Palliative Care: Improving Early Referral with a Protocol Approach

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01/27/2021

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Palliative Care: Improving Early Referral with a Protocol Approach

Palliative care is an interdisciplinary medical specialty that focuses on preventing and relieving unnecessary suffering by supporting the best possible quality of life for patients and their families facing serious and/or life-threatening illness. (Bruena & Dev,2020). The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families, performs early identification, assessment and treatment of pain and other physical, psychosocial and spiritual complications (Brinkman-Stoppelenburg, Witkamp, Zuylen, Rijt, & Heide, 2018). Palliative care teams can collaborate with specialists to optimize patient care while respecting patient and family wishes. This approach may help reduce physical and psychological strain for the patient, family, and caregivers (Payne, Hughes, Wilkinson, Hasselaar, & Preston, 2019).

Various diseases qualify for palliative care when they reach advanced stages. Healthcare providers should advise patients to accept palliative care referrals as soon as possible to promote improved quality of life (Brinkman-Stoppelenburg, Witkamp, Zuylen, Rijt, & Heide, 2018). Early referrals are important because they can reduce the amount of time the patient spends in hospitals. It’s equally important to suggest palliative care to the patient as soon as possible before they are too ill to benefit from such care (Brinkman-Stoppelenburg, Witkamp, Zuylen, Rijt, & Heide, 2018). Medical providers should, therefore, make timely and sound communications to respective patients. Palliative care protocols may serve as a standardized approach to promoting timely referrals in the long-term care setting (Payne, Hughes, Wilkinson, Hasselaar, & Preston, 2019).

Background

Dame Cicely Saunders, a British doctor, initiated the first formal hospice in 1948 to explicitly care for patients with terminal illnesses ((Brinkman-Stoppelenburg, Witkamp, Zuylen, Rijt, & Heide, 2018). The nature of palliative care was designed to care for dying patients and those in the advance stages of an illness. Professionals in the field have a significant responsibility to provide excellent medical care to their patients (Shalev, Phongtankuel, Kozlov, Shen, Adelman, & Reid, 2019). Aside from caring for patients in such a situation, professionals have a duty to educate colleagues to ensure high standards of care for respective patients (University of Texas Arlington, 2016).

Nonetheless, the subject of palliative care is not common to everyone (Alvariza, Häger-Tibell, Holm, Steineck, & Kreicbergs, 2020). Essentially, palliative care strives to achieve the best quality of life for the patient for as long as possible. It involves managing and anticipating pain and any other symptoms that the patient experiences, such as fatigue, shortness of breath, constipation or dysphagia.

One of the main reasons why patients do not get palliative care referrals is because the references take a long time to be implemented (Hawley, 2017). Another reason is because of administrative technicalities such as waiting for the approval of insurance, check if the company that provided palliative care are within the network or determine possible co-payments, that cause a delay in the referral process and conspires against the possibility of providing better care. Additionally, many health facilities lack the resources necessary for palliative care (Alvariza, Häger-Tibell, Holm, Steineck, & Kreicbergs, 2020).

In addition to the previously mentioned issues, there is limited information accessible on how the timing and setting of palliative care referral can affect end-of-life care (Brinkman-

Stoppelenburg, Witkamp, Zuylen, Rijt, & Heide, 2018). With limited information related to palliative care services and benefits to rely on, it is hard for medical providers to convince patients to accept palliative care referrals (Brinkman-Stoppelenburg, Witkamp, Zuylen, Rijt, & Heide, 2018).

The issues with palliative care referrals are wide ranging and can ultimately affect the patient's quality of life. Late or absent referrals not only cause greater suffering for patients and families but also cause unnecessary hospital admissions to utilize their health services (Schroeder & Lorenz, 2018).

Problem Statement

The clinical site for this quality improvement (QI) project is a long-term care facility in an urban South Florida city that has reported multiple issues relating to palliative care referrals including a lack of education, training, and guidance around palliative care referral and palliative care practices. There is no formalized palliative care protocol. In general, this issue is not uncommon in healthcare. In the United States, for example, there are a handful of states had fewer than 40% of their hospitals indicated that they had palliative care teams (Shalev, Phongtankuel, Kozlov, Shen, Adelman, & Reid, 2019).

Misconceptions about palliative care have slowed down the integration of palliative care in the state of Florida. These include the notion that palliative care is only applicable during the end of life and that such care only offers comfort measures and that such consideration is only beneficial to the patient (Alvariza, Häger-Tibell, Holm, Steineck, & Kreicbergs, 2020). Because of these misconceptions, physicians wait too long to suggest palliative care to a patient, leading to a situation where the patient may be too ill to benefit from palliative care. At times, physicians falter in the communication process with the patient (Brinkman-Stoppelenburg, Witkamp, Zuylen, Rijt, & Heide, 2018)

Purpose Statement

The purpose of this QI project is to improve provider knowledge, skills, and attitudes (KSA) towards palliative care referrals by implementing a Palliative Care Referral Protocol (PCRP) in a long-term care setting. To acquire the necessary skills for palliative care, it's important to initiate a training program for physicians of different focus groups (Payne, Hughes, Wilkinson, Hasselaar, & Preston, 2019). The nature of the programs shall involve classroom lectures, case examples, and active demonstrations. Sensitization of the health care personnel will touch on the principles and models of assessment and care of patients under palliative care, among others (Senthil P Kumar & Sisodia, 2011). Implementation of a Palliative Care Referral Protocol (PCRP) in a long-term care setting is cost-effective since will allow physicians to issue referrals within the facility as opposed to sending the patient to another facility. Retaining the patient reduces costs both for the patient and the long-term care facility.

Project Question

PICOT Question: "(P) Long-term care providers caring for adult and geriatric patients (I) will be beneficiary from PCRP (C) Compare to other cases with delayed referrals with the use of the standardized protocol (O) will increase early referrals for palliative care in long term care facility (LTC) (T) over a 5 week period?"

Objectives

In the timeframe of the DNP Project, the following objectives will be achieved:

1. Design and implement an evidence based PCRP in the project site long term care facility.
2. Develop and implement a multi-disciplinary team education regarding the PCRP.

3. Evaluate healthcare providers KSA before and after delivering education on palliative care.
4. Increase referrals for palliative care.

Search Terms

The search for literature on the topic of early referral protocols for palliative care followed the requirements set by the PICOT question and the objectives. The question guided the formulation of keywords that were used to optimize the search. These included “palliative care referrals,” “training on palliative care,” “quality indicators using of palliative care using AHRQ,” “protocols for palliative care,” “perceptions of palliative care,” and “barriers to access to palliative care.” The search engines used were Up-to-date, Cumulative Index of Nursing and Allied Health Library (CINAHL), Cochrane Library, PubMed, Agency for Healthcare Research and Quality (AHRQ), Google Scholar and National Hospice and Palliative Care Organization (NHPCO), with filters on the years and keyword optimization. The search focused on recent journal articles published within the last five years (2015-2020) to effectively determine the current modes of practice. The articles initially numbered 20 forms the search engines, but these were cut down to 10. The defining factor was human data incorporation and how well they answered the PICOT question.

Despite the benefits of palliative care, there is still little integration processes in hospitals and other medical sectors for various factors. Among these are sparse perspectives of palliative care as an ‘end-of-life’ care management strategy and not as a treatment protocol to be used along with regular medical treatment. Another barrier includes the lack of resources that necessitate strict procedures to accept referrals in palliative care centers. The need for integration of palliative care has brought on the creation of NCCN guidelines that are focused on providing palliative care to cancer patients despite their stage in treatment.

Review Coverage and Justification

Patients often need care for their medical and psychological needs in the face of slow dilapidation of health brought on by advanced chronic illnesses and old age. The patients, as well as their family's close friends, often face physical, mental, emotional, and spiritual issues during the progression of the illness. These are mainly caused by the uncertainty and anxiety brought by the disease and the eventual demise. The quality of life for the aged and advanced illness patient often declines drastically in the period preceding death, which could affect the people around them (Gillick, 2017)., Therefore, a need for palliative care to improve the quality of life throughout the stages of the disease or old age. Specialized palliative care is reserved for patients with progressively advanced ailments that cannot be subjected to curative care. However, despite the development in healthcare systems, the universal provision of palliative care is not yet implemented due to the scarcity of resources. This necessitates the selection of patients who can receive palliative care depending on their needs and the treatment requirements at a specific point of their illness trajectory (DuBenske, Mayer, & Gustafson, 2016). The determination of eligibility for palliative care is crucial to improve the patients' quality of life. There is a need to create a criterion for referrals of patients to palliative care based on various factors affecting the patient's care management. While most health organizations, such as the American Society of Clinical Oncology, recommend the early referral to palliative care for advanced cancer patients, the same is not applied to non-cancer patients (Dunn, Pruskowski, & Simonian, 2018). This disparity is due to various factors relating to medical providers such as; a lack of resources for referral; lack of knowledge regarding available resources; lack of understanding regarding what palliative care is; a reluctance to refer; and the reluctance to complete a referral because of refusal from patients and or families to be referred (Hawley,2017). As such, there is a need to create a criterion for referrals of patients to palliative care based on various factors affecting the patient’s care management.

