervention, there was only one score that remained under 90%. It was true or false question eleven that focused on the concept that palliative care and hospice care offer different resources. This was also the same question that had the lowest scores on the pre-test. Although the score was still below 90%, the number of individuals that answered it correctly rose by 9%. On the pre-test, the percentage of individuals that answered question eleven correctly was 72.55, but after the educational intervention that number rose to 81.63%. Overall, the education intervention did improve post-test scores. The average of the pre-test score was 89.7%. However, after introducing the education intervention, the average of the post-test scores raised 7.8% to 97.5%, which is statistically significant. This finding emphasizes the effectiveness of palliative education and demonstrates how implementing adequate education can improve knowledge and decrease misconceptions amongst the interdisciplinary team.

The third research question aimed to compare the pre-test and post-test scores to further prove the effectiveness of the educational intervention. To statistically evaluate the effectiveness of the educational intervention, a pair t-test was utilized. The paired t-test revealed a p value of .0062 with a t value of 2.8694 which was less than alpha (0.5), which means the null hypothesis could be rejected. In the end. the paired t-test revealed a statistical improvement in scores. Participants in this study averaged 7.8 points higher on the post-test than they did on the pre-test which demonstrates the effectiveness of the educational intervention amongst the interdisciplinary team on the acute telemetry unit. This scholarly project was similar to other studies in proving that educational interventions do have an impact on improving knowledge regarding palliative care. Overall demonstrating the need to begin including more palliative care education in the acute hospital setting.

The qualitative portion of this scholarly project was used to answer research question four through eight. An open-ended questionnaire was used to evaluate participants perspectives and feelings about palliative care. Answers were then analyzed for common themes and ideas. Research question four evaluated how many participants planned on using palliative care services in the future after improving their knowledge with the educational intervention. There was an overwhelming number of participants that answered yes that they would utilize and push for more palliative care consults in the future. This is not a surprising finding. Based on previous studies, it was found that once healthcare professionals increased their knowledge, they gained the confidence they needed to discuss palliative care services more frequently with patient and families (Artioli et al., 2019). Improving knowledge not only decreases misconceptions, but also providers members of the interdisciplinary team with the tools to be successful in implementing palliative care services sooner in the acute hospital setting.

Research question number five aimed to identify the current barriers that the interdisciplinary team faces when consulting palliative care. A large barrier that was identified was the lack of education and understanding of the patient and family members. Many participants identified that many patients and families think of hospice and palliative care as synonymous, which makes them extremely hesitant to accepting a consult to palliative care. This was a common theme distinguished in the literature as well. It has been found that many patients and families lack the understanding that palliative care and hospice care are not the same (Jablonski, 2008). Another common barrier mentioned by participants was a lack of an assessment tool to identify those that would benefit from palliative care services. Nurses were the primary participants within this scholarly project accounting for 80.43% of participants. Due to their position as a registered nurse, many felt like a tool to help identify those that would benefit would improve conversations with physicians and families about consulting palliative care.

Research question number six identifies who is primarily responsible for consulting palliative care which ties in well with the themes identified in question five. Thirty of the participants identified that the primary care physician or attending was the person primarily responsible for making the consult to palliative care. On the other hand, a majority of the participants also emphasized that it is the job of the nurse to communicate with the physician the need for a palliative care consult. Nurses have the most contact with patients and family members. Therefore, nurses often can identify early on the patients that would benefit from a palliative care referral. Nurses, case managers, social workers, physical therapists, etc. can all offer unique insight on a patient’s condition and health. This is why physicians must focus on an interdisciplinary approach when getting palliative care involved because an interdisciplinary approach ensures a strong support system for the patient and increases holistic care.

To improve palliative care consults in the future, it was important to understand the participants perspective of why palliative care was underutilized in the first place. This was the primary purpose of research question seven. Similar to research question number one, many participants identified that it was difficult to discuss palliative care with patients and families when they did not truly understand palliative care. Many participants emphasized that they feared scaring the patient or angering the patient because of the association between palliative care and hospice care. Another large theme identified was the miscommunication amongst the interdisciplinary team. An interdisciplinary approach is essential to ensure the success of palliative care. This type of approach allows for holistic and comprehensive care of the patient (Finerg et al., 2004). Unfortunately, many nurses felt like although they could identify the need for palliative care it was still the responsibility of the physician to initiate the consult. However, many felt like some attendings did not want to initiate the consult either because it was not their patient in the outpatient setting or because they did not want to make the patient feel like they were giving up on them. Lastly, a few participants did mention a lack of education amongst staff especially hospitalist physicians. This was expected. Unfortunately, a majority of the participants were nurses. Only one physician completed this scholarly project. Therefore, a true evaluation of hospitalist and physician knowledge on the acute telemetry unit was not able to be completed.

Lastly, the open-ended questionnaire was used to answer the last research question. The last research question focused on identifying ways the interdisciplinary team felt like they could improve the palliative care consult process. The themes remained similar to the previous research questions. The participants identified that nurses should advocate for their patients, should teach their patients about palliative care, and should ultimately assess and discuss with the physician if the patient could benefit from a palliative care consult. It was also evident that many enjoyed and welcomed the palliative care education by promoting the distribution of this palliative care educational intervention to the entire acute care hospital including more physicians. The themes throughout questions four through eight were primarily expected based on the completed literature review. Many participants identified similar barriers and concerns about palliative care in the open-ended questionnaire.

Together the qualitative portion and the quantitative portion of this scholarly project emphasize the importance of improving palliative care education to improve the utilization of palliative care services in the acute hospital setting. Misconceptions and knowledge deficits about palliative care are common amongst healthcare professionals. Unfortunately, many non-palliative care providers have the misconceptions that palliative care is solely end of life care (McDarby & Carpenter, 2018). This is evident after the evaluation of the pre-test. However, although knowledge deficits are present, they are not as significant as one would expect. Despite that fact, the effectiveness of the educational intervention was statistically significant. This emphasizes the importance of acute care hospitals introducing palliative care education to all members of the interdisciplinary team involved in direct patient care.

Similarly, the open-ended questionnaire responses reflected the opinions and perspectives of the participants. Overall, it was identified that education for staff, patients, and families should be a top priority to improve the utilization of palliative care. It was also identified that many do plan on pushing for more palliative care consults in the future after improving their knowledge. One way to improve this process is by ensuring nurses have the ability to identify patients that would benefit from palliative care and equipping them with the confidence to discuss these findings with the attending. All of this can be improved by continuing to improve palliative care education in the acute hospital setting.

Observations

It is important to note that the data collection portion of this project took place during the COVID-19 pandemic. The acute telemetry floor that was participating in this scholarly project had one of their three units converted into the COVID unit. When this project was first started, all three units were acute telemetry and did not have much experience with palliative and hospice care patients. However, once one of the units was converted to a COVID unit, there was an increase in end-of-life discussions, palliative discussions, and end-of-life care. This led to many nurses and members of the interdisciplinary team improving their knowledge about palliative care and hospice care prior to the implementation of this scholarly project.

