Implementing an Alcohol Use Screening Protocol in Palliative Care

by

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Dedication

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Abstract

While statistics have shown that up to 28% of palliative patients have alcohol use disorder (AUD), research has shown that up to 86% of these patients are undiagnosed at the time of palliative referral. This DNP quality improvement project is guided by the Humanistic Nursing Theory (HNT) and employs a validated alcohol use screening tool to improve alcohol use screening for palliative patients as part of an alcohol use screening protocol. The Knowledge-to-Action (KTA) framework was used to guide the project's implementation. Participating staff were educated on the protocol during a face-to-face education session that was recorded and made available on the project site's learning management system. Data from the pre-implementation and implementation phases were collected using a chart audit review. The results were analyzed using a chi-square test of homogeneity to determine if the proportion of patients screened for alcohol use was the same in each project phase. The results showed that there was a significant increase in the rate of screening for alcohol use on admission to the project site during the implementation period as compared to pre-implementation ($p = .003$). A paired t-test was used to analyze the results of the pre-and post-education survey administered to the staff that attended the education session. Overall, attendees perceived their knowledge about alcohol use disorder in palliative patients in relation to their role when working with them improved significantly ($p = .009$), as did their knowledge of their role and responsibilities in relation to caring for palliative patients with AUD ($p = .007$). The result was significant at the $p < .05$ level. The results of this DNP project add to the limited body of knowledge about screening for and managing AUD in palliative care.

Keywords: palliative care, alcohol use disorder, AUD, AUDIT-C, alcohol use screening tool, Knowledge-to-Action, Humanistic Nursing Theory

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Chapter One: Introduction and Overview

In the larger population, substance use is a widespread reality, with 86.4% of people over the age of 18 reporting having used alcohol (Musili et al., 2021a). While the frequency of alcohol use in the palliative population remains unclear, the literature demonstrates that palliative patients continue to use alcohol during this phase of life. Thus, the planning of care should integrate alcohol use as a consideration to improve the provision of quality care (Galvani et al., 2019).

The Centers for Medicare and Medicaid Services (CMS) launched a comprehensive initiative, “Meaningful Measures”, in 2017 that identified areas that are considered high priority for quality measurement and improvement in healthcare (CMS, 2017). One of these measures was preventing and treating substance abuse. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the characteristics of alcohol use disorder (AUD) identify it as a medical condition based on a pattern of problematic alcohol use leading to impairment or distress that is clinically significant (American Psychiatric Association, 2013). Depending on the number of symptoms a patient has experienced in the previous year, AUD can be considered mild, moderate, or severe. As severity progresses, the brain experiences alcohol-induced changes that result in difficulty cutting down or quitting use (National Institute of Alcohol Abuse and Alcoholism, 2022).

While curing AUD is not a goal in palliative care, identifying patients that continue to consume alcohol during the palliative phase can promote quality of life by allowing for proper assessment and management of their alcohol use; as well as the consideration of additional treatment options in light of the impact that alcohol consumption may have on the dosing and

efficacy of medications (Cook et al., 2022). Ferrell et al. (2018) identified that a main goal of palliative care is to improve access to quality care services for anyone with a serious illness regardless of their diagnosis, location, or prognosis. The purpose of this Doctor of Nursing Practice (DNP) project was to implement an alcohol use screening protocol in a residential hospice facility.

Background of the Project

Evidence-based practice is an important foundation for healthcare to use the best evidence to make patient diagnoses and care decisions. The move towards evidence-based practice has resulted in an increase in protocols and guidelines for clinical management of various medical conditions. These protocols and guidelines are means of putting evidence into action when providing care with the goal of providing consistent, appropriate care to patients; thereby improving health outcomes. However, Bhogal (2011), identified that there is often a failure to provide recommended care by healthcare professionals and systems, and that these "care gaps" can impact patient health outcomes negatively and impair quality of life.

Quality of life at end-of-life is a fundamental priority when caring for palliative patients. Interestingly, although both Dev et al. (2011) and MacCormac (2017) identified that up to 28% of palliative patients misuse alcohol, little research to date examines how to manage alcohol use disorder (AUD) in this population. Ebenau et al. (2018) and MacCormac (2017) identified that there is a lack of education and training in palliative care related to the assessment and management of AUD, and no clear distinction of responsibilities for palliative care professionals related to the screening, assessment, and management of the health issue. While the goal in palliative care is not cure, the identification of patients who continue to use alcohol and the management of symptoms in consideration of this promotes quality of life for these patients.

Many palliative patients with AUD go undiagnosed and as a result their withdrawal symptoms may be mistaken for terminal agitation or anxiety, instead of being recognized and managed for the alcohol withdrawal symptoms that they are (MacCormac, 2017). Another important consideration is the impact on drug efficacy or the potential for interaction of the alcohol with other prescribed medications. Dev et al. (2011) noted that palliative cancer patients with undiagnosed alcoholism often were on higher doses of opioids. Alcohol use is not routinely screened for in the palliative population, thus putting palliative patients who have AUD at risk for withdrawal, misdiagnosis, mistreatment, and reduced quality of life (MacCormac, 2017).

Validated Alcohol Use Screening Tools

There are several validated alcohol use screening tools available to identify alcohol-dependency in patients. According to Choe et al. (2019), the alcohol use disorders identification test (AUDIT) and the CAGE, are the two most widely used alcohol screening questionnaires. Webber et al. (2020) noted a number of retrospective studies used either the AUDIT or CAGE questionnaire to assess the prevalence of AUD in patients with advanced cancer. The CAGE resulted in statistics varying from 4% to 38% prevalence of AUD while one study using the AUDIT reported 18% prevalence (Webber et al., 2020).

The World Health Organization (WHO) developed the AUDIT for health care workers to assess a person's recent alcohol use. AUDIT's questions explore patterns of alcohol misuse, alcohol dependency symptoms, and problems related to the use of alcohol. Compared to other alcohol screening instruments, AUDIT has demonstrated reliability and validity and performs significantly better (Allen et al., 1997; Clements, 1998). One drawback is that due to the relatively large number of questions, the AUDIT is not as easy to administer as the CAGE. Developed by John Ewing (1984), the CAGE is a widely used screening and case-finding tool.

The CAGE is brief, consisting of four questions, and as such is easily applied in clinical practice with a high sensitivity for AUD despite its brevity. However, as Ewing (1984) noted, CAGE does not provide information on current alcohol consumption, so it may not be more effective than the AUDIT for screening in a palliative population where the focus is not on ceasing consumption or treating AUD, but rather identification of active alcohol use to provide safer care and monitor for and manage any withdrawal symptoms once the patient's consumption ceases (Higgins-Biddle & Babor, 2018).

AUDIT-C

The AUDIT-C instrument contains three questions and yet it offers good test-retest reliability (0.91 intraclass correlation coefficient) and validity indicated by a 81.8% sensitivity and 79.8% specificity (Jeong et al., 2017). The AUDIT-C is modified from the WHO's original AUDIT instrument designed for use by healthcare professionals to screen patients for alcohol consumption above recommended guidelines (see Appendix A for the AUDIT- C). The AUDIT-C is scored on a scale of 0-12, with each of the three questions including five potential answer options, with a point allotment scaling from 0-4 depending on the patient's answer. In men, a score of 4 or more and women, a score of 3 or more is considered positive and useful for identifying hazardous drinking or active AUD. One important note in relation to the scoring is that when the points are all only from question one, with questions two and three scoring zero, it can be assumed that the patient's alcohol consumption is within recommended limits (Jeong et al., 2017).

Statement of the Problem

Screening for alcohol use can improve quality of life for palliative patients by allowing health care providers to provide personalized care in the context of knowing that with the

continued consumption of alcohol, the patient will require individualized consideration in the prescription of certain medications and as their disease progresses may require intervention for withdrawal signs and symptoms once they are no longer consuming alcohol. The literature supported a need to increase screening for alcohol use in many health care settings, including palliative care (McCormac, 2017). Numerous studies had demonstrated the value of implementing alcohol use screening protocols on improved patient outcomes (Curry et al., 2018; Ziccardi, 2019); however, none were found to be specific to palliative patients, identifying this as a gap in research and practice.

Within the project site, the problem was that palliative patients were not being routinely screened for alcohol use, and alcohol use was not being considered in the planning of patient care. The impact of alcohol use in the palliative population had not been considered a problem to be addressed at the project site although the literature indicated its prevalence (McCormac, 2017). All nursing staff who provided care to palliative patients needed to be educated and trained on how to screen for alcohol use, assess for the patient's wishes related to their alcohol use, and when to notify the physician for intervention orders to promote patient safety and improved quality of life for these patients.

The practicum site selected for this DNP project was a residential hospice facility in a small city in Ontario, Canada. This facility provides 24-hour nursing care for palliative patients in a home-like setting. The population consists of palliative patients with a Palliative Performance Scale (PPS) score of 50% or less who are no longer able to manage in their homes, or do not wish to die in their home, and have a projected life expectancy of three months or less. Alcohol use had not routinely been screened for prior to or upon admission, or while residing in the facility, and alcohol use had not been integrated as a consideration into care planning.

Purpose of the Project

The purpose of this quality improvement project was to improve the identification and care of palliative patients actively using alcohol through the implementation of an alcohol use screening protocol. Implementation of an alcohol use screening protocol would allow at-risk hospice patients to be appropriately identified. Those patients that screen positive for alcohol use would not be expected to abstain unless that was their wish, as curing an alcohol use disorder is not an expectation in this population. The identification of patients who continue to consume alcohol would allow for safer prescription of medications in consideration of interaction with alcohol and enable nursing staff to assess for signs and symptoms of alcohol withdrawal, so that it could be identified and treated appropriately (Anandarajah et al., 2020). Although some patients had continued to consume alcohol in the facility in the past, this protocol was expected to assist healthcare providers in consistently identifying and planning care for these patients in consideration of their alcohol use.

PICO Question

Does the implementation of an evidenced based screening protocol increase the number of palliative patients that are screened for AUD?

Population – The project targeted patients of the residential hospice facility

Intervention – Implementation of an alcohol use screening protocol

Comparison – No protocol used in previous practice

Outcome – Improve alcohol use screening of patients in residential hospice care

Theoretical Framework

Paterson and Zderad's (1976) Humanistic Nursing Theory (HNT) was the theoretical framework for this project (see Appendix A). The HNT is based on humanism, existentialism,

and phenomenology (Paterson & Zderad, 1976). Wu and Volker (2011) stated that the theory can provide unifying language when planning care and describing interventions, which are the goals of this DNP project. Wolf and Bailey (2013) supported the use of this theory by nurse investigators to position their studies.

The first core concept of the theory is that interactions between the nurse and patient, in the context of the lived world, are designed to promote wellbeing and existential growth. It is important to note that the theory has an emphasis on the uniqueness and individuality of each patient in their present situation, although general patterns among people in similar circumstances exist. Through this lens, the nurse cares for the patient by being present while performing nursing actions and by being aware that each person responds differently to personal matters and to their environment (Wu & Volker, 2011).

The second concept is that each human is unique and has the capacity to choose how they want to respond to situations they experience and that the viewpoints of nurses and patients are equally as important. Self-reflection by both nurses and patients can assist with understanding how each interprets and responds to certain experiences. Paterson and Zderad (1976) proposed that the nurse's role is to respond to the call to care for a person whose health-related needs are unmet, thus helping the person meet these needs within the limits of their current life situation.

A third concept of HNT is community which Paterson and Zderad identified as "two or more persons struggling together toward a center" (1976, p.131), which develops between the nurse and the patient, other healthcare professionals, and the patient's family. Each member of the community brings their own biases, so reflecting on oneself and experiences can promote awareness and openness which nurses can use to increase their understanding of their own biases

and expand their personal views, resulting in improved connections with their patients and colleagues (Wu & Volter, 2011).

Significance of the Project

Active alcohol use is not typically screened for and integrated into care planning in palliative care, resulting in a safety risk for palliative patients (McCormac, 2017). This project is significant because it aimed to bridge a gap in care through the development of a protocol that would have all patients screened for alcohol use on admission to the residential hospice facility. For those that screened positive, the protocol would guide further nursing assessments to determine the patient's goals in relation to their alcohol consumption as part of their plan of care and ensure that this information was communicated to their palliative provider. Whether the patient chose abstinence, reduced consumption, or continued alcohol use, their choice could be considered in their ongoing care, improving both the patient's safety and their quality of life. This project implements an evidence-based screening tool and contributed to the limited body of knowledge on alcohol use disorder in palliative patients.

Definition of Terms

Alcohol use disorder (AUD): a medical condition characterized by problematic alcohol use patterns that lead to impairment or distress of clinical significance (American Psychiatric Association, 2013).

Alcohol withdrawal syndrome (AWS): a clinical condition which can develop a few hours or days following reduction or abrupt cessation of alcohol intake. Typical signs and symptoms involve hyperactivity of the autonomic nervous system. According to DSM-5 criteria, it is diagnosed if a patient presents with at least two of the signs or symptoms (Atilia et al., 2018).

AUDIT: the Alcohol Use Disorders Identification Test was developed by the World Health Organization for use by health care practitioners in various settings to screen for unhealthy alcohol use such as risky consumption or an alcohol use disorder (auditscreen.org).

AUDIT-C: the Alcohol Use Disorders Identification Test – Concise an abbreviated version of the original AUDIT screening tool. Using the first three questions from AUDIT, the AUDIT-C reliably identifies people with hazardous drinking habits or who have alcohol use disorder.

CAGE: CAGE is an acronym for a four-question screening tool that can be used to assess for alcoholism. The questions focus on cutting down, annoyance by criticisms of alcohol consumption, guilty feelings about alcohol consumption, and consumption of an eye-opener to feel better or get rid of a hangover (Ewing, 1984).

