Implementing a Bereavement Risk Assessment Protocol:

A Quality Improvement Project

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Abstract

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Hospice care entails the provision of palliative and supportive care services incorporating physical, psychological, social, and spiritual care for dying persons, their family members, and their loved ones (The Joint Commission for Advanced Certification for Palliative Care [Joint Commission], 2018). An estimated 40 million people worldwide require palliative care each year (World Health Organization, 2018). Providing bereavement support to patients, family members, and significant others is a priority of palliative care (Higginson, 2016). Palliative and hospice care facilities must provide support for family caregivers, including bereavement follow-up, as a core end-of-life care service (Higginson, 2016). Caring for bereaved families is an important element of providing hospice and palliative care (Higginson, 2016), as family caregivers are shown to experience the most grief following the death of a loved one (She & Prigerson, 2018).

Medicare mandates hospices offer bereavement support to caregivers and families for a year following the patient’s death (Ghesquiere, Bagaajav, Metzendorf, Bookbinder, & Gardner, 2019). According to a national study, 92% of hospice care facilities perform some sort of family and caregiver bereavement screening upon the patient’s admission, with 69% also screening after the patient’s death (Ghesquiere et al., 2019). However, there are no nationally standardized tools or scales used to predict the level of bereavement in caregivers (Ghesquiere et al., 2019). Even though hospice facilities are certified, many do not meet the requirements of the Joint Commission, which emphasizes exceptional patient- and family-centered care (Joint Commission, 2018). Under Title 42, Part 418 of the U.S. Code of Federal Regulations (U.S. Department of Health and Human Services, 2011), facilities must meet specific standards and conditions to receive agency certification by Medicare and Medicaid. The U.S. Department of Health and Human Services makes certification decisions based on the evaluation of clinical practice guidelines, performance measurements, and improvement activities for addressing a patient’s physical, emotional, social, and spiritual needs (Joint Commission, 2018).

Little published research is specific to strategies for providing exceptional patient- and family-centered palliative care. According to Chen et al. (2014), the failure to address research gaps in palliative care stems from the lack of funding, limited institutional capacity, public and professional misunderstanding of palliative care, and a general aversion to topics related to serious illness and end of life. Kashyap and Kruczynski (2015) noted an unwillingness to study, research, and implement appropriate interventions on the multitude of financial and psychological issues faced by caregivers experiencing bereavement. Even in developed countries, few studies have taken place on bereavement services because of barriers such as the unwillingness to speak freely about the psychological and emotional impact of bereavement (Kashyap & Kruczynski, 2015; Sealey, O’Connor, Aoun, & Breen, 2015). According to Sealey, O’Connor et al. (2015), there is a dearth of evidence-based research on strategies for offsetting the negative impact of bereavement-induced stress on health outcomes, leaving a narrow opportunity of integrating the experiences of survivors of death and loss. Many medical care services do not use evidence-based methods to assess the risk of family members suffering (Institute of Medicine, 2015).

The studies indicate a need for practice improvement in the field of palliative care, particularly in most hospice facilities. An evidence-based model of assessment such as the Bereavement Risk Assessment Tool (BRAT) is compelling for developing best practices, especially for identifying trauma risk among patients experiencing bereavement and rendering appropriate services (American Association of Colleges of Nursing, 2016; MacDonald, 2016). BRAT is a standard tool used to determine if a caregiver or family member is at greater risk for a significantly negative bereavement experience (MacDonald, 2016). BRAT assesses 11 domains and five levels of risk ranging from 1 = *no known risk* to 5 = *high risk*. BRAT has shown to be a valid tool for assessing the risk of developing social, psychological, and physical health consequences associated with a severe bereavement response (MacDonald, 2016). Developing a standard protocol to assess bereavement risk and determining appropriate services is critical in hospice care facilities (She & Prigerson, 2018).

Problem Statement

The project site does not have a structured, standardized risk assessment system in place for bereavement risk assessment. Consequently, it is unknown whether individuals at the project site, family members, or significant others of the patient are at a high risk of developing adverse health conditions because of a negative bereavement experience. Palliative care facilities often lack a comprehensive strategy for bereavement risk assessment of family members and significant others of the patient (Wilson, Avalos, & Dowling, 2016). According to Wilson et al. (2016), inadequate understanding of bereavement and the absence of a standard protocol limits the ability to provide quality patient-centered care. The use of a standardized method for assessing bereavement risk can assist in providing quality patient-centered care, as well as meeting the standards and conditions for designation in the Joint Commission (Institute of Medicine, 2015).

Purpose Statement

The purpose of this project is to develop and implement the use of a standardized bereavement assessment protocol to identify individuals at a high risk of developing adverse health conditions because of bereavement. The relationship between sickness and coping strategies is clearly defined. Schreuder et al. (2011) suggested the bereaving population is at a higher risk of experiencing impairments such as physical pain, cardiovascular disease, cancer, depression, suicide ideation, and a generally reduced quality of life. BRAT is a means to determine if the surviving caregiver or family member is at risk for a significantly negative bereavement experience that can disrupt social, professional, and physical functioning (Sealey, Breen, O'Connor, & Aoun, 2015). The administration of this type of assessment is a critical part of meeting standards and conditions of certification at a palliative care facility (Sealey, Breen et al., 2015).

Nurses and other clinical staff received training in how to use a standard, evidence-based bereavement risk assessment instrument (BRAT) with the families and caregivers served at the project practice site. The purpose of the project is to determine if receipt of training significantly increases the level of nursing staff knowledge regarding the social, professional, and physical functioning disruptions experienced by the surviving family members, as well as the clinical professionals' ability to use the BRAT. Education is essential for the utilization and value of adhering to standard assessment tools such as BRAT to identify caregivers' risk level for experiencing physical or psychological illness as a result of the bereavement experience within a year of the death of a spouse, parent, child, or immediate family member (Sealey, Breen et al., 2015).

Project Question

The project question was**: Will training staff nurses on bereavement assessment risk protocol result in an increase in** application of the tool and resultant increase in identification of level of risk of family members and significant others over a 4-week period?

PICOT, a nursing term, is an acronym for population, intervention, comparison, outcome, and time (Riva, Malik, Burnie, Endicott, & Busse, 2012). PICOT served as the model in formulating the DNP project question. The population was the palliative care nurses at the practice site. The intervention was the implementation of the BRAT at the practice site. The expectation was that the implementation of the protocol post-intervention would supersede the lack of implementation pre-intervention. Expectations were a measured increase of adherence to the protocol, an improved learning experience among providers, and increased client outcomes because of implementing the BRAT. Decreased risk of negative health effects after 4 weeks was the chief desired outcome.

Project Objectives

The objectives of this quality improvement project were:

- Provide educational training sessions to nursing staff based on evidenced-based, validated protocol and assessment tools (BRAT).
- Conduct a pre- and post-training knowledge test to evaluate the effectiveness of the training session for improving nurse knowledge.
    - Implement the bereavement protocol using the BRAT assessment tool at the project setting.
- Conduct a chart audit pre- and post-implementation to determine if the assessment risk protocol occurred.

Search Terms

Conducting a literature search was a means to discover available and applicable resources. Criteria for inclusion in the literature review were English-language articles from peer-reviewed scholarly journals and randomized controlled trials published within the past 5 years. Older materials specific to the BRAT also merited review. Conducting the literature review entailed the use of the scholarly databases EBSCOHost, CINAHL Plus, Academic Search

Complete, ProQuest Central, PubMed, and Medline, as well as the academic search engine Google Scholar. Keywords and phrases searched were *palliative care, end-of-life care, hospice, hospice care, bereavement risk assessment*, *assessing bereavement risk, bereavement impairment, caregiver bereavement, bereavement intervention, bereavement risk assessment tool, palliative care* AND *best practices*, *end-of-life care* AND *best practices*, *end-of-life care* AND *hospice,* and *hospice care* AND *best practices*. This search returned over 1,000 relevant peer-reviewed articles published between 2016 and 2020. Excluded from review were articles published before 2016 and non–peer-reviewed articles not based on established research or assessment instruments. After application of inclusion and exclusion criteria and a review of all material relevant to this project, 79 articles remained for review.

Review of Literature

Different tools and protocols are available to assess the possibility of an individual suffering adverse health effects upon the death of a palliative care patient (MacDonald, 2016). Sealey, Breen et al. (2015) argued for the need to develop a standardized format for determining the risk posed to caregivers of palliative care patients. In their meta-analysis, Sealey, Breen et al. established that the development of a risk assessment protocol would be significant in providing better services to caregivers. According to Kashyap and Kruczynski (2015), systems to aid in bereavement risk assessment would be vital in improving institutional capacity, as well as in increasing public and professional understanding of palliative care. As a result, the risk of individuals developing adverse health outcomes due to bereavement merits assessment using a consistent format that produces replicable results. As noted by Parker (2018), bereavement risk assessment would help develop the capacity for palliative care institutions to offer ongoing services to families after the death of patients, thus increasing the quality of care. To achieve a standard in bereavement risk assessment, it is vital for institutions and professionals in bereavement counseling to use a standard method of evaluation (Sealey, Breen et al., 2015). Thus, the assessment of bereavement risk should have positive mental and physical health impacts on caregivers following the death of their patients.

Hospice and Palliative Care

Palliative care has been a recommended component of the continuum of health care since a declaration by the World Health Organization in 2014 (Meier et al., 2017). Despite this mandate, the United States has not yet fully integrated palliative care across the spectrum of health services, instead focusing primarily on individuals with imminent death in hospice and hospital settings (Meier et al., 2017). Accordingly, U.S. health care providers are not doing enough to alleviate suffering and deliver a higher standard of care (Meier et al., 2017).

According to the National Quality Forum (2012), palliative care is "end-of-life (EOL) care referring to comprehensive care for a life-limiting illness that meets the patient's medical, physical, psychological, spiritual, and social needs" (p. 2). A dying patient's health care team is responsible for the provision of palliative care to improve the patient's quality of life and ease the suffering of both patient and family (Meier et al., 2017). Many of the needs of an end-of-life patient fall under the purview of palliative care, including the address of physical, psychological, and social suffering (Meier et al., 2017). Palliative care is a broader provision of services than hospice alone (Casey, 2019).

In general, individuals enter hospice programs when they have six or fewer months to live (Casey, 2019). Although palliative care delivery may occur in a hospital or long-term care facility, hospice usually takes place in the dying individual's home (Casey, 2019). Hospice services may extend beyond enhancing the quality of life of the patient to include that of family members and even friends, some of whom may be the primary caregivers (Casey, 2019).

Studies have shown the benefits of palliative care in any setting; for example, both home and ambulatory settings have improved the quality of life of dying patients (Conlon et al., 2019). Conlon et al. (2019) conducted a retrospective study of hospice palliative care patients in an Ontario, Canada, ambulatory program from 2012 to 2015. Findings showed that palliative care patients received less-aggressive means of treatment and more peaceful deaths toward the end of their lives (Conlon et al., 2019). Other researchers have noted that family members rated the quality of palliative care higher when their loved ones died at home (de Boer, Hofstede, De Veer, Raijmakers, & Francke, 2017).