Review Synthesis

Despite the consensus that patients with advanced chronic ailments and old persons require palliative care, there are inconsistencies regarding access to palliative care. Various studies show inconsistencies when the patient receives palliative care and variation in the quality of health care and resources available based on the country that the patient resides in. Research shows that in South Korea, the United States, and the United Kingdom, patients receive about 12–21 days of palliative care before their death, while this value is at 60–70 days in Canada (Hui et al., 2016). These discrepancies may be due to the level of the healthcare system in each region. The rural regions, for example, are observed to have a poor quality of and access to palliative care. Age and gender also factor into access to palliative care; men above 65 years of age receive considerably lower access to palliative care (Parajuli, Tark, Jao, & Hupcey, 2020). These trends have a significant effect on the individual’s quality of ‘end-of-life’ stage, especially since they might not receive proper care management (Gaertner et al., 2017). Access to palliative care is indicative of the effective implementation of early referral protocols (Aldridge et al., 2016). This is because early palliative care referral determines how long the patient benefits from the health care service and may even affect disease trajectory.

Early Referral to Palliative Care Improves Patient Outcomes

There are various factors to consider when creating referral protocols that would increase the number of patients receiving early palliative care. One of the factors is the criteria used in the early referral of palliative care patients (Caraceni et al., 2020). In a review paper on the referral of outpatient palliative care for cancer patients, there were twenty unique criteria for this, six of which were most common (Hui et al., 2016). Two of the six were time-based criteria that considered cancer diagnosis, trajectory, and prognosis. The other four criteria were based on: physical symptoms, performance status, end-of-life care planning, and psychosocial distress. The review observed that various research proposals have different definitions of advanced cancer, and only a few recommend early referral immediately after diagnosis (Hui et al., 2016). One paper reviewed recommended referral within eight weeks after the diagnosis of metastatic non-small cell lung cancer (Duggan et al., 2019). Another study used the National Comprehensive Cancer Network (NCCN) to identify the ideal screening criteria for palliative care patients in this study; eight healthcare professionals were required to identify five screening criteria for referring patients to palliative care. Among the 37 patients included in the study, four out of the eight criteria were common (Phua, Peh, Ho, & Yang, 2016). Limited anti-cancer treatment options accounted for 75.6% of referrals, while the rapid decline in functionality accounted for 64% (Phua et al., 2016). Additionally, symptoms not controlled by treatment accounted for 62.1%, while moderate to severe distress on both the patient and their family was at 62.1 % (Phua et al., 2016). When creating the PCRP, there is a need to consider the variation in referral criteria for different people based on cancer diagnosis, non-cancer conditions, and age to determine the number of patients receiving early palliative care referrals.

National Comprehensive Cancer Network Palliative Care Guidelines

The NCCN guidelines are a statement of evidence and agreement of the authors regarding their views of currently accepted lines to treatment. In the new NCCN guidelines, the main goal is to increase the patient's quality of life at all stages.

The use of NCCN guidelines in palliative care is crucial since this important tool offers specifics points to follow as standards steps in order to provide an improvement in quality and honoring individual preferences near the end of life (IOM.Institute of Medicine.2014).

Those steps included palliative care indications such as uncontrolled symptoms, comorbid severe physical and psychosocial conditions, complex psychosocial needs, poor prognosis awareness ; but also provide palliative care interventions like assessment (financial toxicity, coping strategies, personal goal-values-expectations, cultural factors affecting care, symptoms psychosocial and spiritual distress); reassessment (including acceptable outcomes like adequate symptom management, reduction of patient-families-caregiver distress, optimized quality of life); and after death intervention for families and caregivers, this included: immediate after-death care, bereavement support, and cancer risk assessment and modifications (Ferris. FD, Bruera E, Cherny. N et al., 2009).

Also, The NCCN guidelines entail the improvement of pain management systems, especially for chronic conditions management like advanced cancer (Nedjat-Haiem et al., 2020). This policy follows the opioid crisis in the United States, which at times leads to overdose cases. There is, therefore, a need to manage the opioid intake at all disease stages to prevent addiction or dependence. Palliative care is also incorporated into the care management systems as it provides patient education, psychosocial support, and optimizes intervention therapies. The NCCN understands the confusion surrounding opioid management issues; this is the main reason the organization has provided the guidelines to clarify the matter that was previously under the CDC.

Using an Integrated Approach in Palliative Care Referral

Various theories exist on the benefits of early integration of palliative care. The study on patients in Ontario showed that patients who received community specialist palliative care felt better than those who did not (Kain & Eisenhauer., 2016). The results of the analysis showed that palliative care patients had less hospitalization, emergency room visits, and hospital deaths as compared to those who did not receive the care. Palliative care integration into oncology is also encouraged in the early stages after diagnosis to enable the provision of integrated care management (Zimmermann et al., 2016). Additionally, palliative care integration positively impacts the care goal management by providing an environment where the patient can enquire about their condition and discuss the personalized care goals with the physician and caregiver (Zimmermann et al., 2016). This is especially crucial for advanced cancer patients who must cope with the mortality crisis and the oncology treatment therapies that are involved.

The Impact of Palliative Care

Palliative care is often shed in negative light both by healthcare professionals and the patients. The association with the end-of-life perspective makes it less an option in care management despite the benefits it provides to the patients. In their paper, Kain and Eisenhauer investigate the cost-saving benefits of early integration of palliative care into the oncology treatment for cancer patients (2016). According to the study, there is less likelihood for patients to end up in emergency rooms and treatment facilities, which drastically decreases the cost of care. Additionally, the patients can leave the hospital earlier, reducing the hospitalization times and the accruing medical bills. Another impact of palliative care is better pain management, which helps to curb the opioid crisis (Paice, 2018). The psychosocial support and consistent care management allow for better drug administration protocols, which reduce the cases of addiction and overdoses. Psychosocial support also reduces the stress faced by the patients and thus provides an optimal environment for care. Palliative care has also allowed better psychological, physical, and emotional health of caregivers to patients with chronic conditions (Götze et al., 2018). Moreover, apart from care management, palliative care, mainly specialist community care, allows for open forums to share ideas between caregivers and patients. It also allows palliative care specialist to provide guidelines to caregivers who not only improve the quality of their care but allows better coping mechanisms for the stress.

Controversies and Barriers around Palliative Care

The barrier of perception is observed in both care professionals and the general population. In a randomized control trial involving 48 patients and 23 caregivers, the results of the study showed that palliative care was synonymous with 'end-of-life' (Zimmermann et al., 2016). One of the participants even iterates that 'palliative care means death' while others associated it with symptom management and control. This perception has hindered the early referral to palliative care since it is viewed as a last and often merciful reprieve in unrecoverable cases. Other barriers to palliative care are the costs owed by the patients to hospitals and community care centers providing the care; this often necessitates a stringent protocol for referral for patients eligible to receive the care (Kain and Eisenhauer,2016). The financial and human resources should hence be increased if the integration of palliative care is going to happen. The barriers to effective implementation of early referral protocols to palliative care emanate from the perception of both healthcare professionals and patients' families (Kain and Eisenhauer,2016). As such, when creating the PCRP, consideration should be given to these barriers and the effective ways of mitigation, which would determine its rate of success. Another factor to consider when creating the early referral protocol is the patients' needs, which should supersede treatment needs for cancer, non-cancer, and advanced age patients (Götze et al., 2018). By putting the patients' needs first, it is possible to improve the quality of life through palliative care.