Humanistic Nursing Theory (HNT): the HNT, developed by Paterson and Zderad (1976) is a theoretical framework based on humanism, existentialism, and phenomenology that can be used by nurses to plan care and interventions for patients and by nurse investigators to position their studies.

Knowledge-to-Action (KTA) framework: the KTA is a conceptual framework that can be used to translate knowledge into practice. The framework consists of two parts; part one is knowledge creation, and part two is the action cycle (Graham et al., 2006).

Palliative care: palliative care is an approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual (WHO, 2020).

Palliative Performance Scale (PPS): the PPS uses five domains correlated to the Karnofsky Performance Scale (100-0) that are rated by the observer. The PPS is reliable and valid and correlates well with actual survival and median survival time for palliative patients. It can also be used to "identify and track potential care needs of palliative care patients, particularly as needs change with disease progression" (Wilner & Arnold, 2015, p.1).

Residential hospice: a residential hospice is a facility that provides 24-hour care to palliative patients by registered nursing staff and support workers under the direction of a team of palliative care physicians. Care focuses on quality of life and symptom relief for people who are experiencing the advanced stages of a life-limiting illness and takes the burden of care off their caregivers.

Scope, Limitations and Delimitations of the Project

Scope

The DNP student conducted an assessment at a residential hospice facility and determined that alcohol use was not routinely screened for by nurses upon intake into the facility, although some patients continued to consume alcohol after admission. This project implemented routine screening for all patients upon admission using a validated screening tool as part of an alcohol use screening protocol.

The goal of the project was to implement routine screening for active alcohol use in all patients upon admission to the residential hospice facility through the implementation of a validated alcohol use screening tool. To facilitate successful implementation, education and training of nursing staff were provided. Education involved facilitating a session regarding alcohol use and AUD in palliative patients, how to use the AUDIT-C screening tool, and how to assess for a patient's alcohol use management wishes (See Appendix F). Training of nursing

staff occurred in a two-hour session with the implementation of the tool occurring immediately afterwards. Eight weeks' worth of data were collected, including four weeks of pre-implementation data and four weeks of data collected during the implementation phase.

Limitations

The patient population size was a limitation in this project. Size was impacted by the number of patients that had a pre-admission assessment completed, the number of patients admitted to the residential hospice facility over the four-week period, as well as the number of patients that screened positive for active alcohol use.

Delimitations

This project focused on implementing a validated alcohol use screening protocol at the project site. It evaluated how many patients were screened using the AUDIT-C tool. All patients who completed a pre-admission assessment and were admitted to the hospice during the implementation period were screened.

While the project included collaborative care with patients' primary palliative care provider, the focus was on the nurse's role in screening for alcohol use, following the care pathway to determine the patient's wishes regarding management of their alcohol use and informing the primary care provider. Education and training on use of the tool was provided specifically to the nursing staff, as they were assigned to complete the screening, assessments, and reporting. This project did not focus on any medical interventions completed in relation to any patient using alcohol.

Conclusion

There was inconsistent data found regarding the prevalence of alcohol use in the palliative patient population and a lack of research in general regarding screening for and caring

for palliative patients using alcohol as they progress towards end-of-life (Cook et al., 2022). This project sought to implement an alcohol use screening protocol for palliative patients. Poor confidence and confusion about the role that nurses play regarding screening and caring for palliative patients using alcohol may contribute to this lack of knowledge. To support successful implementation of the project, the nurses who would be implementing the protocol were educated and trained on its delivery.

Chapter 2: Literature Review

Once a problem or concern of interest is identified, a literature review must be conducted to determine what is known about the topic of interest as well as identify any unknowns or gaps in knowledge. The literature review supports the value or need to address the clinical question (Moran et al., 2020).

Alcohol is the most widely abused substance around the world with alcohol use disorder (AUD) being a major burden in most countries. There are over three million deaths annually because of alcohol misuse and it is a contributing factor to more than 200 diseases (WHO, 2018). According to the Diagnostic and Statistical Manual for Mental Disorders (DSM 5), AUD affects 3.6% of the global population (American Psychiatric Association, 2013); however, in relation to the palliative population, the research is less prevalent and consistent (Weber et al., 2020).

The literature supported a need to increase alcohol screening in palliative care to improve patient outcomes (McCormac, 2017). Previous studies have demonstrated improved patient outcomes through the implementation of alcohol screening and treatment of AUD (Ziccardi, 2019); however there are no existing practice models for support of palliative patients who continue to consume alcohol, identifying this as a gap in research and practice (Anandarajah et al., 2019; Cook et al., 2022; Ebenau et al., 2018; Ebenau et al., 2020; Galvani, 2019; MacCormac, 2017).

Conceptual Framework

Paterson and Zderad's (1976) Humanistic Nursing Theory (HNT) been identified as being useful for framing nursing practice in palliative care by many authors because the theory's concepts of relationships, communication, the lived experience, and suffering are in line with several of the principles of palliative care (Dobrina et al., 2014; Pereira et al.,2018).

The theory's first concept is that wellbeing and existential growth are a result of the nurse-patient relationship. It is important to note that the theory has an emphasis on context, which specifically looks at each unique patient in their present situation, meaning each patient faces their own experience as they progress through the palliative stage of life (Wu & Volker, 2011).

The second concept is that each human is unique and has the capacity to choose how they want to respond to situations they experience and that the viewpoints of nurses and patients are equally as important. Self-reflection by both nurses and patients can assist them with understanding how they interpret certain experiences and respond to them. Paterson and Zderad (1976) proposed that the nurse's role is to respond to the call of caring for a person whose health-related needs are unmet, helping the person meet these needs within the limits of their current life situation.

Community is a concept of the HNT that develops between the patient, their family, and the healthcare team. Each of the community's members bring their own biases. Palliative nurses can use the strategy of self-reflection to promote awareness, openness and increased understanding of the patient's context, resulting in improved connections with their palliative patients, families and colleagues (Wu & Volter, 2011).

HNT addresses the values and goals of palliative care. Nurses and patients bring their own perspectives and experiences into the therapeutic relationship. The nurse must set aside pre-conceived ideas, expectations, and biases to better understand their patients and accurately assess their needs. The nurse must keep in mind that each patient is unique with their own life experiences and has lived their life in their own way. The theory supports non-judgmental care and the development of a trusting, open, holistic nurse-client relationship.

Related Studies

A literature review was completed to explore current research and practice related to care of palliative patients with AUD. PubMed, ProQuest Central, and Google Scholar were used, and studies were limited to those published in the English language. All searches used the terms "alcohol use disorder" AND "palliative care" OR "hospice" AND "alcohol use screening". The searches produced limited results of literature, with PubMed producing 13 articles, Google Scholar producing 12 articles, and Proquest Central producing 45 articles. From these returns, relevant articles were filtered, and additional articles were found by hand searching the references of the articles chosen from the literature search, with a final result of 33 articles selected.

Upon review of the articles and studies retrieved, it was noted that a wide variety of types of research were used, including mixed method systematic reviews, themed reviews, retrospective studies, qualitative studies, and case studies. Discussion papers, a study protocol, brief reports, practice guidelines and recommendations all contributed to the depth and breadth of knowledge guiding this project. Most of the articles determined that harmful alcohol use and AUD are significant health issues in the palliative care population. Several themes were found repeatedly in the articles: inconsistent screening of alcohol use within palliative care; inconsistent reporting of frequency of AUD in palliative populations; and identification of nursing's role in caring for patients with AUD.

Alcohol Screening in Palliative Care

Using an alcohol screening tool is helpful to provide individualized, informed care to patients. Sacco et al. (2017) stated that screening for alcohol and other substance use is considered best practice in palliative care, and ultimately reflects proper assessment, planning of

care, and treatment. Significantly, Cook et al. (2022) identified that in palliative care, policies to guide practice on the screening and continued use of substances in those with a history of use are not routine in palliative care. Anandarajah et al. (2019) echoed that a lack of screening is one of the biggest barriers to caring for palliative populations. Additionally, subsequent literature also supported these findings and identified challenges to screening palliative patients.

Prevalence of Screening

Varying screening rates for alcohol use were noted in the articles reviewed. MacCormac (2017) stated that an estimated 21% of palliative patients did not receive an assessment of alcohol intake. However, Parsons et al. (2008) noted a 90% prevalence of use of CAGE on charts audited in the institution studied. Furthermore, Sacco et al. (2017) identified that 68.22% of agencies included an assessment but none incorporated a structured tool; most were a check box to assess whether substance abuse was present. Interestingly Sacco et al. (2017) noted that hospice size was the only significant variable influencing screening in which large hospices were eight more times likely to perform screening than small ones.

Challenges to Screening

Three main challenges to screening were noted in the literature. First is the comfort of staff with asking questions about alcohol use for fear of appearing judgmental (Galvani et al., 2018; MacCormac, 2017). Second, there may be a false perception by caregivers that the patient finds pleasure in alcohol intake, and caregivers do not want to deprive them of that so their disorder continues to go unrecognized (Galvani et al., 2018; MacCormac, 2017). Third, a lack of education and training around screening and managing AUD in the palliative population resulted in staff not knowing their role and responsibilities as part of the palliative care team and not having the knowledge and skill to perform the assessments (Berl et al., 2015; Ebenau et al.,

2018; Ebenau et al., 2020; Galvani, 2019; Jones et al., 2022; MacCormac, 2017; Sacco et al., 2017).

Prevalence of AUD in Palliative Care

The prevalence of AUD in palliative populations is unclear. There are inconsistent rates reported in the literature, which could be influenced by screening practices. MacCormac (2017) stated that up to 28% of palliative patients have AUD, while Webber et al. (2020) cited varying statistics of 3-19% depending on the screening tool used and the specific palliative population screened. A study in the United Kingdom used the CAGE questionnaire and found 11% of cancer patients screened positive while the AUDIT showed a rate of 5% (Webber et al., 2020). A retrospective study by Parsons et al. (2008) cited a 17% CAGE-positive result on 665 charts audited in a palliative care clinic and a rate of 38% in another study in an inpatient cancer center. Mercadante et al. (2015) cited positive rates of 17-28% using CAGE. The results can be difficult to interpret as the CAGE refers to lifetime use of alcohol while the AUDIT assesses current use (Higgins-Biddle & Babor, 2018). Additionally, measures vary from study to study, with some using interviews and others using validated instruments or diagnostic criteria. Interestingly, Yusufov et al. (2019) categorized studies by assessment type which revealed that the AUDIT produced frequency rates of 16-28%, CAGE produced frequency rates of 4%-28% and the diagnostic interview or interview produced the most variability in rate of 2%-35%. Ultimately it can be concluded that AUD does exist in the palliative population and these patients need to be identified and properly cared for.

Under-Diagnosed in Palliative Patients

Despite varying statistics on the prevalence of AUD in palliative patients, alcohol use remains under-detected and under-reported among palliative patients and should be routinely

assessed (Giusti et al., 2018; Mauro et al., 2021; Mercadante et al., 2015; Mundt-Leach, 2016; Musili et al., 2021b; Parsons et al., 2008). Dev et al. (2011) found a frequency rate of 17% of CAGE-positive palliative patients in their retrospective study; however only 13% of those had been previously identified as having AUD prior to their palliative care consultation. Similarly, MacCormac (2017) noted that when alcohol screening is routinely performed in palliative care, 67-87% of those identified as having AUD were not previously diagnosed. Anandarajah et al. (2019) and Ebenau et al. (2020) identified the challenge of detecting AUD when palliative patients deny or underreport their consumption, or do not acknowledge their dependence.

Varying Rates Based on Palliative Population Studied

Because alcohol use is a known carcinogen and puts a person at higher risk for specific forms of cancer such as those of the head and neck, liver, and gastrointestinal tract, the specific population of palliative patients studied may influence the prevalence rates of AUD. Parsons et al. (2008) studied patients with advanced cancer, and of the 17% that screened positive, there were more males and more with malignancies of the head and neck. Mercadante et al. (2015) also found significantly more males than females screened positive. Ho and Rosenheck (2018) noted that 24% of patients with hepatocellular carcinoma continue to use alcohol and similarly, Mercadante et al. (2019) reported that studies in the United States that screened for AUD in the palliative cancer population found rates ranging from 17 to 28%. In their study, Dev et al. (2011) found advanced cancer patients had a positive CAGE score with a frequency of 17% and cancers of the lung, GI tract, head and neck were most prevalent in the group. Yusufov et al. (2019) pointed out that the nature of the data collection across many studies exploring AUD in palliative patients made it challenging to identify trends. Many studies used convenience samples, which can skew frequency based on the population sampled.

Recommendations for the Management of AUD in Palliative Care

Multiple articles have identified that there are no existing practice models to support the co-existing needs of palliative patients with AUD (Cook et al., 2022; Galvani, 2019; MacCormac 2017). Cook et al. (2022) stated there is a lack of evidence to support the management of end-of-life care for those dying with alcohol and drug problems, thus, limiting clinicians' ability to understand the care needs of these patients. Witham et al. (2019) claimed similar findings, stating there is a lack of empirical evidence, diversity, and quality papers related to interventions and models to improve palliative care for patients with AUD. Interestingly, Ebenau et al. (2020) identified that exceptions and unconventional care practices are common and that universal policies are not possible when dealing with such a unique population. Anandarajah et al. (2019) agreed, stating the best interventions for patients with AUD depend on a variety of factors and require knowledge of a patient's prognosis, care goals, and effects of alcohol use on the patient's symptoms and management of care.