Despite the widespread use of palliative care and its proven benefits, high-quality research is less available (Chen et al., 2014). Chen et al. (2014) conducted telephone interviews with a purposeful sample of 61 palliative care researchers regarding the barriers to reliable research, subsequently identifying five themes across participants' responses. The first three were standard barriers to research, including funding, capacity of institutions, and availability of researchers. The remaining two were specific to palliative care, the first being participant attrition and the second being misperceptions of palliative care combined with a preference to avoid such somber topics as the demise of individuals who suffered severe and debilitating health conditions (Chen et al., 2014).

Caregiving

Unlike individuals caring for healthy persons in need of supervisory guidance, caregivers providing services to persons at the end of their lives experience more strain, pain, and suffering (Given & Reinhard, 2017). Adverse psychological and physical responses are associated with caregiving, including grief, distress, depression, and the physical manifestations thereof (Given & Reinhard, 2017). Health care teams must ensure they serve not only the patient but also the patient’s family caregivers (Given & Reinhard, 2017). Assessing for the bereavement risk of caregivers is one service providers may offer, indicating the need for follow-up care after the patient’s death (Caserta, Lund, Utz, & Tabler, 2016).

Chi, Demiris, Pike, Washington, and Parker Oliver (2018) examined baseline quantitative and qualitative data collected in a large-scale hospice clinical trial from 28 family caregivers. Quantitative findings showed higher anxiety, reduced physical quality of life, and adverse financial impacts on family caregivers (Chi et al., 2018). In analyzing the qualitative data, Chi et al. identified the reasons for these impacts, including minimal social support, poor communication, and money concerns. Based on their analysis, Chi et al. found four themes common to family caregivers related to finances, communication, social support, and difficulty in providing complete end-of-life care to loved ones.

She and Prigerson (2018) coined the term “caregiving” to fully capture the role of family members providing end-of-life care. The researchers noted that family caregivers feel more profound and long-lasting grief than nonfamily providers. Even so, family members comprise the majority of caregivers in hospice and other palliative care settings, indicating the need to provide sufficient support for these individuals (She & Prigerson, 2018). Bereavement support is an increasingly common part of palliative care services; however, standardized programs of bereavement support are often absent from palliative care settings and associated scholarly research. Accordingly, She and Prigerson (2018) point to the need for inquiry and follow-up based on evidence and theory.

A loved one's quality of death is another determinant in caregiver outcomes (Hirooka, Fukahori, Taku, Togari, & Ogawa, 2017). Hirooka et al. (2017) conducted a quantitative study using data from 805 caregivers whose family members died at home to determine whether there was a connection between intense, intentional rumination, and post-traumatic growth. Using a cross-sectional design, the researchers administered three instruments to participants: Event-Related Rumination Inventory, Good Death Inventory, and Post Traumatic Growth Inventory. Data analysis indicated a strong correlation between the patient's quality of death, the caregiver's rumination, and post-traumatic growth (Hirooka et al., 2017).

To assess caregiving outcomes from the caregivers themselves, Holtslander et al. (2017) conducted a meta-summary of 47 qualitative studies. Common emotions expressed by the caregivers in those studies included sadness, guilt, trauma, and anger (Holtslander et al., 2017). Caregivers discussed beneficial and unhelpful experiences both prior to and following the loss of their loved ones, with helpful situations producing better outcomes. Also identified was the need for a range of support, not just that provided by a single source (Holtslander et al., 2017). Key findings showed the multiple caregiving components that affected bereavement, the uniqueness of everyone's bereavement, and the need for multiple avenues of support.

Bereavement Support

Bereaved individuals can benefit greatly from personalized, evidence-based support (Aoun, Breen, White, Rumbold, & Kellehear, 2018; Hudson, Hall, Boughey, & Roulston, 2018). Despite its importance as a component of palliative care, bereavement support is not well researched, fully funded, or universally administered (Hudson et al., 2018). Following a survey of 678 bereaved individuals recruited from funeral home client lists in Australia, Aoun et al. (2018) found more frequent use of informal support such as friends and family, with less likelihood of the individual to utilize professional services. It is worth noting, however, that the study population comprised family members of deceased relatives, not just those who had cared for loved ones at the end of their lives.

Aoun, Rumbold, Howting, Bolleter, and Breen (2017) also used Australian funeral home clients to conduct an anonymous survey of individuals who had lost family members to terminal illness. Of the 506 participants, 298 had used palliative care services; of these, only half reported receiving sufficient support from the services (Aoun et al., 2017). Aoun et al. noted the importance of developing a relationship between palliative care and caregivers before the family member’s death, as well as ensuring regular follow-up bereavement care. The lack of bereavement assessment tools and guidelines, however, complicates such provision of services (Aoun et al., 2017).

Hudson et al. (2018) found inconsistency in the bereavement risk assessment application, something the researchers attributed to a lack of research and funding. A large-scale review took place using five sources, including a literature review, interviews, workshops, and two surveys. Findings showed the importance of proper application of bereavement assessment and support to incorporate components such as coordination of services, staff training, caregiver assessment, support strategies, and specialist referrals, when appropriate (Hudson et al., 2018).

Ghesquiere et al. (2019) expanded the definition of bereavement to include any advanced or follow-up services provided by hospices. The researchers found 98% of hospices in the study had called or sent a card to the family following the patient’s death. In addition, 95% of organizations provided educational material regarding grief and 72% offered individual or group therapy or both (Ghesquiere et al., 2019). Family members were not as likely to take advantage of these services, however, with less than half of individuals with depression accepting the help.

Burns, Prigerson, Quinn, Abernethy, and Currow (2018) conducted multivariable logistic regressions using data from the South Australian Health Omnibus to examine bereavement adjustment in caregivers. Data collected between 2000 and 2007 indicated respondents' ability to move on within 5 years following the death of a terminally ill family member. Eighty percent of caregivers reported moving on, with the remaining 20% relating adverse impacts from situations such as closeness to the family member and low socioeconomic status (Burns et al., 2018).

Bereavement Assessment

A common observation among researchers is the lack of evidence-based, standardized bereavement assessment tools (Aoun et al., 2017; Balboni et al., 2017; Hudson et al., 2018; Sealey, O'Connor et al., 2015). Specifically, Balboni et al. (2017) called for "for screening and assessment tools that are rigorously developed, clinically relevant, and adapted to a diversity of clinical and cultural settings" (p. 41). Roberts et al. (2017) suggested the need for a brief self-report bereavement risk assessment tool to identify grieving family members in need of support. Blackburn and Dwyer (2017) noted the unstructured and often-overlooked bereavement support offered by hospices and palliative care providers, arguing that bereavement support should occur parallel to patients' final care and extend beyond their death.

Sealey, O'Connor et al. (2015) noted only informal administration of bereavement support outside of standards of palliative care. The scholars conducted an action research study comprising three 90-minute group interviews with nine stakeholders over five weeks. Stakeholders were united in the belief that bereavement assessment measures currently in use in Western Australia were inadequate (Sealey, O'Connor et al., 2015). Following data analysis, Sealey, O'Connor et al. identified four themes to consider in bereavement risk assessment:

systems of caregiver care; organizational oversight; the intersection between grief, burden, and stress among caregivers; and the ability to provide the caregiver with a path forward.

Researchers and practitioners have differentiated between typical and extended grief following the death of a loved one (Delaney, Holloway, Miletich, Webb-Murphy, & Lanouette, 2017; Enez, 2018). Delaney et al. (2017) identified complicated grief as being a “significant chronic impairment that stems from bereavement” (p. e1751) lasting well beyond a typical grief response. Symptoms accompanying complicated grief include social withdrawal, physical distress, avoidance, and suicidal ideation (Enez, 2018). Delaney et al. sought to determine how efficient and practical it would be to screen for complicated grief using two instruments, the Brief Grief Questionnaire, and the Inventory for Complicated Grief. Among the outpatient military mental health clients in their study, 61.7% of the service members reported ongoing adverse symptoms from a loss screened positive on the former tool and 59.2% screened positive on the latter.

Thomsen, Guldin, Nielsen, Ollars, and Jensen (2017) argued for the need to assess for bereavement and provide proactive care to caregivers across the palliative care cycle, beginning before the loved one’s death. Assessment will enable health care teams to deliver the appropriate services to meet an individual caregiver’s needs and minimize the risks resulting from bereavement and grief. Thomsen et al. (2017) investigated interventions used by a Danish palliative home care team to include risk and needs assessment upon care implementation, providing support targeted to the caregiver, and creating a treatment record for the caregiver. Findings were that caregivers fared better following the appropriate risk assessment and treatment.

Among the intermittently, underutilized, and under researched tools administered before or after the loved one's death are the Adult Attitude to Grief Scale (Machin, 2007), Core Bereavement Items (Burnett, Middleton, Raphael, & Martinek, 1997), Grief Evaluation Measure (Jordan, Baker, Matteis, Rosenthal, & Ware, 2005), Inventory of Traumatic Grief (Prigerson & Jacobs, 2001), Texas Revised Inventory of Grief (Faschingbauer, DeVaul, & Zisook, 1977), Bereavement Risk Index (Parkes & Weiss, 1983), Bereavement Risk Inventory and Screening Inventory (Roberts, 2017), and BRAT (Victoria Hospice Society, 2008), as appropriate.

Bereavement Risk Assessment Tool

Victoria Hospice Society (2008) introduced the BRAT as a "psychosocial assessment tool used by care team members to communicate personal, interpersonal, and situational factors that may place a caregiver or family member at greater risk for a significantly negative bereavement experience" (n.p.). Organizations administer the 40-item BRAT to caregivers before the patient's death, with results used to guide the provider team in delivering appropriate and necessary care to caregivers and family members. Beyond predicting a caregiver's risk for extended or severe bereavement, the BRAT measures the individual's resilience, as well as the facility's administration of services (Rose, Wainwright, Downing, & Lesperance, 2011).

The BRAT comprises 11 domains: kinship; caregiver; mental health; coping; spirituality/religion; concurrent stressors; previous bereavements; supports and relationships; children and youth; circumstances involving the patient, the care, or death; and protective factors supporting positive bereavement outcomes (MacDonald, 2016). There are five levels of scoring, ranging from 1 = *no known risk* to 5 = *high risk*. Further assessments of risk levels are *unmitigated* and *mitigated*.

To test the inter-rater reliability of the BRAT, Rose et al. (2011) recruited 36 bereavement professionals to assess 10 cases and estimate the bereavement risk level from 1 to 5. Bereavement professionals were social workers, counselors, psychologists, and clergy members from Canada (*n* = 18), the United States (*n* = 14), and unknown origin (*n* = 4). The researchers created the cases based on real patients and family members who had received care from a hospice palliative care program. Following quantitative analysis, Rose et al. found the tool showed moderately good interrater reliability compared to mere clinical judgment.