The tools utilized in this project were sufficient and effective. The educational PowerPoint and brochure created through a thorough literature review was efficient and effective. These can be found in Appendix A and B. It was also beneficial to allow participants to work through the PowerPoint at their own pace to ensure each participant had ample time to learn and understand the material being presented. It was also important that the pre-test, post-test, and open-ended questionnaire were created using evidence-based research. This increased the validity and reliability of the answers founded in this scholarly project.

The analysis and evaluation of the pre-test, post-test, and open-ended questionnaire reemphasized the need for improving palliative care education in the acute hospital setting. This scholarly project demonstrated that misconceptions and knowledge can be improved with an effective education intervention. It also showed that members of the interdisciplinary team opinions and perspectives align with other studies discussed in the extensive literature review. The lack of education is a common concern often highlighted by many healthcare professionals (Nevin et al., 2020). Focusing on improving palliative care education in the acute hospital setting is the first step in increasing the utilization of palliative care services.

Evaluation of the Theoretical Framework

This project used the Kolcaba’s theory of comfort as the theoretical framework to guide this project and aid in the creation of the educational intervention. Overall, the results of this scholarly project support Kolcaba’s theory. Kolcaba’s theory emphasizes the importance of providing holistic care to improve patient comfort and satisfaction (Petirpin, 2019). This theoretical framework describes three types of comfort. The comfort of ease, the comfort of relief, and the comfort of transcendence. According to Kolcaba's theory it should be the primary goal of the interdisciplinary team to ease a patient's anxiety, provide relief through symptom management and discussion, and provide transcendence by aiding them in improving their quality of life. This all coincides with the primary goal of palliative care and emphasizes the need for early palliative care intervention to meet these goals of comfort. In one study, the early palliative care intervention group demonstrated increase in satisfaction with their care and their quality of life (Sandsdalen et al., 2019, p. 910). Early intervention allows patients and families to define their goals of care early and ensure these goals are being met by the interdisciplinary team.

Through the educational intervention, the participants are able to identify the need for palliative care and early intervention. This ultimately leads to the implementation of Kolcaba's theory of comfort. Improving palliative care education gives the interdisciplinary team the tools to assess patients and their anxieties, understand how treating the patient holistically can improve their symptoms, and realizing how utilizing palliative care can improve a patient's quality of life.

Evaluation of the Logic Model

The results of this project did support parts of the logic model introduced in chapter one. The logic model assumed that once palliative care education was implemented staff knowledge would improve and staff would feel encouraged to utilize palliative care services more in the future. The logic model also assumed that utilization of palliative care services would increase which would lead to a decrease in hospitalizations.

The first two assumptions of the logic model were proven by the results of this scholarly project. Knowledge amongst the interdisciplinary team was significantly improved after receiving an educational intervention. Similar to participants within this project, oncology nurses in Michigan demonstrated a similar increase in knowledge after receiving an on-site palliative care educational intervention (Harden et al., 2017). It was also evident that participants felt stronger about consulting palliative care in the future based on responses to research question number four. This finding is not surprising because similarly to the studies found in the literature review, once healthcare professionals are given the knowledge to be successful, they have the ability to truly discuss palliative care with patients and their families. Wool (2015) emphasized how, “Several other studies support the idea that end-of-life educational programs boost provider confidence” (p.57). In the end, confidence is essential in assessing patients that would benefit from palliative care and involving palliative care services early.

Unfortunately, the second two assumptions of the logic model were not proven by this scholarly project. This scholarly project did not measure if palliative care consults increased following the implementation of this scholarly project. There was no measure if hospital admissions decreased following this project. Due to time constraints, these broader and larger measures will have to be evaluated by a much more extensive research project.

Limitations

The goal of this study was to evaluate the entire interdisciplinary team effectively. Unfortunately, this goal was not reached. A majority of the participants of this study were nurses which accounted for 80.42% of the participants. One limitation to this study was the difficulty to obtain physician participants. Many physicians had the inability to log in to their HealthStream due to inability to remember their login information. This barrier led to many not completing the survey because it was time consuming for them to call the IT department to retrieve their username and password. Another limitation of this study was staffing shortages and lack of time. Due to the staffing shortages amongst every specialty of the interdisciplinary team, many felt like there was not enough time to complete this scholarly project. Many physical therapists, occupational therapists, and speech therapists charge by their time with their patient. They unfortunately do not get reimbursed for their time spent on the computer. Therefore, that was another barrier in recruiting members from the interdisciplinary to completing this scholarly project.

Another limitation of this study was the increase in palliative care and hospice care services prior to the implementation of this scholarly project. Due to the influx of COVID patients on the one unit, there was subsequently an increase in the number of patients that benefited from palliative consults as compared to prior to the pandemic. This influx and rapid need to learn information about palliative and hospice care services may have skewed the results of the pre-test. There is a possibility that if this scholarly project was completed prior to the pandemic that scores on the pre-test may have been significantly lower.

Lastly, a true limitation of this study is the sample size. This project was only available to be completed by voluntary participants November through January. To obtain a large sample size, a more diverse sample size, and more data a longer study should be completed. It would be advantageous to complete a similar study for a six month to one year period.

Implications for Future Projects and Research

The results of this scholarly project demonstrate the effectiveness of including palliative care education in the acute inpatient hospital setting. Although this scholarly project aimed to evaluate the knowledge and effectiveness amongst the interdisciplinary team, it ultimately ended up being a study that focused primarily on registered nurses. Future studies should utilize a more creative approach in the recruitment of members of the interdisciplinary team to ensure the sample is a more diverse group. This will create a better understanding of the knowledge of the entire interdisciplinary team, especially physicians. It would almost be more beneficial to focus primarily on assessing physicians and mid-level providers because they are primarily responsible for consulting palliative care services. Assessing current understanding, improving their knowledge, and emphasizing the importance of an interdisciplinary approach would be extremely beneficial to increasing the number of palliative care consults.

It would also be beneficial to evaluate different outcomes. Knowledge was significantly improved, but it would be interesting to understand the long-term effect of improving palliative care education in the acute hospital setting. Future studies could focus on evaluating if improving palliative care education and experience increases palliative care consults. Hospitals should also examine whether or not increased palliative care consults decrease hospital readmissions. Decreasing hospital readmissions would be a large financial gain for acute care hospitals across America. These findings would also be a significant factor in Medicare reimbursement in terms of decreasing hospital readmissions.

