2020

Nurse Directed Palliative Care Discussions in the Emergency Department

Shannon Lorince Landefeld
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Shannon Lorince Landefeld

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Lynda Crawford, Committee Chairperson, Nursing Faculty
Dr. Barbara Gross, Committee Member, Nursing Faculty
Dr. Robert Anders, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

Nurse Directed Palliative Care Discussions in the Emergency Department

by

Shannon Lorince Landefeld

MS, Stevenson University 2014

BS, Notre Dame University of Maryland, 2005

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

February 2020

Abstract

Emergency department (ED) nurses are in a unique position to discuss with patients who have life-limiting illnesses. However, due to lack of training, ED nurses are often reluctant to have these conversations. Although ED patients receive written information about advanced directives, there is a gap in practice with discussing palliative and end-of-life care, resulting in increased potential for patient isolation, inconsistencies in treatment modalities, and delayed opportunities for patient-centered goal setting. Therefore, the purpose of this project was to address what resources are available to guide evidence-based practice for ED nurses in a small inner city hospital to implement nurse-directed palliative care discussions. A review of the literature was completed to analyze the nurse's role for palliative and end-of-life discussions. ED nurses' concerns were identified through ongoing discussions and conveyed to the DNP student by the ED education specialist during the interview process. In conjunction with an ED education specialist and validated by the institution's leadership and palliative care team, evidence-based clinical practice guidelines (CPG) were created. Validity was determined by the AGREE II instrument. Watson's caring theory and Lewin's change theory provided a foundation for the development of the CPG to facilitate a caring environment within the ED setting and to empower ED nurses with knowledge, skills, and resources. This project contributes to social change by providing educational opportunities to meet the needs of complex patient populations by offering a paradigm shift in nursing care from a bio-medical focus to include comfort and holistic care, thus promoting shared decision-making regarding quality of life and end of life care.

Nurse Directed Palliative Care Discussions in the Emergency Department

by

Shannon Lorince Landefeld

MSN, Stevenson University, 2014

BSN, Notre Dame University of Maryland, 2005

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

February 2020

Dedication

I would like to dedicate this project to my family and my friends who have supported me during my education throughout the years. A special shout out to my PIC and my cubical mates, who supported me in my journey. Mostly, I want to acknowledge Mr. Andy, who supported and paid for me to go to practical nursing school because he saw my journey and my calling in my soul. Rest in peace, Mr. Andy; without you I would not be who I am today. Thank you all for supporting, loving, and believing in me and reminding me to always pay it forward. I love you all!

Acknowledgments

I would like to acknowledge Dr. Lynda H. Crawford, Ph.D. for her unlimited support throughout this process. Dr. Mary Ellen Zaleski RN, DNP, you always believed in me when I did not believe in myself; you were both there for me tirelessly and willing to assist. In addition, I would like to acknowledge Dr. Barbara Gross and Dr. Bob Anders for helping me to find the right path for my project. Thank you all for your unlimited positive influence on my journey.

Table of Contents

Section 1: Nature of the Project

Introduction

Preparing for death is not typically a topic that most people are comfortable talking about. In fact, death is one of the most difficult subjects to discuss (Marcus & Mott, 2014). Although patients are provided written information about advanced directives, there is a gap in discussing palliative and end-of-life care when patients with serious and life-limiting illnesses. People often go to the emergency department (ED) without previously discussing advanced care planning or goals and preferences of care with their healthcare providers or family. Nurses are in a unique position to have these conversations. However, nurses frequently feel reluctant to discuss palliative and end-of-life care (EoLC) with patients and families due to lack of training (Dame & Hoebeke, 2016; Marcus & Mott, 2014; Revels, Goldberg, & Watson 2016). The Worldwide Palliative Care Alliance (WPCA, 2011) reported that more than 29 million individuals who die annually from serious or life-limiting illnesses could have benefited from end-of-life conversations. Given the frequency of interactions of the nurse with the patient and family, the nurse is in a position to promote a caring environment for the patient that encourages engagement in conversations about fears and goals of care in any environment, including high stress and chaotic areas such as the ED (Revels et al., 2016).

The World Health Organization’s (WHO, 2019) definition of palliative care is “an approach to care that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering" (para. 1). The WHO (2019) describes palliative care as the relief of pain and symptom management to enhance quality of life for people facing serious illness at any age and is inclusive of preparation for and discussions of EoLC. Palliative care is not exclusively the care provided at the end of life, but is life affirming and promotes increasing the quality of care for people living with serious and life-limiting illness (WHO, 2019). The National Cancer Institute (NCI) recognizes that the nurses' role represents the core values of palliative care that extends from curative to end-of-life care, as this care encompasses physical, emotional, social, and spiritual support for patients and their families with the goal of pain and symptom management ("Comprehensive Cancer Information," n.d.; Dame & Hoebeke, 2016). NCI ascertains palliative or comfort care should be available to all patients and at any age, for any disease process that produces pain or suffering, and should include discussions of patient goals of care through shared decision-making. Palliative care may include hospice care for terminal care if necessary ("Comprehensive Cancer Information," n.d).

As the population continues to grow older and chronic diseases are on the rise, the need for palliative care and EoLC discussions are becoming a part of the daily responsibilities of the ED nurse (Revels et al., 2016). According to the Emergency Nurses Association (2013), nurses are responsible for promoting and leading the collaborative efforts for palliative and EoLC that may result in an increase in the number of patients that engage in earlier palliative and EoLC decision-making. Providing written information about advanced directives could be used as a catalyst for these discussions in the ED, but these discussions need not stop there. Although the nurses continue to have concerns about when and how to discuss goals and preferences of care (e.g., code status, final wishes, and treatment modalities), providing formal training, updating palliative care protocols, and providing palliative and end-of-life resources may increase the nurse’s ability to provide opportunities for patients to have these discussions (Anderson et al., 2017). The results of this project include evidence-based (EB) clinical practice guidelines (CPG) for nurses as a foundation to begin a new approach to palliative care discussions in the ED.

Due to the historical lack of palliative care education in nursing and medical schools, there is inconsistency with current palliative and EoLC practice and delivery modalities (Revels et al., 2016). Although there is a current movement to include palliative education in nursing and medical schools, there is a gap in the definition of palliative care. More specifically, the definition lacks consistency in language, terminology, and goals of palliative care within the healthcare community (Revels et al., 2016). The incorporation of focused guidelines would promote consistency in language and terminology, communication techniques, and care delivery that may result in decreased misunderstandings about goals of care between the patient, nurse, and the healthcare team (Marcus & Mott, 2014). Decreasing misunderstandings around goals of care is a primary priority for nurses that may result in an increase in quality of care and patient satisfaction by aligning treatment goals and preferences of care (Revels et al., 2016).

This scholarly project proposed a change in clinical practice that incorporates best practices of palliative and end-of-life nursing care by translating evidence into practice, thereby improving quality end-of-life outcomes. Developing EB CPG provide structure and resources for nurses to initiate goal-setting discussions and initiate care for patients with serious and life-limiting illnesses. The change in clinical practice guides the nurses to use EB protocol for discussing palliative care and end-of-life goals in the ED, and include resources and examples of how to document discussions and goals of care in the medical record.

The CPG provides a strategic approach to engaging patients to discuss goals of care and advanced directives. The current advanced care document—the preferred document for discussing advanced directives at the institution—is a reference for the nurse to use as a guide in the discussion and the documentation. Clinical tools for discussing advanced directives and goals of care have been effective in guiding and supporting clinical decision making around treatment preferences and goals, and can aide in identifying the path of treatment for the patient. The CPG guides staff members (nurses) when discussing goals of care, promoting comfort and symptom management, and advocating for the patient to be transitioned to the most appropriate level of care based on their personal goals, thus increasing patient trust and satisfaction. This project was intended to increase quality and safety by promoting shared decision making in the ED among patients, families, surrogate decision makers, and physicians at the pivotal point between curative and comfort care (see Dame & Hoebeke, 2016).

This CPG can contribute to social change by ensuring consistency in the delivery of EB palliative nursing care through providing resources, using guidelines for palliative and EoLC discussions in the ED, and being the foundation for the establishment of specific palliative care language and terminology. Everyone involved will be able to understand the terminology and share in the discussions, including the most important people, the patients (see Marcus & Mott, 2014). Noting that palliative care patients have a range of diseases and respond differently to treatment options, this early palliative care approach is relevant because it promotes understanding, trusting relationships, and establishes patients’ preferences and goals to increase quality of care, patient satisfaction, and comfort for a peaceful, dignified death (see Dame & Hoebeke, 2016). In addition, this change in clinical practice has the potential to increase partnerships and trust between the health care system and the community, as the health care system becomes a trusted source of patient- and family-centered care.

Problem Statement

Local Nursing Practice Problem

Congruent with findings from the literature, local ED nurses do not consistently provide EB palliative care discussions, use consistent language and terminology, or engage in palliative-care communication strategies when caring for patients facing serious and life-limiting illnesses (Zaleski, personal communication, 9/8/2018). Many of the ED nurses admit to not answering the standard administrative questions for the palliative consults as accurately as possible due to time constraints and lack of focus on palliative care (Zaleski, personal communication, September 8, 2018). Inconsistency with messaging and communication promotes misunderstanding and mistrust between the patient and the health care system (Marcus & Mott, 2014). Inconsistencies in palliative care language and delivery methods may be due to a lack of EB education and absence of knowledge, creating barriers leading to patient mistrust and misunderstandings. In addition, lack of consistency increases the potential for patient isolation and inconsistencies in treatment modalities and prolongs the opportunity for patient-centered goal setting, and ultimately results in decreased patient and family satisfaction (Dame & Hoebeke, 2016; Fernández-Sola et al., 2017; Mierendorf & Gidvani, 2014; Revels et al., 2016).

Lack of EoLC discussions are attributed to the lack of focus on palliative care, inadequate communication strategies, time constraints (i.e., actual time spent with patients and the transient nature of the ED), and competing priorities of the nurse (Emergency Nurses Association [ENA], 2019). These inconsistencies lead to barriers in care, resulting in decreased ability of the health care system to meet quality outcomes such as nursing communication and providing care that aligns with patient preferences and values.