Gippsland Region Palliative Care Consortium Clinical Practice Group (GRPCC; 2016) proposed an extended version of the BRAT called the Complicated Bereavement Risk Assessment Tool (CBRAT). The modified tool evaluated five elements: the characteristics of the caregiver, the illness borne by deceased family members, the nature of the individual's death, the caregiver's history with loss and grief, and the relationship between caregiver and patient (GRPCC, 2016). From data analysis, GRPCC identified the need for two bereavement support strategies to enable both overarching and specialist care.

Impact of the Problem

According to Sealey, Breen et al. (2015), bereavement risks are inherent for a caregiver who provides end-of-life care to a patient to experience adverse effects upon the death of the patient. Sealey, Breen et al. observed that persons who are emotionally connected to palliative care patients, especially during the patients' final days, tend to be most affected by the deaths. This group is, therefore, at the highest risk of adverse outcomes upon the patient's death, which may present as social, psychological, or even physical manifestations (Sealey, Breen et al., 2015). Often, these risks emerge when individuals fail to internalize the loss of the patient under their care as a result of experiencing emotional affliction and adverse health outcomes (Sealey, Breen et al., 2015). In most instances, bereavement risks lead to mental manifestations that include depression, suicide ideation, and withdrawal from social circles. Bereavement risks are highest among family members and end-of-life caregivers who are closest to the patient during the final weeks of life.

Addressing the Problem with Current Evidence

The overarching problem is that nurses and clinical staff do not appropriately or regularly assess bereavement risk in end-of-life caregivers. The specific problem is that many hospice and palliative care organizations have no formal program to train health care providers in administering risk assessment tools such as the BRAT. Accordingly, it was necessary to explore the literature related to the project topic and problem. The two most relevant themes were the use of a bereavement risk assessment protocol and bereavement risk assessment training.

Theme 1: Using a bereavement risk assessment protocol. It is necessary to design bereavement risk assessment protocols in a manner that allows the user to examine the personal and situational factors that would increase the risk of negative bereavement (Parker, 2018). A desirable tool would be one that indicates the likelihood of adverse social, emotional, or physical health outcomes in persons associated with patients undergoing palliative care (Roberts et al., 2017). According to MacDonald (2016), bereavement risk assessment to identify the scale of attachment of each caregiver to the palliative care patient will make it possible to discern which individual would be most affected by the death of the patient. A bereavement risk assessment protocol should enable the administrator to rank the probability of adverse experiences among the caregivers and family members of patients in palliative care (Thomsen et al., 2017). Finally, an effective bereavement risk assessment tool should indicate the need for adequate interventions for families preparing for a palliative patient’s death (Thomsen et al., 2017).

Theme 2: Bereavement risk assessment training. Before health care professionals use a bereavement risk assessment protocol, they must first receive training on how to do so (Hudson et al., 2018; Newsom, Schut, Stroebe, Wilson, & Birrell, 2016). Training will teach such individuals how to assess the possibility of negative bereavement experience among the members of a palliative patient's caregiving team. According to Parker (2018), training increases health care professionals' competence in determining at-risk individuals, improves their knowledge of the protocols and tools to use, and imparts the skills to handle the outcomes of negative bereavement. In this way, health care professionals can identify the individuals most impacted by a patient's death and prepare intervention measures as necessary to aid in the caregiver's or family member's transition (Balboni et al., 2017). Training in the use of these risk assessment protocols increases the ability of nursing officials to help persons with adverse bereavement experiences (Blum, 2014). Proper training will improve the quality of care and related services offered to palliative patients and their families, enabling health care providers to address the needs of not only the patients but also their family members (Hudson et al., 2018). Finally, by equipping nursing staff with the necessary bereavement risk assessment capability, palliative care facilities may decrease the adverse effects of a patient's death on the family and caregivers (Newsom et al., 2016).

Bereavement is a state of grieving that all people will undergo at many stages of life (Delaney et al., 2017; Enez, 2018). However, people express different emotions when they are bereaved, with common reactions including anger, blame, guilt, sadness, and depression (Given & Reinhard, 2017). Poor management of psychological and physical outcomes due to a lack of effective palliative care could affect the health of bereaved people (Meier et al., 2017). End-of-life caregivers could experience health issues associated with bereavement. The problem is of high magnitude due to a lack of appropriate hospice care involving bereavement risk assessment of caregivers (Aoun et al., 2017). When stricken with intense feelings of anger, sadness, and depression, bereaved people face more significant difficulties in leading a quality life compared to individuals who are not bereaved (Pearlman, Wortman, Feuer, Farber, & Rando, 2014).

Different tools and protocols are available to assess the possibility of an individual suffering adverse health effects upon the demise of a palliative care patient (Burnett et al., 1997; Faschingbauer et al., 1977; Jordan et al., 2005; Parkes & Weiss, 1983; Prigerson & Jacobs, 2001; Roberts et al., 2017; Victoria Hospice Society, 2008). Sealey, Breen et al. (2015) noted the necessity to develop a standardized format for determining the risk to caregivers of palliative care patients. In their meta-analysis, Sealey, Breen et al. also established that the development of a risk assessment protocol would be significant in capacity-building. Kashyap and Kruczynski (2015) suggested that the development of systems to aid in bereavement risk assessment is vital to improving institutional capacity and boosting the level of public and professional understanding of palliative care. Therefore, the risk of individuals developing adverse health outcomes due to bereavement merits examination using a consistent format that produces replicable results. Along these lines, Parker (2018) noted that bereavement risk assessment would help develop the capacity in palliative care institutions to offer ongoing services to families even after the death of patients, which would increase the quality of care provided to families. To achieve these objectives, institutions and professionals in bereavement counseling must use a standard method of testing (Sealey, O’Connor et al., 2015). Thus, the assessment of bereavement risk should yield outcomes on the possible and expected mental and physical health impacts on caregivers following the death of their patients.

Current Management

There is currently no management or protocol of bereavement assessment at the practice site. The practice site does not provide adequate hospice care services needed to manage depression, anger, sadness, and anxiety affecting bereaved individuals. In addition, there is no process for family members to receive timely counseling after the burial or cremation of their loved ones.

The protocol guidelines used for bereavement care at the practice site are limited in scope, which suggests that bereavement risk assessments are poorly done or not done at all. Therefore, the bereavement needs of family caregivers of end-of-life patients might receive an improper response. To address these concerns, the practice site should make the BRAT available to assist nursing staff in providing optimal care for bereaved families.

Significance of the Problem and Project Purpose

Using evidence-based practice in the clinical setting is essential (Kashyap & Kruczynski, 2015); accordingly, this application provides crucial resources to develop and implement a standardized bereavement assessment tool. Within clinical settings, the use of evidence in practice is a crucial component of allocating finite resources to competing needs (Hudson et al., 2018). Therefore, adopting an evidence-based assessment tool would improve the efficiency of medical care (GRPCC, 2016). This project entailed the staff education and implementation of an evidence-based bereavement assessment protocol to identify individuals at the highest risk of adverse health conditions following the death of palliative patients.

Theoretical Framework

The theoretical framework selected for this DNP project was Peplau’s theory of interpersonal relations (see Appendix A), a middle-range nursing theory published in 1952 and

1968 (D’Antonio, Beeber, Sills, & Naegle, 2014). Nursing practice and psychiatric nursing care often incorporate Peplau’s theory, considered the heart of psychiatric nursing (D’Antonio et al., 2014).

Historical Development of Theory

Peplau, the first published nursing theorist since Florence Nightingale (D’Antonio et al., 2014), was dedicated to providing psychiatric nursing care based on promoting stable relationships with patients. Peplau published several journal articles and a book on providing the best care for psychiatric patients (D’Antonio et al., 2014). According to Hagerty, Samuels, Norcini-Pala, and Gigliotti (2017), nurses apply the theory of interpersonal relations to improve therapeutic interactions with people who need to receive care at various stages of the palliative care process.

Peplau graduated in 1931 from Pottstown Hospital Training School and continued in Bennington College in Vermont as an undergraduate student, earning a degree in nursing (Deane & Fain, 2016). While attending Bennington College, Peplau worked at Maryland’s Chestnut Lodge from 1941 to 1942, gaining transformative experience from work and close relationships with neo-Freudian analysts (D’Antonio et al., 2014). Peplau’s work with these individuals provided the opportunity for others to learn treatment techniques and constructs that would later help in interactions with the social and relational aspects of the interpersonal dynamics of patient care (D’Antonio et al., 2014). Peplau’s educational endeavors further indicated the need for strong interpersonal relations between nurses and patients, thus producing better outcomes for patients. The teachings of Frieda Fromm Reichmann and Henry Stack Sullivan influenced Peplau in applying the relational approach when working with patients (D’Antonio et al., 2014).

Peplau served as a military nurse during World War II and transferred her learned experiences of interpersonal relations to those in her care (Deane & Fain, 2016). After the war, she obtained a master’s degree and became a professor at Columbia University (Deane & Fain, 2016). Peplau’s scholarly contributions included the 1952 publication of *Interpersonal Relations in Nursing: Offering a Conceptual Frame of Reference for Psychodynamic Nursing* (D’Antonio et al., 2014). The book presented a foundational framework for nurses to establish interpersonal relations with patients and led to the development of Peplau’s theory of interpersonal relations (see Appendix A; D’Antonio et al., 2014). This theory became a component of nursing education and practice, including psychiatric nursing (D’Antonio et al., 2014).

Applicability of Theory to Current Practice

Current nursing practice incorporates Peplau’s theory of interpersonal relations. The application of this theory is a means of helping individuals identify personal challenges based on interpersonal relations between patients and nurses (Hagerty et al., 2017). These relationships are necessary for the patient to achieve specific goals, such as meeting health care needs. Nursing practice requires a stable interaction between patients and health care providers (Hagerty et al., 2017). The theory is often used in the emergency department, a setting in which nurses need to identify patient needs immediately through personal interaction (Keller-Senn, Lee, Imhof, & Sturt, 2017). The theory further facilitates the development of strong relationships between nurses and patients in hospice care (Hagerty, 2015). With these relationships, patients can trust nurses or hospice care providers to provide all the information needed. Sharing information helps health care providers to determine the psychiatric care most appropriate for the individual.

Major Tenets of the Theory

Peplau’s theory of interpersonal relations provides an understanding of the nurses’ importance to health care settings and patient health. The theory includes six major concepts focused on the four phases of a therapeutic patient-nurse relationship and the six roles of the nurse (Hagerty et al., 2017). First, nurses have to apply human relations principles to address issues arising at any level of their experience (Adams, 2017). Second, the theory incorporates key phases of interpersonal relations, defining nursing roles in different situations as well as describing approaches for studying nursing. Third, the theory shows nursing to be an interpersonal process in which more than two individuals can interact to achieve a common goal. Fourth, the view of nursing is as a therapeutic process in the healing arts, with individuals either healed or receiving the required health care service. Fifth, a series of steps and a specific pattern enable nurses to achieve the set goals. Finally, patients and nurses require a close working relationship for both parties to be knowledgeable (Adams, 2017).