Recovery Versus Harm Reduction

Recommendations for management of alcohol use in palliative care have align with a harm reduction approach, as AUD is a complex, multifaceted, chronic challenge that impacts the lives of patients, families and supports, and healthcare providers. Cook et al. (2022) stated that it is unrealistic to expect enforced abstinence in palliative patients, and that having an abstinence policy may deter patients from accessing essential care. MacCormac (2017) stated that management of AUD in palliative care settings ought to be directed by informed choice, whether palliative patients choose medically supported detoxification or continued alcohol use. The choices of abstinence with treatment support and continued alcohol use were also discussed by Anandarajah et al. (2019), Galvani et al. (2019), Jones et al. (2022), McNeil et al. (2012), Musili

et al. (2021b), Passik and Theobald (2000), and Templeton et al. (2022). A qualitative research report published by Witham et al. (2018) agreed that good practice when caring for palliative patients with AUD includes non-judgmental attitudes and innovative practice solutions such as providing a fridge for alcohol for palliative inpatients who choose to continue consuming. Cook et al. (2022) suggested dispensing a standard amount of alcohol on demand as a harm-reduction strategy, and MacCormac (2017) also suggested controlled usage may be appropriate. Similarly, McNeil et al. (2012) suggested three strategies for harm reduction which include access to supplies, support by nurses, and supportive environments. A themed review by Anandarajah et al. (2019) noted that as patients approach end of life that screening for alcohol use and acknowledging dependence can be barriers to care, which are unique to the individual and may involve supporting a desire for abstinence or planning treatment around continued alcohol consumption. Cook et al. (2022) similarly found that patients wanted to be valued as an individual and be listened to.

Symptom Burden

Palliative patients with AUD have been identified has having a significantly higher symptom burden, most notable in relation to pain and dyspnea and have more frequent use of opioids (Groninger & Knapik, 2019; Kim et al., 2016; Mercadante et al, 2015; Musili et al., 2021b). Jones et al. (2022) and Sacco et al. (2017) echoed the poor response to symptom management. Cook et al. (2022), Dev et al. (2011), and Ebenau et al. (2020) stated that palliative patients who use chemicals such as alcohol to cope were likely to express more symptoms; referred earlier to palliative care; prescribed opioid therapy; and reported as having increased levels of pain, sleep, dyspnea, and decreased sense of well-being. Additionally, Ebenau et al. (2020), Witham et al. (2019), and Del Fabbro (2014) identified that sometimes opioids will not

control pain in this population, resulting in an increased consumption of alcohol or opioids to cope with both physical and non-physical pain.

Holistic Care

Dzul-Church et al. (2016), Galvani et al. (2019) and Musili et al. (2021b) echoed the importance of communication, non-judgmental care, and patient choice in developing a plan of care. Cook et al. (2022) noted that respectful communication by staff is important when caring for palliative patients with AUD, as the patient's perception of being unwelcomed by staff is a barrier to care. Anandarajah et al. (2019) stated that having honest conversations about goals-of-care with patients and their families are important in being able to implement the most appropriate interventions so that patients can participate in informed decision making and potentially improve their quality of life. The need to develop a trusting therapeutic relationship was addressed by many articles (Anandarajah et al., 2019; Del Fabbro, 2014; Dzul-Church et al., 2010; Ebenau et al., 2020; Galvani et al., 2018; Galvani et al., 2019; Mundt-Leach, 2016). Jones et al. (2022), McNeil et al. (2012), and Templeton et al. (2022) identified that person-centred practice does not necessarily mean recovery, but that harm reduction should be the focus and the outcome measure should be the patient's quality of life in terms of what the person wants for their palliative care and death.

Several articles identified the need for a biopsychosocial approach to planning care, ensuring that the physical, psychological, emotional, social and spiritual needs of patients are considered (Anandarajah et al., 2019; Ebenau et al., 2018; Ebenau et al, 2020; Galvani et al., 2018; Jones et al., 2022). Jones et al. (2022) also stated that substance use care should be integrated into the patient's care plan to promote the health of the whole person, and that to

develop an individualized care plan requires an understanding not only of patients' needs but their goals as well.

Methodological Framework

Knowledge translation can be used to bridge gaps in practice. For this project, the *Knowledge-to-Action* (KTA) framework by Graham et al. (2006) was used. KTA is based on 31 change theories, and is a structured approach to change implementation that has two parts; a knowledge creation phase and an action cycle. These two parts are fluid and may occur sequentially or simultaneously, influencing one another throughout the knowledge translation process (Graham et al., 2006; see Appendix A).

Knowledge Creation

Within KTA, the creation of knowledge can occur at three levels and produce three generations of knowledge: knowledge inquiry (first-generation), knowledge synthesis (second-generation), and creation of knowledge tools and/or products (third-generation). Knowledge can be empirical, contextual, or experiential (Government of Canada, 2014). Practice guidelines, protocols, care pathways, and decision aids are considered third generation knowledge. They impact the knowledge and informational needs of stakeholders by presenting knowledge clearly and concisely and providing explicit recommendations based on current evidence, thus facilitating the acceptance and application of knowledge. As knowledge is funneled and filtered through each stage in the process of knowledge creation, the results have the potential to become more useful to stakeholders. Knowledge producers can better reach their intended audience by customizing the method of dissemination based on what should be disseminated to whom, by whom, how, and with what effect (Graham et al., 2006).

The Action Cycle

The action cycle includes the activities that lead to implementation of knowledge and includes the following phases:

1. Identifying the problem to be changed, selecting knowledge to address the problem, and determining the gap between knowledge and practice
2. Adapting knowledge to the context of the planned change
3. Assessing barriers to knowledge use in the practice setting
4. Selecting and implementing the correct strategies to make changes
5. Monitoring knowledge use
6. Evaluating outcomes
7. Sustaining the use of knowledge

While the phases of the action cycle all need to be addressed, they are not required to be completed in order, and movement back and forth between phases may occur (Registered Nurses Association of Ontario, 2022).

A citation analysis and systematic review by Field et al. (2014) explored the application of the KTA framework to implementation projects. They found that the framework demonstrated flexibility because it had been applied in practice in a variety of ways, from informing projects to full integration and could be customized to meet the needs of the facilitator and the context (Field et al., 2014).

Conclusion

Although there are no clear models of care for people with AUD and palliative needs, there were many recommendations and considerations for practice brought forth through the literature, many with a focus on harm reduction as opposed to recovery in this population. There

was emphasis on the need for routine screening of all palliative patients using a validated tool and the development of a holistic plan of care that is led by the patient's informed choice and biopsychosocial needs in consideration of their complex comorbidities, including continued alcohol use. Through the development of a strong therapeutic relationship based on good communication and nonjudgmental care, nurses can achieve the goal of enhancing quality of life and access to care.

Chapter 3: Methodology

The purpose of this DNP project was to determine if implementing an alcohol use screening tool would improve the identification and planning of care for palliative patients who actively consume alcohol after admission to a residential hospice facility. Historically alcohol use had not been screened for routinely at the project site, so there was no consistent data on frequency rate of active alcohol consumption at the facility or the diagnosis of AUD as a comorbidity in the plan of care (personal communication, n.d.). The literature has demonstrated that therapeutic relationships are strengthened through communication and non-judgmental, patient-centered care. In the palliative phase of a person's illness, cessation of alcohol consumption may or may not be possible. Through proper screening and assessment of the patient's needs and wishes, an individualized plan of care can be developed.

Grounded in the Humanistic Nursing Theory (Paterson & Zderad, 1976), this project aimed to incorporate the theory's concepts of relationships, communication, the lived experience, and suffering in the assessment and patient-guided planning of care for this population. A biopsychosocial approach to care had been recommended to guide practice, as many patients with AUD also suffer from other symptomatic challenges that may be related to their disease process or the impact of AUD on symptom expression and management (Anandarajah et al., 2020; Ebenau et al., 2020; Jones et al., 2022).

Project Design

The structure of the project was based on the knowledge translation process of the Knowledge-to Action (KTA) framework (Graham et al., 2006). This framework was deemed appropriate because it allowed the guidance of knowledge translation and the implementation of a validated alcohol use screening tool and recommended practice guidelines for the management

of care for specific populations with holistic needs, focusing on context, impact, trust and inclusiveness (Plamondon et al. 2019).

KTA is composed of a knowledge creation phase and an action cycle. The knowledge creation phase funnels the knowledge known about a topic into the development of evidence-based practice tools, protocols, decision aids, guidelines, or other products used to translate the knowledge into practice. The action cycle contains seven steps and may overlap with the knowledge creation phase in the development of a product that is context appropriate.

Application of KTA to Project

Knowledge Creation

For the palliative population with AUD, the research states that harm reduction strategies are best (Cook et al., 2022), and the guidelines for care include:

1. Routine alcohol use screening for all palliative patients (Sacco et al., 2017)
2. For patients that screen positive for current alcohol use, their informed choice should guide the plan of care (MacCormac, 2017)
3. Choices for management of palliative patients who currently use alcohol ought to include medically supported abstinence, gradual reduction of consumption, or continued consumption (Anandarajah et al., 2019; Jones et al., 2022)

This knowledge was translated through the implementation of an alcohol use screening protocol, which included a validated alcohol use screening tool, the AUDIT-C, and the development of an alcohol use conversation guide to be used by the nurses responsible for completing the screening and assessment of each new patient at the project site.

Published Guidance

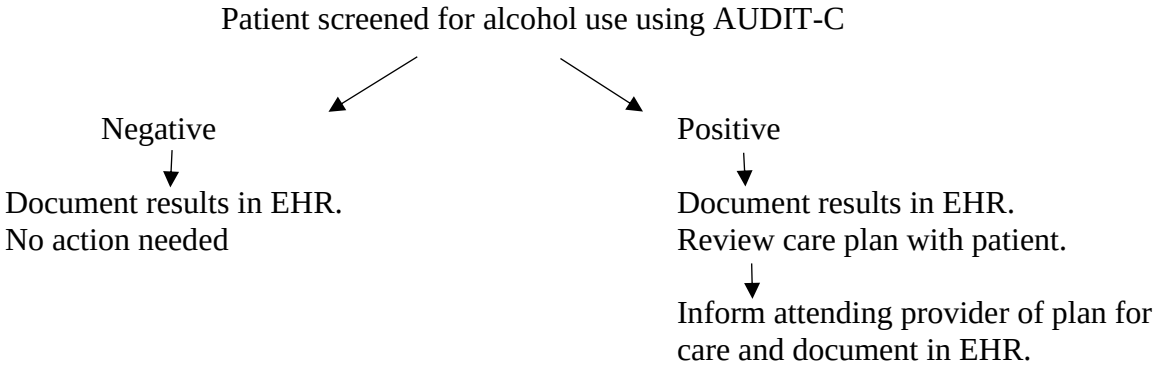
Galvani et al. (2019) published their document *Good Practice Guidance: Supporting People with Substance Problems at the End of Life* with the intention to guide the palliative care of people who use substances, drawing from a variety of sources, including evidence from international research and the lived experiences of patients and professionals. There is a need for early identification of problematic use and to put a care plan in place to meet the patient's complex needs. Additionally, Galvani et al. (2019) stated that better education and training on substance use during the palliative phase of life is required for healthcare professionals, as is guidance of practice through the development of policies. Realistically, harm reduction interventions are more of an appropriate focus than recovery when it comes to alcohol use in palliative patients, as keeping the patient's health stable is more of a focus than pushing for abstinence from alcohol unless that is the desire of the patient (Galvani et al, 2019).

Conversations to discuss the patient's alcohol use in relation to their care plan are important to providing the patient with safe, individualized care. Conversations are preferred to paper-based forms as they promote open communication and development of the therapeutic relationship [Galvani et al., 2019] (See Appendix B for conversation guide).

From this guidance, a screening protocol (see Appendix A) was developed to guide alcohol use screening upon intake and admission for all patients being referred to the project site and planning of care for patients using alcohol. Figure 1 shows a simplified version of the algorithm.

Figure 1

Screening Protocol Simplified Algorithm



Note. This algorithm will be used by the screening nurse to determine course of action for patient's care plan based upon the results of the screening tool.

Action Cycle

The KTA's action cycle has seven phases, which are not considered to be sequential, but must all be addressed (Graham et al., 2006). The process of moving knowledge into action is considered dynamic and complex.

The Gap in Knowledge and Practice

The first phase is the identification of a problem to change, the selection of knowledge to address the chosen problem, and then determining the gap between knowledge and practice. It was identified that alcohol use was not routinely screened for at the project site; and as a result, continued alcohol use was not recognized or incorporated into the plan of care. The purpose of this project was to address this gap in practice by implementing the use of a validated alcohol use screening tool and evidence-based guidance on communicating with palliative patients that were actively consuming alcohol to determine their goals for care in relation to alcohol consumption. The gap between knowledge and practice was that there was no policy or protocol at the project

site for the screening and care of palliative patients with ongoing alcohol use and as a result, the staff were not educated or trained on how to do so.

Setting and Sample

This project was conducted at a residential hospice facility in Ontario, Canada. On average, 200 patients and their families are cared for each year between in-house community outreach support. This evidence-based project for quality improvement was supported by the nursing staff and leadership at the hospice.

Nurses and other registered staff at the project site participated in education and training about the protocol. Education and training included identifying the purpose of the project implementation; introducing the screening tool; instructing on how to use the tool and document the results; guiding on how and when to have a conversation to assess patient needs and wishes for alcohol use, reduction, or abstinence; and how to document patient choice.

The personal support workers, volunteers or administrative staff of the facility, or any other staff that are not involved in the direct care of the patients did not participate.

Barriers and Facilitators

The third phase is to assess barriers and facilitators to knowledge use. The Agency for Healthcare Research and Quality (AHRQ; 2015) identified that there are several barriers to alcohol screening by providers, including perceived lack of time, unfamiliarity with the screening tool being used, and lack of education and training on the topic and tool. In the literature specific to palliative care, MacCormac (2017) noted that many palliative healthcare professionals are unsure of their role when caring for palliative patients who continue to use alcohol. These barriers were also reflected among the nurses at the project site, who agreed that screening for alcohol use in patients would be valuable but did not have the knowledge,

resources, or direction on how to implement it (personal communication, n.d.) . Facilitators to the implementation of the project included the support of the hospice administration for the project, interest of the nursing staff to gain knowledge and skills to deliver the protocol, and the backing of the palliative physician group to implement the protocol in the hospice. The prevalence of these barriers and facilitators in the study were assessed for through the conduction of surveys before and after the education and training sessions (See Appendix E).