In another paper review (Lindvall, Ch., Hultman, T., Jackson, V. 2015), found that patient with heart failure was not receiving palliative care as much as a cancer patient. When this kind of patient reached the end-stage of the disease, they required more hospitalizations, creating anxiety and distress to patients, families, and caregivers. At that time is when palliative care become more useful since it can work with the patient's overall goals. In the same study was observed that all medicals providers participating adopted palliative care philosophy in the care of patients with heart failure. Nevertheless, it was evident that the medicals providers had not a clear idea of what is precisely palliative care and the difference with hospice care; they even recognized one of the most critical aspects, palliative care is not related to diseases' prognosis and can be offered alongside life-prolonging therapy.

Review of Study Methods

The journal articles reviewed employed different methodologies in their research on palliative care, both in barriers and determinants of early referrals. In a UK-focused retrospective cohort study, they sought to identify the organizational factors influencing the hospice palliative care durations (Allsop et al., 2018). Among the factors identifies were age, geographical, gender, and condition-based disparities for patients receiving palliative care. The patients in rural areas, for example, received worse care than those in urban areas while males above the age of 65 years received less care than their female counterparts (Allsop et al., 2018).

A research paper used randomized clinical trials to identify the impact of early referral compared to 'normal' referral to palliative care for cancer patients (Kuusisto, Santavirta, Saranto, Korhonen, & Haavisto, 2020). Impacts like better quality of health care, reduced in-hospital deaths, and better care management were some of the impacts observed. The incorporation of patient's needs into care management was a primary factor observed for identifying care goals (Kuusisto et al., 2020). As such, the needs of the patient must be prioritized before commencing any treatment and care.

A literature review of research journals from Ovid MEDLINE and Embase identifies the importance of early integration of palliative care into standard oncology care (Kain & Eisenhauer, 2016). Factors like cost saving for the patients and the provision of care with consideration for patients' needs come up in the study. The paper also addresses the measures to mitigate barriers to the provision of early palliative care and proposes adequate resource provision and normalization of palliative care to prevent negative perceptions (Kain & Eisenhauer, 2016). A research journal review used 21 articles to identify criteria used for outpatient referrals of cancer patients (Hui et al., 2016). The new NCCN guidelines provide an amalgamation of CDC guidelines and other health organizations like the American Society of Clinical Oncologists (ASCO) to provide a common standard of palliative care referral (Haider et al., 2017). The paper identifies standard criteria like psychological stress to caregivers. Pain management and disease stage requirements for the patients as standard criteria used to determine referrals to palliative care (Haider et al., 2017).Although varied research and reviews have been undertaken regarding the palliative end of life care, the creation of a universal protocol like the new NCCN guidelines would allow for the success of early integration of palliative care into healthcare practices.

Significance of Evidence to Profession

While there are well-documented benefits from early palliative care referrals, the number of patients who receive it is still below the recommended levels. In oncology, for example, there is a need to have clear goals for care, which poses a challenge in the implementation of early palliative care (Kain & Eisenhauer, 2016). In a Queen’s University study, out of 222 patients used in the sample, only 4% had discussions with their oncologist on the goal-of-care with documentation, and only 41% received palliative care (Kain & Eisenhauer, 2016). Studies show a contrasting view where the concurrent provision of palliative care and cancer therapy could change the symptoms throughout the various phases of cancer, improve the quality of life, and increase the success of the treatment (Duggan et al., 2019). There is also a need for more randomized clinical trials to compare the long and short outcomes for patients who receive a universal referral to palliative care after diagnosis of advanced cancer, and the ‘normal’ referral that is based on patient’s needs.

Theoretical Framework

Wagner and his colleagues at MacColl Institute developed the Chronic Care Model (CCM) to redesign ambulatory care for primary care providers to meet national health care quality improvement initiatives. The CCM framework can be applied in all healthcare settings to improve palliative care outcomes, lower healthcare costs, and enhance provider satisfaction. Consequently, the model does not define processes; therefore, the project will use CCM to define parts of the health care system in palliative care. The elements of the CCM framework include community resources, policies, and health systems [see Appendix A] (Gammon et al., 2015). The CCM framework will be applied in the DNP project to improve the early referrals for palliative care by creating a protocol approach.

Historical Development of the Theory

Wagner and his colleagues at MacColl Institute developed the CCM framework in the mid-1990s to improve the quality of health care. Dunn and Conard (2018) argue that Wagner's team developed the CCM to enhance the quality of care for chronic illnesses, such as diabetes, cancer, heart disease, pulmonary disease, and hypertension. CCM considers the basic interlinked system components to improve the quality of care for chronic diseases (Silva et al. 2016). Wagner's team developed the CCM framework at the time when the United States health system was shifting to managed care in a bid to lower the cost of health care. Davy et al. (2015) posit that Wagner's team focused on improving the quality of care in different settings. In 1997, the panel of experts refined the model to improve the quality of care across various settings. According to Boehmer et al. (2018), the CCM model involves the integration of various elements or components that support patient-centered care. Likewise, the team of experts updated the model in 2003 to include the six elements. Thus, "CCM is based on six key elements, which include decision support, community resources, delivery system design, clinical information system, health care organization, and self-management support" (Davy et al., 2015, p. 2). The framework is characterized by interactions between activated patients and a highly effective team. CCM guides improvements in health care by reconfiguring clinical systems to address the needs and interests of chronically ill individuals (Grover & Joshi ,2015).

Applications to Current Practice

CCM is relevant in today's healthcare society. The CCM has been applied in improving the quality of life of patients with chronic and life-threatening illness both at the individual and population levels. It is highly relevant to palliative care (Sendall et al.,2016). The model assumes that improvement in care is a multidimensional approach that incorporates providers, patients, and interventions (Boehmer et al., 2018).

For instance, providers apply the CCM in disease management for patients with diabetes. Also, the model is applied to patients with tuberculosis to enhance the quality of life (Boehmer et al., 2018).

The CCM is a useful model for creating an implementation program with an advanced care plan since one of the crucial components of the CCM is the concept of driving care for patients with chronic diseases and life-threatening illnesses from an acute and reactive state to be a proactive one. A second essential component is to provide adequate information to patients and families to get involved in their care. Performing these two components into patient-centered care ensured the proper end of life care is delivered.

Major Tenets

The major tenets of the CCM framework are the six elements that will be consider in the DNP Project, as discussed below.

Decision Support

The decision support element focuses on changing the health care provider’s behavior to enhance care. Decision support interventions involve the distribution of educational materials, case discussions, clinical guidelines, and the integration of evidence-based guidelines in patient care (Yeoh, E. et al., 2018). Thus, the model integrates primary care and specialist expertise in the treatment and management of chronic and life-threatening illnesses (Boehmer et al., 2018).

Community Resources

The CCM framework mobilizes community resources and encourages patients and health care providers to participate in disease treatment and management programs. Grover and Joshi

(2015) posit that a community participation approach improves the treatment and management of chronic and life-threatening illnesses.

Delivery System Design

The delivery system design in the CCM refers to the movement from reactive care to proactive care. The model provides efficient and effective clinical care, define roles and distribute responsibilities among individual members, support scientific approach, implement follow-up procedures, promotes cultural competence, and provide holistic care (Boehmer et al., 2018).

In general, the Healthcare system should advance to a proactive model in all aspects of patient care, including end of life care, to be active and sustainable in the future (Hickman, Rolley, & Davidson, 2010). When this happened, it is essential to place the patient at the center of decision-making, which is primarily related to end of life care to ensure that care given is adequate and fulfills the patient's/resident's desires (Lusk & Fater, 2013).

Clinical Information System

The model collects and uses patient and population information to provide individuals and providers with timely reminders and identify relevant subpopulations to improve palliative care services. This will contribute to, promoting early referral using a protocol approach. Gammon et al. (2015) hold that the clinical information system component of the CCM refers to disease registries, electronic medical records, or other information-based systems.

Health Care Organization

The model creates a culture that promotes safety and quality through leadership commitment to patient-centered care. Besides, the health care organization element encourages systemic handling of errors and facilitates care coordination across the organization (Boehmer et al., 2018). Moreover, senior leaders apply the model to identify critical processes and translate them into solutions (Dunn, P., & Conard, S. ,2018).

Self-Management Support

The model empowers critically ill patients to improve self-care by engaging them in setting goals and monitoring their conditions. The model applies a variety of resources and tools to enable patients with visual reminders to improve their knowledge related to palliative care (Gammon et al., 15). Also, the model supports self-management, including strategy, goal setting, problem-solving, action planning, and follow-up programs.