Local Relevance

This project was designed for a small inner city 70 bed hospital with 26 emergency department beds, and eight intensive care beds (Bon Secours Health System [BSHS] Fact Sheet, 2017). Basic demographics of this community include a high percentage of unemployed, minimally educated, medically uninsured African Americans with a statistically lower life expectancy (64.2 years of age) in comparison to the surrounding geographic area due to a high incidence of chronic diseases leading to premature death (Community Health Needs Assessment [CHNA], 2016). Data from the CHNA showed a substantial need for increased access to preventive medical services and health literacy to improve physical health, mental health, and overall well-being for this community. ED visits reached 24,538 in 2018; with one-third (33%, 8,179 visits) of the visits were patients seeking care for pain or symptom management for their serious or life-limiting illnesses. Many of the community residents use the ED as their primary source of medical care (Zaleski, personal communication September 9, 2018).

Lack of medical insurance, mistrust in the medical community, and decreased participation in preventive health care eludes to the high number of community residents that rely on the ED for medical care (CHNA, 2016). These specific circumstances may increase the tendency of residents to prolong seeking medical care and may result in increased severity of medical issues when they present in the ED, which coincides with the data from the CHNA as evidenced by the morbidity and mortality percentages for this community that range from 5% for people ages 65-84 to 13.5% for people 85 and older of the patients who died in the ED (CHNA, 2016). Based on the characteristics of this community (e.g., decreased life expectancy, older population, high mortality rate, high use of ED), there are a large number of people in this community who may benefit from early interventions such as palliative care conversations when they seek care in the ED.

This institution has a focused mission to increase the resources to the community that includes care from preventive to end-of-life care.

Significance for Nursing Practice

Historically, nursing school curricula has not supported education about palliative and end-of-life care (Alderidge, 2016), yet nurses are expected to promote comfort and advocate for patients. The problem is that nurses are expected to do so without formal training and tend to develop care strategies based on previous experiences that lead to inconsistent care delivery and irregularities in language and terminology, messaging, and processes of palliative and EoLC (Revels et al., 2016). With the increase in the aging and chronically ill population, nursing and medical schools have added palliative care education to the curriculum due to the necessity of comfort care, end-of-life symptom management, and communication skills are becoming a priority in all areas of healthcare and especially in the care of the dying (American Nurses Association Professional Issues Panel, 2017). Despite this new standard of education, mature and experienced nurses continue to provide this care without the formality of receiving EB palliative care instruction.

This PCG provides a resource for consistency in care delivery, which promotes continuity for initiating palliative and EoLC conversations beyond providing written information about advanced directives. These resources promote the foundation for nurses to feel comfortable, therefore promoting a comforting environment for patients to engage in conversations about fear, goals, and treatment preferences.

The significance of this project was to guide nursing practice for patients in need of palliative care and support early palliative care conversations sooner in the ED admission and treatment process. As research shows, nurses (critical care and ED nurses) successfully support earlier palliative and EoLC discussions for patients and families in the absence of palliative care physicians with formal training in other settings (Anderson et al., 2017). This research suggests that the collaborative relationships among the nurse, patient, and physician may increase the quality of care and patient satisfaction for seriously ill patients at times when the patient and family need to have these discussions. This EB project might increase the ability and comfort of the nurse and extend the ability to advocate for patient needs, allowing more patients to have the opportunity to have conversations related to palliative and EoLC, thus increasing quality of care and patient satisfaction (Anderson et al., 2017).

Early palliative care discussions are associated with increased quality outcomes through identification of patient-centered goals of care including effective pain and symptom management, practical support, and end-of-life care that includes promoting a dignified death (Anderson et al., 2017). Through this project, I intended to provide nurses with strategies for communicating with patients to accelerate early identification of goals of care at a time when health care may be moving quickly from curative to comfort. In addition, by providing valuable information to patients and family, the nurse can be in an informed position to advocate for the patients’ preferences and desires for treatment (Revels et al., 2016).

According to the 2016 American Nurses Association (ANA) position statement, “Nurses’ Roles and Responsibilities in Providing Care and Support at the End of Life,” the recommendations include additional standardized practice, education, research, and administration changes to overcome barriers to end-of-life care (ANA, 2016). Practice changes focus on healthcare providers having a basic knowledge of palliative and EoLC, allowing nurses to stay abreast of basic skills to provide comfort and symptom management. Nurses should also be comfortable having discussions with and advocating for families and patients regarding palliative goals of care and preparing for a dignified death (ANA, 2016). Due the current lack of a standardized EB palliative care guidelines, the recommendations for clinical changes to overcome these barriers were the foundation for this project to ultimately provide ED nurses and staff with knowledge and resources concerning palliation and EoLC discussions, as well as how to promote a comforting environment conducive to addressing palliative care needs. Therefore, when the nurse incorporates this practice as routine, it has the potential to increase the opportunity for patients to engage in these discussions and include shared-decision making to increase quality of care for this patient population (see Kurian, 2014).

Purpose

Meaningful Gap-in-Practice

In the local setting, about one in five of the ED patients have palliative care needs (Zaleski, personal communication, September 8, 2018). Lack of accurate documentation, increase in patient needs, and lack of access to palliative care staff have resulted in many patients with unresolved pain and symptoms, mismatched patient goals and preferences, and may have led to inappropriate admissions, unwanted referrals to hospice, and futile admissions to the intensive care unit (ICU, Zaleski, personal communication, September 8, 2018).

The ANA (2016), the Emergency Nurses Association (ENA, 2019), and the American Nurses Association Professional Issues Panel (2017) recognized that the use of evidence-based palliative guidelines and EoLC nursing educational resources decreases barriers to initiating conversations about and providing palliative care sooner in the care trajectory from diagnosis to death for people facing serious and life-limiting illnesses, specifically when curative treatment is no longer effective or an option. The institution involved in this project required all patients to be offered information about advanced directives in the form of a patient information booklet, yet did not possess CPG for nurses to initiate the discussion. Therefore, the CPG developed in this project is associated with a new protocol process for nurses to initiate palliative care discussions in the ED. In addition, this CPG has the ability to decrease misunderstandings about treatment options and goals by providing a standardized language and approach.

The local ED nurses have expressed confusion about hospice versus palliative care (Zaleski, personal communication, September 8, 2018). These nurses reported being reluctant to initiate conversations related to goals of care with patients because they believed this task was out of their scope of practice (Zaleski, personal communication, September 8, 2018). This project provided focused EB palliative care guidance, and assisted with communication strategies that may help to overcome barriers to identifying palliative needs and initiating discussions of patient-centered goals through the use of a CPG. The ED nursing educator developed and delivered the educational curriculum for the implementation and evaluation of the project.

Practice-Focused Question

The practice-focused question for this project was: What resources are available to guide evidence-based practice for nurses to initiate discussions about palliative care needs with patients in the emergency department?

This evidence-based approach was intended to close the gap between clinical practice and research by empowering nurses with knowledge, skills, and resources to meet the needs of their patient population (Black, Balneaves, Garossino, Puyat, & Qian, 2015). Consistent with the literature, EB practice has proven to improve patient care and quality outcomes by improving efficiency through the promotion of standardized methods for the identification of and provisions of palliative and end-of-life conversations and care. This transformational strategy could improve the patient experience and lead to increased quality of care and patient satisfaction through early identification of goals and preferences and shared-decision making (Yankovsky, Gajewski, & Duton, 2016).

Addressing the Gap-in-Practice

This scholarly project was designed using the “Walden University Manual for Clinical Practice Guideline Development” (2019) and was based on data collected from the most recent Community Health Needs Assessment (CHNA) for the institution. The demographics of the community showed a large proportion of older adults with chronic and serious illnesses that lend to increased and early rates of mortality in this community. In addition, it described the residents as lacking preventive and ongoing care for chronic and life-limiting conditions, therefore increasing the risk for complexity of illnesses when seeking urgent care. Because of the lack of engagement with the healthcare system, the admission to the ED may be the only opportunity for the patient to have discussions about their care. This project addressed the need to increase opportunities for patients to discuss goals and preferences of care by providing evidence-based CPG to accompany the new protocol for nurses to initiate palliative care discussions when providing written information regarding advanced directives. In return, this intervention may increase the number of patients that have the opportunity to have palliative and EoLC conversation in the ED on a routine basis.

This project provided ED nurses with CPG to implement the protocol for initiating palliative care discussions in the ED when providing printed information about advance care planning. It also provided evidence-based information and resources to formulate a knowledge base of palliative care for continued learning and sustained EB nursing practice. In addition, the resources included a pocket aide to assist the nurses when directing the discussions and documenting the encounter. This CPG is consistent with the extending role of the nurse and provides suggestions for improving quality of care, patient safety, and patient and family satisfaction through shared decision-making and the formulation of a patient-centered plan of care (Hartjes, 2015; Hollyday & Buonocore, 2015). This CPG provided the institution with resources and is expected to create an increase in the quality of care by better patient outcomes, increased patient satisfaction ratings, and improvement in overall quality of life reported by patients and family members, as has been documented in the literature (ANA, 2015; Mishelmovich, Arber, & Odelius, 2016).

Nature of the Doctoral Project

Sources of Evidence

Peer-reviewed literature, systematic reviews, and evidence-based tools relevant to palliative and end-of-life discussions by nurses in the ED or ICU provided a foundation to develop unit specific nurse directed palliative care guidelines for discussions. This CPG included information and resources related to palliative care and evidence-based protocols for early identification and intervention. Consideration of the Emergency Nursing Scope and Standards of Practice (2011), the Emergency Nurses Association, “Palliative and End-of-Life Care: Position Statement” (2019), and the American Association of Colleges of Nursing, “Essentials for Doctoral Nurses” (2006), provided standard principles as a foundation of care within the project.

The sources of evidence for this doctoral project were initially collected by searching CINAHL and Medline for literature from the past five years, nursing standards for clinical practice, national nursing organization position statements, and peer-reviewed articles. These searches focused on the role of the nurse in palliative care, end-of-life discussions, standards of emergency and palliative care, initiating goals-of-care discussions in the ED, and advanced care planning discussions to formulate the basis for this project. In addition, a subsequent literature review was conducted in regards to Watson's caring theory/caring science for palliative care in the ED, palliative care discussions, and identifying the nurse as the caring environment. Because the literature review was limited to the ED nurse's role in these discussions, research based on palliative-care communications in the ICU and the burn unit were included because nursing in these areas is comparable to nursing in the ED. Articles that were six or more years old were included because of their relevance and the paucity of more recent studies. The most recent nursing guidelines were used that were available that related to the topic.