Implementation

The fourth phase of the action cycle is to select the right implementation strategies to make changes in the project setting. For this project, implementation included the development and delivery of an education module to deliver the key concepts learned about AUD in the literature review, teaching participating nurses about the AUDIT-C tool and how to use it, and a discussion about communication strategies for having the conversation with patients about their plan of care in consideration of their alcohol use.

Data Collection and Data Analysis

The fifth and sixth phases of the KTA action cycle are monitoring knowledge use and evaluating outcomes. This includes examining the impact of the change to the practice setting and determining whether the project's goals have been achieved.

Structured surveys were conducted on participating nurses' confidence pre-and post-education to assess nurses' knowledge, attitudes and beliefs related to assessing and caring for palliative patients who use alcohol. Specifically, perceived improved knowledge related to alcohol use in the palliative population, changes in confidence to administer the protocol, motivation and attitude towards the protocol, and comfort level with administering the protocol were assessed, as this has previously been determined to be a barrier to the delivery of quality

assessments and care (MacCormac, 2017). Patient charts for the four weeks preceding the project's implementation and during the four-week time of the implementation phase were audited to determine the frequency of alcohol use screening on admission.

This project focused on the implementation of a validated alcohol use screening tool upon admission to a residential hospice facility. Several measurements were completed, as well as statistical analysis. The data were analyzed to determine if there is a change in the percentage of patients screened prior to implementation compared to after implementation. Measurements were employed to determine if there was a statistically significant change in staff confidence about caring for patients who use alcohol based on the answers to the pre-education and post-education surveys.

Sustaining the Change

The final phase is sustaining the change, which means ongoing utilization of the protocol at the practice site. The results of the project will be disseminated to the stakeholders at the site with the goal of support of a permanent practice change. Another way to sustain the change will include dissemination of the project results to other palliative care agencies in the community that may be interested in their own implementation of the protocol for community-dwelling palliative patients.

Ethical Considerations

Approval for this QI project was sought by the project site as well as the Institutional Review Board at Aspen University. The screening results were HIPPA compliant and there was no significant risk of any confidentiality issues or ethical misconduct. The project presented minimal risk to participants pertaining to experimental treatment or exposure to physical or

psychological harm and were not greater than any ordinarily encountered in daily life or during the performance of routine heath examinations or tests.

No staff or patient names or identifying information were used when gathering and auditing the data. Data were tracked using Likert scale responses and for any comparisons of the same person, they were assigned a random number. Any paper copies of data were stored in a locked filing cabinet that only the site's assigned data collector has the key to and all electronic information, including the gathered and analyzed data, was kept in a password-protected file on one password-protected computer which was only accessible by the site's assigned data collector. Upon completion of the project, all paper and electronic files were destroyed to ensure confidentiality is maintained.

All patients were screened as part of their pre-admission assessment and on admission into the facility. Nurses completing the screening tool were not compensated outside of their regular wage during working hours. Participation was not required, and staff had the option to opt out without penalty. Consent of the nursing staff was implied through their voluntary attendance and participation in the education sessions and application of the protocol in practice. Their use or non-use of the protocol had no effect on their employee performance evaluations, nor did it impact their continued employment at the hospice.

Internal and External Validity

Andrade (2018) stated that validity is a way to explain how well an instrument does what it is supposed to do. Internal validity examines whether there is bias in the design, conduction, and analysis of the study and whether the research questions are answered without bias. External validity supports the transferability of the study's findings to other contexts. The screening tool used for this project is the AUDIT-C, which has been tested for its internal and external validity

in a variety of healthcare environments as demonstrated by Jeong et al. (2017). Internal validity may be influenced by the sample size and the pre- and posttest design (Choueiry, 2022). Nursing staff completed the protocol on all new patients; thus, the number of patients being screened was not impacted by the number of nurses completing the screening. Conducting a pre- and post-education survey demonstrated internal validity by supporting that the education and training sessions increased sample confidence and competence in administering the protocol.

The project was expected to have external validity in that it can be applied to palliative patients in other settings, such as the community. Because the protocol is specific to palliative patients and their choices as they progress towards the end of their illness trajectory, it cannot be assumed or expected to be transferrable to any other groups of patients.

Conclusion

Based on the tenets of the HNT and structured using the KTA framework, this QI project aimed to improve alcohol screening for palliative patients though the implementation of an alcohol use screening protocol. Through education and training, the hospice nurses gained confidence in using the protocol. Care providers for other palliative populations outside of the residential hospice setting may also find benefit in using this protocol to improve alcohol use screening and care planning for palliative patients.

Chapter 4: Results and Discussion of Findings

The literature has shown that up to 28% of palliative patients consume alcohol during this phase of life, and that alcohol use is not routinely screened for in this population (MacCormac, 2017). Unrecognized alcohol use disorder (AUD) in palliative patients can result in health risks to the patient such as withdrawal; misdiagnosis; and mistreatment, resulting in challenges to management of care and reduced quality of life (MacCormac, 2017). Routine screening for alcohol use has been identified as the first step in improving the ability to provide quality care to patients who actively continue to use alcohol during the palliative phase (Cook et al., 2022). This Doctor of Nursing Practice (DNP) project sought to implement an alcohol use screening tool for palliative patients admitted to a residential hospice facility. An alcohol use screening protocol was developed and integrated into the electronic health record (EHR) at the project site (See Appendix C). Education about alcohol use by palliative patients and training for the delivery of the protocol were provided to the nurses involved in the implementation to improve their confidence and competence to support successful project implementation (See Appendix F). The following section presents the results of the analyzed data gathered pre-and post-implementation of the alcohol use screening protocol as well as the survey results from the educational session. A discussion of the key findings from the project follows.

Summary of Project Analysis

The purpose of this quality improvement project was to implement a validated alcohol use screening tool, the AUDIT-C, as part of an alcohol use screening protocol for palliative patients admitted into a residential hospice facility. To complete the implementation all nursing staff were invited to an education session about alcohol use in palliative care and training for the use of the AUDIT-C screening tool and related protocol. The session consisted of a DNP

candidate led PowerPoint presentation which discussed alcohol use disorder in the palliative population, introduced the purpose of the screening tool and protocol and why it was important to integrate knowledge of alcohol use into the care plan for these patients. Prior to the education session, all participating staff were surveyed for their perceived knowledge of alcohol use in the palliative population and confidence in caring for this group (See Appendix E for survey). After the education session was completed, the staff survey was repeated to determine if their perceived knowledge and confidence had improved (See Appendix G for data analysis). The education session was recorded and made accessible for all staff to watch or review. Implementation of the new protocol was initiated the day after the education session and lasted four weeks. Post-implementation, a patient chart audit was performed to determine staff compliance with the alcohol use screening protocol.

Screening for Alcohol Use on Pre-Admission and Admission Assessments

A review of the patients charts from the four weeks prior to project implementation was performed as well as during the four weeks of project implementation. The chart audit data from each phase were analyzed using a chi-square test of homogeneity, which is used to analyze data that have been intentionally collected on two or more distinct groups, as in a change implementation with a comparison group. A single variable of interest is compared between the two samples to test whether the proportions differ between them (Franke et al., 2012). In this project, the expectation was that alcohol use was screened for during the pre-admission assessment as well as during the admission assessment. The data in each phase of the project were analyzed and then compared to determine if there was a statistically significant improvement in screening rates after the protocol was implemented. The chi-square test was performed with the following possible null and alternative results:

H_O: the proportion of patients screened for alcohol use is the same

H_A: the proportion of patients screened for alcohol use is different

For the chi-square tests, a significance threshold of p=.05 was used for analysis of the results.

Pre- and Post-Education Knowledge and Confidence

Paired t-tests were used to test differences in perceived knowledge and confidence of the staff who completed pre- and post-educational surveys and participated in the educational session provided (See Appendix G for data analysis). A paired t-test is used to compare the means of two related groups and was deemed an appropriate test for this data.

Results

The goal of the DNP project was to improve screening for alcohol use in palliative patients at a residential hospice facility through the implementation of an alcohol use screening protocol. The results showed an improvement in the frequency of screening for alcohol use in the patient population at the project site. Additionally, the results showed that the education session provided to the nursing staff improved their perceived knowledge and confidence related to their role and responsibilities in screening and caring for palliative patients who actively consume alcohol and removed this barrier that was identified in the literature.

Screening for Alcohol Use on Pre-Admission and Admission Assessments

Prior to this project, patients were not routinely screened for alcohol use during their pre-admission assessment or on admission to the facility. A review of the patients charts from the four weeks prior to project implementation was performed. Of the nine patients that had both a pre-admission assessment and an admission assessment completed, six were screened for alcohol use during the pre-admission assessment, but none had been screened for alcohol use on admission. During the four weeks of project implementation, 13 patients had pre-admission and

admission assessments completed. All 13 patients were screened for alcohol use during both their pre-admission and admission assessments following the protocol.

Table 1 shows the results of the data analysis using chi-square tests. The results for the comparison rates of screening during pre-admission assessments between the two project phases returned a p-value of .317, which is greater than a p-value of .05. This result indicates that the increase in screening during pre-admission assessments after the project implementation was not statistically significant. Although not considered statistically significant, a noteworthy observation is that compliance increased to 100% during the implementation phase, compared to 66.67% during the pre-implementation phase.

Regarding screening for alcohol use during the patient's admission assessment, the data analysis returned a p-value of .003, which is less than a p-value of .05. This result indicates that there was a significant improvement in the rate of screening during admission assessments during the project implementation period as compared to the pre-implementation period.

Table 1

Chi-Square Test Data Analysis Results for Frequency of Alcohol Use Screening

Alcohol Use Screening	Pre-Implementation		Implementation		p-value
	Observed	Expected	Observed	Expected	
Pre-admission assessment	6	9	13	13	.317
Admission assessment	0	9	13	13	.003

The results show that there was a significant increase in the rate of screening for alcohol use on admission to the project site during the implementation period as compared to pre-implementation. However, there was not a statistically significant increase in the rate of screening for alcohol use during patient pre-admission assessments when comparing the two time periods.

Pre- and Post-Education Knowledge and Confidence

The pre-implementation education session was attended by nine staff members. A 13-question paper-based survey was provided to attendees prior to and after the session (See Appendix E for survey). All nine of the attendees completed both surveys. The responses to these pre- and post-education surveys were used to determine if attendees' perceived knowledge and confidence regarding AUD in the palliative population, screening for AUD in this population, and providing care for palliative patients with AUD had improved after the education session. The data from the pre-and post-education surveys were analyzed using paired t-tests (See Appendix G for data analysis). Of the 13 questions asked on the survey, attendees perceptions improved statistically significantly ($p < .05$) on six items after the education session was held. Overall, attendees perceived their knowledge about alcohol use disorder in palliative patients in relation to their role when working with them improved significantly ($p = .009$), as did their knowledge of their role and responsibilities in relation to caring for palliative patients with AUD ($p = .007$).

Implications for Nursing Practice

There are several implications for nursing practice and the management of AUD in palliative patients from this DNP project. There was a statistically significant improvement in screening for alcohol use on admission to the project site when comparing the data gathered pre-and post-implementation of the protocol. The results demonstrated the importance of staff education in successful implementation through improved knowledge, confidence, and motivation related to AUD, alcohol use screening tools, and their role and responsibilities when caring for palliative patients who continue to consume alcohol. Given that previous research studies showed a lack of clarity related to expectations regarding role and responsibilities when caring for this population,

this project demonstrated that education could improve role clarification and responsibility expectations and ultimately, improve compliance and successful implementation. The findings can be utilized to add to existing studies and further research on the various attributes of the alcohol use screening protocol.

Conclusion

This project focused on implementing an alcohol use screening protocol in palliative care to screen patients for active alcohol consumption on admission to a residential hospice facility. A review of the literature identified the need for improved screening to identify palliative patients who are actively consuming alcohol and to improve quality of care and outcomes (Galvani et al., 2019). The PICO question guiding this project aimed to determine if the implementation of an evidenced based screening protocol increased the number of palliative patients that were screened for AUD. The project results confirmed that the implementation of the alcohol use screening protocol significantly improved the rate of assessment on admission to the hospice facility compared to the facility's previous practice. Based on this knowledge, other palliative care providers may consider implementing an alcohol use screening protocol as a standard part of admission assessment to assist with the planning and management of care for palliative patients with AUD.

Chapter Five: Discussions and Conclusion

The literature has established that undiagnosed alcohol use disorder (AUD) in palliative patients contributes to low quality of life and poor patient outcomes due to increased symptom burden, misdiagnosis, and mismanagement of symptoms (Ebeneau et al., 2018). Guiding research supported a harm-reduction approach at this stage of life in consideration of the patient's preferences regarding their alcohol use and end-of-life wishes (Galvani et al., 2019). To improve the quality of care provided to this population, this DNP project implemented an evidence-based alcohol use screening protocol in a residential palliative care facility with the goal of increasing the frequency of screening palliative patients for AUD. Incorporating the alcohol use screening protocol into admission assessments at the facility through staff education and electronic health record (EHR) integration have resulted in a significant improvement in screening frequency. The nurse-driven protocol will open communication around alcohol use with patients that screen positively and improve planning and management of care for patients who continue to use alcohol.