The major elements of the model to consider in the project include implementing clinical information systems and encouraging self-management support programs and the health system. Therefore, the project will focus on clinical information systems to enhance data management to support evidence-based care for critically ill patients and support self-management to empower individuals to manage health care (Sendall et al., 2016). Also, the health system component will enable leaders to create a culture that promotes safety and quality in the health care system. Yeoh et al. (2018) claim that CCM applies a multidimensional approach to restructuring health care systems to improve early referrals for palliative care.

Theory Application to the DNP Project

Improving the early referrals for palliative care with a protocol approach will provide coordinated care through the application of the six elements of the CCM framework

Decision Support

The decision support element will help distribute educational materials to patients and health care providers, which will support evidence-based practices in decision making. The use of healthcare professionals with previous background in Palliative Care will be very helpful.

Community Resources

The project will mobilize community resources to provide holistic care. These included: long-term care facility administrator, palliative care medical director, palliative care program director, nursing department, patient representative team and admission department. Thus, the proposed model will eliminate barriers to access healthcare resources and utilize advanced information systems to improve general knowledge about palliative care (Daaleman and Helton, 2018).

Delivery System Design

Likewise, the delivery system design will promote teamwork through the definition of roles and procedures, cultural competence, and a scientific approach to improve early referrals for palliative care.

Clinical Information System

The clinical information systems on the CCM refers to the availability of patient information longitudinally across disparate electronic health records (EHR). The DNP project will apply the clinical information system element to collect and analyze patient and population data to support evidence base practice. Also, we will use the patient’s charts and all documents related to patient’s care.

Health Care Organization

The health care organization element will promote a culture of safety, reduce errors in the initial assessment, and set up a scientific criterion to increase the process of early referrals for palliative care.

Self-Management Support

The application of the CCM on the DNP project will empower no only patients, families, and caregivers but also healthcare providers with evidence-based elements to involve all of them on the importance of providing holistic care for the patient with a chronic and life-threatening illness, especially at the end of life.

Plan for Implementation

Setting

The project will take place at a long-term care facility in South Florida. Currently, the center accommodates 311 patients; 149 of which are higher acuity beds. Services including physical therapy, private companions' services, multiples cultural activities (dance, music, movies), etcetera (etc.), are offered on site.

The facility EHR is Practice Fusion and the Kareo. EHR's are used to maintain the records of the facilities (Al-Mashari, Majed, 2002). Kareo and Practice Fusion are said to work together to give the user the best experience. This EHR is used for provider order entry and to keep patient's records digitalized. Furthermore, the platform has a very intricate design that is easy to use for data collection in this DNP Project (Ahmed, Fareeba & Candidate & Ramadhan, Sherzad & Koutaini, Hassan & Ma'moun, Candidate & Aridah, W, Msc. 2019)

Population of Interest

The direct population of interest in this DNP project are the healthcare practitioners, including physicians and advances practice providers; They are providing patient care and are the most important link of this chain, since they will determine if the patient meets criteria to be referred to palliative services. Those providers are contracted by the facility and have privileges to practice there. The Center has a multi-disciplinary clinical team of approximately 50 staff members caring for the residents. The clinical staff includes licensed practical nurses (LPN), registered nurses [RN] (associate degree nurses [ADN] and Bachelor of Science nurses [BSN]), social workers (MSW), and nursing assistants. Also includes four physicians and two advance practice providers. The largest percentage of nursing staff are LPNs (77%). The role of the RNs (ADN-BSN) are different than the LPN's role, specifically the first group are in charge of floor supervision, nursing managers and charge nurse positions, while the second group are responsible for direct patient's care including medication administrations and wound care procedures. This distribution is crucial since the literature supports improved outcomes with higher level of nursing education (Blegen, Goode, Park, Vaughn, & Spetz, 2013; IOM, 2011).

The indirect population that is likely to benefit from the DNP project are the patients in the LTC facility. Currently the patient census ranges from 70-100 years old.

Stakeholders

The key stakeholders of the project include the Board of Directors, site administrator, nurse manager/ staff, medical director, admission department, and the director of palliative care program. All of them are crucial to the DNP project on different levels. These key stakeholders are extremely important as they will be able to directly evaluate the effectiveness of the DNP project.

The LTC administrator is very supportive of change resulting in improved patient care and this will be great for the success of the DNP project. The nursing staff includes the nurse manager and direct patient's care nurses, who are crucial for this project since they are providing direct patient care.

These nurses are the first members of the chain to notice any important change in the patient condition that may qualify them to receive the services of the palliative care program.

The admission department is responsible for evaluation and determination of appropriateness for palliative care using the NCCN guidelines. The director of the palliative care program's role will be essential for the DNP project since she can identify patients in advance stages of disease needing better care.

Permission

The medical director and the administrator of the project site has provided verbal consent to proceed with this DNP project (Appendix B). However, it is important to ensure that all the employees are aware of the project and understand the implementation plan (Nishad & Channakeshavalu, 2013). There are no affiliation agreements necessary for the project.

Interventions

The time frame for this DNP project in total is five weeks, including the implementation and evaluation process. On week one, our primary intervention will be organizing a formal meeting at the practice site that will include all stakeholders. The DNP Project leader will explain the project at the long-term care (LTC) facility. During the meeting, a survey, PaCKS, will be given to assess the knowledge of the healthcare providers related to palliative care (Appendix C). Along with the survey, an educational session will be held using the designated tools (Appendix D). A post-test will be performed using the same survey at the end of the educational session on the same meeting.

Between week one and week two, the project leader will be implementing the NCCN Guidelines for Palliative Care as an essential part of our PCRP (Appendix E). The PCRP will instruct the LTC facility staff on identifying possible candidate cases for palliative care and how to proceed upon receiving a referral for this program.

In week three, will offer ongoing education and support to staff. This education will reinforce palliative care concepts and guidelines to clarify all misunderstandings and misconceptions that the healthcare practitioners and the stakeholders might have.

In week four, a chart audit (Appendix F) will be performed by the project lead. The plan includes analysis after four weeks using EMR to assess palliative care referrals before the QI project began and then four weeks after the educational session was provided. The goal is to review 149 patient's medical records and evaluate effectiveness of the PCRP focusing on numbers of referrals for palliative care.

On week five we will be completing the data collection for analysis and statistical tests will be performed.

Tools

During the implementation process of the DNP project, different tools will be used including the PaCKS, educational materials, PCRP, a chart audit tool, and a code book to reflect the results of the surveys.

Palliative Care Knowledge Scale (PaCKS).

The PaCKS (Appendix C) is used to assess healthcare professionals' general knowledge regarding palliative care. It contains 38 true or false questions addressing a wide range of facts and fundamental principles about palliative care. The rating scale facilitates the evaluation of palliative care knowledge among physicians and education programs in primary palliative care settings (Al-Ansari et al., 2019). This questionnaire was used and validated in previous studies to evaluate the healthcare provider's knowledge of palliative care, and no permission to use it is required (Kozlov, 2016). For the validation process, a preliminary survey (38 pool true or false questions) was administered to a community sample of 614 adults aged 18-89 and 30 palliative care professionals. Exploratory and Confirmatory Factor Analysis (EFA & CFA), correlational analyses, ICC, and KR-20, were used. The author assessed the reliability, stability, internal consistency, and validity of a 13-item for PaCKS (Kozlov, 2016).

In this DNP project, a modified questionnaire with just 13 true and false questions will be applied as recommended by the author of PaCKS.

PCRP

The PCRP (Appendix E) has been developed to improve the early referral using the NCCN Guidelines for Palliative Care. This protocol will be used as a guideline for health care practitioners at the LTC facility to assist them on how to identify possible cases with criteria to receive a referral for palliative care. It could be used on a different diagnosis like Cancer, Dementia, Parkinson's Disease, and on the management of signs and symptoms of distress including pain, dyspnea, anorexia/ cachexia, nausea and vomiting, constipation, diarrhea, malignant bowel obstructions, sleep/wake disturbances including insomnia and sedation and delirium. The PCRP will also offer tips to prepare patient/family/caregivers for the end-of-life and transition to hospice. These resources were developed by the project lead and reviewed and approved by the team and stakeholders at the facility.

Chart Audit Tools

A Chart Review (Appendix F) will be performed using the EMR system focusing on referrals for palliative care. We will be analyzed 4 weeks before educational training and 4 weeks after, to compare the number of referrals for palliative care and evaluate the effectiveness of the our PCRP. This tool was created by the project lead and reviewed and approved by the team and stakeholders at the facility.