Implications for Education

This scholarly project continues to echo the results of similar studies. It is evident there is a need for palliative care education amongst members of the interdisciplinary team in the acute hospital setting. Based on the significance of improvement amongst nursing knowledge in this project, it would be beneficial for nursing programs to consider implementing palliative care education in undergraduate curriculum. If unable to add to curriculum, hospitals should consider adding palliative care education interventions to new hires or/and during new graduate orientation. The need for palliative care education will continue to grow as the elderly population continues to grow. Therefore, nurses and members of the interdisciplinary team need to be equipped with the knowledge, the tools, and the assessment skills to know when to involve palliative care early. The results of this scholarly project demonstrate the effectiveness of education, but also demonstrates how many participants want more education to feel more confident and competent in terms of palliative care.

Conclusion

The purpose of this study was to assess current knowledge of the interdisciplinary team, assess the effectiveness of an educational intervention, and identify common themes amongst participants in terms of utilizing palliative care in the future, barriers they face today, and what can be done to improve palliative care consults in the acute hospital setting. Although this study proved the effectiveness of the educational intervention, this project ended up primarily focusing on nursing professionals rather than the entire interdisciplinary team. The paired t-test ended up proving the statistical significance of the educational intervention. While the open-ended questionnaire demonstrated the need for continuing education, improving the consultation process, and the need to equip the interdisciplinary team with the tools to be successful in identifying those that would benefit from palliative care.

Ultimately, this study sets the stage for future research projects and demonstrates the significant need for acute hospitals to continue implementing palliative care education. Due to the growing need for palliative care, hospitals should consider expanding research to evaluate how palliative care can help decrease hospital readmissions and focus on implementing a formal palliative care education program. Improving utilization of palliative care will help set up the hospital, the interdisciplinary team, the patients, and the families for success. Overall, the palliative care education intervention implemented within this scholarly project demonstrated a positive impact on knowledge and encouraged participants to consider pursing more palliative care consults in the future.

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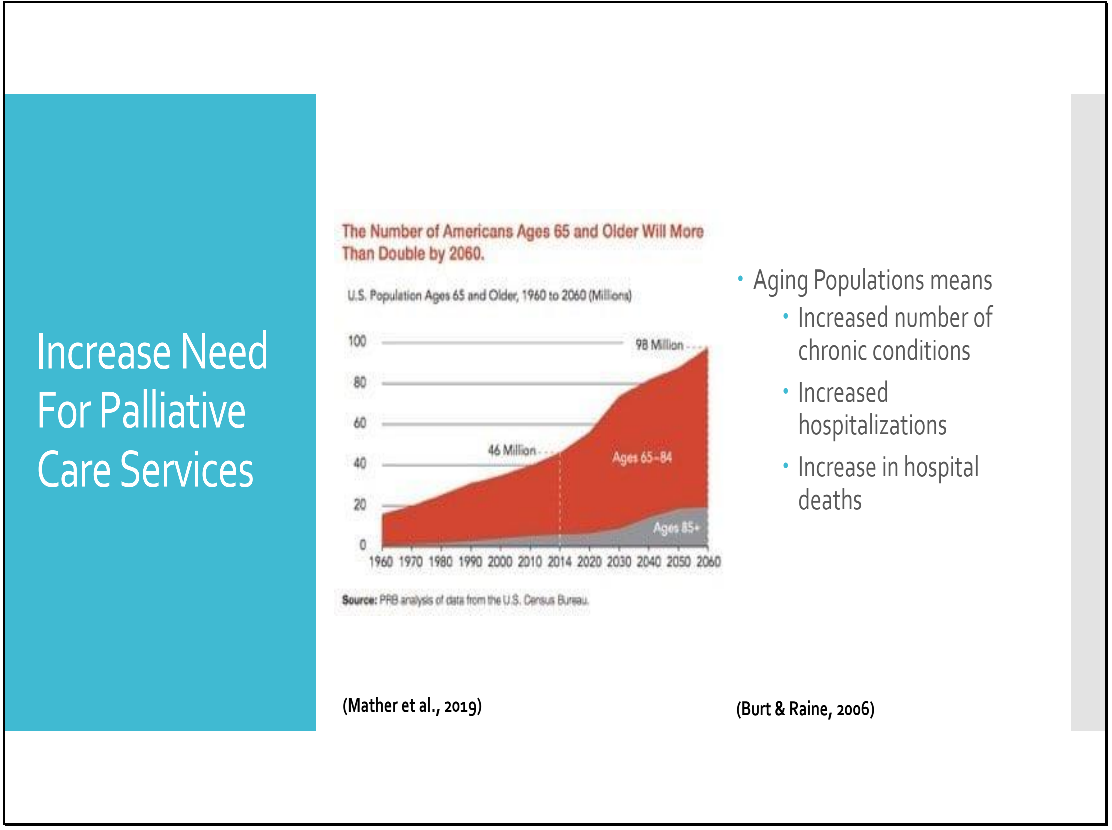
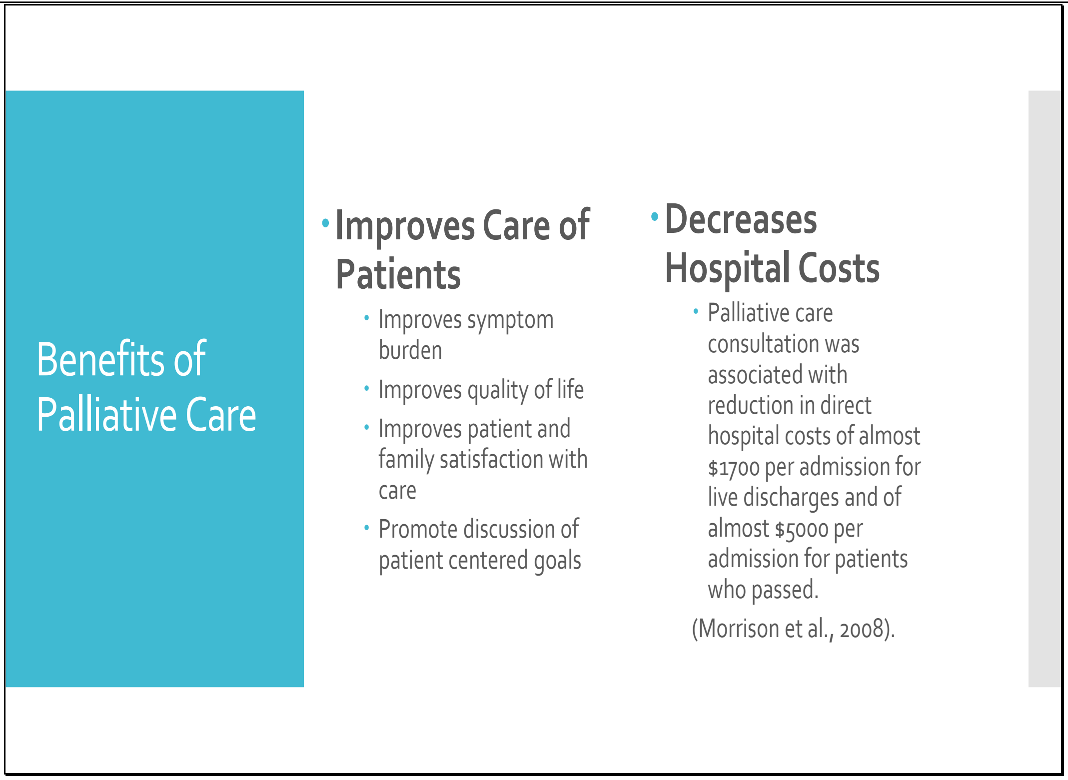
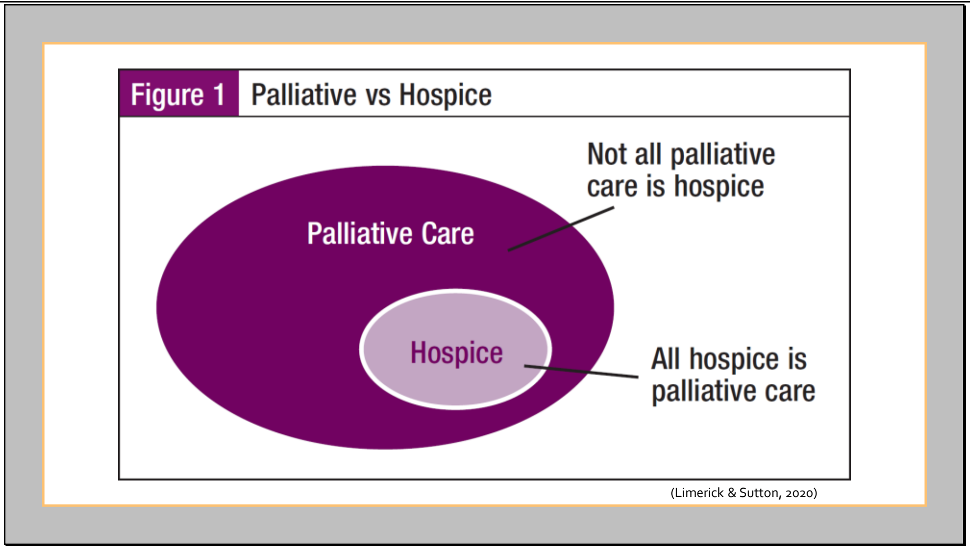
Appendix