Further explanation of these concepts comes from the six roles of the nurse and the four phases of the nurse-patient relationship. The roles of the nurse include stranger, teacher, resource person, counselor, surrogate, and leader. The explanation of each role follows (Paiva Góes da Silva et al., 2015):

- **Stranger:** Nurses receive and welcome strangers by creating an acceptable climate, which leads to the establishment of a high level of trust (Paiva Góes da Silva et al., 2015).
- **Teacher:** Nurses impart knowledge by referring to a specific interest of need.
- **Resource person:** Nurses provide the information needed to understand a new situation or problem.

- **Counselor:** Nurses provide an understanding and integration of prevailing life circumstances as well as the changes required.
- **Surrogate:** Nurses clarify dependence, independence, and interdependence domains as they advocate for patients.
- **Leader:** Nurses bear the greatest responsibility for meeting treatment goals and satisfying patient needs.

The four phases of the nurse-patient relationship are orientation, identification, exploitation, and resolution, explained as follows:

- Orientation entails the patient seeking assistance, followed by the nurse meeting the patient, identifying the problem, and providing the services needed.
- Identification involves finding the best person to support the patient’s needs or feelings to the level of personal satisfaction.
- At the exploitation stage, the patient explores and understands how to address the problem, thus having the independence to achieve the set goal.
- Resolution entails the termination of the therapeutic relationship between the nurse and patient after establishing an emotional balance between the two parties.

The tenets of this theory define the position of the provider in nurse-patient relationships. The nurse plays a central role in establishing a stable relationship with the patient (Hagerty et al., 2017). The role of the nurse is to provide a therapeutic process, with a quality patient outcome that meets the health care needs of the patient (Hagerty et al., 2017).

Application of theory to DNP project. Peplau’s theory of interpersonal relations effectively integrates into this DNP project. Peplau’s theory is useful when working with bereaved clients affected by emotional disorders after losing their loved ones. Implementation of the bereavement risk assessment protocol is possible using the four phases of the nurse-patient relationship. During the orientation phase, the nurse will meet the patient, introduce services, and identify problems of the bereaved client; next, the identification phase entails finding the best person to support the client and involves the direct application of the bereavement protocol. The third phase is exploitation, which has a high significance to the hospice care setting. As applied to this project, the exploitation phase requires using professional assistance to understand how to address the needs of those seeking bereavement care services (Deane & Fain, 2016).

The use of Peplau's theory of interpersonal relationship supports promoting a nurse-patient relationship while implementing a bereavement protocol. These relationships facilitate the identification of patient needs. In addition, the tenets allow nurses to maintain stable communication as a strategy for understanding patient health care needs (Adams, 2017).

Project Design

Description of the Project Design

This DNP project used a quality improvement approach. The purpose of this project was to implement the use of a standardized bereavement assessment protocol to identify individuals at a high risk of developing adverse health conditions. At the time of the study, there were no standardized assessment tools in use at the project site that would assist in identifying clients at risk of developing adverse health conditions from bereavement. Developing a standardized protocol to assess bereavement risk and determining appropriate treatment is an important initiative in a hospice setting (She & Prigerson, 2018). Hence, this quality improvement project was a means to determine whether implementing the BRAT might assist in identifying bereaved individuals at a high risk of experiencing adverse conditions.

The population of interest was all licensed providers and members of the interdisciplinary team who provide direct care to patients at the project site. Participants received training on the use of the BRAT, an evidence-based protocol and validated assessment tools. In addition, the project lead developed and administered pre- and post-training questionnaires to measure if there was an increase in knowledge, as well as pre- and post-implementation chart audits to determine if the assessment risk protocol occurred. Proper training to providers and the interdisciplinary team will improve their knowledge of bereavement assessment (Hudson et al., 2018).

The aim of this quality improvement project was to determine if training licensed providers and interdisciplinary team members on bereavement assessment risk protocol results in increased application of the tool and in the identification of the level of risk of family members and significant others over 4 weeks. The project lead conducted quantitative analysis of the data collected from the pre- and post-implementation questionnaires and chart audits. The data collected underwent analysis to measure whether training licensed providers and interdisciplinary team members on bereavement assessment risk protocol can aid in increasing the use of the tool and identifying high-risk family members. The dependent variable for the project was the BRAT; independent variables were gender, age, ability to assess, referral, and intervention. Analysis of the collected data included the use of Statistical Package for Social Sciences (SPSS) input and *t*-test computation. The project findings justified the implementation of a bereavement protocol using the BRAT assessment tool at the practice site.

The participants completed a questionnaire both before and after the educational sessions. Scores from the pre-test served to establish a baseline, whereas post-test responses showed whether learning had occurred. In between the tests was an educational session incorporating a PowerPoint presentation and a printed handout of information from the presentation. The project lead also conducted pre- and post-implementation chart audits of all patients currently receiving hospice care at the project site. The pre-implementation audit established a baseline 4 weeks before BRAT implementation, with a subsequent audit 4 weeks post-implementation to determine the efficiency of the assessment protocol.

Stakeholders

The stakeholders of this DNP project included the hospice care center owner and chief executive officer, medical directors, director of patient care services, case managers, pharmaceutical companies that supply the medications, durable medical equipment company, data entry clerk, administrator, bereavement coordinator, interdisciplinary team, licensed vocational nurses, and certified hospice aid. These stakeholders were essential because they provided the necessary information to conduct the project. In addition, procuring the support of stakeholders assists in the success of a project (Rizza et al., 2015). The project lead established a rapport with all the stakeholders, conducting regular meetings to keep them informed about the project. In addition, the project lead provided the stakeholders with weekly progress updates.

Population of Interest

The population of interest for this DNP project included licensed providers and interdisciplinary team members currently employed at the practice site. The practice site employs two medical directors, two nurse practitioners, seven registered nurses, eight licensed vocational nurses, eight certified home health aides, three medical social workers, two physical therapists, one occupational therapist, and one chaplain. Inclusion criteria required that licensed providers and interdisciplinary staff were currently employed by the project practice site and would engage in implementing the BRAT at the practice site. Any interdisciplinary staff or licensed providers not employed at the practice site or who would not be implementing the BRAT were excluded from participation. The patients and family members at the practice site are an indirect population needed for the interdisciplinary team members and licensed providers to implement the intervention. This indirect population included all adult patients and family members who were 18 years of age or older.

Setting

The setting for this DNP project was a privately owned hospice care facility located in San Bernardino County, California. The site is a freestanding Medicare and Medicaid certified hospice facility with Joint Commission designation. The hospice provides care for up to 50 patients. Among the patient population, 80% are at least 40 years of age and 65% are male. The facility's services include providing nursing care, administering pain medications, and extending emotional support to the patients and their families as well as caregivers. Facility leadership granted permission to use the facility for the DNP project (see Appendix B).

Recruitment Method

Direct recruitment for this DNP project took place through workplace interdisciplinary meetings, workplace dashboard notifications, and e-mail messages from the project lead. Participants received information regarding the project and the educational training on BRAT through the workplace dashboard and e-mail messages. Because this was a quality improvement project at the practice site, faculty administration communicated to all the employees via e-mail that participation is mandatory. There were no compensation or incentives for employee participation in this project. No identifying information of the participants are available to protect their privacy.

Chart Recruitment

The project lead developed a chart audit tool (see Appendices H and I) to collect information from 50 patient charts before and after BRAT implementation. Chart audits measured the utilization of the BRAT pre-implementation and the adherence following implementation. Inclusion criteria included patients currently receiving hospice services and those whose care started within the last 12 months and expired within the last 6 months. Excluded were charts of patients deceased for more than 6 months. The variables in the chart audit tool included age, gender, assessment completed, referral made, and intervention initiation. Only the project lead conducted the chart audit. To ensure patient confidentiality, chart identification was by random numeric identifier rather than patient name or clinic medical record number. The project lead input all data collected from pre- and post-implementation chart audits into an Excel spreadsheet and then into SPSS for analysis. For additional anonymity, only the project lead has access to the exam and chart audit results, which remain in a locked and secured cabinet away from the project site.

Tools and Instrumentation

The tools utilized in this DNP project included the BRAT, pre- and post-implementation questionnaires, an educational PowerPoint presentation, and a chart audit tool. The confidentiality and privacy of all participants remains secure, with no identifying information included in the tools and instruments.

Bereavement Risk Assessment Tool

The primary tool for the project was the BRAT (see Appendix C), for which the project lead received permission to use (see Appendix D). This tool helps in identifying persons who are at risk of negative bereavement experiences, thus providing guidance for initiating timely intervention measures. The tool consists of four domains of emotional well-being assessed on a 5-point scale to determine an individual's risk. The scale ranges from 1 = *no known risk* to 5 = *high risk* across 11 domains, which are: kinship; caregiver; mental health; coping; spirituality/religion; concurrent stressors; previous bereavements; supports and relationships; children and youth; circumstances involving the patient, care, or death; and protective factors supporting positive bereavement outcomes. The reliability and validity of this tool are shown through its use in the assessment of the risk of developing social, psychological, as well as physical health consequences following bereavement (MacDonald, 2016). BRAT is a psychosocial assessment tool used to identify personal and interpersonal factors during bereavement experiences (Victoria Hospice Society, 2008).

Questionnaire

The project lead created and administered pre- and post-educational questionnaires (see Appendix E) containing 10 questions on bereavement risk assessment, the BRAT, intervention, and treatment. The questionnaire was a means to evaluate the effectiveness of the training session for improving participants' and staff members' knowledge, skills, and attitudes. The pre- and post-tests were the same and took between 10 to 15 minutes to complete. Test questions were from topics covered in the educational PowerPoint presentation. Created from the pre- and post-test scores was an exam results sheet (see Appendix F). The results from both tests were recorded on a score sheet and stored off-site in a locked cabinet to which only the project lead has access. The content validity index utilized was to determine the content validity and reliability of the questionnaires. The CVI tool went to three expert raters so that each could rate the questions: the course instructor, academic mentor, and project mentor. The questionnaires received mean I-CVI scores of 1.0 from the three expert raters, suggesting that all the questions were moderately to highly relevant to this project (see Appendix J).

PowerPoint Presentation

The project lead created a PowerPoint presentation (see Appendix G) to provide educational training sessions to the participants based on evidenced-based, validated protocols and assessment tools (i.e., BRAT). Before health care professionals use a bereavement risk assessment protocol, they must first receive training on how to do so (Hudson et al., 2018; Newsom et al., 2016). According to Parker (2018), training increases health care professionals' competence in identifying at-risk individuals, improves their knowledge of the protocols and tools to use, and imparts the skills needed to handle the outcomes of negative bereavement. Because this was a quality improvement project at the project site, site administrators made participation mandatory for the interdisciplinary team and the licensed providers. Dissemination of the information regarding the project and the training was through the workplace information dashboard and e-mail messages. The educational training session covered information on BRAT risk assessment, adverse effects, when to administer, intervention, treatment, and referral. The educational session lasted for about an hour and was repeatable upon request. The PowerPoint presentation and handout created by the project lead could also be incorporated into new-hire training materials.