Discussion of Findings and Best Practices

Alcohol use screening tools are helpful to provide patients with individualized, informed care. Screening for alcohol use is considered best practice in palliative care and leads to the ability to complete proper assessments as required and plan care and treatments in consideration of the results (Sacco et al., 2017). Cook et al. (2022) identified that in palliative care, the use of policies to guide practice on the screening and continued use of substances in those with a history of use are not routine. Anandarajah et al. (2019) added that one of the biggest barriers to proper care for this population is a lack of screening. This DNP project was significant because it aimed to bridge a gap in care through the development of a protocol that would have all

palliative patients screened for alcohol use on admission to the project site. Historically, patients were not consistently screened for alcohol use on admission. The protocol would guide further nursing assessments and communication with patients who screened positively to determine their goals for care in consideration of their alcohol use. Based on the Knowledge-to-Action Framework by Graham et al. (2006), this evidence-based quality improvement project implemented a validated alcohol use screening tool and contributed to the limited body of knowledge on screening for alcohol use disorder in palliative patients.

The literature review performed for the DNP project identified that poor knowledge and confidence by palliative nurses related to their role and responsibilities when screening for alcohol use and providing care for the palliative patient who continues to actively consume alcohol contributed to the lack of screening performed (Ebeneau et al., 2018; MacCormac, 2017). The results of the data analysis from this DNP project supported that role and responsibility clarification improved the rate of alcohol use screening by staff at the project site. The project identified that nurses needed not only training on the tool but education to improve their knowledge and confidence in delivering care to this population. The education session was brief but provided the attendees with the information to develop their understanding of their role and responsibilities as well as to strengthen their perceived knowledge and confidence. Education about the rationale for the need for change is important when implementing a change to help with staff buy-in and improve motivation to participate in the change process (Kotter, 2012).

Screening for alcohol use on admission to the project site during the project implementation phase occurred with 100% compliance. Additionally, there was an improvement in the frequency of screening during pre-admission assessments. Although not a statistically significant

improvement, 100% compliance was also achieved for alcohol use during pre-admission assessments completed in the implementation phase. This demonstrated that once staff were provided the education and training on the tool and the expectation of their nursing role and responsibilities was clearly communicated, they readily adapted the screening into their patient assessments.

Another consideration is the standardization of the screening tool used on patients at the project site. The literature demonstrated a great amount of variability in the reported frequency of AUD in the palliative population based on the type of screening tool used (Webber et al., 2020; Yusufov et al., 2019). The use of the AUDIT-C tool and its electronic integration into the project site's EHR allowed easy access for staff to utilize and review patient results and trends. While the AUDIT-C may not be the preferred validated screening tool for every organization to use, consistency with using the same screening tool within the same patient population at various points of assessment will facilitate the reliability of results and visualization of trends when completing assessments and planning patient care.

Implication for Practice and Future Projects

Implementing this intervention in all practice settings that provide care for palliative patients would be a straightforward process that would reach all palliative patients in the community and provide consistency in care. Considering many palliative patients die at home or in hospital, it is important to move the alcohol use screening protocol beyond the project site and implement it when patients are first referred for palliative services and by palliative care providers in the community. Many palliative patients are still high functioning upon initial referral to palliative services, so early screening, assessment, and care planning in consideration

of their comorbidities, including alcohol use, will promote an open therapeutic relationship and improve quality of care and patient outcomes.

Mandatory staff education on the topic of alcohol use in palliative patients and contributing factors related to continued alcohol use in this stage of life is critical in creating understanding, dispelling myths, reducing stigma and enabling the provision of open communication and non-judgmental care. Role confusion was identified in the literature as a main reason that alcohol use was not screened for in practice (MacCormac, 2017). Increasing nurses' awareness of AUD in palliative patients as well as the value of the alcohol use screening protocol is critical to increasing nurses' knowledge, confidence, and motivation to care for palliative patients in a way that meets their individual needs and goals.

Plan for Dissemination

Dissemination of the results of a quality improvement project is essential so that the findings can be shared to increase the body of nursing knowledge known about the topic. The final project and results will be presented to the DNP committee at Aspen University team during the final defense of the project which includes a PowerPoint and oral presentation. The project results will also be shared with the key stakeholders at the project site through a poster presentation. Additionally, the project manuscript will be submitted to the DNP Project repository. A fourth plan for dissemination is to present the results of the project to community partners that provide homecare to palliative patients with the goal of extending the application of the alcohol use screening protocol into the community to improve the care of palliative patients while they remain in their homes.

A restriction on publication was a condition of the project's site approval by the administration at the project site. A goal for dissemination is to lobby the administration to grant

permission for publication based on the findings of the project and the importance of dissemination to improve the quality of care for other palliative populations beyond the site.

Sustaining the Change

Several initiatives were incorporated at the project site to sustain the application of the alcohol use screening protocol. The first was in integration of the AUDIT-C screening tool into the site's EHR to facilitate documentation and the easy retrieval of results and trends. With the support of the site's management team, a section has been added onto the admission assessment worksheet that prompts the admitting nurse to complete the AUDIT-C as an expected part of their responsibilities.

The pre- and post-education survey results demonstrated that attendees had a statistically significant improvement in their ability, willingness, desire, and intent to mentor colleagues on the alcohol screening protocol ($p = .021$). This peer-to-peer support will be important to support the change ongoing among new staff. Additionally, the education session that was provided as part of the project was recorded and has been uploaded to the site's learning management system so that it can be accessed and reviewed by new employees.

Recommendations for Future Projects and Practice

This DNP project achieved the first step of the alcohol use screening protocol, which was to implement the use of a validated alcohol use screening tool on admission to the project site. For patients who screen positive on their assessment, future research could explore what decisions patients make related to their continued alcohol use, how their care plan is developed, and their care is managed in relation to their choices. Although the integration of the AUDIT-C as part of routine assessments is an important first step in implementing the alcohol use screening protocol as part of nursing practice at the project site, more research is needed on the

patient outcomes associated with following through with the planning of care in consideration of the patient's alcohol use. The second step of the alcohol use screening protocol includes identifying the unique health management needs for patients who screen positively using the screening tool and the development of a holistic plan of care that is led by the patient's informed choice and biopsychosocial needs in consideration of their complex comorbidities, including continued alcohol use. Grounded in the Humanistic Nursing Theory (Paterson & Zderad, 1976), this project aimed to incorporate the theory's concepts of relationships, communication, the lived experience, and suffering in the assessment and patient-guided planning of care for this population. A biopsychosocial approach to care had been recommended to guide practice, as many patients with AUD also suffer from other symptomatic challenges that may be related to their disease process or the impact of AUD on symptom expression and management (Anandarajah et al., 2020; Ebenau et al., 2020; Jones et al., 2022). Future projects exploring the effect of the protocol on the patient's quality of life and outcomes will provide further understanding on the impact of the protocol on the patient's lived experience during their palliative phase of life.

It is essential that all nurses caring for palliative patients screen for active alcohol use to promote early detection and help to improve their patients' quality of life. As the awareness around substance use disorders continues to increase, it is important to acknowledge that these disorders exist as comorbidities in the palliative population. Patients are typically admitted to the project site with a projected life expectancy of three months or less and a Palliative Performance Scale (PPS) score of less than 50%. Timing for the implementation of this protocol for admission to the residential hospice facility may have been late in the patient's health trajectory, so future

projects may look at implementing the protocol at the time of initial referral to palliative services which is often when the patient is still living in the community at a high level of functioning.

Achievement of the DNP Essentials

The AACN (2006) outlined eight essentials needed to obtain the Doctor of Nursing Practice (DNP) degree in their publication, *The Essentials of Doctoral Education for Advanced Practice Nursing*. The DNP is skilled in enhancing leadership, improve patient outcomes, provide complex practice, and advance the practice of nursing (AACN, 2006). This project was expected to meet all eight DNP Essentials and was successful in doing so.

Essential I: Scientific Underpinnings for Practice

Essential I was achieved in several ways. First, using the HNT as the theoretical framework for the project grounded it in nursing science and provided a foundation for practice. The literature review enabled the project to be grounded within the current field of literature and to contribute to further nursing knowledge by addressing a gap in both research and practice. From the evidence gathered a practice approach that would improve the quality of care provided to palliative patients using alcohol was developed.

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking

Essential II focuses on improving patient and healthcare outcomes by focusing on the needs of a target population and creating new feasible, evidence-based care delivery models within an organization. This is in line with the goal of developing, implementing, and evaluating an alcohol use screening protocol in a palliative care population, which was the focus of this project. Additionally, role-modelling evidence-informed practice will help to foster an environment that is supportive and conducive to change.

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

Essential III focuses on achieving scholarship through integration and application of evidence to solve practice problems. This project achieved this essential by using the evidence from the literature to identify a gap in practice and engaging in evidence-informed practice to fill the gap. Links were made between the evidence in the literature to create an alcohol use screening protocol to guide the care of the target population.

Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care

Essential IV focuses on using information technology to improve patient outcomes and healthcare systems. This project included the extraction of data from the electronic health record database, and the design and implementation of an electronic alcohol screening tool within the electronic health record system.

Essential V: Health Care Policy for Advocacy in Health Care

The design and implementation of a protocol for alcohol use screening meets Essential V because it created an organizational standard to improve quality of care for patients using alcohol within the facility that previously did not exist. Additionally, the dissemination plan contributes to advocating for similar practice within the local setting and ideally influencing others beyond the local context.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

This Essential focuses on the collaboration of healthcare workers from a variety of professions to accomplish positive patient outcomes. This is important for the palliative patient using alcohol because as the literature identified, they have multiple complex needs and care

should have a biopsychosocial approach, meaning that medicine, nursing, social work, and potentially substance use professionals will need to collaborate to provide the patient and their supports with holistic care. During the project implementation, there was collaboration between patients, families, nurses, physicians, administrators, and social workers.

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

The premise of this DNP project was the identification of alcohol use in palliative patients and the implementation of harm reduction strategies into their care plan to improve their quality of life. In relation to health equity, this helps to ensure those patients with AUD receive equitable care within the palliative care system. This is in line with Essential VII, which focuses on implementing activities to improve population health.

Essential VIII: Advanced Nursing Practice

Essential VIII has been addressed in the project by focusing on the specialty of palliative care and refining assessment of a target population within this area. More specifically, it provided routine alcohol use screening in a residential hospice and implemented recommendations for care of the palliative patient using alcohol.

Conclusion

This quality improvement project sought to improve screening for alcohol use in palliative care through the implementation of an alcohol use screening protocol. The project was carried out at a residential hospice facility in Ontario, Canada. The project was based on the Humanistic Nursing Theory and its core concepts of relationships, human uniqueness, and community (Patterson & Zderad, 1976). The methodology was guided by the steps of the Knowledge-to-Action framework. After a short education session, the nursing staff completed

the alcohol use screening protocol during all pre-admission and admission assessments performed during the project's implementation phase. Analysis of the screening results revealed that the intervention significantly improved the rate of alcohol use screening for patients admitted at the site. This project aimed to increase the screening for alcohol use in palliative patients to improve their quality of life. The results will add to the limited body of nursing knowledge available on screening for alcohol use in palliative care and managing the care of patients who continue to use alcohol in the palliative phase of their lives.

References

Allen, J. P., Litten, R. Z., Fertig, J. B., & Babor, T. (1997). A review of research on the Alcohol Use Disorders Identification Test (AUDIT). *Alcoholism: Clinical and Experimental Research*, *21*(4), 613-619.http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.852.9317&rep=rep1&type=pdf

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice.* https://www.aacnnursing.org/Portals/42/Publications/DNPEssentials.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, 5th edition: DSM-5*. (5th ed). American Psychiatric Publishing.

Anandarajah G, Mennillo HA, Rachu G, Harder T, & Ghosh J. (2020). Lifestyle medicine interventions in patients with advanced disease receiving palliative or hospice care. *American Journal of Lifestyle Medicine,14*(3), 243-257. doi:10.1177/1559827619830049

Andrade, C. (2018). Internal, external, and ecological validity in research design, conduct, and evaluation. *Indian Journal of Psychological Medicine*, *40*(5), 498-499. https://journals.sagepub.com/doi/pdf/10.4103/IJPSYM.IJPSYM_334_18

Attilia, F., Perciballi, R., Rotondo, C., Capriglione, I., Iannuzzi, S., Attilia, M. L., Coriale, G., Vitali, M., Cereatti, F., Fiore, M., Ceccanti, M., & Interdisciplinary Study Group CRARL - SITAC - SIPaD - SITD - SIPDip (2018). Alcohol withdrawal syndrome: diagnostic and therapeutic methods. *Rivista di Psichiatria*, *53*(3), 118–122. https://doi.org/10.1708/2925.29413

Berl, K., Collins, M. L., Melson, J., Mooney, R., Muffley, C., & Wright-Glover, A. (2015).

Improving nursing knowledge of alcohol withdrawal: Second generation education strategies. *Journal for Nurses in Professional Development*, *31*(6), 328. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4738842/

Bhogal, S. K. (2011). *Application of the knowledge-to-action framework: Delayed administration of systemic corticosteroids in children with acute asthma* (Order No. NR61969). Available from ProQuest Central. (908901229). http://ra.ocls.ca/ra/login.aspx?url=https://www.proquest.com/dissertations-theses/application-knowledge-action-framework-delayed/docview/908901229/se-2

Centers for Medicare and Medicaid Services. (2017). *Meaningful measures initiative.* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy

Choe, Y. M., Lee, B. C., Choi, I. G., Suh, G. H., Lee, D. Y., & Kim, J. W. (2019). Combination of the CAGE and serum gamma-glutamyl transferase: an effective screening tool for alcohol use disorder and alcohol dependence. *Neuropsychiatric Disease and Treatment*, *15*, 1507–1515. https://doi.org/10.2147/NDT.S203855

Choueiry, G. (2022). *One-group pretest-posttest design: An introduction.* https://quantifyinghealth.com/one-group-pretest-posttest-design/

Clements, R. (1998). A critical evaluation of several alcohol screening instruments using the CIDI-SAM as a criterion measure. *Alcoholism: Clinical and Experimental Research*, *22*(5), 985-993. doi: 10.1111/j.1530-0277.1998.tb03693.x.