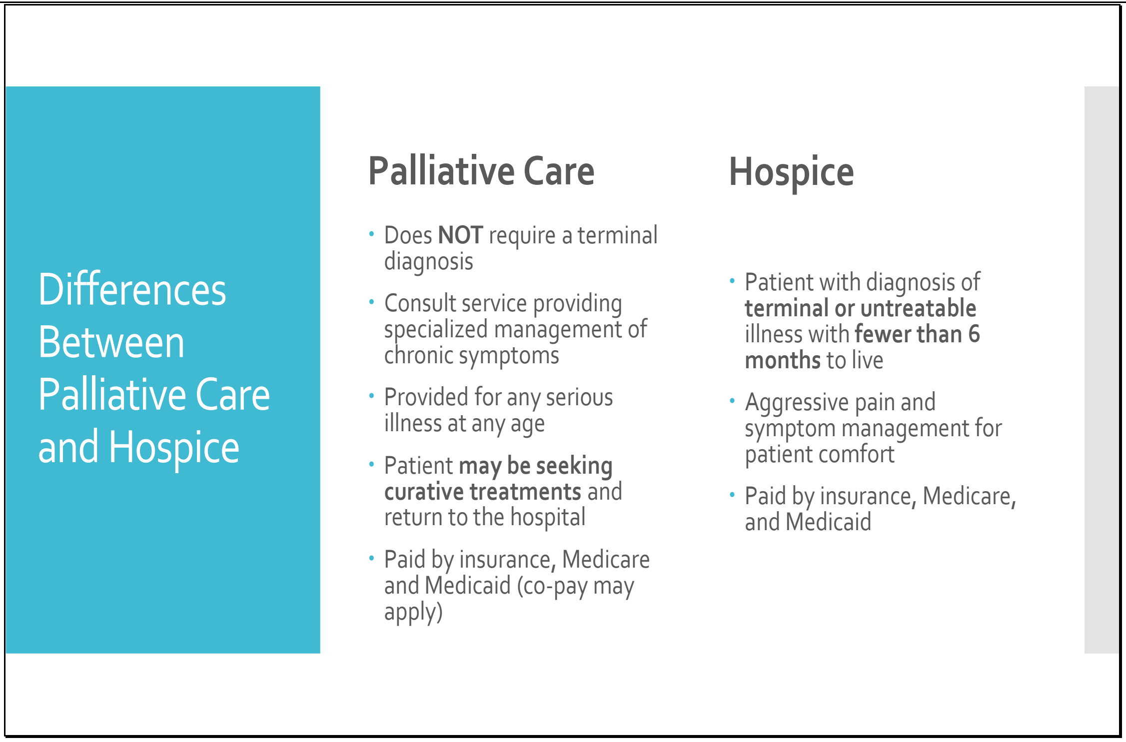
Appendix A

Slide 1	 Palliative Care Education Created by: Maria Klug, BSN

Slide 2	
	Increase Need For Palliative Care Services
	The Number of Americans Ages 65 and Older Will More Than Double by 2060.
	U.S. Population Ages 65 and Older, 1960 to 2060 (Millions)
	
	Source: PRB analysis of data from the U.S. Census Bureau.
	• Aging Populations means
	  • Increased number of chronic conditions
	  • Increased hospitalizations
	  • Increase in hospital deaths
	(Mather et al., 2019)
	(Burt & Raine, 2006)

Slide 3	 Benefits of Palliative Care - Improves Care of Patients - Improves symptom burden - Improves quality of life - Improves patient and family satisfaction with care - Promote discussion of patient centered goals - Decreases Hospital Costs - Palliative care consultation was associated with reduction in direct hospital costs of almost $1700 per admission for live discharges and of almost $5000 per admission for patients who passed. (Morrison et al., 2008).
Slide 4	 Figure 1 Palliative vs Hospice (Limerick & Sutton, 2020)