Analysis and summarization of literature using Melnyk's hierarchy of evidence matrix focused on effectiveness, appropriateness, and feasibility of best practices (see Melnyk & Fineout-Overholt, 2011). The information collected provided data congruent with the gap in evidence-based clinical practice and suggested strategies to support ED nurses' understanding, confidence, and comfort when partaking in conversations with patients and family members to identify physical, emotional, and spiritual needs. A summary of the relevant findings from the literature offered a description of the current state of the evidence on the topic that supported the use of evidence-based guidelines, resources, and early palliative care nursing communication in the ED.

Approach Summary

Implementation of a CPG provided current best practices for optimal patient outcomes to increase quality of care and patient safety. An analysis and summary of findings based on the literature review was distributed to key members of administration, palliative care team, and the nursing education staff to provide a proposal to promote best practices for this intervention for this setting. It was my recommendation that the institution track documentation related to care of end-of-life patients in the ED, as well as patient satisfaction surveys to measure the impact of the new process. Learning objectives of the project were to increase knowledge, implement a new CPG, and promote a caring environment. The administration of the facility may use the CPG to expand to other nursing units at the institution to provide opportunities for all patients to discuss goals of care and advance care planning.

Anticipated Findings

The analysis and summarization of relevant findings of current literature using best practices and support from Watson’s theory of caring provided a theoretical framework for this project. Regular collaboration with nursing leadership, the clinical practice committee, the quality and safety committee, the palliative care team, and the ED staff educator provided input for quality assurance and performance improvement suited for the design and implementation of the project. The education department collaborated with leadership on financial matters for implementation and evaluation of the project.

Providing new EB CPG provided resources and support for nurses to promote a safe and caring environment for patients to discuss sensitive topics despite the chaotic environment of the ED (e.g., increased patient acuity, time constraints, and conflicting patient care priorities; Pagano, 2016). Suggestions from the literature provided assumptions that the implementation of the PCG would increase the likelihood that nurses will be able to (a) assess and identify patients who will benefit from palliative care discussions, (b) promote a caring environment that increases trust between the nurse and patient by using evidence-based palliative-care communication strategies, (c) develop a person-centered plan of care using advanced directive patient information booklet, (d) document the encounter using consistent language and terminology for clarity of patient goals and preferences of care, and (e) refer patient for palliative care consult if warranted.

Concise Statement

Current literature included suggests training critical care nurses to use evidence-based palliative care to promote consistency in the approach to care for patients with serious and life-limiting illness (Aslakson, Curtis, & Nelson, 2014). This CPG provided nurses with a standard approach and resources to advocate for patients' needs and preferences of care as an extension of the palliative care team in a clear and consistent manner, as discussed in the literature (see Salmond, & Echevarria, 2017). Care delivery consistent with patient-centered goals decreased redundancy and duplication of treatments (see Kettner, Moroney, & Martin, 2013).

Significance

This DNP project was significant to the field of nursing because it followed the recommendation from the Palliative and Hospice Nursing Professional Issues Panel “Call for Action: Nurses Lead and Transform Palliative Care,” (ANA, 2017) as it provided resources for nurses to deliver consistency when caring for seriously ill patients, patients with life-limiting illness, or dying patients in an environment that is not conducive to providing comfort care. Watson’s caring theory provided a theoretical framework to promote an environment of caring and compassion that encourages trust when discussing intimate thoughts and feelings regarding EoLC, especially in an area that focuses on bio-medical care as opposed to comfort care for patients and families (see Anderson et al., 2017). Providing a comfortable environment and consistent communication strategies including language and terminology encourage nurses to focus and share openly at a time when emotions are high for patients, families, and healthcare providers addressing the physical, emotional, and spiritual needs of patients as they approach a sensitive time and begin to discuss feelings of concerns about life and death (Jamison & Vulaj, 2015).

Key Stakeholders

The primary key stakeholders for this project included ED nurses, patients, and medical/palliative care providers (see Kettner et al., 2013). Educational opportunities for nurses and other health care staff using EB best practices provided increased basic knowledge that sponsors collaboration around a framework to promote care and comfort. The use of CPG provided consistency across the continuum of care from diagnosis to death by decreasing inconsistencies and barriers to care earlier in the ED. Increasing stakeholder participation in clinical practice through the incorporation of an EB framework and standardization of care delivery encouraged a change in awareness, competency, and confidence that potentially could benefit all patient populations in any setting (see Jamison & Vulaj, 2015). This approach offered a paradigm shift in the culture of care delivery, as it promotes shared decision-making and lends to a change in the patient's perspective of end-of-life care, as well as encourages trust between the community and the healthcare system.

The target population for this project was the ED registered nursing staff. These nurses were identified as the main points of contact for patients entering the ED and spend a large portion of time with the patients, making it easier to interject with patients and begin early discussions around preferences and needs in an area that is fast-paced with competing patient priorities. In addition to the nursing staff and the ED nursing educator, other key stakeholders were the providers (e.g., ED physician, internal medicine and ED physicians, and palliative care practitioners), as they collaborate with nursing staff to provide care for the patients in the ED for insight to manage pain and symptoms. It is expected that the entire nursing staff will use the CPG to ensure optimal implementation of the new clinical practice protocol.

Patients receiving consistent messages about healthcare and participating in shared decision-making are more likely to be satisfied with their health care and quality of life (see Black et al., 2015). This CPG provided mutual understanding between the nurse, patient, and physician when addressing the discussion, documentation, and advocacy for treatment preferences (see Black et al., 2015).

Contributions

This project contributed to nursing practice in all clinical areas by providing nurses guidelines for discussing advanced directives and palliative care, specific language and terminology, and communication skills to address the patient's physical, emotional, and spiritual needs (see Bailey, Murphy, & Porock, 2011). The impact of the project has the ability to increase the nurses' knowledge, ability, and comfort level when discussing goals of care, advanced directives, and caring for patients with serious and life-limiting illnesses in the ED. The provisions in the CPG offered nurses the directives to move seamlessly between providing curative and crisis care when caring for patients in need of palliation and comfort care in the ED.

Potential Transferability

Patient safety and quality outcomes are associated with the skill levels of nurses and the provisions of ongoing educational opportunities that include formal and informal direction to promote evidence-based clinical practice and generalizability to other environments (see Kristensen, Nymann, & Konradsen, 2016).). Prepared nurses who incorporate EB concepts of palliative care into everyday emergency practice can increase quality, safety, and patient satisfaction for all patients through consistency and providing a caring environment (see Bailey et al., 2011). The CPG is a resource to open communication and advocacy for patient preference and goals. The use of the CPG in routine care gives rise to patient and family satisfaction, increased patient dignity, and enhanced quality in any environment (see Bailey et al., 2011).

Positive Social Change

This project contributed to Walden University's social change policy by prompting nurses to pursue educational opportunities in all areas to meet the growing and changing needs of complex patient populations (Walden University, 2017). This resulted in supporting initiatives that promoted access to quality care, safer care, and reduction of overall health care cost locally and globally (Institute of Medicine [IOM], 2010). Increased engagement and collaboration at the staff level was the first step in developing a network of local professionals and professional organizations that work together to resolve challenges related to quality patient care, safety, and decreasing the financial burden on the health care system (see Salmond & Echevarria, 2017). This project aligned with social change, as it provided an avenue to increase the application of evidence-based clinical practice to improve the access to shared decision-making and increases quality of care earlier in the course of treatment for patients with serious and life-limiting illness. The project provided clinical guidelines for consistency and communication to promote care, respect, and dignity to patients, thus, promoting a paradigm shift with the way patients and healthcare workers view quality of care at the end of life (see Walden University, 2017).

In addition, this project supported initiatives to build understanding and trust between the patient populations and the healthcare community to reduce inconsistencies that created barriers to trust in the healthcare community and increased quality and safer care consistent with the 2010 IOM (2010) report. This project aligned with the American Association of Colleges of Nursing (AACN, 2006), “The Essentials of Doctoral Education for Advanced Nursing Practice, Essential I: Scientific Underpinnings for Practice,” as it promoted the use of evidence-based clinical research to enhance health care delivery and improve patient outcomes. This project fostered the use of Watson’s caring theory to promote a caring environment in the ED nurse when initiating sensitive conversations with the aging and sick population.

Summary

Through this doctoral project, I provided a CPG for standardizing the nurse’s approach to palliative and end-of-life advanced care planning for seriously ill patients who are admitted to the ED. This CPG focused on using knowledge and understanding of palliative and EoLC to include pertinent information, current resources, and clinical aides to initiate palliative goals of care and advanced directive conversations, therefore overcoming barriers to communication when the focus of patient care shifts from curative to comfort. Building trust through consistency and increased communication using the CPG provided the nurses with an avenue to identify the patient’s goals and preferences of care (Revels et al., 2016).

The use of the evidence-based clinical guidelines provided the nurses with resources to build upon the patient’s current knowledge, discuss life-limiting illness, death, and the dying process with patients and to collaborate with physicians and other healthcare providers to advocate for patient care and treatment based on their preferences and values (see Dame & Hoebeke, 2016). The use of CPG allow the patient to explore current medical and organizational processes and protocols (e.g., ICU admission, extensive testing, and artificial ventilation) to determine their personal desires for treatment (see Dame & Hoebeke, 2016). Using consistent concepts, strategies, language, and terminology that the patient and family are able to understand decreased misunderstandings among stakeholders and decreases delays in appropriate care (see Aslakson, Curtis, & Nelson, 2014).

Providing guidance for care that is congruent with current evidence-based literature can affect quality improvement and quality outcomes for patients by directing an overall cultural change related to end-of-life patient care in all areas. Provisions of a consistent theoretical framework empowered nurses to direct patient care using EB resources, best practices, and knowledge for understanding patient disease processes, prognoses, and treatment options (see Kettner et al., 2013).