Cook, O., Doran, J., Crosbie, K., Sweeney, P., Millard, I., & O'Connor, M. (2022). Palliative

care needs and models of care for people who use drugs and/or alcohol: A mixed methods systematic review. *Palliative Medicine, 36*(2), 292-304. https://doi.org/10.1177/02692163211061994

Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B., Davidson, K. W., ... & US Preventive Services Task Force. (2018). Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA, 320*(18), 1899-1909. https://jamanetwork.com/journals/jama/article-abstract/2714537

Del Fabbro, E. (2014). Assessment and management of chemical coping in patients with cancer. *Journal of Clinical Oncology, 32*(16), 1734-1738. https://www.slaop.org/pdf/93397.Dor%20Assessment%20and%20Management%20of%20Chemical%20Coping%20in%20Patients%20With%20Cancer.pdf

Dev, R., Parsons, H. A., Palla, S., Palmer, J. L., Del Fabbro, E., & Bruera, E. (2011). Undocumented alcoholism and its correlation with tobacco and illegal drug use in advanced cancer patients. *Cancer, 117*(19), 4551-4556. https://acsjournals.onlinelibrary.wiley.com/doi/pdf/10.1002/cncr.26082

Dobrina, R., Tenze, M., & Palese, A. (2014). An overview of hospice and palliative care nursing models and theories. *International Journal of Palliative Nursing, 20*(2), 75-81. https://doi.org/10.12968/ijpn.2014.20.2.75

Dzul-Church, V., Cimino, J. W., Adler, S. R., Wong, P., & Anderson, W. G. (2010). “I'm sitting here by myself…”: experiences of patients with serious illness at an Urban Public Hospital. *Journal of Palliative Medicine, 13*(6), 695-701. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2938893/

Ebenau, A., Dijkstra, B., Stal-Klapwijk, M., Ter Huurne, C., Blom, A., Vissers, K., & Groot, M. (2018). Palliative care for patients with a substance use disorder and multiple problems: a study protocol. *BMC Palliative Care*, *17*(1), 1-9. https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-019-0502-x

Ebenau, A., Dijkstra, B., Ter Huurne, C., Hasselaar, J., Vissers, K., & Groot, M. (2020). Palliative care for patients with substance use disorder and multiple problems: a qualitative study on experiences of healthcare professionals, volunteers and experts-by-experience. *BMC Palliative Care*, *19*(1), 1-13. https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-019-0502-x

European Association for the Study of the Liver. (2018). EASL clinical practice guidelines: Management of alcohol-related liver disease. *Journal of Hepatology*, *69*(1), 154-181. http://www.lcgdbzz.org/fileLCGDBZZ/cms/news/info/zngs/9135.pdf

Ewing, J.A. (1984). Detecting alcoholism. The CAGE questionnaire. *JAMA*, *252*(14), 1905–1907. doi:10.1001/jama.1984.03350140051025

Fawcett, J. (2005). Criteria for evaluation of theory. *Nursing Science Quarterly*, *18*(2), 131-135. https://doi.org/10.1177/0894318405274823

Field, B., Booth, A., Ilott, I., & Gerrish, K. (2014). Using the Knowledge to Action Framework in practice: A citation analysis and systematic review. *Implementation Science*, *9*(1), 1-14. https://implementationscience.biomedcentral.com/articles/10.1186/s13012-014-0172-2

Franke, T. M., Ho, T., & Christie, C. A. (2012). The chi-square test: Often used and more often

misinterpreted. *American Journal of Evaluation*, *33*(3), 448-458. https://www.academia.edu/download/40411203/The_Chi-Square_Test_Often_Used_and_More_20151126-27537-1ldyftt.pdf

Galvani, S., Dance, C., & Wright, S. (2018). *Experiences of hospice and substance use professionals: End of life care for people with alcohol and drug problems*. https://e-space.mmu.ac.uk/621802/1/End%20of%20Life%20Care%20and%20SU%20Prof%20experience%20Strand%205%20full%20report%20final%205%20Nov%202018.pdf

Galvani, S., Wright, S., & Witham, G. (2019). *Good practice guidance: Supporting people with substance problems at the end of life*. https://e-space.mmu.ac.uk/623172/1/Good%20practice%20guidance%20EoLC%20and%20SU%20April%202019%20Web%20version.pdf

Galvani, S. (2020). Offering the best death possible: Supporting people using substances at the end of life. *Addiction*, *115*(3), 391. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7027735/

Giusti, R., Mazzotta, M., Verna, L., Sperduti, I., Di Pietro, F. R., Marchetti, P., & Porzio, G. (2019). The incidence of alcoholism in patients with advanced cancer receiving active treatment in two tertiary care centers in Italy. *Alcohol and Alcoholism*, *54*(1), 47-50. https://academic.oup.com/alcalc/article/54/1/47/5107615

Government of Canada. (2014). *Integrating ethics and the Knowledge-to-Action cycle.* Retrieved September 26, 2022 from https://cihr-irsc.gc.ca/e/48802.html

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., & Robinson, N.

(2006). Lost in knowledge translation: Time for a map?. *Journal of Continuing Education in the Health Professions*, *26*(1), 13-24. https://onlinelibrary.wiley.com/doi/pdfdirect/10.1002/chp.47

Graham, I. D., Kothari, A., & McCutcheon, C. (2018). Moving knowledge into action for more effective practice, programmes and policy: protocol for a research programme on integrated knowledge translation. *Implementation Science, 13*(1), 1-15. https://implementationscience.biomedcentral.com/articles/10.1186/s13012-017-0700-y

Groninger, H., & Knapik, M. (2019). Twelve-step programs and spiritual support at the end of life. *American Journal of Hospice and Palliative Medicine*, *36*(9), 807-811. https://doi.org/10.1177/1049909119832809

Higgins-Biddle, J. C., & Babor, T. F. (2018). A review of the Alcohol Use Disorders Identification Test (AUDIT), AUDIT-C, and USAUDIT for screening in the United States: Past issues and future directions. *The American Journal of Drug and Alcohol Abuse*, *44*(6), 578-586. https://www.tandfonline.com/doi/pdf/10.1080/00952990.2018.1456545

Ho, P., & Rosenheck, R. (2018). Substance use disorder among current cancer patients: rates and correlates nationally in the Department of Veterans Affairs. *Psychosomatics, 59*(3), 267-276. https://doi.org/10.1016/j.psym.2018.01.003

Hospice Palliative Care Ontario (HPCO) (n.d.). *Accreditation*. https://www.hpco.ca/accreditation/

Jeong, H. S., Park, S., Lim, S. M., Ma, J., Kang, I., Kim, J., & Kim, J. E. (2017). Psychometric

properties of the alcohol use disorders identification test-consumption (AUDIT-C) in public first responders. *Substance Use & Misuse*, *52*(8), 1069-1075. Doi:10.1080/10826084.2016.1271986

Jones, K. F., Ho, J. J., Sager, Z., Childers, J., & Merlin, J. (2022). Adapting palliative care skills to provide substance use disorder treatment to patients with serious illness. *American Journal of Hospice and Palliative Medicine*, *39*(1), 101-107. https://doi.org/10.1177/1049909121999783

Kim, Y. J., Dev, R., Reddy, A., Hui, D., Tanco, K., Park, M., & Bruera, E. (2016). Association between tobacco use, symptom expression, and alcohol and illicit drug use in advanced cancer patients. *Journal of Pain and Symptom Management*, *51*(4), 762-768. https://www.sciencedirect.com/science/article/pii/S0885392415009604

Kotter, J. P. (2012). *Leading change*. Harvard business press.

Lakens, D. (2013). Calculating and reporting effect sizes to facilitate cumulative science: a practical primer for t-tests and ANOVAs. *Frontiers in Psychology*, 4, 863.

MacCormac, A. (2017). Alcohol dependence in palliative care: A review of the current literature. *Journal of Palliative Care 32*(3-4), 108-112. https://doi.org/10.1177%2F0825859717738445

Mauro, P. M., Askari, M. S., & Han, B. H. (2021). Gender differences in any alcohol screening and discussions with providers among older adults in the United States, 2015 to 2019. *Alcoholism: Clinical and Experimental Research*, *45*(9), 1812-1820. https://doi.org/10.1111/acer.14668

McNeil, R., Guirguis-Younger, M., Dilley, L. B., Aubry, T. D., Turnbull, J., & Hwang, S. W.

(2012). Harm reduction services as a point-of-entry to and source of end-of-life care and support for homeless and marginally housed persons who use alcohol and/or illicit drugs: a qualitative analysis. *BMC Public Health*, *12*(1), 1-9. https://link.springer.com/article/10.1186/1471-2458-12-312

Mercadante, S., Porzio, G., Caruselli, A., Aielli, F., Adile, C., Girelli, N., & Casuccio, A. (2015). The frequency of alcoholism in patients with advanced cancer admitted to an acute palliative care unit and a home care program. *Journal of Pain and Symptom Management*, *49*(2), 254-257. https://www.sciencedirect.com/science/article/pii/S0885392414003467

Mercadante, S., Adile, C., Ferrera, P., & Casuccio, A. (2020). Association between alcoholism and symptom expression, patient symptom goals, and clinical response in advanced cancer patients. *Supportive Care in Cancer*, *28*(7), 3361-3369. https://doi.org/10.1007/s00520-019-05152-x

Moran, K. J., Burson, R., & Conrad, D. (2020). *The doctor of nursing practice project: A framework for success (3rd ed.)*. Jones & Bartlett Learning.

Mundt-Leach, R. (2016). End of life and palliative care of patients with drug and alcohol addiction. *Mental Health Practice*, *20*(3). https://search.proquest.com/openview/1f4e32ba9ac345a858161e0e523b3792/1.pdf?pq-origsite=gscholar&cbl=2042234&casa_token=B9zTimvK60QAAAAA:ciqxu2HqFXoa31zKZ2TTjiargiEXpqqUHJENSe8kSNlfXPClueSdmv1id7vPuvmsW67dOVRATxYH

Musili, P. M., Kimotho, S. K., Ouma, C. A., Amisi, E., & Njoroge, N. M. (2021a). *Journal of Palliative Care & Medicine, 11*(9). https://www.researchgate.net/profile/Nicolous-Njoroge/publication/359482382_Journal_of_Palliative_Care_Medicine_Alcohol_and_Su

bstance_Use_among_Patients_in_Palliative_Care/links/623ef4c85e2f8c7a033d7c09/Journal-of-Palliative-Care-Medicine-Alcohol-and-Substance-Use-among-Patients-in-Palliative-Care.pdf

Musili, P., Kimotho, S. K., Ouma, C., Amisi, E., Kinyanjui, A., & Muchiri, S. (2021b). Prevalence and Risk of Alcohol Use among Palliative Care Patients in Kenya: Case Study of Coast Region. *African Journal of Alcohol & Drug Abuse*, *6*, 41-49. https://nacada.go.ke/sites/default/files/2022-03/Ajada%20Volume%206%20December%202021%20Isssue.pdf#page=42

National Institute on Alcohol Abuse and Alcoholism. (2022). *The health professional's core resource on alcohol*. https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol

Parker, M. & Smith, M. (2005). *Nursing theories and nursing practice* (3rd ed.). F.A. Davis.

Parsons, H. A., Delgado-Guay, M. O., El Osta, B., Chacko, R., Poulter, V., Palme, J. L., & Bruera, E. (2008). Alcoholism screening in patients with advanced cancer: Impact on symptom burden and opioid use. *Journal of Palliative Medicine*, *11*(7), 964-968. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2988458/

Passik, S. D., & Theobald, D. E. (2000). Managing addiction in advanced cancer patients: Why bother?. *Journal of Pain and Symptom Management*, *19*(3), 229-234. https://www.sciencedirect.com/science/article/pii/S0885392400001093

Paterson, J.G., & Zderad, L.T. (1976). *Humanistic nursing.* John Wiley & Sons.