Code Book

Also, we will use a Code Book (Appendix G) to organize the data collected on the survey and analyze them to evaluate effectiveness of our DNP project. These resources were developed by the project lead and reviewed and approved by the team and stakeholders at the facility.

Study of Interventions/Data Collection

Data in this project will be collected through two main techniques. The first involves participant surveys to be conducted on week one before and after educational session using the proper tool (Appendix D) in a clinical site (LTC facility), to the staff involved with palliative care in the site. A specific number will be assigned to the participants to pair them pre- and post-educational session. Participants' confidentiality is guaranteed using a codebook (Appendix G) that links the subject's private information to code only known by the participants.

To supplement data collected in the field, chart reviews will be conducted to analyze previous four weeks and four weeks after the implementation of the PCRP with regard to palliative care referrals (Appendix E). This process will take place during week four of the implementation period. To complete this process, the project lead will be use the facility EMR system, running a report just looking for Palliative Care Referrals. Data collection shall involve an statistician specialized in data abstraction to decrease reviewer bias (Matt & Matthew, 2013).

Ethics/Human Subject Protection

Ethical considerations are essential in any research dealing with human subjects. In terms of ethical implementations, the project does not require IRB review at the sponsoring university or the project site since it is a quality improvement (QI) project (Whicher et al., 2015). The project involves human subjects and participation will be voluntary. All identifying information will be coded to protect the confidentiality of the participants. Data collected will be store in a lock file, and the access is limited to the project lead.

Benefits and Risks

The main benefit of engaging in this project is that stakeholders will improve their knowledge about palliative care programs in general, facilitating a proper referral process.

Upon implementation period of the DNP project, more appropriate patients will get a referral for palliative care improving the quality of their lives and reduce distress form them and caregivers. On the other hand, no potential risks for patients and staff are associated with the observance of the new PCRP.

Compensation

Since the educational session and application of the survey (PaCKS) will take place during normal working hours, no extra compensation will be needed, and this option was discussed and approved by facility administration.

Recruitment Methods

The recruitment method used in the project involves direct recruitment of all potential staff in the clinical site (LTC facility). Recruitment invitation will be sent to the stakeholders and the rest of the staff via email using the internal communications system. This invitation will contain an overview of our proposal and the importance of their participation

Measures/Plan for Analysis

Paired T-tests will be used to test differences in knowledge about palliative care for stakeholders and other staff, engaged pre- and post-the PCRP. A paired t-test is justified since it involves getting the means of two groups within the same population, reporting the mean improvement with a standard error of the difference for the pre and post staff surveys (Lakens, 2013). The T-tests assumes your data are independent, are (approximately) normally distributed and have a similar amount of variance within each group being compared (a.k.a. homogeneity of variance).

After collecting data from patient's chart review, chi-square tests will be conducted to determine the effectiveness of the PCRP. But if the finals results have any rare cells (<5 expected in one of the cells in the 2x2 table for the test), may need to do a Fisher's exact test.

The assumptions made in conducting analysis are that the data variables have equal variances and follow a normal distribution. Equally, during analysis, it is also assumed that the observations made are mutually exclusive.

Both t-tests and χ^2 tests (or Fisher's exact test) will be conducted using SPSS. Finally, a statistician will be involved in the process of data coding and analysis.

Analysis

Data were tested for requisite statistical assumptions prior to data analysis. Data met all requisite assumptions (i.e., normality, sphericity, and homogeneity of variance) and no univariate outliers were detected in the data. Hence analyses continued as planned without making any statistical adjustments to the data. Data from the survey was recorded in Excel and later exported to SPSS for analysis. Measures of effect size were interpreted as Cohen's d for the t-test and Glass' Δ for the $\chi 2$. Cohen's d represents the standardized mean difference between pretest and posttest, and thus, is interpreted in a z-score distribution with a mean of 0 and a standard deviation ± 1. Glass' Δ is similar in that it represents the magnitude of the difference between two or more discrete instances/events/categories.

Results

Demographic characteristics of the sample are displayed in Table 1. Table 2 displays the mean total correct responses and standard deviations and the internal consistency reliability coefficients of the PaCKS scores pretest and posttest.

Table 1

Demographic Characteristics of the Sample

Demographic Variable	*n*	%
Age		
36-45 years old	6	37.5
46-55 years old	10	62.5
Gender		
Male	5	31.2
Female	11	61.8
Religious Affiliation		
Christianity	11	68.8
Judaism	2	12.5
Other	3	18.8
Education		
College Degree	8	50.0
Baccalaureate	2	12.5
Masters	2	12.5
Doctoral Degree	4	25.0
Years Employed		
6-10	5	31.3
11-15	6	37.5
16-20	3	18.8
21-25	2	12.5

N = 16

Table 2

Descriptive Statistics and Internal Consistency Reliability Coefficients for Pretest and Posttest Palliative Care Knowledge Scale (PaCKS) Scores

Variable	Pretest			Posttest		
	M	*SD*	α	*M*	*SD*	α
PaCKS Score	9.00	2.16	0.63	12.69	0.61	0.71

N = 16

Note. M = Mean; SD = Standard Deviation; α= internal consistency reliability coefficient, Cronbach's alpha.

Results of the dependent samples *t*-test revealed a statistically significant difference between pretest and posttest PaCKS scores, $t(15) = -7.41$, $p < .001$ (pretest-posttest $r = 0.41$), Cohen's $d = -1.96$ ($CI_{95\%} = -2.91, -1.01$), indicating a large effect size. As seen in Table 2, there was a significant increase in PaCKS scores at posttest compared to pretest scores, suggesting that the PCRP educational intervention was successful (see Figure 1).

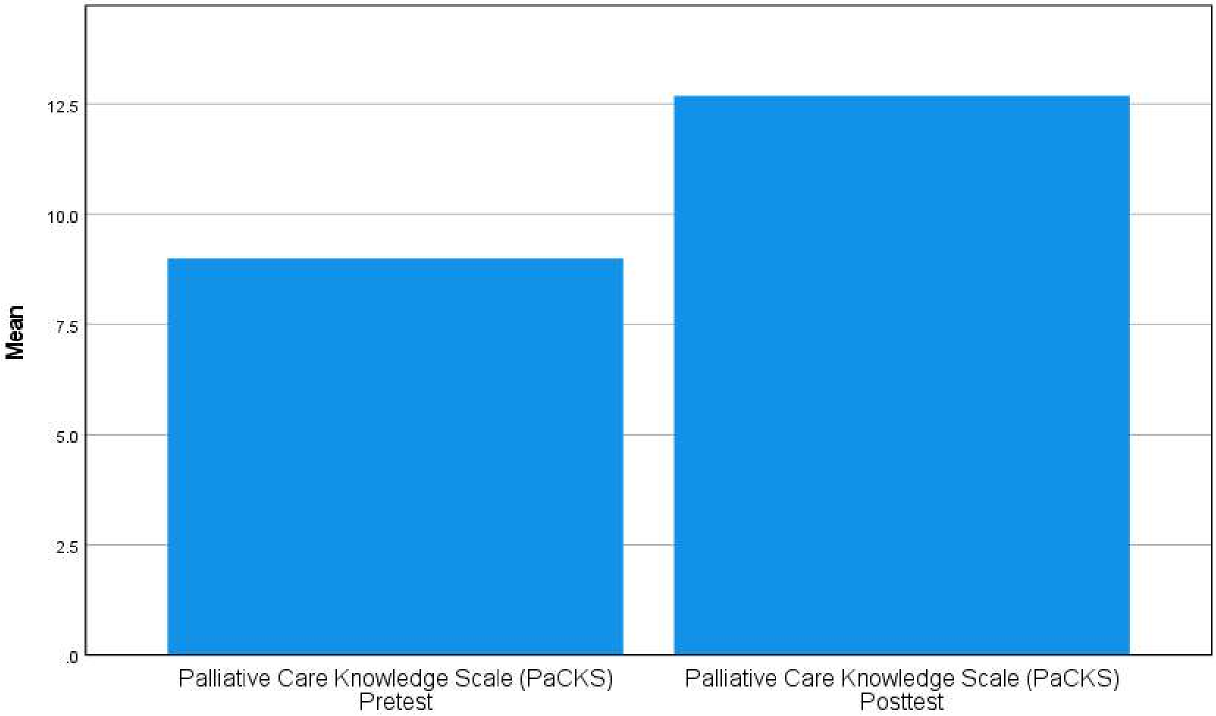

Figure 1. Bar chart of the dependent samples *t*-test for the PaCKS results.