Section 2: Background and Context

Introduction

The identified gap in current clinical practice for this DNP project was that the nursing staff at the institution’s ED were not using evidence-based clinical protocols when discussing care planning, such as advanced directives, with patients with serious and life-limiting illnesses beyond providing written advanced directive patient information. In addition, the staff in the ED had expressed concern that there was lack of consistency and follow up with palliative and EoLC discussions. This gap was consistent with the literature, which revealed missed opportunities to discuss goals of care because many patients are discharged from the ED or die before a palliative care consult can be initiated (see WPCA, 2011).

This CPG was an attempt to close this gap, providing the ED nurses with EB guidelines that included information and resources supporting the role of the nurse in palliative and end-of-life care discussions. Therefore, the assumption was that there would be an increase in the patient’s understanding of diagnosis and treatment options if the nurse was empowered to provide an opportunity for patients to engage in advance care discussion and shared-decision making earlier. This CPG provided guidance for a standard first line approach for nursing staff to initiate discussing palliative care options in the ED. This project addressed the following practice question: What resources are available to guide evidence-based practice for nurses to initiate discussions about palliative care needs with patients in the emergency department?

Current evidence showed the importance of consistency, training, and resources for leveraging the ability of ED nurses and other staff to promote early discussions about palliative care (Wang, 2016). In order for the ED nurses to promote early discussions, there must be a standard for care delivery provided by safe and competent educated practitioners who can carry it out effectively and efficiently. Therefore, this EB project was the development of CPG for nurse-directed palliative care discussions by the ED nursing staff to promote competency and consistency to improve the quality of care for patients. Watson's caring theory was the basic theoretical foundation for the nurses to promote an environment of comfort and compassion that is conducive to encouraging these discussions in the ED.

Concepts, Models, and Theories

The theoretical foundation of this quality improvement project was grounded in the caring framework of Jean Watson's caring theory, including the Caritas process, transpersonal caring, and the caring moment as the theoretical foundation upon which the nurse could build a caring and comforting environment in the ED to increase the quality of initial palliative care conversations and the discussion of patient guided treatment goals (advance directive). Kurt Lewin's change theory was also used as the framework for change to occur. Barriers to change were identified during the design of the CPG. The project was designed with the end user, the nurse, in mind to encourage stakeholder buy-in.

Caring Theory

Caring science (caring theory) is the philosophy of human caring, a theory defined by Jean Watson, PhD, RN, AHN-BC, FAAN, as a foundation of nursing care, as a discipline, and a profession (Foss-Durant et al., 2015). The caring theory defined the role of the nurse as the person, health, and as the environment and is often used to assist nurses to embrace their passion for nursing as a caring profession (Bayuo, 2018; Revels et al., 2018). The caring theory incorporates the Caritas process, which is a significant part of the foundation characterized by 10 themes of caring that include the following: the formation of a humanistic-altruistic system of values, installation of faith-hope, cultivation of sensitivity to one's self and to others, development of a helping-trust relationship, promotion and acceptance of the expression of positive and negative feelings, systematically using a scientific problem-solving method for decision making, promotion of interpersonal teaching-learning, promoting a provision for a supportive, protective and/or corrective mental, physical, socio-cultural and spiritual environment, assisting with the gratification of human needs, and allowing for existential-phenomenological forces to promote spiritual and emotional healing (Watson, 2008). The theory also defines the transpersonal relationship between the nurse and the patient, and the caring moment as a spiritual encounter. These elements are congruent with the mission and values of the practicum site "to bring compassion to health care and to be good help to those in need, especially those who are poor and dying" (BSHS para. 1, 2017).

Change Theory

The introduction of Kurt Lewin's change theory implemented change through the stages of unfreezing, moving/change, and refreezing. Cumming et al. (2016) described Lewin's change theory as a simplistic approach to change that identifies the challenges and barriers (unfreeze), implementation of new behaviors (moving/changing phase) to incorporate the change in clinical practice (re-freeze). This theory is noted to be one of the most commonly used in nursing practice, as it was useful to implementing this change in the delivery of patient care in the ED.

The unfreezing phase included discussions with facility administration and staff regarding the need for the project, addressing the reluctance of nursing staff to have end-of-life conversations, and identification of the barriers and challenges to initiating discussions about palliation (e.g., goals of care and advanced directive) with patients in the ED. Provision of the palliative care PCG are considered as the moving/changing phase of implementation of the new protocol as the guidelines are developed. Refreezing occurs once the new process becomes routine.

Definitions

Advanced directive information (Five Wishes): written information provided to the patient upon admission to the hospital about advanced care planning.

End-of-life care discussions (advanced care discussions): care that emphasizes the importance of frank, timely, supportive care. discussion of such matters as preferences for life-extending care, including cardiopulmonary resuscitation, mechanical ventilation, artificial hydration and nutrition, renal dialysis, and surgery before decisions about the use of such measures become necessary (“End-of-Life Care,” 2012).

Nursing educator: A registered nurse certified in emergency nursing and possesses degree in nursing education or certification that focuses on incorporating evidence-based practice into the care provided in the emergency department and other units to maintain best practices for increasing and maintaining quality patient care.

Palliative care: a holistic approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through assessment and treatment of pain and other problems, physical, psychosocial, and spiritual (WHO, 2019).

Project site: small inner city 70-bed hospital with 26 emergency department beds, and eight intensive care beds in Northeast region of the United States.

Relevance to Nursing Practice

Emergency department care is grounded primarily in a bio-medical model of care where priorities for lifesaving and curative care are prioritized above palliative and comfort care. In this bio-medical model of care, staff are often in conflict as to the prioritization of interventions and conversations regarding patient-centered goals of care when comfort care is warranted. The role of the nurse has expanded over time to support the federal law to written information about advance directive information to patients who seek care. Providing structure through standardized CPG and EB palliative care resources empowered nurses to initiate these first line conversations, provide appropriate care referrals, and be a support and advocate for patients and families when initially providing the written information. Although advance care planning can be very difficult for patients and professionals to discuss, the use of Watson's (2008, 2012), theoretical framework in this CPG promotes an environment that is congruent to communicating on a compassionate and caring level as nurses converse with patients.

As the population grows older and the number of patients with serious and life-limiting illnesses increases and there continues to be a disproportional need for follow up with palliative care providers, the CPG provides nurses with resources to initiate these palliative care discussions and promote goal setting early in the admission and treatment process so that palliative care providers can focus on palliation (see Salmond & Echevarria, 2017). The preliminary research reviewed for this CPG project identified increasing numbers of patients who died without palliative care discussions (see WPCA, 2011). This review helped identify the need for advancement in the way that this institution is able to support patients to promote earlier conversations. Standard resources and guidelines to support the frontline ED nurses provided consistency and were considered a first step to afford patients an early opportunity to engage in conversations so their wishes and treatment choices are known (Gloss, 2017; Wang, 2016).

Current palliative care practice in this specific ED were limited to a screening assessment that included information about disease state and chronic co-morbidities, current advance directives, previous palliative care consultations, previous hospice admissions, and readmission within the last 30 days. These questions focus on the administrative strategies to identify potential patients with palliative care needs but lack the necessary information to formulate patient-centered care that address the immediate suffrage. The steady influx into this ED of patients with immediate palliative care needs and follow up take hours or days to address, missing the opportunity for a discussion about palliative care needs or EoLC and therefore patients may be discharged without their palliative care needs being addressed, (Zaleski, personal communication, September 8, 2018). The CPG make available a framework to provide an opportunity for initial discussion and documentation to support a foundation for the follow-up comprehensive assessment by the physician or palliative care team if necessary.

Gloss (2017) recognized that poor ED design, lack of consistent communication, lack of formal education, high nurse to patient ratio, the need for structured clinical guidelines, and inconsistencies in EB protocols increased barriers to having palliative and EoLC discussions with patients in the ED setting. Thus, given the time that the nurse spends with the patient and family, using the CPG, provides a resource for the nurse to identify and discuss palliative care goals with patients early in the admission process (see Dame & Hoebeke, 2016; Revels, et al., 2016). In this position and with the CPG, the nurse may be able to provide opportunities to initiate discussions given the proper training and resources to do so (see Revels et al., 2018). Congruent with the literature, the potential outcome of this project is reasonable to assume the number of patients that have palliative care discussions in the ED will increase by providing nurses with the resources to initiate the conversation.

Local Background

Demographics of this local community included a high percentage of unemployment and uninsured African Americans, with a statistically lower life expectancy in comparison to surrounding geographic areas (CHNA, 2016). Death rates among this population range 5% for people ages 65-84 to 13.5% for people 85 and older. Discussed in the previous section, serious and life-limiting illnesses (mental health disorders, cancer, heart disease, renal failure, and HIV/AIDs) rank among the top reasons for ED visits documented for this population (CHNA, 2016). Death rates for this community were consistent with the national death rates, which climbed to 2,712,630 (844.0 deaths per 100,000 population) nationally in 2017, terminal cancer and heart disease were among the highest reason for mortality (CDC, 2017). Based on the above data (e.g., decreased life expectancy, older population, high mortality rate, high use of ED), there is a large number of people in this community that may benefit from palliative care discussions when admitted to the ED.

Lack of resources may be a key factor in the inability of nurses to initiate end-of-life goal planning in this environment. Research has documented that the ED bio-medical focus is not conducive to such discussions, therefore, the environment (e.g., fast paced, bio-medical focus, noise, fast turn over, and competing priorities) causes barriers to communication, decreases understanding, and promotes the growth of confusion and mistrust between patients and the healthcare team (Alderidge et al., 2016; Gloss, 2017).

The ED staff identified a gap between the number of patients that would benefit from palliative care conversations and those that actually receive discussions about goals of care and advance directives while in the ED. The ED nursing educator indicated that there was also a lack in the follow up for patients referred for palliative care consults in the ED and lack of continuity of care for patients between the acute environment and in the outpatient care settings (Zaleski, personal communication, September 8, 2018).