Chart Audit Tool

The project lead created and utilized a chart audit tool (see Appendix H) to collect information from the patient charts meeting the inclusion criteria. Also conducted were chart audits, both pre- and post-implementation, to determine if the assessment risk protocol was used. Data collection using the chart audit tool occurred 4 weeks before BRAT implementation to establish a baseline and 4 weeks after BRAT implementation to assess adherence. The variables in the chart audit tool were age, gender, assessment, BRAT completion status, unable to assess, refused assessment, referral, and referrals. Completed chart audit results sheets (see Appendix I) followed from the use of interventions. Data was recorded into the chart audit tool, compiled, input into an Excel spreadsheet, and analyzed using SPSS. To maintain confidentiality, chart identification was via numeric identifier and only the project lead conducted the chart audits.

Data Collection

The data collection procedure consisted of administering pre- and post-educational questionnaires to participants as well as conducting pre- and post-BRAT implementation chart audits. The project lead administered a pre-educational questionnaire immediately before the educational training sessions to measure knowledge before training, and a post-educational questionnaire to evaluate the effectiveness of the training session for improving the participants' knowledge, skills, and attitudes. To measure the effectiveness of the training, the project lead compared the pre- and post-educational chart audit results as well as the educational training responses by the participants. The result of the pre- and post-educational questionnaires were recorded into the score sheet and stored in a locked filing cabinet away from the project site; only the project lead has access to the audit results.

Chart Audits

The project lead conducted a pre- and post-implementation chart audit to determine if the assessment risk protocol occurred. The independent variables were age, gender, assessment completed, referral, and intervention, and the dependent variable was BRAT. The pre-implementation chart audits and data collection were 50 audits conducted 4 weeks before implementation to establish the baseline, with subsequent audits 4 weeks post-implementation to determine if the assessment risk occurred. To maintain confidentiality, chart identification was via a numeric identifier, and only the project lead conducted the chart audits. The project lead determined whether the rate of BRAT completion after implementation significantly differed by comparing the pre-implementation completion rate to the post-implementation completion rate, and then dividing the number of audited charts that meet the inclusion criteria by the number of screenings completed. To conduct the analysis, the project lead entered data from pre- and post-implementation chart audit score sheets and data from pre- and post-educational training result sheets into SPSS, with a subsequent *t*-test analysis. The use of a statistician helped to ensure accurate results.

Intervention/Project Timeline

A timeline is crucial in project management because it helps to align activities within realistic timescales that can, in turn, be used to assess progress. Implementation of the DNP project occurred over 4 weeks. The implementation phase included applying the intervention, collecting data, and evaluating the project results. The nursing supervisor approved the implementation of the DNP project at the practice site (see Appendix B).

Week 1 entailed a review of the training and implementation guidelines with the stakeholders, participants, and project site leadership. The project lead provided clear communication about the date and time of the training. Also, the project lead conducted the pre-implementation chart audit. In Week 2, the participants completed a pre-knowledge questionnaire, attended an educational training presentation, and completed the post-training, post-knowledge questionnaires. The project lead then launched the implementation of the BRAT protocol. In Week 3, the project lead continued to monitor the progress of the BRAT implementation, offer guidance, and ensure all participants were familiar with the assessment tool. During Week 4, the project lead conducted post-implementation chart audits, and then completed data analysis and evaluation of project data from pre-and post-knowledge training, and pre-and post-implementation chart audit utilizing SPSS, *t*-test, and chi-square analysis. The project lead conducted a total project evaluation by comparing the completion of bereavement risk assessment using BRAT before implementation to the completion rate after implementation to determine if use increased. Also evaluated was the impact of the training on the hospice providers. The project lead then disseminated the outcome of the project implementation to stakeholders, colleagues, and academic mentors. The project timeline follows.

Table 1

DNP Project Implementation Timeline

Week	Tasks
1	• Review training and implementation guidelines with the stakeholders, participants, and project site leadership. • Clear communication through e-mail notification and workplace information dashboard reminders to all participants regarding the date and time of training and implementation of the project. • Conduct pre-intervention chart audit to determine the patterns of bereavement risk assessment at the project site (baseline information).
2	• Conduct pre-implementation knowledge questionnaires, record results on the score sheet. • Conduct one educational session utilizing the PowerPoint educational tool. Educational sessions may be repeated upon request by the practice site. • Complete post-test knowledge questionnaires to assess participants’ knowledge, skills, and attitudes, record results on the score sheet. • Compare pre- and post-intervention knowledge questionnaire results sheets to determine participants’ knowledge, skills, and attitudes. • Implement BRAT immediately after education.
3	• Continue to monitor process implementation. • Monitor progress, offer guidance, and provide support for participants.

Week	Tasks
4	• Conduct post-intervention chart audits. • Conduct complete data analysis and evaluation of project data from pre-questionnaire and post-knowledge training, and pre-questionnaire and post-implementation chart audit utilizing SPSS. • Review all statistical reports in preparation for dissemination. • Disseminate to project leads, project mentor, stakeholders, and colleagues.

Ethics/Human Subjects Protection

The Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) presents key principles to which researchers and health care providers must adhere to when dealing with human subjects. These principles include respect for persons, justice, and beneficence (Mandal, Acharya, & Parija, 2011). This quality improvement project meets the Touro University Nevada Institutional Review Board (IRB) exemption criteria; hence, this project did not require IRB approval before implementation. The project lead completed the required Collaborative Institutional Training Initiative course to ensure ethics and human subjects protection. To adhere to all Health Insurance Portability and Accountability Act (HIPAA) privacy laws, the project lead deidentified all patient and participant information. Chart identification was by random numeric identifier rather than patient name or medical record number. The project lead will input all data collected from the pre- and post-implementation chart audits into an Excel spreadsheet, and then into SPSS for analysis. For additional anonymity, only the project lead has access to the chart audit results, which remain in a secured cabinet away from the project site.

Plan for Analysis/Evaluation

Data collected for this DNP project underwent quantitative analysis using SPSS software. The two-tailed *t*-test for statistical testing was used to test for statistical significance. The project lead evaluated the BRAT completion rate after nurse education, as well as measured the training effectiveness in improving the participants' knowledge, skills, and attitudes. Collected data came from the pre-questionnaire and post-knowledge training questionnaires results sheet as well as the pre-questionnaire and post-educational chart audit score sheets. To ensure the accuracy of data entries, the project lead and a statistician confirmed the information from both sources. Descriptive analysis of data from the pre- and post-knowledge questionnaires occurred with the use of a *t*-test, a type of inferential statistical analysis to determine whether two or more groups are related, and then test the level of significance for the findings (Wang & Liu, 2016). A *t*-test is best suited for assessing the means of two data sets of samples drawn from the same population (Wang & Liu, 2016). The baseline values of the pre-implementation questionnaire data underwent comparison against the post-implementation questionnaire data to determine if there was a significant difference in the mean values between the pre- and post-implementation questionnaires. A *t*-test is an appropriate distribution for determining significant statistical differences (Wang & Liu, 2016). By testing for statistical significance in the difference between the mean values, the *t*-test indicates whether there has been an improvement after the proposed intervention (Wang & Liu, 2016).

The second data source was the pre- and post-implementation chart audit score sheets. Data analysis for this source was by binomial test, measuring the rate of BRAT completion before and after the training. This statistical analysis showed whether there was a positive and statistically significant improvement in the BRAT completion rate and an increase in the quality of palliative care after the response. The results from this DNP project provide the basis for future recommendations on the applicability of the BRAT tool use at the practice site.

Significance/Implications for Nursing

The findings of this DNP project have significant implications for nursing practice in palliative and hospice care settings. The project lead sought to determine whether patients' family members or significant others are at a high risk of developing adverse health conditions because of a negative bereavement experience. Nurses at the practice site lacked a comprehensive strategy for bereavement risk assessment of the family members and significant others of patients. The project lead facilitated a knowledge assessment of the nursing staff through an effectiveness analysis of the BRAT tool in solving the problem of the lack of a comprehensive bereavement risk assessment strategy under palliative and hospice care nursing environments. BRAT is an evidence-based tool that is validated to identify at-risk individuals following bereavement. Caregivers continue to suffer adverse health conditions after bereavement; therefore, a standardized assessment protocol using evidence-based tools is necessary to identify individuals at high risk of adverse health outcomes. Project findings provide direction to nurses on the practices needed for an effective bereavement intervention strategy and the benefits inherent in such an intervention.

According to Parker (2018), training increases health care professionals' competence in identifying at-risk individuals, improves their knowledge of the protocols and tools to use, and imparts the skills needed to mitigate the outcomes of negative bereavement. The training methods used in this project equipped nurses with the knowledge they need to use the BRAT tool successfully.

Analysis of Results

This quality improvement project involved the implementation of a bereavement protocol at the practice site and determining if the protocol was used by providers by measuring the number of assessments completed and referrals. In addition, the project included an educational training session to providers and the effectiveness of training was measured by comparing pre- and post-test scores.

The hospice care providers fall into three categories: (a) primary care practitioners, which include physicians and nurse practitioners, (b) registered nurses, and (c) ancillary care providers, including medical social workers, physical and occupational therapists, and a chaplain. The analysis includes data which measures if the BRAT protocol was used by the providers before and after the training initiative. In addition, hospice caregivers' knowledge of bereavement was measured by the pre- and post-test scores. SPSS was used to perform the analysis of the information obtained before and after the training program. The statistical tests used were a parametric *t*-test and a nonparametric binomial test, with the significance of the changes from the training sessions being determined.

Training Session Pre-/Post-Test Knowledge Scores

Eleven providers ($N = 11$) attended the educational program on bereavement and completed the questionnaires before and after training (Table 2). The participants included three primary care practitioners, four registered nurses, and four ancillary care providers. All the participants completed the administered questionnaire before and after the training session. Statistical analysis of the scores of the participants from all training sessions occurred by using a *t*-test. The pre-test mean score for the 11 participants was 70.5%; after the educational training session, the mean score increased from 70.5% to 98.9% which is an increase of 28.4%.

Table 2

Pre- and Post-Bereavement Training Test

Test	*N*	Mean (*SD*)
Pre-	11	70.5
Post-	11	98.9

Chart Audit

A total of 71 patient charts were audited four weeks before and four weeks after the educational training session (Table 3). The charts included those of discharged patients older than 18 years (*N* = 71). The chart audit results included the demographic composition of the patients, male patients were 47.9% and 52.1% were female. All patients were above 50 years of age. Table 3 presents the specific demographic variables.