Analysis of chart reviews demonstrated a significant increase in palliative care referrals post-intervention (40) compared to pre-intervention (29), $\chi^2(1) = 41.03$, $p < .001$, Glass' $\Delta = 1.06$, suggesting a large effect in the increase in palliative care referrals between pretest and posttest (see Figure 2).

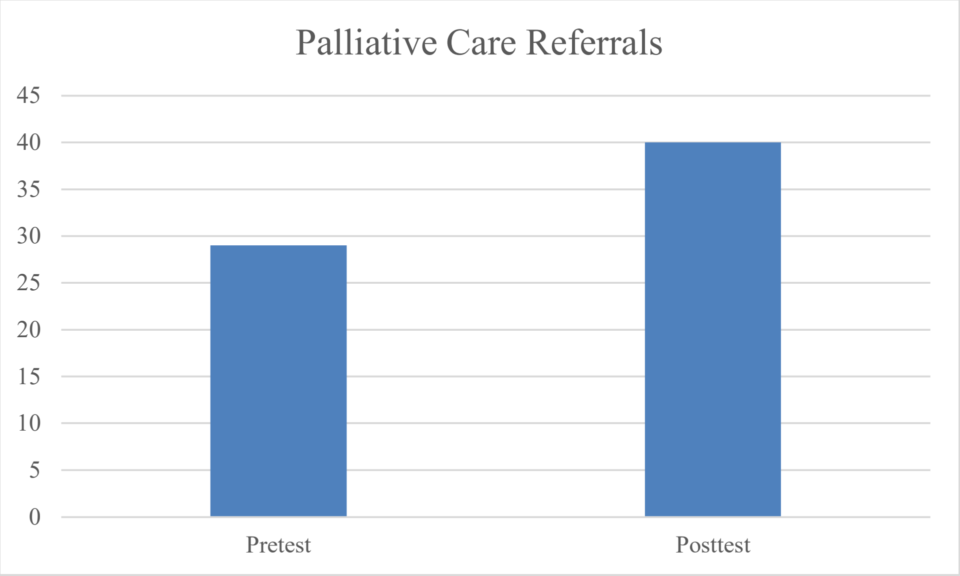

Figure 2. Bar chart review of the palliative care referrals before and after the intervention.

Discussion

With the creation of PCRP, healthcare practitioners and other stakeholders were given the tools to identify palliative care patients appropriately and efficiently. This process helped us fulfill the PICOT questions and two of the main objectives (1-2) outlined at the beginning of this project.

As shown in Table 1, the Educational level was high on the survey participants. This finding is essential to obtain better results, as the literature supports improved outcomes with a higher education level (Blegen, Goode, Park, Vaughn, & Spetz, 2013; IOM, 2011).

Table #2 referred to the PaCKs survey results. Those results show the effectiveness of the education session with the stakeholders during the formal meetings. This finding is supported by previous research on the topic (e.g., Balicas,2018; Jors et al., 2016; Pieters et al., 2019; Rice, 2019).

The PaCKS survey was essential during the implementation phase of this project to obtain a confident and accurate measure of knowledge of palliative care from healthcare providers and other stakeholders at the practice site. With the use of this survey, another of the principal objectives (3) was satisfied. The results obtained with this survey in the project coincided with Kozlov, E. (2016), who used and validated this tool to assess healthcare practitioners' palliative care knowledge.

Finally, after a chart audit of 149 charts using EMR, data was collected with the IT department's information at the facility site. A notable increase in referrals for palliative care was observed. Before implementing our DNP project, only 29 patients (19.4%) were receiving palliative care services, but four weeks after, this number increased to 40 patients (26.8%). This increment of 7.4% in referrals for palliative care suggested a successful effect of our DNP project for this facility, fulfilling the last of the objective set (4).

Significance

The facility leadership verbalized their support for implementing a PCRP at the LTC facility. They described it as an excellent tool for the correct comprehension of palliative care services, facilitating the referral process.

It was demonstrated that with proper education and healthcare providers' training, a better understanding of the palliative care service could be achieved. Always using the NCCN guidelines (NCCN-2020) and evidence-based research, the facility could save cost, time and obtain an improvement in the number of early referrals for palliative care. This outcome coincides with the literature reviewed for the preparation of this project (Jors et al., 2016; Pieters et al., 2019; Rice,2019), as show below:

Jors et al., (2016) said, “Nevertheless, a majority of physicians and nurses working at cancer centers feel unprepared for this task. As part of a larger survey study, we investigated what suggestions experienced physicians and nurses have to improve education/training on end-of-life care / palliative care”. (p. 1).

The outcomes obtained with this DNP project at the practice site were significant for all the stakeholders and participants on the survey and for the nursing staff who will use this PCRP as a guideline, originating changes on facility policies and protocols related to the palliative care approach. Concrete steps to take upon receiving a referral for palliative care are established. Nursing responsibilities are settled down, including nursing interventions always in compliance with the scope of nursing practice (see Appendix E). Those results obtained with the PaCKs survey and training, matched with the current literature, e.g., with Balicas (2018) when expressed, “Nurses need to be equipped with palliative care nursing knowledge to provide optimal care for patients and their families to improve the quality of life. Lack of education in pain and symptom management and communication about goals of care can result in a suboptimal and high cost of care”. (p., 1).

Also, a considerable increment in patients who are receiving palliative care services since the facility started using our DNP protocol has been observed, guiding healthcare practitioners with lack of experience in these services, on the process to identified and refer the proper patient with advances and chronic disease, reducing distress and suffering, just bringing comfort and dignity for them and their families. (Götze et al., 2018).

Limitations

In this project, some limitations were encountered. One of the most significant was related to the current COVID-19 pandemic that created challenges to meet in person with different stakeholders, including facility management's staff. The stakeholders were forced to cancel some meetings altogether and re-schedule others due to limitations on time, space, and difficulty to meet with people simultaneously, following the CDC measures to keep social distance and avoid personal contact (CDC,2020). The above issues created delays, and meetings had to be held via video conferencing software like Zoom, Facetime, and other encrypted technological tools to fulfill what was planned.

As a project leader, multiple problems were faced, such as the need to work double. I need to explain it twice, in two different groups, as the training meetings were divided into two separate sessions to follow the CDC requirements. I also had to explain the project's main idea to facility management during the DNP project's preparation portion on two separate occasions.

Although it was expected that it was possible to conduct training during nurses' scheduled work hours, the reality was that nurses faced unforeseen patient issues and complications that caused interruptions during the training period. This can be considered a weakness in the implementation phase and required additional training.

Another barrier, because it was not a real limitation, was related to data collection; it was necessary to depend on the IT department's personnel to assist with the process. Since the census and the patient's chart are fully electronic, their collaboration was vital to obtain numbers of patients with palliative care pre-and post-training sessions. They are not always available, but with administrative support, this issue was resolved properly and timely.

An additional limitation concerning the project is that it failed to showcase how to integrate palliative care at the policy development level. Protocols and policies regarding palliative care for patients who have cancer are established well but providing this care to patients suffering from other chronic illnesses is not well developed, making it inaccessible (Antonacci et al., 2020). There is a need to discuss extending palliative care policies and regulations to all patients who require palliative care services other than cancer patients. Global policies related to multiple diseases should also be integrated into palliative care (Meier et al., 2017).

Dissemination

Dissemination is the communication of knowledge obtained from implementation or research (Dudley-Brown, 2012). It is vital to share with other colleague any new results to ensure the growth of knowledge in the area.

The plan for dissemination of this DNP project initially was to share the results and outcomes with the leadership of the practice site, where this project received support starting from the beginning to the implementation phase. A formal discussion with the facility management, including administration, Nurse Manager, and Medical Director, occurred during a formal meeting.

The project's outcomes will be disseminated to the Touro University of Nevada's faculty and other peers as well as through DNP repository submission.

Also, will be introduced in the form of a poster presentation to The Southeast Florida Chapter of Hospice and Palliative Care (HPNA) meeting, pending approval by the organizational committee.

And will be shared through an abstract and poster presentation, at the 2021 Fourteenth National Doctor of Nursing Practice Conference on August 11, 2021. The poster will highlight specific findings and outcomes as shown in the dissemination plan.

Sustainability

Previous discussion and analysis with facility management concluded the importance of including this proposal in their standard policies and protocols since they will not incur extra costs for the facility, becoming this project doable and realistic. New employees and other healthcare professionals with a lack of palliative care experience will benefit by being able to use this protocol as a guideline to identify proper patients that should receive palliative care.