The CPG addressed the current process for initiating conversations about advance directives as it is not consistent with promotion of patient-centered care, shared-decision making, or building trust with the patients within this community due to lack of health care literacy, lack of trust, and lack of follow up (Zaleski, personal communication, September 8, 2018). According to the ED nursing educator, lack of palliative-care staff availability during off shifts and the amount of patients that meet the criteria for palliative care consults, result in one-third (33%) of patients receiving alternate referrals such as hospice referral or admissions to the hospital. Additional patients are being discharged to home and some do not receive appropriate palliative-care follow up at all (Zaleski, personal communication, September 8, 2018). This project addressed the lack of standard guidelines that will empower the nursing staff to provide an opportunity for patients to discuss how they wish to live and to die in an area that has historically not provided such care or discussions.

Acting as a patient advocate in a specialty area such as the ED, the nurse can alleviate additional challenges by understanding palliative care concepts and addressing the patient’s preferences and values for care. Demonstrating understanding of the policies and protocols, while continuing to provide clinical and emotional support to the patient and family can be challenging in any area. This Doctor of Nursing Practice (DNP) project developed an EB CPG to decrease the barriers and challenges for nurses to address such issues beyond providing written material to patients for review of advance directives in the ED.

Role of the DNP Student

I see my role in this project as providing available EB resources to empower nurses to advocate for patients who otherwise may not have opportunities for discussions about the way they want to live their lives, what treatment modalities they prefer, and how they want to die. Johnson (2013) thought that mistrust in the health care system increased barriers due to a lack of understanding and knowledge, cultural beliefs, and treatments that are misaligned with the patient’s spiritual and religious practices thus, causing a conflict with treatment modalities. Conflicting beliefs may be one of the reasons that patients in this community mistrust the health care providers (e.g., traditional treatment vs cultural practices and prayer) and do not routinely engage in preventative and palliative care. This project has the ability to initiate a ripple effect by promoting early share-decision making that may decrease mistrust for the patient, family, and potentially causing a ripple effect by positively discussing the experience within the community.

Although this responsibility is expanding and has become the role of the bedside nurse, in my nursing career I have felt ill prepared to initiate palliative care discussions or initiate advance care planning due to lack of training and resources. Although there is a strive to include palliative-care instruction in medical and nursing schools, I believe there is still the gap in the educational foundation for the mature doctors and nurses that have historically provided this type of care based on past experiences. As a clinical instructor for registered nursing students, I understand there is still a gap in the way the palliative care curriculum was provided in schools that continues to affect the continuity of palliative care globally. Being aware of the lack of consistency makes me a proponent of continuous education for nurses that include end-of-life care training that includes the discussion of advance directives. In addition, my greater goal is to promote sustainability for palliative care by first providing structure and consistency to promote trustworthiness between the community and the health care system. It is my opinion, patients who lack opportunities to discuss their personal preferences on a level that they can understand and feel comfortable are at higher risk for confusion, distrusting health care in general, and creating a forum for lack of follow up.

In addition, my observation has been that bedside nurses provide comfort care to dying patients and the family all the time and promote palliative care and advance care decision-making, but lack consistency in their approach. Advance care discussions are not a once and done conversation; they are fluid and demand consistency, time, and follow-up to help patients to understand and identify their wants and needs. Providing nurses with EB CPG increases the ability of the nurse to consistently initiate these conversations, advocate for patient needs, and collaborate care among all disciplines using consistency in language and approach. Starting these conversations in the ED allows patients to become active participants in directing their treatment and identifying personal treatment goals.

This CPG was the focus of my practicum experience for Walden University and was developed in collaboration with an adult ED education specialist and validated by the institutions leadership and palliative care team through the routine change policy process. The literature review analysis was completed and provided insight for a consistent approach to advance care planning and language for nurses to initiate these discussions. The final written assessment of the implementation of this EB project was the final component of the DNP program.

Summary

Preparing ED nurses to take on the role and responsibility of initiating goals of care discussions for patients with palliative care needs promoted a vector for shared decision making and consistency in the approach for advocacy and discussions of palliative and end-of-life care. This approach encourages new and mature ED nurses and ED staff to be life-long learners, to initiate research to improve patient care, and pursue the most current best practices that guide safety and quality patient outcomes and decrease barriers that lead to patient mistrust and misunderstandings. The next section focuses on the analysis of evidence that supported this EB project.

Section 3: Collection and Analysis of Evidence

Introduction

Care at the end of life is often fragmented and often increases within the last six months of life, as Medicare beneficiaries experience a higher level of care transitions; 9.5% of the care transitions are individuals presenting to the ED with end-of-life care needs (Wang et al., 2017). The ED nurses at this local hospital have expressed concerns about the increased number of terminal patients visiting the ED who do not have their personal needs or goals of care discussed in a timely manner (Zaleski, personal communication, September 8, 2018). Inconsistencies are exaggerated in the care by the transient nature of the ED patient, lack of access to palliative care practitioners, and limited time to discuss palliative goals of care and end-of life choices (Revels et al., 2016). Nurses confirmed this idea by sharing that they feel reluctant to initiate the conversations due to lack of formal training, lack of standard guidelines, and time limitations (Zaleski, personal communication, September 8, 2018).

Through consistency of EB CPG, the nurses were provided resources for promotion of patient and family comfort, trust building, and to foster compassion, thus opening the door to discuss such topics as end-of-life care (Dame & Hoebeke, 2016; Fernández-Sola et al., 2017; Mierendorf & Gidvani, 2014; Revels et al., 2016).

Operational Definitions

Alternate care pathways: care provided outside of the hospital setting such as inpatient or home-based hospice, home health care, or palliative care in the community setting.

Educational survey: survey questionnaires developed and used for the purpose of evaluating the perceived effect of the education on the nurses' understanding of training. Questions may include the perceived preparation of the nurses to deliver palliative care discussions in the ED, the characteristics of transition to practice activities and their perceived difficulty in delivering the new protocol, and the overall perception of usefulness of the training, and content delivery of the faculty and program characteristics.

Palliative care consultation: medical evaluation and treatment delivered by palliative care experts that assist ED clinicians in managing the complexity of pain and symptoms beyond the traditional methods in the ED.

Palliative care experts: organizational professional staff that specializes in managing complex pain, symptoms, comorbidities, patient/family communication, and other issues pertaining to serious and life-limiting illnesses.

Palliative care protocol: a specific written nursing procedure specific to this organization that describes the nurse's actions required to ensure consistency and quality of palliative care.

Pocket card (aide): a clinical tool to promote quality, safe care for nurses beginning a new protocol. It contains essential knowledge, skills, and strategies necessary for basic patient care and documentation for the use of adequately communicating patients' needs to other members of the interdisciplinary team.

Resource booklet: a collection of information that pertains to palliative care for nurses containing education, journal articles, pocket cards, etcetera to promote knowledge to provide quality and safe care.

Practice-Focused Question

Upon initial environmental assessment, the ED nurses expressed inconsistencies with care delivery methods of comfort care and discussions surrounding goals of care that increased their reluctance to engage in conversations about advance directives and goals of care with patients. The nurses stated that access to the palliative care team was limited, leaving patients with their needs either not met or inconsistently met, therefore promoting confusion and encouraging lack of trust in the healthcare community. This project was developed and delivered to answer the following project practice-focused question: What resources are available to guide evidence-based practice for nurses to initiate discussions about palliative care needs with patients in the emergency department?

In order to meet the concerns of the ED nurses (e.g., lack of comfort and consistency when communicating or initiating palliative care, an increasing aging population, and the projected life-span of this community), there was a consistent need for prepared and committed palliative care trained nurses to deliver the first-line discussions about palliative goals of care that included discussions about advance directives and treatment options. The ultimate goal of developing the CPG was to give the ED nurses the resources necessary to have increased confidence and perceived competence to promote a caring and comfortable environment in this very high stress, high acuity unit to build trust and initiate conversations with patients about their palliative care needs in a consistent and compassionate way.

Sources of Evidence

In response to the expressed need from the staff in the adult emergency department for training and resources to promote palliative care discussions, a literature search was conducted to collect evidence for best practices for ED nurses to initiate conversations about advance directives and goals of care as the first-line approach for palliative care in the ED. This EB palliative-care guideline for clinical practice was designed in collaboration with the ED educator and the palliative care staff. Pre-implementation included an EB CPG for palliative-care nursing and initial advanced care planning discussions for nurses. In addition, grounding the CPG and associated care in Watson's caring science theoretical framework created a foundation for the nurses to promote an environment that is conducive for patients with palliative care concerns. The ED educator the ED physician, and the palliative care team reviewed the draft CPG and the resources for accuracy, consistency, and content validity. Addressing the ED nurses' needs for additional education, updated guidelines, and resources was vital to this project. The nursing education department, the ED nurses, and the hospital leadership expressed interest and support of the implementation and success of the project. Relevant outcome data results collected and analyzed by the institutional committees will support the change in clinical practice to improve quality of care for patients in need of palliative care in other nursing areas.

Using thematic analysis, common themes found in the initial review of research included the need for early palliative care discussions, consistency of approach for end-of-life discussions, palliative care education of nursing staff, and standard guidelines for initiation of palliative care conversations in the ED. This type of intervention can increase the amount of patients who have conversations related to palliative care, early EoLC planning, and understanding and completion of advance directives. It may also surpass the delivery in the ED and become a standard of care in other areas, including the advancement of palliative care and early palliative care discussions in the community setting. This CPG project provided valuable resources for nurses to initiate discussions with patients when providing them with written information about advance directives. It also empowers nurses to pursue nursing professional development and employs nurses to become proficient as the first line professional to approach the subject of end-of-life care at the bedside.

Published Outcomes and Research

An exhaustive literature search was conducted using the Cumulative Index for Nursing and Allied Health Literature (CINAHL) and Medline through the Walden University Library online. Articles were limited to peer-reviewed and evidence-based research related to clinical practice, role of the nurse, and other standards of care within the past five years related to the practice problem. The literature searches for relevant EB practice using the following terms was performed: *palliative care in the ED, palliative care education for nurses, palliative care education, end-of-life care and palliative education, and palliative care discussions by nurses, the role of nurses in end-of-life discussions,* and *advance care planning.* This review collected data until the trending of topics were exhausted for new information of current research and best practices. The incorporation of several articles used were six or more years old because of their relevance and the paucity of more recent studies. The sources included that are related to professional guidelines were the most current information available and had not been updated since the sources used, which included the Emergency Nursing Scope and Standards of Practice (2011), and the American Association of Colleges of Nursing, Essentials for Doctoral Nurses (2006) as a foundation of current standards of care.