Table 3

Demographic Distribution of the Sample Patient Population

Demographic	*N*	Percentage (%)
Gender		
Male	34	47.9
Female	37	52.1
Age group		
Above 80 years	35	49.3
70–80 years	22	31.0
Below 70 years	14	19.7

Assessment Completion

Providers did not conduct any chart audits before the implementation of the BRAT protocol, representing a completion rate of 0%. Post-implementation audits of all 71 patient charts were at a 100% rate of completion. Binomial statistical tests indicated a *p* value of 0.00, representing a 100% increase in the rate of assessment completion. In addition, these results showed that providers used the bereavement assessment tool.

Referrals

In addition to determine if providers used the BRAT protocol, the number of referrals was measured (Tables 4 and 5). As shown in the 71 patient chart audits, 20 referrals occurred in the patients' charts audited before the implementation of the bereavement protocol (28.17%). Post-bereavement protocol implementation, the number of referrals increased to 41 (57.7%), representing a 100% growth. Subjecting the data to the binomial test showed that the change is statistically significant (*p* = 0.00). Thus, the providers used the protocol, which increased the number of completed assessments.

Table 4

Pre- and Post-BRAT Implementation Outcomes

Outcome	Pre-	Post-	*p* value
Assessment completed			0.00
Yes	0 (0%)	71 (100%)	
No	71 (100%)	0 (0%)	
Referrals			0.00
Yes	20 (28.17%)	41 (57.7%)	
No	51 (71.8%)	30 (42.3%)	
Intervention			0.00
Yes	12 (16.9%)	38 (53.5%)	
No	59 (83.1%)	33 (46.5%)	

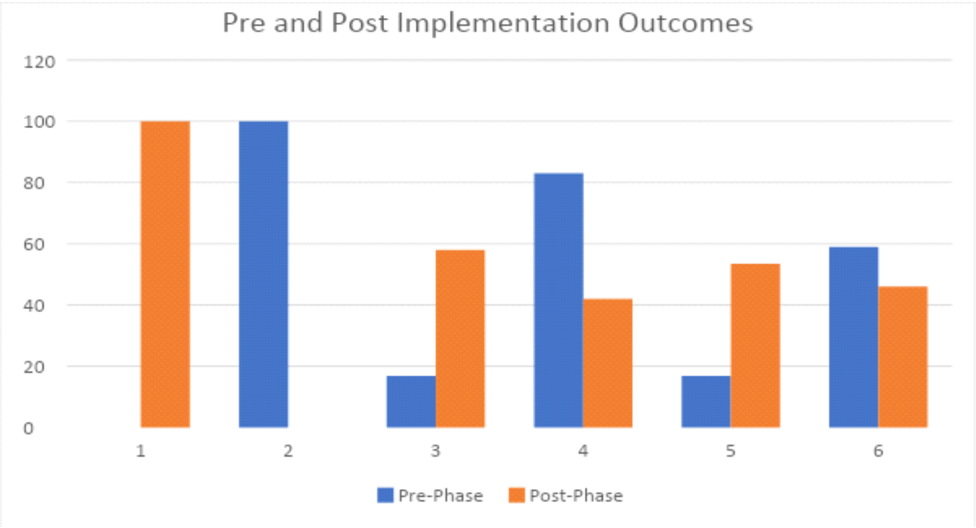

Figure 1. Pre- and post-BRAT implementation outcome.

Discussion of Findings

The implementation of the quality implementation project was successful in fulfilling its objectives. The purpose was to implement the use of a standardized bereavement assessment protocol to identify individuals at a high risk of developing adverse health conditions, to educate and provide awareness to hospice care providers on bereavement and its underlying risks. According to Parker (2018), training increases health care professionals' competence in determining at-risk individuals, improves their knowledge of the protocols and tools to use, and imparts the skills to handle the outcomes of negative bereavement. Thus, this quality improvement project set to answer the following question: Will training staff nurses on bereavement assessment risk protocol result in an increase in application of the tool and resultant increase in identification of level of risk of family members and significant others over a 4-week period? The results of the pre and post educational analysis indicated that the quality improvement project successfully improved the knowledge of the hospice care providers, as indicated by their difference in the test scores before the educational sessions and after the sessions. The scores increased significantly ($p < 0.01$) from 70.5% to 98.9%. Therefore, the project, under its education program, led to significant knowledge gains on the providers' ability to provide quality hospice care to patients.

Notably, the implementation of the BRAT helped raise the quality of hospice care, as indicated by the analysis of pre and post patient's chart audits. Developing a standardized protocol to assess bereavement risk and determining appropriate treatment is an important initiative in hospice setting (She & Prigerson, 2018). The increased assessment completion to 100% indicates the tool is useful in encouraging hospice care providers to perform risk assessments for all the 71 patients' charts audited. The outcome of the quality improvement project helped to facilitate completion of assessment of patients by hospice care providers and promote treatment measures to help the patients deal with challenges. The assessments completed were done without a standardized tool before the implementation of the BRAT protocol, the number of referrals made was small, and there were very few intervention measures to assist cases that had adverse risks and complications. Following the implementation of the assessment tool, the number of assessments completed significantly increased from 0% to 100%. The increase of assessments indicates the success of the project to ensure that hospice care providers carried risk assessments on patients to identify potential adverse effects bereavement may have on the patients and their loved ones. The number of referrals significantly increased from 28. 17% to 57.7%, which indicates the success of the project in implementing the assessment tool to improve the quality of hospice care. The interventions also increased from 16.9% to 53.5%, an indication of the success of the assessment tool implementation in ensuring those exposed to risks of bereavement are adequately treated to prevent complications such as mental health when the individuals find the bereavement impacts unbearable.

The increase in interventions shows the effectiveness of BRAT in helping the clinical staff identify bereavement risks that require primary care providers and other specialists to offer treatment. The cases are essential in reducing or eliminating the short term and long-term emotional effects and illness caused by bereavement. Therefore, the project helped in ensuring the staff are compliant in implementing the bereavement risk assessment tools in determining risks and providing treatment interventions for appropriate cases. It also helped to increase determination of underlying risks that would result in the short term or long-term illness if they were not attended to and corrected. Hence, the project findings justified the implementation of a bereavement protocol using BRAT at the project site.

Significance

The project aimed to educate and provide awareness to hospice care providers on bereavement and its underlying risks. Additionally, it was also meant to implement the BRAT to help determine the underlying risks and initiate intervention measures for the identified risks. Knowledge and awareness improved among the staff who participated in the quality improvement project training and in the implementation of BRAT protocol at the project site. According to Parker (2018), training increases health care professionals' competence in determining at-risk individuals, improves their knowledge of the protocols and tools to use, and imparts the skills to handle the outcomes of negative bereavement. The project thus reshaped the work environment around hospice care provision as indicated by the results of the overall analysis. The work output changed from low to increased assessment completions, referrals, and intervention measures. Overall, the project demonstrated that it is essential and necessary to implement standardized bereavement risk assessment tools in hospice care facilities and health centers to help the hospice caregivers in providing quality services towards helping patients and their loved ones cope up with the outcomes of the situations. The findings of the project help ensure support to families experiencing a bereavement situation and helping them win against the emotional downfalls of such conditions. Summarily, the education of hospice care providers and the implementation of BRAT helps in improving the quality of hospice care in health facilities. Using evidence-based practice in the healthcare setting is essential (Kashyap & Kruczynski, 2015); accordingly, this quality improvement project will improve and assist nursing staff in providing optimal care for bereaved families.

Limitations of the Project

There were a few limitations noted during the implementation process of the quality improvement project. The limitations of this project are: 1) sample size of participants; and 2) project time frame. First, the small sample size of hospice care providers is a limitation to consider. There were 11 participants in the pre and post educational training sections. A small sample size may lead to information bias, especially when the participants strongly relate to the topic and have perceived employment implications. Under Title 42, Part 418 of the U.S. Code of Federal Regulations, facilities must meet specific standards and conditions to receive agency certification by Medicare and Medicaid. (U.S. Department of Health and Human Services, 2011). The U.S. Department of Health and Human Services makes certification decisions based on the evaluation of clinical practice guidelines, performance measurements, and improvement activities for addressing a patient’s physical, emotional, social, and spiritual needs (Joint Commission, 2018). Since the participants are an integral part of the compliance team at the project site, maintaining sustainability and compliance is an ongoing concern for them. Failure to maintain compliance could impact the employment of staff at the practice site, hence their commitment to maintain sustainability and compliance.

Another limitation was the project time frame to complete the QI project. The time frame of this project was four weeks and hospice bereavement care support to caregivers generally lasts about 12 months. Therefore, a timeframe of 4 weeks is not sufficient to determine the impact of the intervention program on the improvement of the quality of hospice health care at the practice site. Medicare mandates hospices offer bereavement support to caregivers and families for a year following the patient's death (Ghesquiere, Bagaajav, Metzendorf, Bookbinder, & Gardner, 2019). To accurately assess the full effect of the intervention, the period for the project needs to be extended. An extended timeframe may result in findings that further support the use of the BRAT in hospice settings.

Judith Carrion 9/22/2020 1:27 PM
Comment [1]: Were the patients at your site inpatient or outpatient or a combination of both? If you are using just inpatient or just outpatient then this would be a limitation also. This comment is in reference to Dr. Tarrant's prior comments on prior attemtps.

Dissemination

The dissemination of the project will formally be delivered to Touro University Nevada Nursing school faculty, project leads and students in partial fulfillment of the requirements for the Doctor of Nursing Practice by a PowerPoint presentation via a teleconferencing platform. The content of the project will then be disseminated by the project lead to the practice site leadership, stakeholders, and the nursing supervisors during an interdisciplinary team meeting. The project will also be shared with other hospice facilities in the community. The abstract of the QI project in form of poster will also be submitted to the City of Hope for consideration and inclusion in their upcoming End of Life Symposium in December 2020. City of Hope is a designated comprehensive Cancer Center with research and treatment protocols to advance care throughout the nation. The upcoming End of Life Symposium will explore grief and

Judith Carrion 9/22/2020 1:30 PM
Comment [2]: good

bereavement at the end of life to help patients and caregivers better manage the situation. Finally, the project will be shared in the Doctoral Project Repository.

Sustainability of the Project

Bereavement Risk Assessment Tool (BRAT) is compelling for developing best practices, especially for identifying trauma risk among patients experiencing bereavement and rendering appropriate services (American Association of Colleges of Nursing, 2016; MacDonald, 2016). The implementation of the BRAT helped raise the quality of hospice care at the project site as indicated by the analysis of pre and post patient chart audits. The increased assessment completion to 100% demonstrated how the tool is useful in encouraging hospice care providers to perform risk assessments. The project results indicated a need for continued training and education of practicing care providers at the practice site. Project site leadership have indicated their interest in adapting the BRAT protocol as part of their new hire orientation requirement. New primary care providers, nurses and ancillary practitioners will be trained on the use of BRAT and its application before hire and while offering hospice care.