Pereira, A., Ferreira, A., & Martins, J. (2018). Nursing theories in palliative care investigation: A review. *Hospice Palliative Medicine International Journal*, *2*(4), 231-4.

https://www.researchgate.net/profile/Alexandra-Pereira-5/publication/328115924_Nursing_theories_in_palliative_care_investigation_a_review/links/5c1e749a92851c22a33fcc0b/Nursing-theories-in-palliative-care-investigation-a-review.pdf

Plamondon, K. M., Caxaj, C. S., Graham, I. D., & Bottorff, J. L. (2019). Connecting knowledge with action for health equity: A critical interpretive synthesis of promising practices. *International Journal for Equity in Health*, *18*(1), 1-10. https://link.springer.com/article/10.1186/s12939-019-1108-x

Registered Nurses Association of Ontario. (2022). *Knowledge-to-action framework*. https://rnao.ca/leading-change-toolkit/knowledge-to-action

Sacco, P., Cagle, J. G., Moreland, M. L., & Camlin, E. A. (2017). Screening and assessment of substance use in hospice care: Examining content from a national sample of psychosocial assessments. *Journal of Palliative Medicine*, *20*(8), 850-856. https://www.academia.edu/download/53573136/SaccoCagleMorelandCamlin2017.pdf

Straus, S. E., Tetroe, J., & Graham, I. (2009). Defining knowledge translation. *Canadian Medical Association Journal*, *181*(3-4), 165-168. https://www.cmaj.ca/content/181/3-4/165.short

Templeton, L., Galvani, S., & Peacock, M. (2022). When “good enough” isn’t good enough: Interdisciplinary perspectives on caring for adults using substances at the end of life. *International Journal of Mental Health and Addiction*, *20*(3), 1311-1324. https://link.springer.com/article/10.1007/s11469-020-00445-3

The Sudbury & District Health Unit (2017). *The Sudbury & District Health Unit alcohol use and*

the health of our community. https://www.phsd.ca/resources/research-statistics/research-evaluation/reports-knowledge-products/the-sudbury-district-health-unit-alcohol-use-and-the-health-of-our-community/

Webber, K., Davies, A. N., Leach, C., & Bradley, A. (2020). Alcohol and drug use disorders in patients with cancer and caregivers: Effects on caregiver burden. *BMJ Supportive & Palliative Care*, *10*(2), 242-247. http://dx.doi.org/10.1136/bmjspcare-2019-002127

Wilner, L.S., & Arnold, R. (2015). The Palliative Performance Scale (PPS). https://www.mypcnow.org/fast-fact/the-palliative-performance-scale-pps/

Witham, G., Peacock, M., & Galvani, S. A. (2018). *End of life care for people with alcohol and other drug problems: Rapid evidence assessment. Research report*. https://e-space.mmu.ac.uk/622042/1/KI%20full%20report%2031%20July%202018%20FINAL.pdf

Witham, G., Galvani, S., & Peacock, M. (2019). End of life care for people with alcohol and drug problems: Findings from a rapid evidence assessment. *Health & Social Care in the Community*, *27*(5), e637-e650. https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/hsc.12807

World Health Organization (2018). *Global status report on alcohol and health 2018.*

World Health Organization. (2020). *Palliative care.* https://www.who.int/news-room/fact-_sheets/detail/palliative-care

Wolf, Z. R., & Bailey, D. N. (2013). Paterson and Zderad's humanistic nursing theory: Concepts and applications. *International Journal of Human Caring*, *17*(4), 60-73. DOI:10.20467/1091-5710.17.4.60

Wu, H. L., & Volker, D. L. (2011). Humanistic nursing theory: Application to hospice and

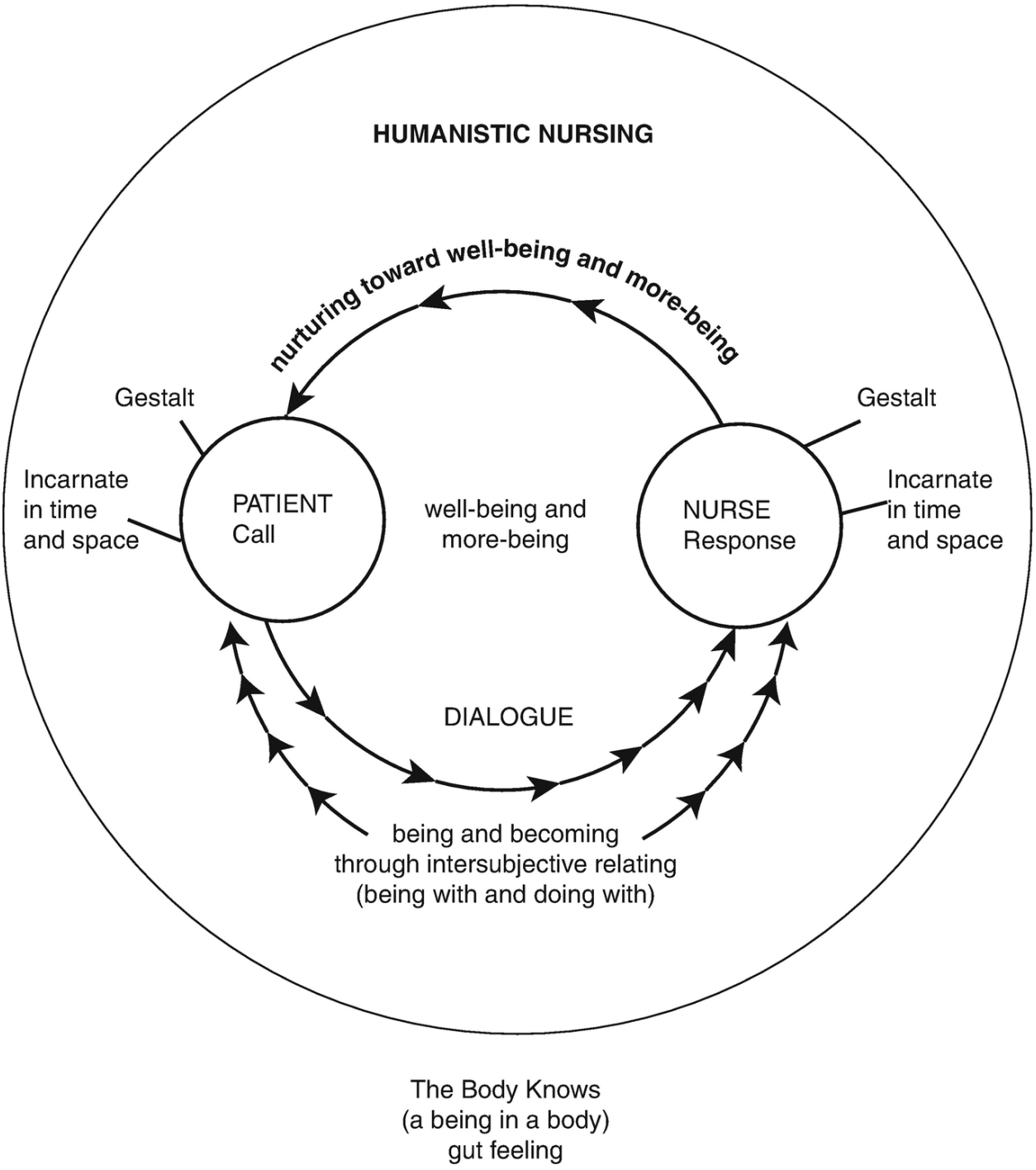
palliative care. *Journal of Advanced Nursing*, *68*(2), 471-479. https://doi.org/10.1111/j.1365-2648.2011.05770.x

Yusufov, M., Braun, I. M., & Pirl, W. F. (2019). A systematic review of substance use and substance use disorders in patients with cancer. *General Hospital Psychiatry*, *60*, 128-136. https://doi.org/10.1016/j.genhosppsych.2019.04.016

Ziccardi, S. L. (2019). *Screening for alcohol use upon hospital admission: Changing perceptions, improving outcomes. (Doctoral dissertation, Carlow University)*.http://ra.ocls.ca/ra/login.aspx?url=https://www.proquest.com/dissertations-theses/screening-alcohol-use-upon-hospital-admission/docview/2108627738/se-2

Appendix A

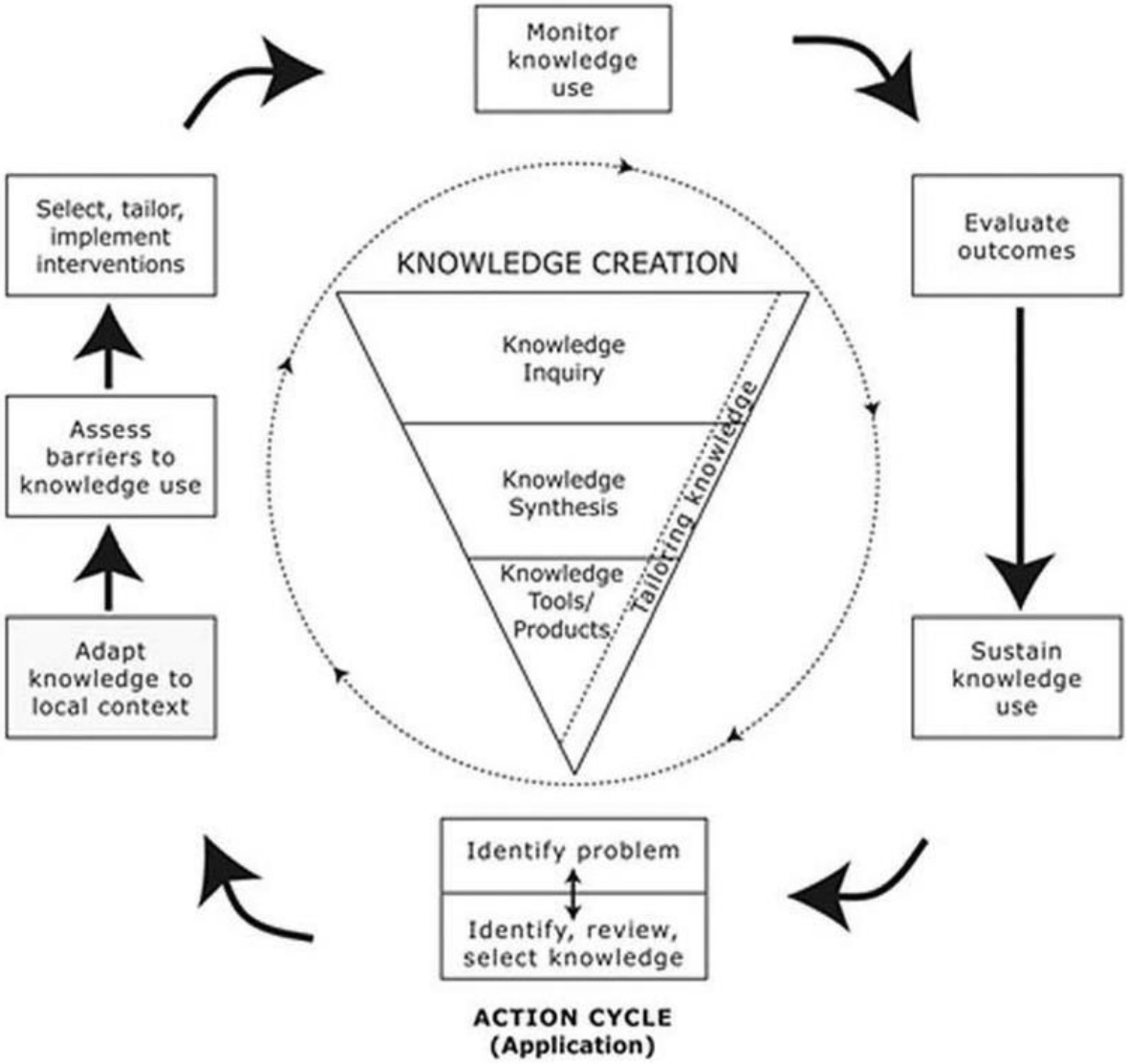
Humanistic Nursing Theory



Parker, M. & Smith, M. (2005). *Nursing theories and nursing practice* (3rd ed.). F.A. Davis.

Appendix B

Knowledge-to-Action Framework



Reference: Graham, I.D., Logan, J., Harrison, M.B., Straus, S.E., Tetroe, J., Caswell, W. et al. (2006). Lost in knowledge translation: Time for a map. *Journal of Continuing Education in the Health Professions*, 26(1), 13-24.

Appendix C

Alcohol Use Screening Protocol

All patients are to be screened for alcohol use during pre-admission assessment

Frequency: Minimum of upon initial pre-admission assessment into the hospice bed queue, and then again upon acceptance of a bed at the residential hospice.

Tool: AUDIT-C Alcohol Screening Tool

Screener: Intake coordinator (registered nurse); admitting nurse

1. **Steps to be taken for all patients**
   - 1.1. Complete the AUDIT-C with the patient as part of the pre-admission assessment
   - 1.2. Calculate the overall score for the AUDIT-C
   - 1.3. Review the score of the AUDIT-C with the patient and family as appropriate
   - 1.4. Interpret the results and related meaning for the patient
   - 1.5. Document the results of the AUDIT-C in the patient's chart

2. **If the patient screens negative (males score <4, females score <3, no further action needed**

3. **If the patient screens positive (males score 4 or more, females score 3 or more) discuss options for care in consideration of alcohol use**
   - 3.1. The screening nurse will refer to the reference page titled *Conversations about Alcohol Use and Needs and Wishes for Palliative Care* for suggestions on how to approach opening communication to guide the assessment of the patient's wishes for their care related to their alcohol consumption.
   - 3.2. Document the contents of the conversation in the patient's chart to inform decisions regarding the plan of care.
   - 3.3. Notify the attending physician if there are any urgent needs.

AUDIT-C

AUDIT-C The three-item Alcohol Use Disorders Identification Test (AUDIT-C) is a brief survey instrument designed to identify at-risk drinking behaviors that could indicate alcohol use disorder. AUDIT-C has been validated in mental health and primary care clinics.

Interpretation Instructions

Drinks should be counted using standard drink measurements (see image below). Add up the circled numbers for each item to derive a total score. If the answer to question 1 is NEVER, no further questions need to be asked. When the points are all only from question 1, with questions 2 and 3 scoring 0, it can be assumed that the patient's alcohol consumption is within recommended limits.

Total scores are interpreted differently for men and women.

For men: A total score of 4 or more is considered positive for hazardous drinking or active alcohol use disorder.

For women: A total score of 3 or more is considered positive for hazardous drinking or active alcohol use disorder.

Greater scores indicate greater risk posed to the patient's health and safety.

(The Sudbury and District Health Unit, 2017)

AUDIT-C

To the patient: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Question	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a month	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

(AUDIT-C is free to use in the public domain)

If patient screens positive using AUDIT-C, ask these additional questions to assess active alcohol consumption:

In the last week, did you have any drinks containing alcohol? If so, about how many drinks did you have each time? When was your last drink?

Appendix D

Conversations about Alcohol Use and Needs and Wishes for Palliative Care

(Adapted with permission from *Good Practice Guidance: Supporting People with Substance Problems at the End of Life* by Galvani et al., 2019)

The best approach to conversations about alcohol use begins with an openness about why you are asking and your value base. Approach the conversation in a non-judgmental manner, with a person-centred focus so the patient knows that you are a palliative professional who is not judging the person for their challenges with alcohol consumption, but wanting to offer the person choices and support around their drinking as their illness progresses.