Slide 5



Differences Between Palliative Care and Hospice

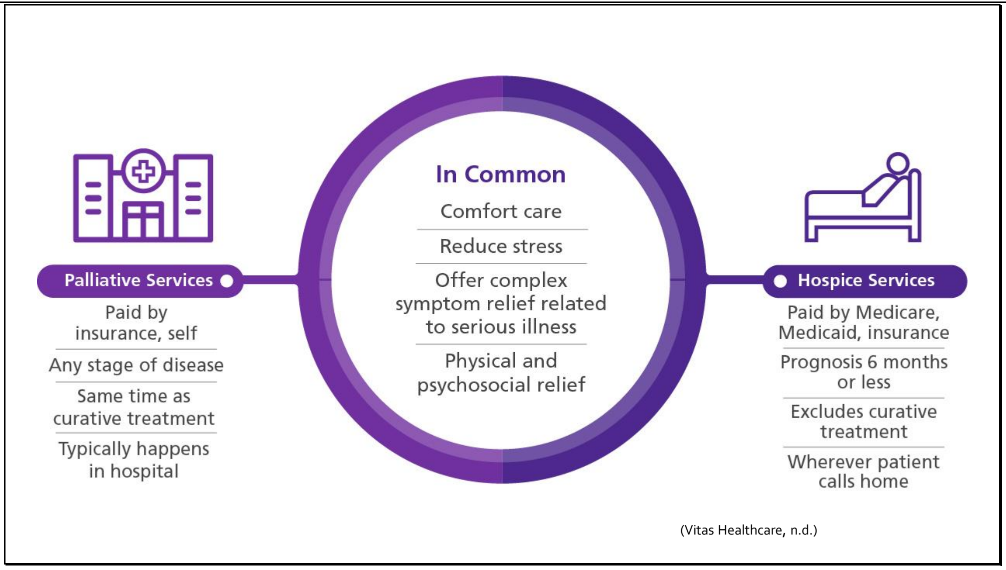
Palliative Care

- Does **NOT** require a terminal diagnosis
- Consult service providing specialized management of chronic symptoms
- Provided for any serious illness at any age
- Patient **may be seeking curative treatments** and return to the hospital
- Paid by insurance, Medicare and Medicaid (co-pay may apply)

Hospice

- Patient with diagnosis of **terminal or untreatable** illness with **fewer than 6 months** to live
- Aggressive pain and symptom management for patient comfort
- Paid by insurance, Medicare, and Medicaid

Slide 6



Palliative Services

Paid by insurance, self

Any stage of disease

Same time as curative treatment

Typically happens in hospital

In Common

Comfort care

Reduce stress

Offer complex symptom relief related to serious illness

Physical and psychosocial relief

Hospice Services

Paid by Medicare, Medicaid, insurance

Prognosis 6 months or less

Excludes curative treatment

Wherever patient calls home

(Vitas Healthcare, n.d.)

Slide 7	 **When to Consult Palliative Care At Olathe Health** • Patient/family/care team feel medical treatment may have detrimental outcomes • Declining function with decreased ability to complete ADLs • Frequent hospitalizations • Frequent phone calls to your staff for symptom management or distress • Help with complex decision-making and determination of goals of care • Complex psycho-social concerns that impact care • Uncertainty of end-of-life status and/or hospice appropriateness • Limited therapeutic impact of artificial nutrition and hydration • Goals of care conflicts within the family • Expected ongoing and frequent education in the outpatient setting • Increasing symptom burden with treatment
Slide 8	 **How Olathe Health Palliative Care Team Helps** Discuss goals of care with patients and their families Align treatment with patient goals Fully discuss advanced directives like living will, DPOA, and code status Help patient and family determine next step in care that aligns with patient goals Support the primary care team

Slide 9

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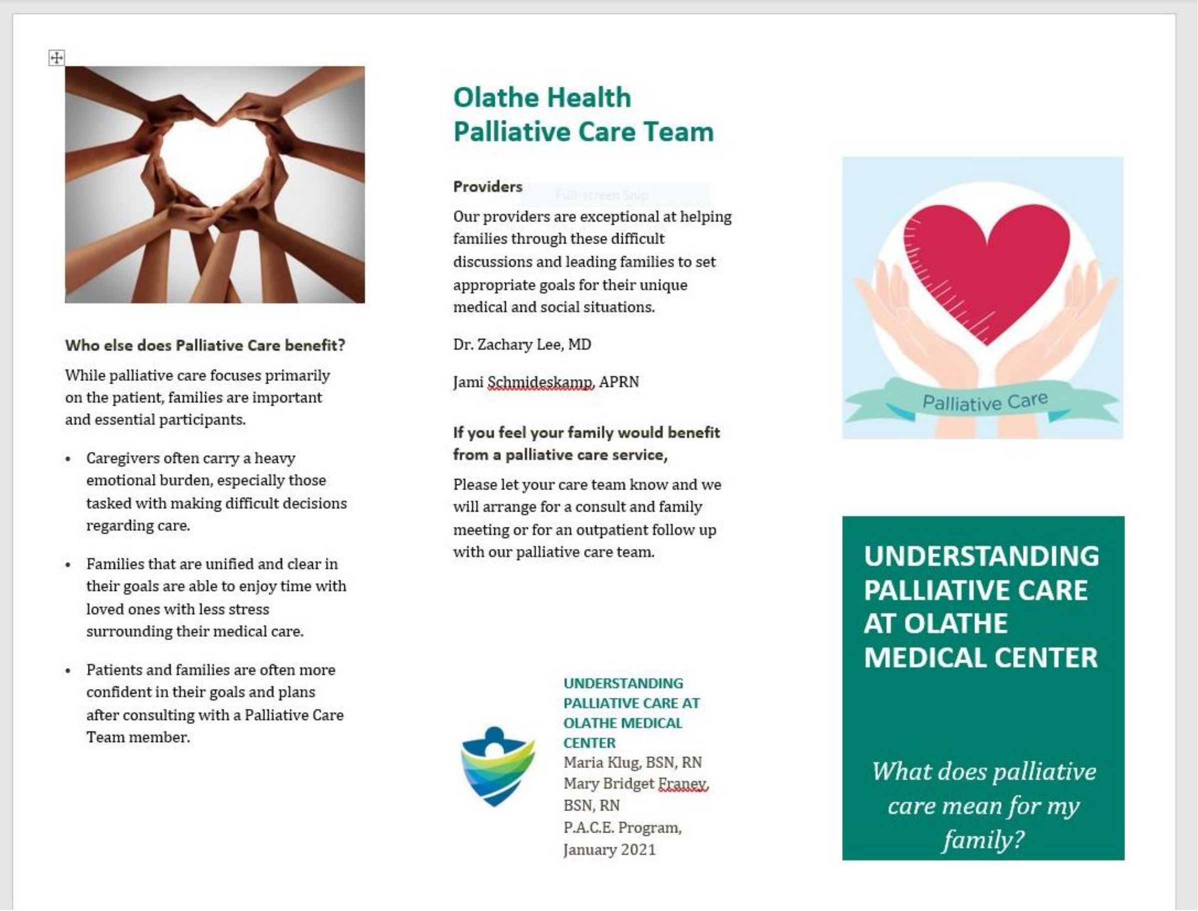
Appendix B



Who else does Palliative Care benefit?

While palliative care focuses primarily on the patient, families are important and essential participants.

- Caregivers often carry a heavy emotional burden, especially those tasked with making difficult decisions regarding care.
- Families that are unified and clear in their goals are able to enjoy time with loved ones with less stress surrounding their medical care.
- Patients and families are often more confident in their goals and plans after consulting with a Palliative Care Team member.

Olathe Health Palliative Care Team

Providers

Our providers are exceptional at helping families through these difficult discussions and leading families to set appropriate goals for their unique medical and social situations.