According to Kashyap and Kruczynski (2015), systems to aid in bereavement risk assessment would be vital in improving institutional capacity, as well as in increasing public and professional understanding of palliative care. This project could be easily replicated at other hospice settings. The use of the BRAT at the practice site as well as throughout the state and nation would be beneficial.

Conclusion

The project displays the importance of training hospice care providers on bereavement and providing them with knowledge on the risks involved in such cases. The project offered solutions to the application of bereavement risk assessment tools to help hospice caregivers to conduct a complete assessment of the underlying risks and help them make necessary interventions to patients experiencing challenges. The project findings demonstrated the benefits of providing knowledge to the caregivers based on the outcomes and the increased awareness and application of BRAT in risk assessment. The results also indicated that BRAT improves the quality of the hospice care delivery as evidenced by the finding of the assessments completed. The project, however, has limitations with the small sample of hospice care providers involved in the project, which may generalize the information, and the short time frame of the project period may not demonstrate findings which represent the best outcomes accurately. Further implementation of the project may support the use of the BRAT and indicate the use as a tool to improve the quality of hospice care in hospice facilities. In addition the dissemination of the project in publications, presentations, and educational platforms will also provide a basis for promoting the impact of the project on practicing healthcare providers and students.

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Appendix A: Peplau's Theory

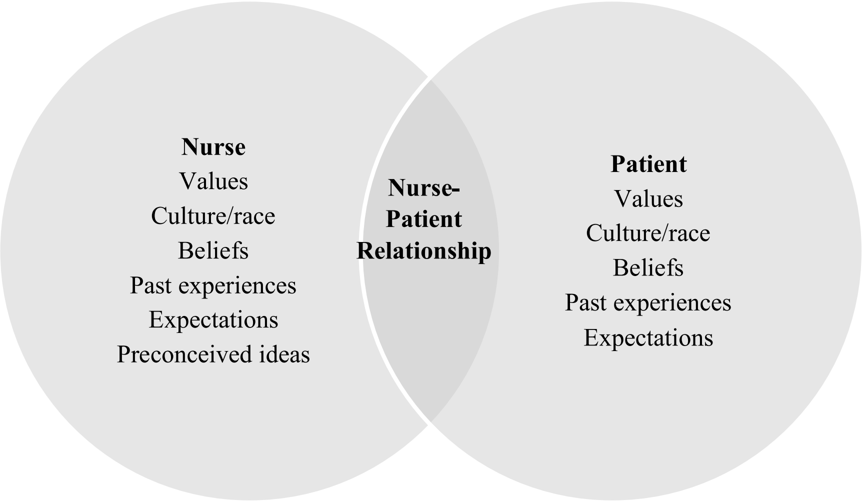
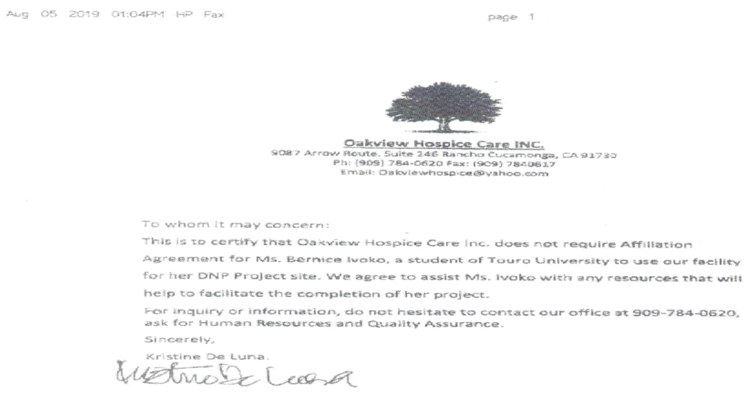


Figure 2. Peplau's theory of interpersonal relations. Adapted from "Peplau's Theory of Interpersonal Relations," by H. E. Peplau, 1997. *Nursing Science Quarterly, 10*(4), pp. 162-167. Copyright 1997 by Sage.

Appendix B: Permission to Use the Facility



Aug 05 2019 01:04PM HP Fax page 1

Oakview Hospice Care INC.
9087 Arrow Route. Suite 246 Rancho Cucamonga, CA 91730
Ph: (909) 784-0620 Fax: (909) 7840617
Email: Oakviewhospice@yahoo.com

To whom it may concern:

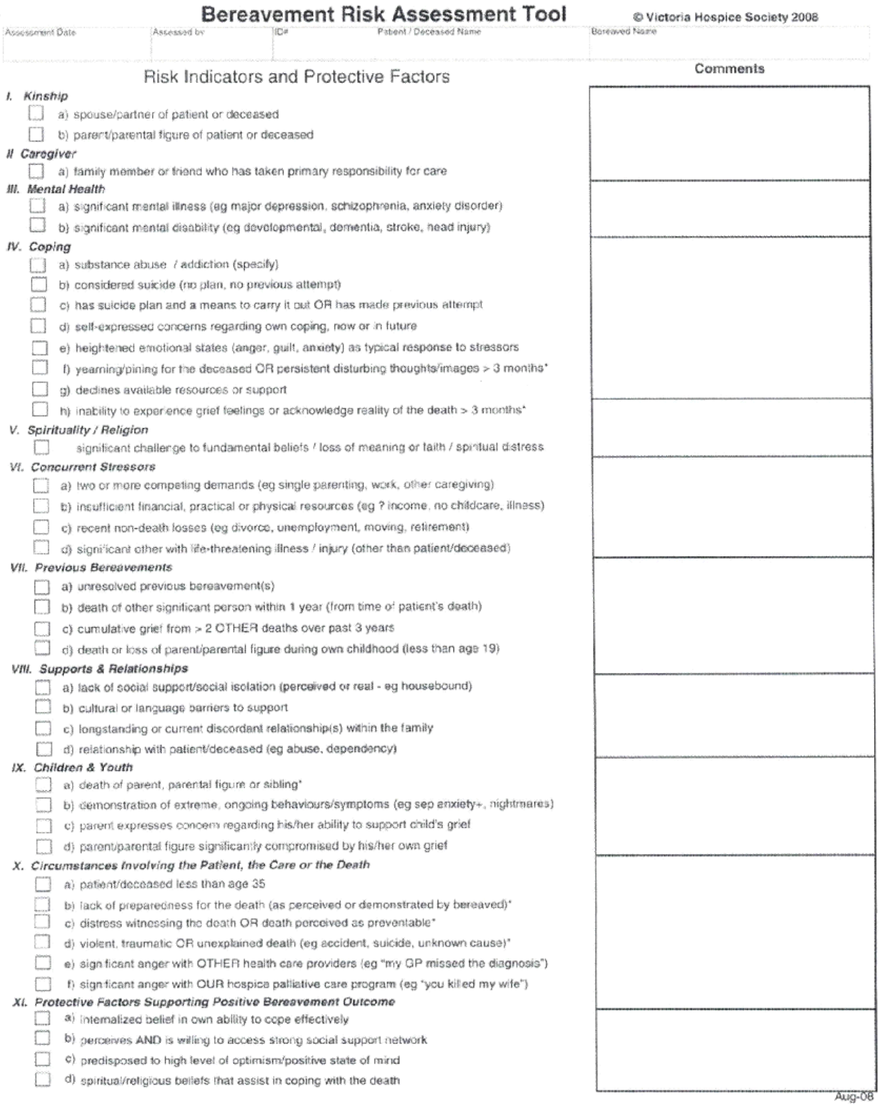
This is to certify that Oakview Hospice Care Inc. does not require Affiliation Agreement for Ms. Bernice Ivoko, a student of Touro University to use our facility for her DNP Project site. We agree to assist Ms. Ivoko with any resources that will help to facilitate the completion of her project.

For inquiry or information, do not hesitate to contact our office at 909-784-0620, ask for Human Resources and Quality Assurance.

Sincerely,

Kristine De Luna.

Appendix C: Bereavement Risk Assessment Tool



Bereavement Risk Assessment Tool

© Victoria Hospice Society 2008

Assessment Date	Assessed by	ID#	Patient / Deceased Name	Bereaved Name

Risk Indicators and Protective Factors

Comments

I. Kinship
- ☐ a) spouse/partner of patient or deceased
- ☐ b) parent/parental figure of patient or deceased

II Caregiver
- ☐ a) family member or friend who has taken primary responsibility for care

III. Mental Health
- ☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder)
- ☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)

IV. Coping
- ☐ a) substance abuse / addiction (specify)
- ☐ b) considered suicide (no plan, no previous attempt)
- ☐ c) has suicide plan and a means to carry it out OR has made previous attempt
- ☐ d) self-expressed concerns regarding own coping, now or in future
- ☐ e) heightened emotional states (anger, guilt, anxiety) as typical response to stressors
- ☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months*
- ☐ g) declines available resources or support
- ☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*

V. Spirituality / Religion
- ☐ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress

VI. Concurrent Stressors
- ☐ a) two or more competing demands (eg single parenting, work, other caregiving)
- ☐ b) insufficient financial, practical or physical resources (eg ? income, no childcare, illness)
- ☐ c) recent non-death losses (eg divorce, unemployment, moving, retirement)
- ☐ d) significant other with life-threatening illness / injury (other than patient/deceased)

VII. Previous Bereavements
- ☐ a) unresolved previous bereavement(s)
- ☐ b) death of other significant person within 1 year (from time of patient's death)
- ☐ c) cumulative grief from > 2 OTHER deaths over past 3 years
- ☐ d) death or loss of parent/parental figure during own childhood (less than age 19)

VIII. Supports & Relationships
- ☐ a) lack of social support/social isolation (perceived or real - eg housebound)
- ☐ b) cultural or language barriers to support
- ☐ c) longstanding or current discordant relationship(s) within the family
- ☐ d) relationship with patient/deceased (eg abuse, dependency)

IX. Children & Youth
- ☐ a) death of parent, parental figure or sibling*
- ☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares)
- ☐ c) parent expresses concern regarding his/her ability to support child's grief
- ☐ d) parent/parental figure significantly compromised by his/her own grief

X. Circumstances Involving the Patient, the Care or the Death
- ☐ a) patient/deceased less than age 35
- ☐ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)*
- ☐ c) distress witnessing the death OR death perceived as preventable*
- ☐ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)*
- ☐ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis")
- ☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")

XI. Protective Factors Supporting Positive Bereavement Outcome
- ☐ a) internalized belief in own ability to cope effectively
- ☐ b) perceives AND is willing to access strong social support network
- ☐ c) predisposed to high level of optimism/positive state of mind
- ☐ d) spiritual/religious beliefs that assist in coping with the death

Aug-08

Appendix D: Permission to Use the Bereavement Risk Assessment Tool

VICTORIA HOSPICE

EDUCATION & RESEARCH
T: 250-370-8283
F: 250-370-8172

April 14, 2020

Bernice Ivoko
Touro University Nevada
562-824-5099
bivoko@hotmail.com

Dear Bernice,

Thank you for your interest in the Bereavement Risk Assessment Tool (BRAT). Please be advised that the BRAT is currently under review and therefore not being sold or supported by our team. Please know that we are not recommending or promoting its use at this time due to the "under review" status.