The initial literature search revealed an abundance of research on palliative and end-of life care discussions, but little on providing the discussions by nursing staff in the ED. Therefore, information was included in analysis of research to discuss initial conversations that are provided in the ICU and burn unit for patients requiring palliative conversation. The selection process included palliative care discussions, delivery of palliative care in the ED, and relevance to the role of the nurse. In addition, best practices for preparing staff to have standardization, competency, clarity, and consistency to promote sustainability in the acute clinical setting were also included in the search. Additional searches included Watson’s caring theory and additional information defining Lewin’s change theory to describe change in clinical practice.

Evidence Generated for the Doctoral Project

The nursing educator stated that the quality data from the hospital site suggested that one in five ED patients were identified as having palliative care needs (Zaleski, personal communication, September 8, 2018). The lack of consistency (e.g., language surrounding palliative care, inconsistent documentation, increased patient needs, and lack of access of palliative care staff) left many patients with unresolved pain and unmanaged symptoms as well as mismatched patient goals and preferences and lack of follow up (see Revels, et al., 2016). This gap in care was compounded by the increase amount of patients that do not have palliative care discussions, unwanted referrals to hospice, and futile admissions to the ICU (Zaleski, personal communication, September 8,2018). Recommendation for post implementation evaluation of the project will be completed by the hospital quality department as they collect data related to satisfaction scores from hospital satisfaction surveys. To promote initial palliative care discussions with patients in the ED, this CPG project was designed to improve knowledge and provide a standard set of instructions for nursing staff to effectively engage in conversation about palliative care including advance directive discussions. This design of the CPG was to improve quality for patients through providing consistency in the process.

Following the recommendation from the Palliative and Hospice Nursing Professional Issues Panel: “Call for Action: Nurses Lead and Transform Palliative Care” (2011), nurses are called to provide quality palliative care to patients and families regardless of the setting. In an attempt to improve quality at this practicum location, an

CPG was developed to include having discussions about advance directives and goals of care as a first line intervention in addition to providing written information about advance directives. In preparation for these discussions, the CPG was developed for nurses using evidence-based resources and best practices to promote consistency in the approach to setting palliative care goals and assisting patients to identify and meet their individual treatment preferences.

Because the nurse is the first person to assess and interview the patient and family, the nurse is able to provide a professional and caring environment to promote trust and opening the avenue to approach palliative care discussions (Revels, et al., 2016). Practice guidelines related to palliative care nursing, palliative care conversations, and documentation of the palliative discussions and interventions were incorporated to prepare and promote consistency (Revels, et al., 2016).

In order to evaluate the validity of the created clinical guideline, the draft document was reviewed, revised, and approved by an expert panel using the appraisal of guidelines for research and evaluation (AGREE II) tool. As it is noted to be the gold standard for those desiring to develop CPG. The AGREE II tool appraises the draft document for validity of content (AGREE II Instrument, 2013). The AGREE II tool was also used to organize and analyze the evidence found in the literature and allowed for the collaboration with the project team to review key findings for appropriateness for use in this local setting and for evaluating validity and reliability of the drafted nursing guidelines as outlined in the “Walden University Manual for Clinical Practice Guideline

Development" (2019). Copyright permission allows reproduction of the tool for appraising clinical guidelines (Brouwers et al., 2016).

The AGREE II Tool

The AGREE II tool identified 23 items organized into 6 quality domains as a framework to guide the development and the appraisal of CPG. Once the draft document was reviewed for congruence with the literature and checked for inconsistencies with quality practices, it was forwarded to the expert panelists to review.

The AGREE II checklist was provided to the expert panelist as an appropriate method for assessing the quality for CPG (Zaccagnini & White, 2011). The expert panel consisted of the palliative care physician, the palliative care nurse practitioner, the ED nursing educator, and the ED medical director. The panel members have extensive experience working with and treating patients with serious and life-limiting illnesses with palliative care needs in the emergency care environment. Prior to the review, the panelists were asked to declared whether they have any competing interests to the development of the guidelines. Being they were all employees of the institution and the guidelines were supported by leadership, the panel was able to proceed with the evaluation to respond to the requests of nurses to meet the needs of this patient population. Using the tool, the expert panelists were asked to evaluate the guideline based on the domains outlined in the AGREE II checklist with narrative comments for discussion. Once the reviews were completed, the panel met with the project team to discuss any comments or concerns. The document was accepted with recommendations, to revise the document to include contact information for the family spokesperson to be recorded in the medical record; it was added to the documentation portion of the guidelines. All experts agreed that they would recommended the guidelines for nurses to use in addition to the completing the existing palliative care screening tool for palliative care consults used at the institution. All were in favor of having the guidelines as a foundation for the nurse to use critical thinking and creative expression to meet the objectives in the ED environment (e.g., providing a private area, using therapeutic touch, etc.). Once revisions of the CPG were completed, the guidelines were referred to the ED operations board for final approval. A description of the checklist is summarized in Section 4.

Protection of Human Participants

This project was aligned with the goals and objectives of the practicum site's quality improvement process. The project consisted of evidence-based best practices found in current peer-reviewed literature and standards of care. No direct contact with patients was necessary to complete this DNP CPG development project. In congruence with the Walden University institutional review board (IRB) an expedited review and approval was requested to ensure that this DNP project complies with Walden University policies and federally regulated ethical standards for research. Once the DNP project proposal met the requirements for approval, notification of approval was provided to the institution and the design and development of the project commenced. The institutional leadership at the site had verbally expressed a commitment to the project and signed the consent. Current public facing data was used for the project; no other data was collected for this project. The site does not have an IRB therefore the project was deferred to Walden IRB for protection of human subjects; approval number is #10-30-19-0616316. The education, implementation, and the evaluation of the project will be conducted through the education department of the institution. Careful consideration was taken to protect the physical, social, ad psychological concerns of the nurses and protect the personal health and identification and information of the patients in the ED. Nurses were informed of the project justification as clinical research for a doctoral project as well as the plan of study, identifiable risks, confidentiality, and participation guidelines for the project. All information collected through this project will be used to inform quality improvement at the institution and is protected by the Health Insurance Portability and Accountability Act (HIPAA).

Summary

Through a review of current evidence-based practice and individual and group discussions with the ED nurses, current barriers to palliative care discussions were identified and there was a request for standardization of care guidelines and supplementary resources to aid the nurses in the identification of patients for early discussions related to palliative care in the ED. The purpose of this project was to provide CPG to support the initial palliative care discussion encounter between the nurse and patients that seek care for serious and life-limiting illness in the ED setting. This initial conversation forms a basis for directing the treatment centered on patient goals and preferences and initiation of advance directives discussions that may affect the patient length of stay at the hospital, financial burden, and patient and family satisfaction. The new guidelines provided consistency in the delivery and documentation to increase confidence and competency of each ED nurse as they engage in palliative care discussions to increase the number of patients that are provided the opportunity to discuss advance directives and goals of care. Additional benefits could be the improvement of staff satisfaction, educational preparedness, and staff retention rates. Section 4 focuses on the findings and recommendations for future practice based on the implementation of this CPG for nurse directed palliative care discussions in the ED.

Section 4: Findings and Recommendations

Introduction

The ANA (2016) defined the essential role of the nurse as discussing treatment goals and advance care planning with patients with serious illness. Although all patients in the local setting are provided an information booklet titled Five Wishes in accordance with the federal Patient Self-Determination Act of 1990 (PDSA), no other information has been routinely provided and the ED nurses have not been providing evidence-based palliative care discussions about goals of care for patients with serious and life –limiting illnesses. This DNP project was designed and developed in collaboration with the emergency department education department, nursing leadership, and the institution's palliative care team to address this practice gap providing a standard of care integrating high quality, family-centered compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients, families, and surrogate decision makers. Because there are still alarming numbers of patients admitted to the ED without advance directives, this project was designed to provide evidence-based resources for nurses to institute a new protocol to discuss advanced directives and goals and to empower nurses to offer opportunities for patients to engage in shared-decision making and goal setting. Full implementation and evaluation of these CPG and protocols will be the responsibility of the ED education staff at the institution.

Palliative care is not synonymous with end-of-life care; yet, it includes the care of patients throughout the disease process, including life-prolonging interventions, life maintaining practices, and hospice care (WHO, 2019). CPG were developed in collaboration with the ED education department, nursing leadership, and the institution's palliative care team to initiate palliative and advance care discussions in the ED. Based on the nursing process (i.e., assessment, diagnosis, plan, intervention, and evaluation), these steps were taken to develop the CPG to provide consistency and standardization for care delivery, encouraging shared-decision making, promoting quality of palliative care, and increasing patient satisfaction. Incorporation of the caring theory provides a framework for the nurses to promote an environment of comfort, caring, and compassion.

Findings and Implications

A comprehensive literature review was performed by searching CINAHL and Medline through the Walden Library including peer-reviewed academic journals produced 1403 articles for palliative care in the emergency department or emergency room. The search was refined to include only those articles from 2014 through the current date, and to include the role of the nurse. The articles were reduced to 62 articles that related to the topic of nursing roles in discussing advanced directives and palliative care and were reviewed for relevance to the topic. Information applying to palliative care provided by physicians and actual care of the dying patient was removed from the review. Articles pertaining to palliative care discussions in the ED and incorporating Watson's caring theory (science) to promote a caring environment in the ED were included.

Analysis and summarization of literature using Melnyk’s hierarchy of evidence matrix was used to rank the evidence as it focused on current effectiveness, appropriateness, and feasibility of best practices for nurses discussing goals of care (Melnyk & Fineout-Overholt, 2011). The literature was used throughout the paper to connect evidence with practice. In addition, the literature provided strategies to address the gap in clinical practice and to support ED nurses’ understanding, confidence, and comfort when supporting patients and family members to identify immediate goals of care at this pivotal moment in their health trajectory. The next section includes a summary of the relevant findings from the literature to describe the current state of the evidence that supports the development of evidence-based CPG, resources, and early identification of goals of care and initiation of advance directives in the ED.