Dr. Zachary Lee, MD

Jami Schmideskamp, APRN

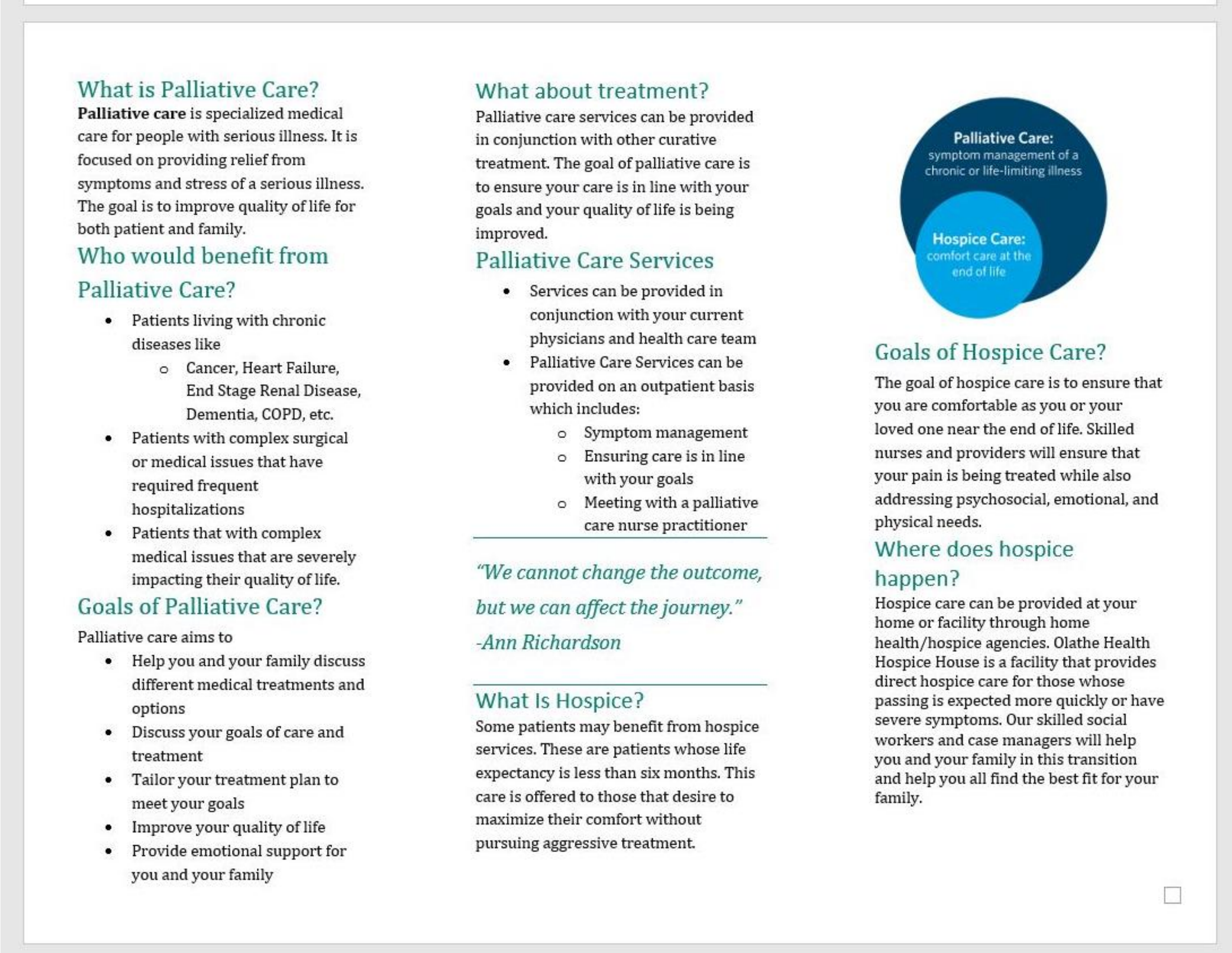
If you feel your family would benefit from a palliative care service,

Please let your care team know and we will arrange for a consult and family meeting or for an outpatient follow up with our palliative care team.

UNDERSTANDING PALLIATIVE CARE AT OLATHE MEDICAL CENTER
Maria Klug, BSN, RN
Mary Bridget Franey, BSN, RN
P.A.C.E. Program,
January 2021

UNDERSTANDING PALLIATIVE CARE AT OLATHE MEDICAL CENTER

What does palliative care mean for my family?



What is Palliative Care?

Palliative care is specialized medical care for people with serious illness. It is focused on providing relief from symptoms and stress of a serious illness. The goal is to improve quality of life for both patient and family.

Who would benefit from Palliative Care?

- Patients living with chronic diseases like
    - Cancer, Heart Failure, End Stage Renal Disease, Dementia, COPD, etc.
- Patients with complex surgical or medical issues that have required frequent hospitalizations
- Patients that with complex medical issues that are severely impacting their quality of life.

Goals of Palliative Care?

Palliative care aims to

- Help you and your family discuss different medical treatments and options
- Discuss your goals of care and treatment
- Tailor your treatment plan to meet your goals
- Improve your quality of life
- Provide emotional support for you and your family

What about treatment?

Palliative care services can be provided in conjunction with other curative treatment. The goal of palliative care is to ensure your care is in line with your goals and your quality of life is being improved.

Palliative Care Services

- Services can be provided in conjunction with your current physicians and health care team
- Palliative Care Services can be provided on an outpatient basis which includes:
    - Symptom management
    - Ensuring care is in line with your goals
    - Meeting with a palliative care nurse practitioner

"We cannot change the outcome, but we can affect the journey."

-Ann Richardson

What Is Hospice?

Some patients may benefit from hospice services. These are patients whose life expectancy is less than six months. This care is offered to those that desire to maximize their comfort without pursuing aggressive treatment.

Palliative Care: symptom management of a chronic or life-limiting illness

Hospice Care: comfort care at the end of life

Goals of Hospice Care?

The goal of hospice care is to ensure that you are comfortable as you or your loved one near the end of life. Skilled nurses and providers will ensure that your pain is being treated while also addressing psychosocial, emotional, and physical needs.

Where does hospice happen?

Hospice care can be provided at your home or facility through home health/hospice agencies. Olathe Health Hospice House is a facility that provides direct hospice care for those whose passing is expected more quickly or have severe symptoms. Our skilled social workers and case managers will help you and your family in this transition and help you all find the best fit for your family.