If you wish to use the BRAT as is, you have Victoria Hospice's permission to do so.

This permission is subject to the following conditions:

- A credit line will appear in the immediate area of the tool and will include: © *Victoria Hospice Society, BRAT Manual (2008), Victoria, BC, Canada. Tool currently under review.*
- It cannot be altered or used in any way other than as intended and described in the BRAT manual.
- Permission granted is for non-exclusive English rights only.

Please do not hesitate to contact me if you have any further questions: **250-370-8719** or **Helena.Daudt@viha.ca**

All best regards,

Helena Daudt, PhD
Director, Education and Research
Victoria Hospice

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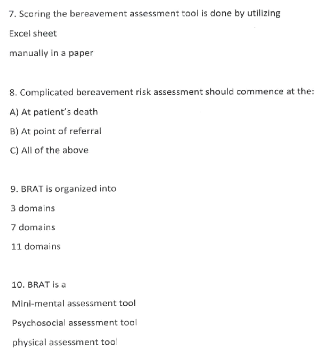
WWW.VICTORIAHOSPICE.ORG | Charitable Registration Number 87440 9964 RR0001

Appendix E: Pre-Questionnaire and Post-Educational Session Questionnaire



7. Scoring the bereavement assessment tool is done by utilizing

Excel sheet

manually in a paper

8. Complicated bereavement risk assessment should commence at the:

A) At patient's death

B) At point of referral

C) All of the above

9. BRAT is organized into

3 domains

7 domains

11 domains

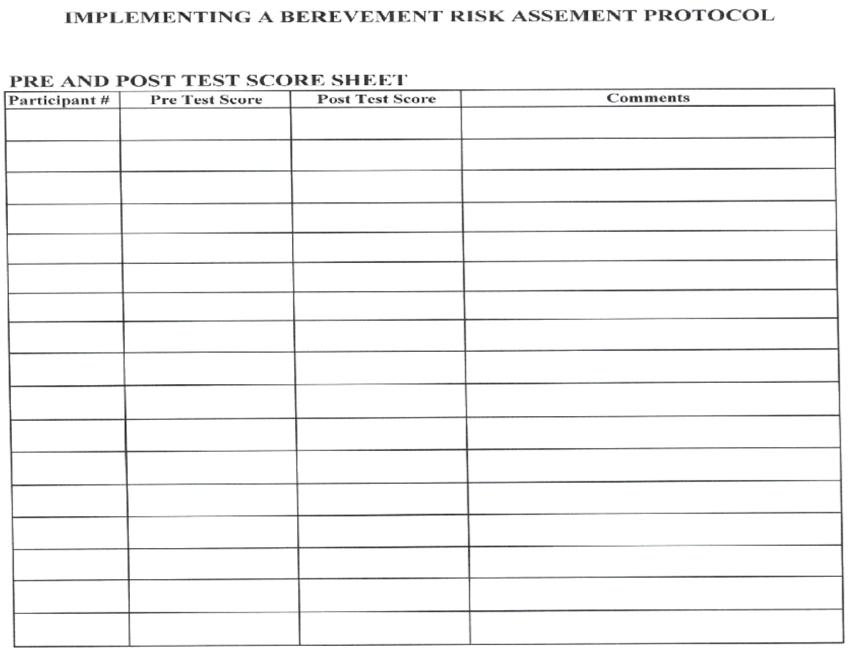
10. BRAT is a

Mini-mental assessment tool

Psychosocial assessment tool

physical assessment tool

Appendix F: Exam Results Sheet



IMPLEMENTING A BEREVEMENT RISK ASSEMENT PROTOCOL

PRE AND POST TEST SCORE SHEET

Participant #	Pre Test Score	Post Test Score	Comments

Appendix G: PowerPoint Educational Presentation

IMPLEMENTING BEREAVEMENT RISK ASSESSMENT PROTOCOL

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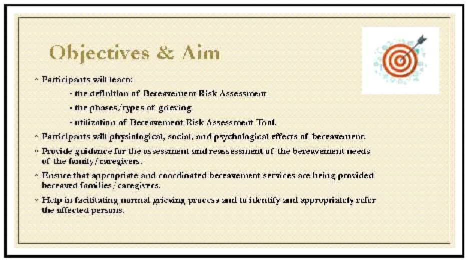
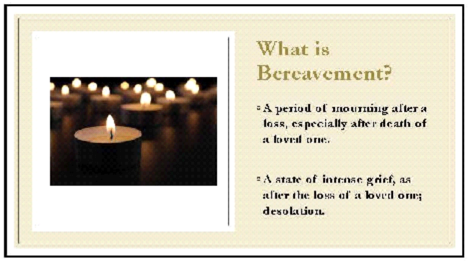


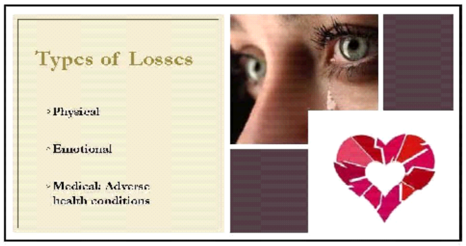
Objectives & Aim

- Participants will learn:
  - the definition of Bereavement Risk Assessment
  - the phases/types of grieving
  - utilization of Bereavement Risk Assessment Tool.
- Participants will physiological, social, and psychological effects of bereavement.
- Provide guidance for the assessment and reassessment of the bereavement needs of the family/caregivers.
- Ensure that appropriate and coordinated bereavement services are being provided bereaved families/caregivers.
- Help in facilitating normal grieving process and to identify and appropriately refer the affected persons.



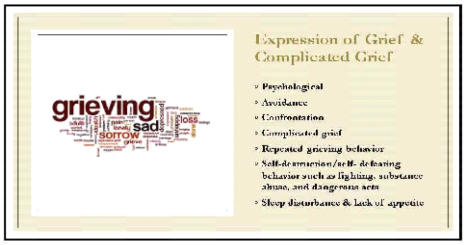
What is Bereavement?

- A period of mourning after a loss, especially after death of a loved one.
- A state of intense grief, as after the loss of a loved one; desolation.



Types of Losses

- Physical
- Emotional
- Medical: Adverse health conditions



Expression of Grief & Complicated Grief

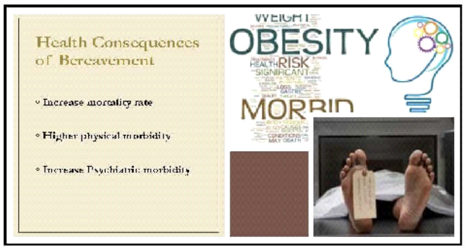
- Psychological
- Avoidance
- Confrontation
- Complicated grief
- Repeated grieving behavior
- Self-destruction/self- defeating behavior such as fighting, substance abuse, and dangerous acts
- Sleep disturbance & lack of appetite

Bereavement Risk Assessment

- What is bereavement risk assessment?
- Why perform bereavement risk assessment?
- When to initiate bereavement assessment
- Assessment Tool
- Incident/Prevalence of bereavement/adverse health condition

Risk Factors & Types of Risk

- High Risk
- Medium risk
- Low risk

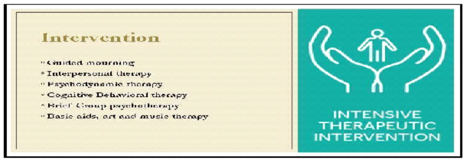


Health Consequences of Bereavement

- Increase mortality rate
- Higher physical morbidity
- Increase Psychiatric morbidity

What is your role?

- Witness
- Facilitator
- Collaborator



Intervention

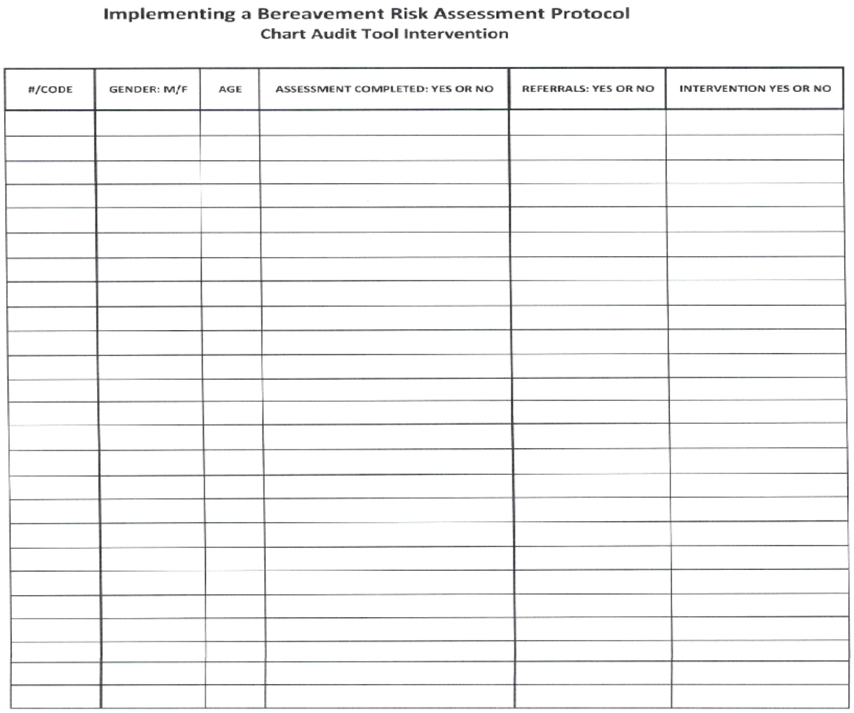
- Guided mourning
- Interpersonal therapy
- Psychodynamic therapy
- Cognitive Behavioral therapy
- Brief Group psychotherapy
- Basic aids, art and music therapy

INTENSIVE THERAPEUTIC INTERVENTION

Treatment

- Counseling
- Medication
- Support group
- Psychotherapy

Appendix H: Screening Chart Audit Tool



Implementing a Bereavement Risk Assessment Protocol
Chart Audit Tool Intervention

#/CODE	GENDER: M/F	AGE	ASSESSMENT COMPLETED: YES OR NO	REFERRALS: YES OR NO	INTERVENTION YES OR NO

Appendix I: Chart Audit Results Sheet

	Pre-Chart Audit Score	**Post-Chart Audit Score**
Total assessment completed		
Total referral completed		
Total intervention initiated		

Appendix J: Content Validity Index Table

Content Validity Index Table

Item	Expert 1	Expert 2	Expert 3	Mean I-CVI
1	3	3	3	1
2	4	4	4	1
3	3	4	4	1
4	4	4	4	1
5	4	4	4	1
6	3	3	3	1
7	4	3	4	1
8	4	4	4	1
9	3	4	4	1
10	4	4	4	Mean I-CVI = 1.0