One pertinent article discussed the findings of a single-blind, randomized clinical trial at Mount Sinai Hospital in New York, where palliative care consults were initiated for patients with advanced cancer in the ED. The data suggested that early consultation may improve quality of life, decrease hospital length of stay and decrease ICU admission, and may even extend life (Grudzen et al., 2016). Given this information, the purpose of this DNP project was to provide focused EB palliative care nursing guidelines to empower ED nurses to overcome barriers when identifying palliative needs and initiating discussions of patient-centered goals and advance directives. In addition, the Patient Self-Determination Act (PDSA) was adopted into law in 1991 to increase the public’s use of advanced directives. This federal law required all health care facilities that receive payment from Medicare or Medicaid provide advance directive information to all adult patients seeking care (Teoli, 2019). This CPG is the foundation for nurses to discuss advanced directives initially in the ED along with patient preferences for treatment.

Nursing in this ED is consistent with the literature, filled with inconsistencies in palliative care delivery, thus promoting barriers and leading to patient mistrust and misunderstandings, as well as increased patient isolation and inconsistent treatment modalities that decrease patient and family satisfaction (Dame & Hoebeke, 2016; Fernández-Sola et al., 2017; Revels et al., 2016). This EB project addressed the gap in practice for palliative care discussions to be initiated by promoting an opportunity to discuss AD in the ED by the nursing staff instead of waiting for palliative care consults or allowing for missed opportunity to discuss patient needs and goals. Consistent with the position statements of the Emergency Nurses Association (2019) and the ANA (2016), the ED nurse is obligated to address care concerns with seriously ill patients who enter the ED for care.

Trends from the evidence suggested that nursing roles are changing to proactively advocate for patient’s goals of care and nurses are initiating the conversations around end-of-life and palliative care in the ICU and burn unit for patients with serious and life-limiting illnesses when the palliative care staff is unavailable; these situations and environment are similar to the care provided in the ED. The literature also describes the role of ED nurse as the first person to assess the patient and typically spends the majority of the time with the patient; the nurse is in a unique position. Within the evidence review, the authors consistently focused on the importance of nursing support (protocols, guidelines, etc.), continued education regarding palliative care, and Watson's theoretical framework to promote a caring environment in healthcare organizations to foster patient engagement.

The Emergency Nurses Association (2019) has found that the focus in the ED is life-saving and urgent to the point that it can be a challenge for staff to provide palliative or comfort care due to the chaotic environment. However, there are a number of studies that demonstrated that lack of training and resources also contribute to barriers to providing palliation in the ED (Bailey et al., 2011; Beckstrand et al., 2017; Wolf et al., 2015). Wolf et al. (2015) suggested that palliative care would be more prevalent if included in basic nursing education and opined that there is a great need for CPG for palliative nursing to improve the consistency of patient care. In an additional study conducted by Bailey et al. (2011), the lack of consistent knowledge and training for ED nurses decreased the lack of focus on comfort needs of all patients. Studies were consistent with the argument that palliative care education, including strategies for communication should be provided to the nursing staff as continuing education.

The ANA and Hospice and Palliative Nurses Association (HPNA) presented a call to action for nurses to lead and transform palliative care. Both the ANA (2016) and the ENA "Position Statement on Palliative Care" (2019) recognize that nurses can play an important role in the early identification and discussions around goals of care, resulting in reducing futile admissions to the ICU and in the development and execution of patient preferences for treatment goals. Additional studies suggested that early discussion around advance directives increased shared decision making and the ability of the patient to communicate goals of care (Grudzen et al., 2016; Schroeder & Lorenz, 2018).

Early consultation may improve quality of life, decrease hospital length of stay and decrease ICU admission, and may even extend life. The American Nurses Association Call for Action: “Nurses Lead and Transform Palliative Care” (2017) recognized 3.6 million nurses that are able to engage in discussions related to palliative and holistic care; Adams (2017) noted, however, that although critical care nurses are currently extending their roles to include the palliative care discussions with patients and families, they continue to feel as though they are not educationally prepared to communicate effectively with families. As nurses are in a unique position to provide written information about advance directives and promote an opportunity to discuss values, religion, culture, and philosophy that are personal to the patient’s treatment process, communication skills and resources to initiate these discussions continue to be paramount (Revels, et al., 2016).

Advance directive and palliative care discussions can be challenging for staff members as they are faced with providing quality care for seriously-ill patients who have not expressed their wishes or goals of care with their provider or with their family. Staff have suggested that the most impactful challenges for providing palliation in the ED is education and training, ED design, lack of family support, work load, ED staff communication and decision making, resource availability (time, space, appropriate interdisciplinary personnel) and integrating palliative care discussions in ED (Alqahtani & Mitchell, 2019). Literature suggested that early and efficient communication can improve with patients and families by addressing organizational and educational barriers through providing EB education and resources such as CPG, standardized language, and consistent documentation to provide consistency in care (see Revels, et al., 2016).

As the nurse is the first medical professional to have contact with the patient, this is an opportune time to set the stage to discuss goals of care and advance directives (see Revels, et al., 2016). The use of information tools such as the Five Wishes discussion booklet, provide information for the nurses to stay constant and use consistency in the communication and language when discussing matters such as goals of care with patients and with staff; this approach may increase quality and patient satisfaction (Hartjes, 2015; Hollyday & Buonocore, 2015). Other studies suggested providing a space that is dedicated to the palliative patient that provides privacy and a space for patients and families to be more comfortable and not be subjected to the chaos of the ED (Bradley et al., 2013, Basol et al., 2015, Tse et al., 2016).

In addition, applying Watson's caring theory specifically to the establishment of a safe, caring, and comfortable environment to discuss goals of care can greatly improve the quality and trust in care. Watson's theoretical framework can improve communication though the use of core concepts of caring; transpersonal caring relationship, caring moment, and use of the Caritas Process, whereby care is transformed into wholeness, beauty, comfort, dignity, and peace within the meeting (Cara, 2003; Watson, 2008). Alqahtani and Mitchell, (2019) suggested that providing an environment of comfort in the ED can greatly increase the communication between the nurse and the patient. Watson believed the nurse can become the comforting environment through transpersonal caring, the caring moment, and the Caritas process (Revels, et al., 2016).

Watson (2008, 2012) defined transpersonal caring as the essential communication between the nurse and the patient, as it is defined as the connection between the nurse and the patient that protects and enhances human dignity by providing respect and honoring the patient's needs, wishes, routines, and rituals (Cara, 2003; Watson, 2008). This practice can be achieved as the nurse practices and honors wholeness of mind-body-spirit of the patient as a person. Transpersonal caring can be achieved as the nurse is in harmony with the needs of the patient; promoting the intention of doing and caring for a person and just being there for support paying special attention to providing love and trust as she completes nursing tasks for the patient as a person and not as an object or task to be completed (Cara, 2003; Watson, 2008). This action is consistent with the nurse's ability to discuss current goals for care with patients and initiating a discussion around advance directives as a starting point for shared-decision making and patient-centered care (see Schroeder and Lorenz, 2018). Promoting privacy, controlling noise, providing thermal comfort and ample lighting in conjunction with a caring attitude will increase the nurse's ability to provide a comforting environment to discuss what is important to the patient and family currently and in the future as the illness progresses in the midst of the

ED chaos (see Alqahtani and Mitchell, 2019). The Caring moment thus becomes the moment when the nurse and the patient come together in an encounter that is meaningful, authentic, intentional, and increases the understanding and of new internal and external discovery of self and others (Watson, 2008, 2012).

Linking Literature to Clinical Practice

Being that the ED nurse is the first person to assess the patient and typically spends the majority of the time with the patient; the nurse is in a unique position to promote conversations around palliative goals and discussions of advanced directives. Using the existing screening assessment used by the institution (which includes information about disease state and chronic co-morbidities, current advance directives, previous palliative care consultations, previous hospice admissions, and readmission within the last 30 days) gives the nurse an idea of patients that may benefit from discussing goals of care and advance directives early in the ED. The nurse then has an opportunity to provide the information booklet (in the patient’s language) and begin the discussion with the family about diagnosis, prognosis, and treatment options. Consistent with the literature, providing nurses with resources and training to communicate allows the nurse to promote an environment that is conducive to discussing goals of care and advance directives. The nurse must take the time to provide privacy; if possible the patient should be provided a private room away from the main area to reduce interruptions. Noise reduction, adequate lighting, and allowing the family to be involved also reduces stress and increases comfort. As the nurse begins to provide care and discussion with the patient the use of therapeutic touch increases comfort and promotes the caring moment (see Watson 2012).

The nurse must take a moment before discussion to prepare by first reflecting on her own beliefs and understanding of the situation (see Revels, et al., 2016). Involving the family and spokesperson in discussion and using the resources provided as a foundation for the discussion increases and adds value to the development of the goals of care. As the nurse provides patient and family education regarding palliative care using the information provided at a level the patient and family can understand; using Watson's theoretical framework promotes a caring environment to discuss it using the Caritas Process within the current situation.

This project focused on the nurse's role in identifying seriously-ill patients with palliative care needs and initiating the discussion around goals of care and advanced directives to include what is important to them when defining treatment. Goal setting and discussion is the initial step in developing a holistic approach to care (physical, emotional, psychosocial, and spiritual) for people that require palliative care and increased comfort measures in their overall treatment plan. The use of Watson's caring theory as the framework for this project will encourage a paradigm shift in the nurse's perspective to include a palliative mind-set in a bio-medically focused environment to provide an environment of comfort and caring when the need arises.

The use of Watson's caring theory assists the nurse in promoting a caring environment for patients by incorporating the Caritas process, along with the development of a transpersonal caring relationship between the nurse and the patient, and a sacred moment of being to make up the core values reflective of human caring (Watson, 2008, p. 34). The Caring theory or Caring science practices loving kindness, the act of being an authentic presence, knowing and promoting one's holistic connection of mind, body and spirit, therefore being present and allowing the flow of the spirit to connect the nurse and the patient (Watson, 2008, 2012). In essence, it promotes the nurse-patient relationship through the nurse as the healing environment. In the CPG the nurse will focus on the use of Watson's Caritas process to incorporate the mission of the institution (the mission of the local setting is to extend the compassionate ministry of Jesus by improving the health and well-being of our communities and bring good help to those in need, especially people who are poor, dying and underserved; BSHS, 2017) into the framework of care provided in the ED. By using Caritas process, the nurse will be able to incorporate loving, kindness as the environment of healing in the ED as the nurse seamlessly will promote comfort and healing into every encounter with the patient to initiate palliative care goal setting in this chaotic, bio-medical focused area.