Appendix C

Palliative Care Knowledge Test Pre-Test

Participant Employee Number:

Demographics:

Gender

Female

Male

Age

Under 18

18-25

25-30

30-35

40-45

50-55

55+

Please List Your Occupation__________________________

Knowledge

1. Palliative care is an interdisciplinary team-based approach.

[✓ True] False

2. Palliative care treats the patient holistically: physically, emotionally, spiritually, and psychologically.

[✓ True] False

3. Palliative care is exclusively for the last six months of life.

True [✓ False]

4. Palliative care helps better understanding of the treatment options being offered.

[✓ True] False

5. To be on palliative care the patient must stop all curative treatments.

True [✓ False]

6. All palliative care patients need hospice.

True [✓ False]

7. Palliative care improves patient’s daily activities.

[✓ True] False

8. Palliative care helps manage side effects of other treatments.

[✓ True] False

9. Palliative care addresses stress from serious illnesses.

[✓ True] False

10. Palliative care helps families to cope.

[✓ True] False

11. Palliative care and hospice care provide the same resources.

True [✓ False]

12. Palliative care is only for cancer patients.

True [✓ False]

13. Palliative care is only for older adults.

True [✓ False]

14. Palliative care is offered in the hospital setting and the outpatient setting.

[✓ True] False

15. Palliative care stops all consults to other specialties.

True [✓ False]

16. Palliative care and hospice care are often covered by insurance, Medicare, and Medicaid.

[✓ True] False

Palliative Care Knowledge Test Post-Test

Participant Employee Number:

Knowledge

1. Palliative care is an interdisciplinary team-based approach.

[✓ True] False

2. Palliative care treats the patient holistically: physically, emotionally, spiritually, and psychologically.

[✓ True] False

3. Palliative care is exclusively for the last six months of life.

True [✓ False]

4. Palliative care helps better understanding of the treatment options being offered.

[✓ True] False

5. To be on palliative care the patient must stop all curative treatments.

True [✓ False]

6. All palliative care patients need hospice.

True [✓ False]

7. Palliative care improves patient's daily activities.

[✓ True] False

8. Palliative care helps manage side effects of other treatments.

[✓ True] False

9. Palliative care addresses stress from serious illnesses.

[✓ True] False

10. Palliative care helps families to cope.

[✓ True] False

11. Palliative care and hospice care provide the same resources.

True [✓ False]

12. Palliative care is only for cancer patients.

True [✓ False]

13. Palliative care is only for older adults.

True [✓ False]

14. Palliative care is offered in the hospital setting and the outpatient setting.

[✓ True] False

15. Palliative care stops all consults to other specialties.

True [✓ False]

16. Palliative care and hospice care are often covered by insurance, Medicare, and Medicaid.

[✓ True] False

Appendix D

Open-Ended Questionnaire

1. What barriers do you feel limit your referrals to palliative care?

2. Who do you believe is primarily responsible for consulting palliative care?

3. How can you help this process?

4. Why do you believe palliative care is underutilized in the hospital setting?

5. Do you foresee yourself initiating or pushing for more palliative care consult in the future?

6. Do you have any comments or concerns you would like to share here about palliative care?

Appendix E

Question 1: What barriers do you feel limit your referrals to palliative care?
1. Sometimes family members do not agree that palliative care is appropriate at the time, and this can limit the resources we can offer.
2. Physician’s decision
3. Palliative care team availability, patient/family perception of palliative care
4. Lack of assessment tool to present to physicians
5. NA
6. NA
7. Not knowing when it is appropriate
8. How the client will take the referral. I find it scares them even when we explain the benefits and misunderstanding of palliative care.
9. None
10. I don’t feel that I have any.
11. Not understanding what it means to be on palliative care or why it is important.
12. Palliative care referrals can only come from a physician. We can give our opinion, but consult placed must be from a physician.
13. I feel that the patient or family members don’t understand what palliative care entails, therefore they decline a consult without having all the information.
14. Patient misunderstanding use of palliative care
15. Patient and family lack of understanding of disease process and what palliative care can offer. Palliative care team is also only one physician and one APRN
16. Patient/family receptiveness as the general public equivocates palliative care to hospice care.
17. Main barrier is patient, or often family denial. Usually this is from lack of understanding the difference between hospice and palliative care prompting patient/family to thinks only death and dying.
18. No barriers
19. Patient education, small palliative care team
20. Family concerns, family, or patient not ready to move in that direction
21. Lack of knowledge
22. Some doctors feel that it is the patient or patient’s family that should initiate the conversation. I do not want to overstep. No real tool to identify who would benefit.
23. Family reluctance to palliative care
24. Unknown process for referral.
25. Physicians
26. NA
27. Physicians willing to place consults for patients in the hospital setting.
28. Primary care that may be covering for another primary care physician and not familiar with the patient.

29. Trying to remember that they are an option. A tool would be helpful.
30. Lack of education
31. NA
32. Doctors not wanting to consult palliative care
33. Curative approach in the hospital and unfamiliar with palliative care
34. Knowledge deficit of the patient and the family regarding goals and prognosis
35. Feeling comfortable asking difficult questions
36. Physicians not ready to consult
37. NA
38. Not being a doctor and small palliative care team
39. I’m not sure when to consult palliative care or when to ask the doctor to consult palliative care
40. Night shift
41. Patient and provider understanding of what palliative care is—the belief that it is only for end of life.
42. Doctors willing to initiate conversation with patients
43. Knowing when it is okay and to ask the doctor to consult. Lack of way to identify patients that would need palliative care
44. Culture and religious beliefs of the patient and family, lack of awareness about benefits of palliative care
45. None
46. NA

Question 2: Who do you believe is primarily responsible for consulting palliative care?
1. Admitting physician
2. Primary care physician
3. Physician
4. No comments
5. I think that it usually falls on the nurse, the nurse is the one who sees and hears the patient and family struggles and is that one that should report that to the provider
6. Doctors
7. The attending physician
8. The staff at the bedside, nurses, case managers, and physicians.
9. Attending
10. PCP/Hospitalist
11. Doctor
12. Interdisciplinary approach
13. Primary or any specialty
14. Any provider
15. Primary care provider
16. Any interdisciplinary team member caring for a patient

17. Anyone can but usually as a consulting specialty, I leave it to the attending physician or the specialist guiding the illness that is prompting the need for palliative care.
18. Attending or consultants
19. PCP
20. Hospitalist
21. Doctors and reporting should come from the nursing staff
22. PCP
23. MD, DO, or APRN
24. Everyone involved in patient care should be an advocate for the patient
25. Physician
26. Attending or rounding physician
27. Attending
28. All providers
29. A patient’s providers
30. Any member of the care team, patient, family
31. Social work and Dr’s
32. Physicians, but nurses should mention
33. PCP
34. Practitioner/MD/RN
35. PCP
36. Team effort, can be a physician or nursing
37. Doctor
38. PCP
39. I believe it is the doctors who are responsible but that should refer to the nurses for a reliable input on the patient’s condition
40. Collaborative effort
41. PCP
42. Attending
43. While the nurse may see that palliative care would be helpful, it is the doctor’s responsibility
44. Physicians
45. Physicians
46. None

Question 3: How can you help this process?
1. Nursing can call the consults, suggest to physician that it might be necessary, and support patient’s decision
2. Being patient advocate
3. Listen to patient and family about concerns with treatment, symptoms, ADLs and communicate that with physician
4. No comments
5. Having open conversations with the patients about their goals of care, and if they guidance then getting the palliative care team involved.