Examples of How to Discuss Alcohol Use

1. Can you tell me about your alcohol use right now and any ways you feel that drinking helps you?
2. What would you like to do in relation to your use of alcohol, and how can we help?
3. I won't judge you for your drinking, we just need to make sure that we give you the right medications and care because sometimes they can interfere with each other, and we want to make sure we can keep you comfortable and safe at the same time.
4. I'm not suggesting you stop drinking if that's what you want to do, but knowing a bit more about how much you are drinking will help us to keep you safe medically while we are caring for you.
5. To what extent, if at all, would you like to change anything about your drinking at this time?
6. Is there anyone around you that we should know about that can support you in the changes you want to make to your alcohol use?
7. Is there anyone in your life that you might want to avoid, to help you make the changes you want to make in relation to your alcohol use?

Examples of How to Discuss Alcohol Use in Relation to Palliative Care

1. What do you want your life to look like as your illness progresses? Is there anything you would like to change now that we can help with?
2. How can we improve your palliative experience? How can we help to make it what you want it to be?
3. Would you like to be supported to continue drinking as your illness progresses?
4. What are your fears or concerns about your alcohol use as your illness progresses towards end of life?

Appendix E

Pre- and Post-Education Survey

Numeric Rating Survey

1= Strongly disagree
2= Disagree
3= Neutral
4= Agree
5= Strongly agree

Please indicate how much you agree or disagree with the following statements about alcohol use in palliative patients and providing care to this population.

1. I feel I have a working knowledge of alcohol and alcohol-related problems.

   1 2 3 4 5

2. I feel I know enough about alcohol use disorder in palliative patients to carry out my role when working with them.

   1 2 3 4 5

3. I feel I know what my role and responsibilities are when caring for palliative patients with alcohol use disorder.

   1 2 3 4 5

4. I feel I know enough about how to manage care for palliative patients who continue to actively consume alcohol.

   1 2 3 4 5

5. I feel comfortable having conversations with palliative patients about their alcohol use.

   1 2 3 4 5

6. I feel I know what options are available to provide education and support for palliative patients who continue to consume alcohol.

   1 2 3 4 5

7. I feel I understand the reasons a patient may continue to consume alcohol during the palliative phase of their life.

   1 2 3 4 5

8. I feel I know how to support palliative patients who desire to reduce or cease their alcohol consumption.

   1 2 3 4 5

Overall, how would you rate:

1. Your overall knowledge of validated alcohol screening tools?

   1 2 3 4 5

2. Your knowledge of steps to complete a further alcohol-focused assessment for patients that screen positive?

   1 2 3 4 5

3. Your motivation and attitude toward alcohol screening and care planning in consideration of alcohol use?

   1 2 3 4 5

4. Your comfort and confidence when discussing alcohol consumption and desires for future care with a palliative patient and their family?

   1 2 3 4 5

5. Your ability/willingness/desire/intent to mentor colleagues on the alcohol screening protocol?

   1 2 3 4 5

Appendix F

Education Session Presentation

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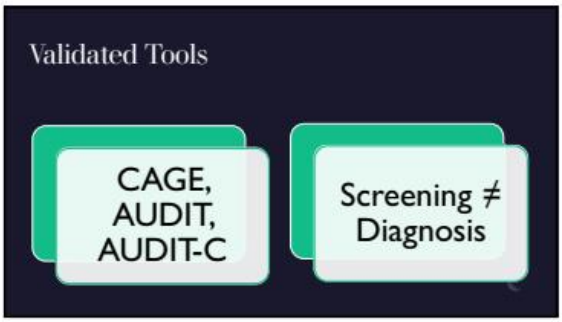

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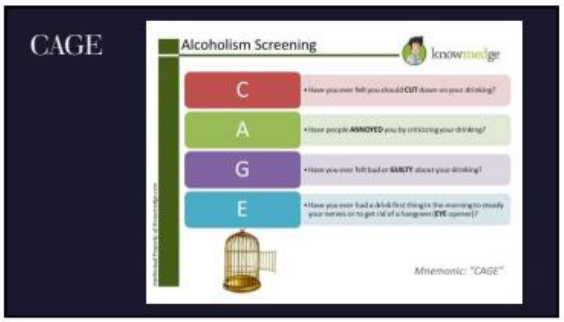

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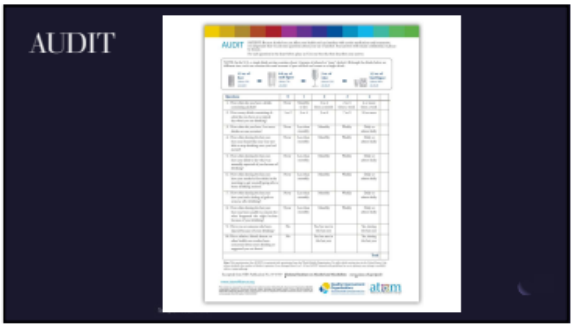

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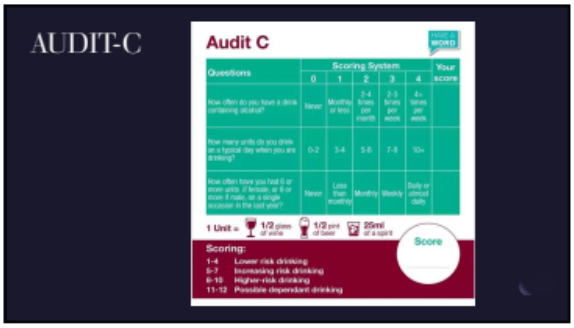

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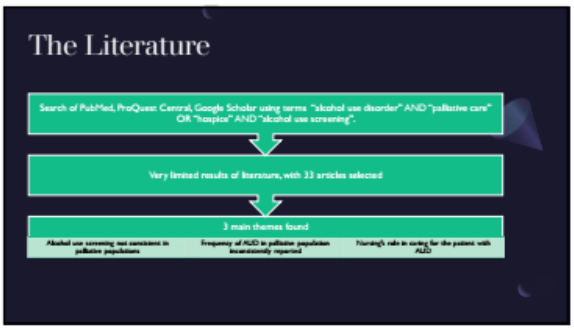

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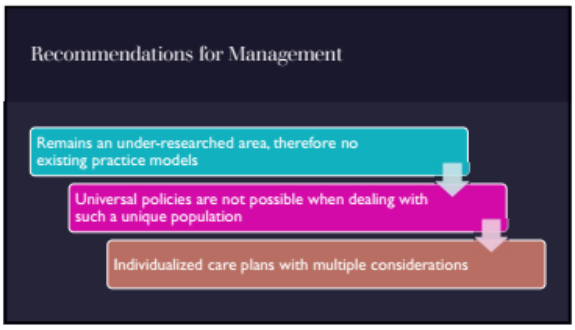

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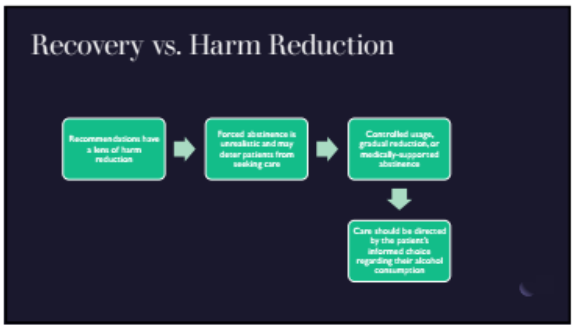

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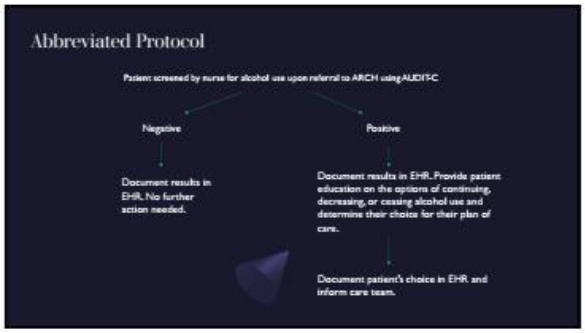

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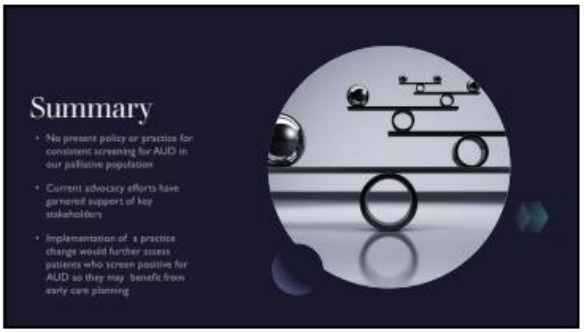

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Appendix G

Average Change in Attendees' Perceptions Pre- and Post-Education

Survey Statement	p-value
1. I feel I have a working knowledge of alcohol and alcohol-related problems.	.225
2. I feel I know enough about alcohol use disorder in palliative patients to carry out my role when working with them.	.009
3. I feel I know what my role and responsibilities are when caring for palliative patients with alcohol use disorder.	.007
4. I feel I know enough about how to manage care for palliative patients who continue to actively consume alcohol.	.276
5. I feel comfortable having conversations with palliative patients about their alcohol use.	.169
6. I feel I know what options are available to provide education and support for palliative patients who continue to consume alcohol.	.023
7. I feel I understand the reasons a patient may continue to consume alcohol during the palliative phase of their life.	.169
8. I feel I know how to support palliative patients who desire to reduce or cease their alcohol consumption.	.088
How would you rate:	
1. Your overall knowledge of validated alcohol screening tools?	.003
2. Your knowledge of steps to complete a further alcohol-focused assessment for patients that screen positive?	.001
3. Your motivation and attitude toward alcohol screening and care planning in consideration of alcohol use?	.195
4. Your comfort and confidence when discussing alcohol consumption and desires for future care with a palliative patient and their family?	.169
5. Your ability/willingness/desire/intent to mentor colleagues on the alcohol screening protocol?	.021

Appendix H

Project Site Authorization

ARCH hospice

December 29th, 2022

Dear IRB Administrator,

I have granted authorization for Elizabeth Ubaldi to conduct their quality improvement project titled: "Implementing an Alcohol Use Screening Protocol in Palliative Care" at our facility, and I attest that I have the authority to grant such permission. I understand the purpose of the project is to improve the quality of care for palliative patients with alcohol use disorder admitted to the residential hospice facility. Intake nurses will obtain informed consent from each patient willing to participate in this quality improvement project and complete a validated screening tool, and then document the results in the resident's chart. For the participating patients that screen positive for alcohol use, a further assessment will be completed by the intake coordinator to determine their wishes in relation to their alcohol consumption, and planning for their care by the interprofessional team will include this consideration.

Algoma Residential Community Hospice (ARCH) will allow the following over the duration of the project:

- *The intake Coordinators will obtain informed consent from each patient willing to become part of the quality improvement project.*
- *The Intake Coordinators will complete structured surveys on participant confidence pre- and post-education to assess their knowledge, attitudes and beliefs related to assessing and caring for palliative patients with alcohol use disorder (I have reviewed the survey)*
- *Elizabeth Ubaldi will provide education and training to each intake coordinator regarding alcohol use disorder in palliative patients, the AUDIT-C screening tool, and the alcohol use screening protocol (I have reviewed the AUDIT-C and the protocol)*
- *ARCH grants permission for Elizabeth Ubaldi to receive de-identified data specific to alcohol use screening and consideration of patient's alcohol use into care planning to improve their quality of care. No PHI will be disclosed at any point.*
- *Elizabeth Ubaldi is required to follow all HIPAA and all Personal Health Information (PHI) policy and procedures related to obtaining, storing, and destroying of HIPAA and PHI protected data*

It is expected that these project is not to be published by IRB or Elizabeth Ubaldi and is for quality improvement only. I request a copy of your quality improvement summary to ensure the report falls within these guidelines to grant approval prior to releasing. If the IRB has any concerns about the permission being granted by this letter, please contact me by phone or email.

Sincerely,

Nicole Pearce, Executive Director
(705) 942-1556 ext. 233 pearcen@archhospice.ca
229 Fourth Line West, Sault Ste. Marie, ON
Canada P6A 0B5

Appendix I

Permission to Adapt *Good Practice Guidance: Supporting People with Substance Problems at the End of Life*

Liz Ubaldi

From: Gary Witham <G.Witham@mmu.ac.uk>
Sent: September 30, 2022 7:49 AM
To: Liz Ubaldi
Subject: Re: request for permission

Hi Liz,

This sounds a really interesting project, yes, no problems in you adapting our questions. I hope it goes well

Kind regards

Gary

Dr Gary Witham RN PhD
Senior Lecturer in Nursing
Manchester Metropolitan University
Department of Nursing
Brooks Building
Birley Campus
53 Bonsall Street
Hulme
Manchester
M15 6GX
0161 247 2464

From: Liz Ubaldi <Liz.Ubaldi@saultcollege.ca>
Sent: 29 September 2022 14:53
To: Gary Witham <G.Witham@mmu.ac.uk>
Subject: request for permission

Hello Dr. Witham,

I am currently a student working towards my Doctorate of Nursing Practice. As part of my QI project on improving screening and care planning for palliative patients with alcohol use disorder I was hoping to adapt some of the questions in the 2019 publication *Good Practice Guidance: Supporting People with Substance Problems at the End of Life* into a protocol that I am developing to implement alcohol use screening upon intake to a residential hospice facility in Canada. For those that screen positive, they would then be followed up with a conversation to determine the patient's wishes for their plan of care regarding their alcohol use (continue, cut back, or supported abstinence). I would like to integrate some of the questions and guidance suggestions in the publication to provide examples to guide the nurses that will be completing the assessments, providing full credit, of course.

Thank you for your consideration,

Liz Ubaldi

Liz Ubaldi, BA, MN, RN, CCNE
(pronouns: she/her)
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