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Appendix A

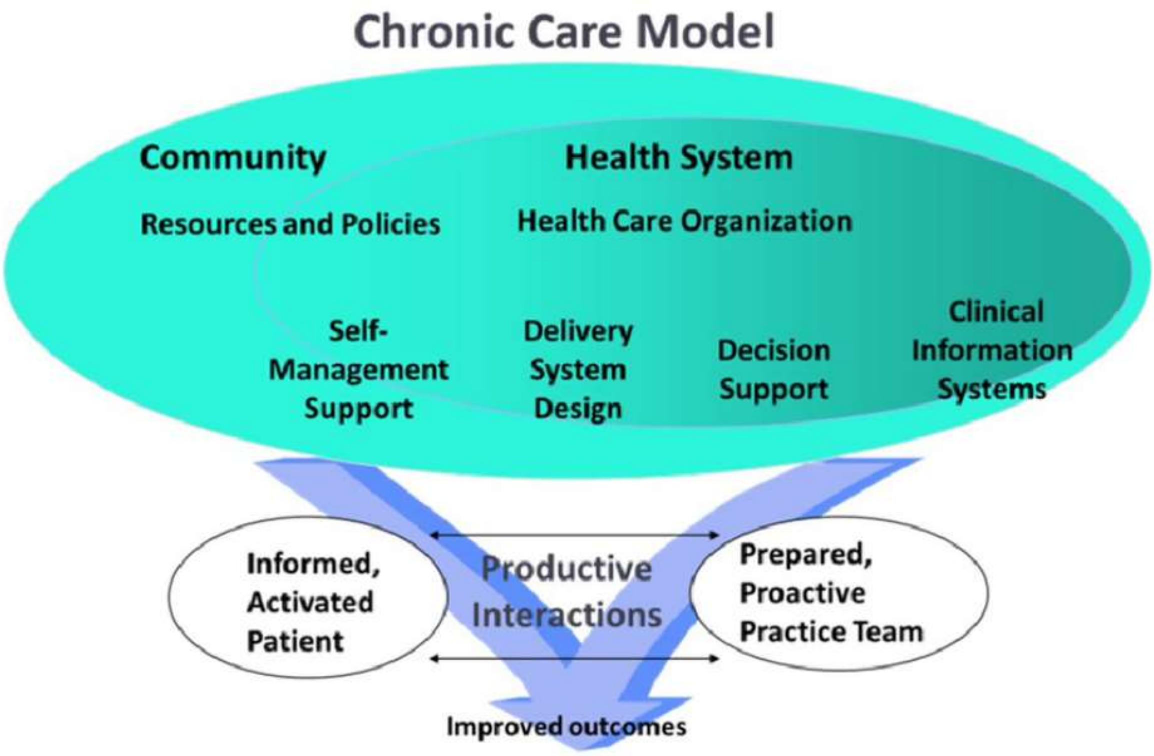


Figure 1-Chronic Care Model (Gammon et al., 2015)

Appendix C

Palliative Care Knowledge Scale (PaCKS)

1. A goal of palliative care is to address any psychological issues brought up by serious illness. (T)

2. Stress from serious illness can be addressed by palliative care (T)

3. Palliative care can help people manage the side effects of their medical treatments. (T)

4. When people receive palliative care, they must give up their other doctors. (F)

5. Palliative care is exclusively for people who are in the last six months of life. (F)

6. Palliative care is specifically for people with cancer. (F)

7. People must be in the hospital to receive palliative care. (F)

8. Palliative care is designed specifically for older adults. (F)

9. Palliative care is a team-based approach to care. (T)

10. A goal of palliative care is to help people better understand their treatment options. (T)

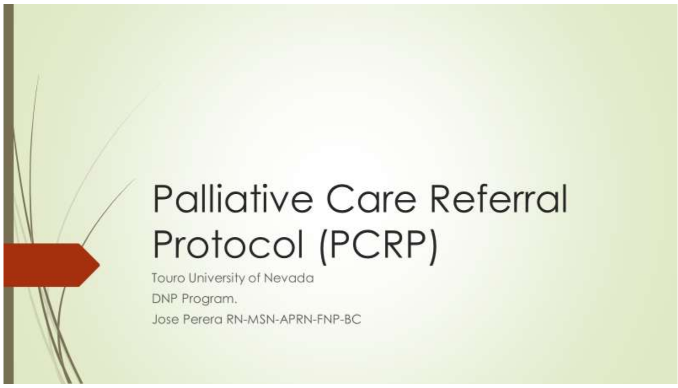
11. Palliative care encourages people to stop treatments aimed at curing their illness. (F)

12. A goal of palliative care is to improve a person's ability to participate in daily activities. (T)

13. Palliative care helps the whole family cope with a serious illness. (T)

Appendix D

Educational Material

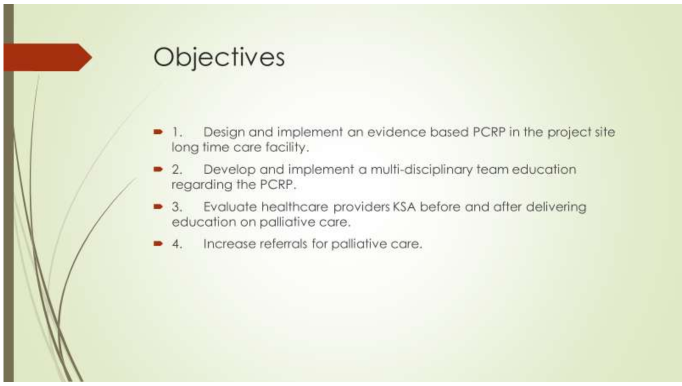


Palliative Care Referral Protocol (PCRP)

Touro University of Nevada
DNP Program.
Jose Perera RN-MSN-APRN-FNP-BC

Introduction

- Palliative care is an interdisciplinary medical specialty that focuses on preventing and relieving unnecessary suffering by supporting the best possible quality of life for patients and their families facing serious and/or life-threatening illness. (Bruena & Dev,2020). The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families, performs early identification, assessment and treatment of pain and other physical, psychosocial and spiritual complications (Brinkman-Stoppelenburg, Witkamp, Zuylen, Rijt, & Heide, 2018)
- Essentially, palliative care strives to achieve the best quality of life for the patient for as long as possible. It involves managing and anticipating pain and any other symptoms that the patient experiences, such as fatigue, shortness of breath, constipation or dysphagia.
- Palliative care is often shed in negative light both by healthcare professionals and the patients. The association with the end-of-life perspective makes it less an option in care management despite the benefits it provides to the patients
- Palliative care is not related to diseases' prognosis and can be offered alongside life-prolonging therapy.

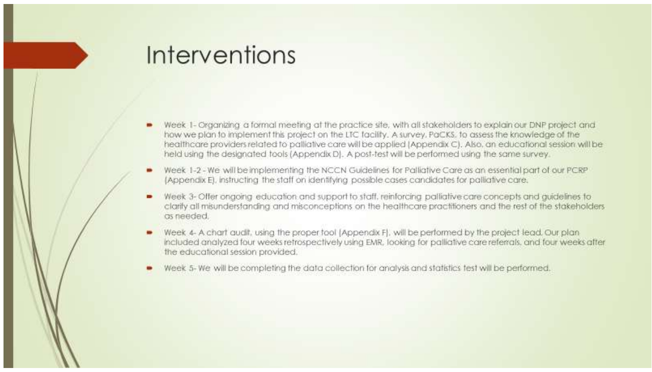


Objectives

- 1. Design and implement an evidence based PCRP in the project site long time care facility.
- 2. Develop and implement a multi-disciplinary team education regarding the PCRP.
- 3. Evaluate healthcare providers KSA before and after delivering education on palliative care.
- 4. Increase referrals for palliative care.

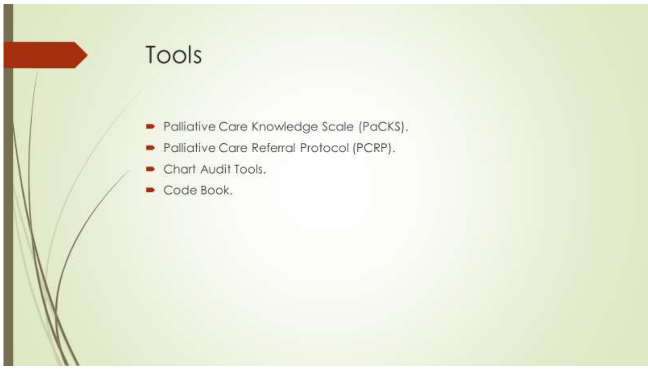
Purpose Statement

- The purpose of this QI project is to improve provider knowledge, skills, and attitudes (KSA) towards palliative care referrals by implementing a Palliative Care Referral Protocol (PCRP) in a long-term care setting.