6. Offer a consult
7. Advocate to attending physician that it may be beneficial to have consult
8. Be involved in those referrals and patient education session on palliative care
9. None
10. By making suggestions towards to use of this service, if I feel a patient is in need, to his or her physician
11. By talking to provider or other staff members
12. Make it a team approach
13. Talking to the patient, the family, other team members and physicians involved in care
14. Discuss with patient and family
15. Review disease process, goals of care, and treatment options with patients as appropriate
16. Inform patients about the benefits of palliative care
17. I try to make sure that patients and family members understand the goal of palliative care as it differs from hospice care. If I am not the appropriate provider to place the consult in the hospital setting than I clearly document my recommendation.
18. Talk to the patient and family
19. Educate the patient and family
20. Speak with family and keep them updated on patient status
21. Assessment, observation from nursing and using interdisciplinary team
22. Speak with doctor
23. Ask provider
24. Become more familiar with consult process and the palliative care team
25. Continue talking with them about it and approach the physician
26. Report assessment findings to physician
27. By filling out the palliative care screening tool on my patients and notifying the physician
28. Facilitate conversation
29. Remember it is an option
30. Start the conversation
31. Talk to the families about the options available
32. By encouraging physicians to consult
33. Be knowledgeable about palliative care and advocating for my patients
34. Interdisciplinary cooperation regarding prognosis and future care of patient
35. Suggest it more
36. I just contact palliative with my concerns and let them deal with the physicians
37. NA
38. Help when I can
39. By being in close loop communication with doctors and having these tough conversations
40. Make recommendations during shift change since I work nights
41. By educating patient about palliative care and how it can benefit them, informing the treating physician of patient interest
42. Suggesting it to the attending

43. Advocating for patients that seem like they would benefit from palliative care and bring it up to the doctors
44. Palliative care consultants can ease this process
45. Talking with family and physicians
46. Be more involved

Question 4: Why do you believe palliative care is underutilized in the hospital setting?
1. I feel like the palliative care is often misunderstood and used interchangeably with the term hospice.
2. Lack of teaching to family and staff
3. Perception of palliative care and those hospitals are supposed to “fix” people
4. No comment
5. I think a lot of patients hear palliative car and they think hospice. They then decline to have the palliative care team come and talk to them. Lots of confusion
6. People don’t want to be the bear of bad news
7. Misunderstanding for patients not thinking they are sick enough
8. Providers are reluctant to suggest despite the benefits
9. Families and patients are not education by staff about option of palliative care
10. I think by and large there is a misconception behind the use of it and the need for it.
11. Because it’s so misunderstood
13. They do not fully understand that it is not hospice
14. Patient understanding
15. Lack of understanding by patients, families, and providers
16. Patient and family receptiveness is poor
17. I think that has actually change in recent past as I see it utilized much more often in the past year.
18. Patients and families refusing palliative care because they do not understand the difference between palliative and hospice care
19. Staffing education
20. Patient and family not ready to give up treatment
21. Being scared to bring up the subject
22. Yes
23. Palliative care at time of diagnosis would be good so that families can plan
24. Not much is known about it
25. Yes
26. I feel that there is come confusion between hospice and palliative
27. Physicians and staff do not understand palliative care
28. No
29. Forgotten. Hard to remember.
30. Yes because it is not fully understood.
31. I think families hear palliative and think hospice
32. No idea. I think it should be brought up more frequently.
33. Often times it seems to add support and help patients with difficult decisions.

34. Resistance to perception of palliative care to be not utilizing acute care/curative care. Knowledge deficit of poor prognosis of patient’s condition
35. Not knowing when to use it
36. Should be started at time of diagnosis
37. Yes
38. NA
39. Because nurses do not understand what our part is
40. Not the first thing people think of
41. It is misunderstood as end-of-life care, telling a patient you want to consult palliative care before explaining what it is can make patients very anxious
42. Misperception that it is giving up on the patient
43. I do not think many nurse sand providers fully understand palliative care and believe it is basically the same thing as hospice
44. Workforce and provider capacity issues
45. No
46. People are afraid and do not understand

Question 5: Do you foresee yourself initiating or pushing for more palliative care consults in the future?
1. Yes, they are most often very helpful
2. Yes
3. Yes
4. No comment
5. Yes
6. Yes
7. Yes
8. Yes
9. Yes
10. On a case-by-case basis.
11. Yes
12. Yes
13. Yes
14. Yes
15. I do discuss options with patients; however, they generally prefer to discuss further with a primary care physician.
16. Yes
17. Yes
18. Yes
19. Yes
20. Yes
21. If necessary, yes.
22. Yes
23. Yes
24. Yes

25. Yes
26. Yes
27. Yes
28. No
29. Possibly in the right setting
30. Yes
31. No
32. I always do
33. Yes, now that I know more about it
34. I will collaborate with the case manager about that same that I do now. I usually bring in the social worker team to explain more in detail what is encompassing the palliative team plan for the patient. They have literature readily available to offer support in the patient and family decision making process
35. Hopefully
36. Absolutely
37. Yes
38. NA
39. Yes. After being education more I will be pushing for palliative care in the future.
40. Yes
41. I believe that I will continue recommending palliative care the same amount that I do now.
42. Yes
43. If I see patients that I believe will benefit, I will let the doctors know.
44. Maybe
45. Yes
46. Yes

Question 6: Do you have any comments or concerns that you would like to share here about palliative care?
1. No
2. None
3. No comment
4. No comment
5. NA
6. No
7. NA
8. NA
9. No
10. I need to learn more about the subject
11. NA
12. I feel like making it more of a team process and decision could greatly improve the number of consults.
13. I believe we do a good job, but an interdisciplinary approach could help.
14. Making a great resource for patients and families.

15. NA
16. NA
17. Nothing specific
18. No concerns, but working together to consult palliative care
19. Palliative is extremely helpful
20. No
21. Not at this time
22. No
23. None
24. No
25. I hope the physicians received this education
26. NA
27. Great presentation, please send out to more employees
28. No
29. I think are another good option and can be a bridge between aggressive and goal to keep living to realization that perhaps end of life is becoming more of a reality
30. Thank you for the lesson, great information
31. No
32. I love our new palliative care team
33. NA
34. NA
35. It is great when used correctly
36. Wish we had more physicians educated. Seems to be very controversial for them
37. NA
38. No
39. NA
40. Great education
41. It would be if clinic physicians had a better understanding of palliative care. I think it is pretty well understood in the inpatient setting but could be used much more widely in the outpatient setting.
42. No
43. No
44. No
45. More teaching for patient, families, staff. More of an interdisciplinary approach.
46. More education so people with have more confidence discussing the topic