Interventions

- Week 1- Organizing a formal meeting at the practice site, with all stakeholders to explain our DNP project and how we plan to implement this project on the LTC facility. A survey, PaCKS, to assess the knowledge of the healthcare providers related to palliative care will be applied (Appendix C). Also, an educational session will be held using the designated tools (Appendix D). A post-test will be performed using the same survey.
- Week 1-2 - We will be implementing the NCCN Guidelines for Palliative Care as an essential part of our PCRP (Appendix E), instructing the staff on identifying possible cases candidates for palliative care.
- Week 3- Offer ongoing education and support to staff, reinforcing palliative care concepts and guidelines to clarify all misunderstanding and misconceptions on the healthcare practitioners and the rest of the stakeholders as needed.
- Week 4- A chart audit, using the proper tool (Appendix F), will be performed by the project lead. Our plan included analyzed four weeks retrospectively using EMR, looking for palliative care referrals, and four weeks after the educational session provided.
- Week 5- We will be completing the data collection for analysis and statistics test will be performed.



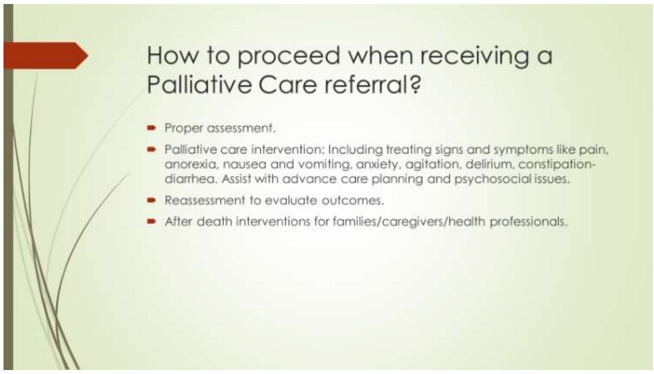
Tools

- Palliative Care Knowledge Scale (PaCKS).
- Palliative Care Referral Protocol (PCRP).
- Chart Audit Tools.
- Code Book.

How can we identify patients for Palliative Care ?

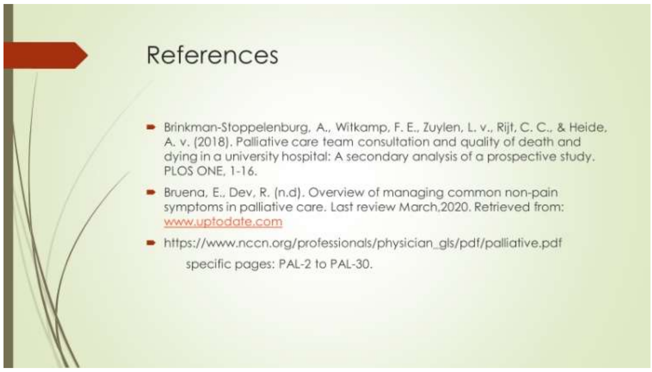
- Indications:

Uncontrolled symptoms.
Serious comorbid physical and complex psychological needs.
Poor prognosis awareness.
Potential life-limiting disease.
Patient/ families/ caregivers concerns about course of illness and decision making.
Patient/families/caregivers requests for Palliative Care.
Patient request a hastened death.



How to proceed when receiving a Palliative Care referral?

- Proper assessment.
- Palliative care intervention: Including treating signs and symptoms like pain, anorexia, nausea and vomiting, anxiety, agitation, delirium, constipation-diarrhea. Assist with advance care planning and psychosocial issues.
- Reassessment to evaluate outcomes.
- After death interventions for families/caregivers/health professionals.



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  specific pages: PAL-2 to PAL-30.

Appendix E

Palliative Care Referral Protocol (PCRP)

Based on NCCN Guidelines for Palliative Care Version1.2020

DNP Program.

Project Proposal to Increase Early Referrals for Palliative Care in LTC Facility.

Project Leader: Jose Perera.

1-Title: Palliative Care Referral Protocol (PCRP)

2-Project Objectives:

- Educate the healthcare practitioners and stakeholders on Palliative Care program.
- Facilitate the referrals process for Palliative Care program at the LTC facility.
- Provide the LTC facility with proper resources to evaluate and determine if a patient is appropriate for Palliative Care program.
- Increase referrals for palliative care using NCCN Guidelines for Palliative Care.
- Guide the healthcare practitioners on how to proceed when they found or receive a new referral for Palliative Care.

3-Department Involved:

- Healthcare Practitioners: (Included Physician, Nurse Practitioners [N.P] and Physician Assistant [P.A].)
- Facility Administrator.
- Nursing Department.

4 -Indication for Palliative Care Referrals: One or more of the following:

-Uncontrolled symptoms.

-Moderate to severe distress related to Cancer diagnosis and therapy.

-Serious comorbid physical and Psychological needs.

- Complex psychosocial needs.
- Poor prognosis awareness.
- Potentially life-limiting disease.
- Metabolic solid tumors and refractory hematologic malignancies.
- Patient/family/caregivers concerns about course of disease and decision making.
- Patient/family/caregivers requests for palliative care.
- Patient requests of hastened death.

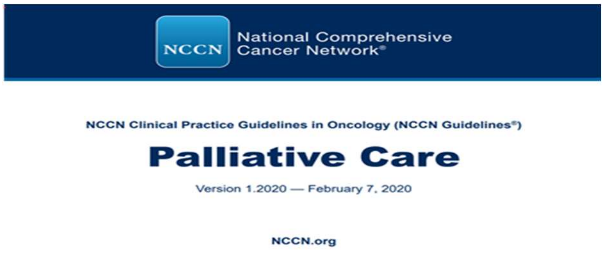
6- Upon Referrals for palliative care is received, needs to proceed with the following steps:

- Proper assessment
- Palliative care interventions.
- Reassessment (evaluate outcomes).
- After death interventions (for families / caregivers/health care team).

7- For specific assessment/reassessment, palliative interventions, after death interventions and advance care planning visit:

https://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf

specific pages: PAL-2 to PAL-30.



NCCN National Comprehensive Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Palliative Care

Version 1.2020 — February 7, 2020

NCCN.org

Appendix F

Chart Review Tool

Numbers of Chart Reviewed: ____

Numbers of Referrals for Palliative Care BEFORE Educational session: _____

Numbers of Referrals for Palliative Care AFTER Educational Session: ______

Appendix G

Code Book for Palliative Care

Item	Variable Code	Response Code
Participant Age	AGE	1=18-25 2=26-35 3=36-45 4=46-55 5=56-65 6=65+
Gender	GEN	1=Female 2=Male 3= Others
Religious Affiliation	RLA	1= Christianity 2=Hinduism 3=Islam 4=Confucianism 5=Judaism 6=Others
Level of Education	EDU	1= Below high school 2=High school graduate 3=College Degree 4=Bachelor's Degree 5=Master's Degree 6=Doctoral Degree
Years of Employment	EMP	1=1-5 2=6=10 3=11-15 4=16-20 5=21-25 6=26+
A goal of palliative care is to address any psychological issues brought up by serious illness	Q1	1= True 2= False
Stress from serious illness can be addressed by palliative care	Q2	1= True 2= False
Palliative care can help people manage the side effects of their medical treatments	Q3	1= True 2= False

When people receive palliative care, they must give up their other doctors	Q4	1= True 2= False
Palliative care is exclusively for people who are in the last six months of life	Q5	1= True 2= False
Palliative care is specifically for people with cancer	Q6	1= True 2= False
People must be in the hospital to receive palliative care	Q7	1= True 2= False
Palliative care is designed specifically for older adults	Q8	1= True 2= False
Palliative care is a team-based approach to care	Q9	1= True 2= False
A goal of palliative care is to help people better understand their treatment options	Q10	1= True 2= False
Palliative care encourages people to stop treatments aimed at curing their illness	Q11	1= True 2= False
A goal of palliative care is to improve a person's ability to participate in daily activities	Q12	1= True 2= False
Palliative care helps the whole family cope with a serious illness	Q13	1= True 2= False