Step 1: Development of clinical practice guidelines. The goal of this project was to develop CPG that reflect current best practices to achieve optimal patient outcomes through quality of care and patient safety. A review of literature was conducted and the literature, summarized and analyzed findings using Melnyk's (2011) hierarchy of evidence matrix, and the summary of findings were distributed to the to key members of administration, ED medical staff, palliative care staff, and nursing educator for review.

These key members collaborated in the identification of best practices appropriate for use in this local facility. It was necessary to develop guidelines to formulate education for nurses to maintain consistency in the approach to screening, delivery, and documentation for goals of care and initial advance care planning. The existing screening for palliative care consults resulted in a robust number of referrals for consults that were not able to be completed in a timely manner. Providing the nursing staff with the resources to initiate the discussions about this topic allowed the palliative care team to focus on patients that are in need of pain and symptom management. This intervention was the first step in developing an interdisciplinary approach to end-of-life care and initiating it in the ED.

Step 2: Palliative care presentation. A draft of the CPG was developed from the best practices identified and grounded in Watson's theory. Once the draft guideline was developed, the same expert project committee reviewed the document using the AGREE II checklist and returned the document for revisions until the contents met the local standards for implementation and the content was deemed valid.

The expert panel consisted of the palliative care physician, the palliative care nurse practitioner, the ED nursing educator, and the ED medical director. The panel members had extensive experience working with and treating patients with serious and life-limiting illnesses with palliative care needs in the emergency care environment.

AGREE II checklist. The AGREE II checklist served as an outline for recording, tracking, organizing, and analyzing the recommendations obtained from the expert panel of stakeholders. The checklist also provided an outline for guidance for the development of the CPG. The domains of the AGREE II model checklist were followed as below:

Domain 1: The expert panel assessed the CPG as it related to the to the targeted population.

Domain 2: The expert panel evaluated the CPG based on knowledge of palliative care and clinical experience and the need for guideline development.

Domain 3: Melnyk and Fineout-Overholt's (2011) rating system was utilized to appraise the literature used for the creation of the guideline. Using this rigorous method of development established validity of the best practices found in the literature.

Domain 4: Presentation of the checklist addressed the format, clarity of the guideline, and the consistency and appropriateness of the language.

Domain 5: The determination of applicability of the key criteria of the guideline occurred before dissemination to the target population.

Domain 6: Editorial independence allowed the expert panel to offer recommendations and guidance regarding the CPG and resolve conflicts of interests when appropriate (Brouwers et al., 2016).

The expert panelists were allowed one week to review, appraise, and make recommendations for revisions. Once the appraisals were completed, panelists and I met twice within the next two weeks to discuss the document and reach a consensus for approval to move to the next level (Method 2: Reaching consensus). The document was accepted with recommendations to revise the document to include contact information for the family spokesperson to be recorded in the medical record; this information was added to the documentation portion of the guidelines. All experts agreed that they would recommended the guidelines for nurses to use in addition to the completing the existing palliative care screening tool for palliative care consults used at the institution. Once revisions of the CPG were completed, the guidelines were referred to the ED operations board for final approval. The approved guidelines were based on the updated protocols for palliative care in the ED, information, and resources. Continual collaboration required discussions with nursing leadership at the site throughout the development of this project. Once CPG draft was reviewed, revised, and approved by the experts, the draft moved forward for review and approval from the by the ED Operations Board for implementation.

Step 3: Implementation of the clinical practice guidelines. The hospital has indicated that an educational curriculum for the new guidelines will be developed by the education department using current best practices and palliative care standards. The EB resources provided by the project, including a resource booklet of educational information for those staff members who are not able to attend the scheduled presentations, was provided to the institution that included a list of the references from this project, a copy of the protocol and guidelines, The Caritas process and the Five Wishes pocket aide. All staff educational information will be developed and delivered by the institution’s Nursing Education department.

Step 4: Evaluation of the clinical practice guidelines. The CPG plan included my recommendations for the local site to collect data post implementation to improve performance: consistency of documentation of screening assessment of palliative care needs, increased discussions of goals of care and advanced directives, and increased referral and follow-up palliative care consultations to meet the quality standards for accreditation and certification. Data collection in the areas of patient satisfaction and the financial impact of increasing the ED flow can be used to inform continued quality improvement to increase patient treatment choices to alternative care pathways (hospice, community palliative care), and decreased financial burden on the patient and the institution from futile admissions to the hospital or intensive care units. Any data collected from the project will be done by the education department and will follow institutional and federal protocols. The final draft of the guidelines was distributed to the administrative and education staff. Pre and Post survey evaluations of the educational presentation will be completed by the education staff using existing institution evaluation forms to measure attainment of knowledge and effectiveness of the content.

Recommendations

This CPG was based on the Emergency Nursing Scope and Standards of Practice (2011), the Emergency Nurses Association, “Palliative and end-of-life care: Position statement” (2019), developed in collaboration with the ED nursing educator and the palliative care staff experts at the project site. The CPG were originally created for the adult emergency department to provide guidance to the nurses when discussing palliative care goals and advance directives: however, it could easily be replicated for use in other areas of the institution with modifications to suit the unit population and nursing focus. The administration and leadership agreed that there was a need for nurses to engage in palliative care discussions as an extension of the palliative care team. I recommend that since this tool was developed for this project, it should be further researched for effectiveness within the institution and revised if needed to be consistent with the needs of the nurses and the population.

The WPCA (2011) reported that more than 29 million individuals could have benefited from end-of-life conversations prior to their deaths. Providing the nursing staff with additional training, preparation, and support from leadership will allow the nursing staff to consistently promote the initiation of these discussions and advocate for patient goals of care and preferences of treatment early in the admission process. This process will be used in addition the existing palliative care screening to identify patients with palliative care needs and discuss immediate treatment preferences based on the advance directives. Discussing early goals of care may eliminate the overwhelming amount of palliative care consults and place the focus on patients with palliative needs beyond discussing advance directives.

My recommendations included the incorporation of the clinical practice protocol (see Appendix A) and the CPG (see Appendix B) into the daily nursing routine to promote consistency and collaboration among staff members advocating for quality of patient care. Once implementation has occurred, revisions from feedback from nursing staff, palliative care team, and the nursing educator will be incorporated if necessary to further streamline the process.

The components of the CPG were based on Jean Watson's Caring theory (Caring science), specifically the Caritas process (see Appendix D) and transpersonal caring for providing a sacred space/environment, promoting the transpersonal experience, and embracing the sacred moment between the nurse and the patient to discuss advance directives and goals of care in the ED. This project optimized consistency in guiding the nurses to initiate these discussions and address the need for evidence-based resources to support the nursing staff in implementing the new guidelines for clinical practice (see Appendix B). The practice-focused question: What resources are available to guide evidence-based practice for nurses to implement nurse directed palliative care discussions in the emergency department?

The institution established a protocol that coincides with the mission and values of the institution to be used an internal quality check for patients receiving initial palliative care discussions about goals of care in the ED by nurses. As the nurse is the first person to have a conversation with the patient it is important that the nurse be aware of her own feelings and beliefs around dying and caring for patients that are facing death. Watson realizes that although this theory cannot be verifiable, measured, or testable, it provides professionals to a way to connect with patients as beings and not objects and allows for care to be a basis for the connection that occurs between the nurse and the patient (see Watson, 2008).

The following interpretation of the guidelines using Watson’s Caritas process to promote the nurse as the environment in the ED will provide a course of action to integrate high-quality, family-centered compassionate care to patients, families, and surrogate decision makers. This policy addresses nursing staff’s ability to provide support to patients and families when discussing goals of care pertaining to their serious and life-limiting illness in the ED. The following interpretive guidelines are to be used by the nurse to ensure standardization in the approach when providing discussions around advance care planning, goals of care, and the advocacy for patients with serious and life-limiting illnesses that present into the ED when using the CPG (see Appendix B).

Watson identifies the nurse first as a person, with feelings, beliefs, and values of their own that can influence how the nurse interacts and provides care to the patient. Watson describes the encounter between the nurse and the patient as entering into a caring moment that goes beyond the completion of tasks to provide holistic care to allow the nurse and the patient form a deeper connection. In preparation for this interaction between the nurse and a patient, the nurse may practice deep breathing and meditative exercises to help relax and focus on herself as a person as well as a professional before providing patient care. These practices help the nurse to identify their own inner feelings of providing palliation to patients that are in need of comfort care and encourages the practice of incorporating compassion, kindness, and love toward self and others as proposed by the process of caritas nursing (see Watson, 2008).

Additionally, Watson realizes that the word nurse is synonymous with health. Nursing is a caring science where the nurse connects to patients as to preserve humanity and dignity. The nurse recognizes that health is holistic in nature and embraces spiritual health as important as emotional and physical. Watson believes that the transpersonal caring relationship between the nurse and the patient is the foundation for a holistic approach to health (Watson, 2008).

Finally, as the nurse prepares the environment for the patient with palliative needs, the nurse is empowered to promote any atmosphere into a venue of loving, caring, kindness that helps people connect mind, body, and spirit (see Watson, 2008). Watson approach sponsors preserving dignity and harmony and the promotion of healing environment. Practicing nursing tasks and protocols that reduce stress on the individual, endorse restraint reduction initiatives, and enhance fall prevention initiatives, are some other examples of promoting the theory. Taking the time and the initiative to sit down with patients, hold their hand, maintain eye contact, and provide reassurance are some primary examples of practicing Watson's theory.

Watson believes the nurse has the ability to enhance healing through the use of the caring theory and that it encompasses the ideas of the nurse as the person, health, and the environment. The following guidelines with interpretation reflect Watson's approach to ministering to patients in the ED to support the nurse as the person, health, and as the environment. The caring theory promotes acts of loving kindness, of being an authentic presence, knowing and promoting one's holistic connection of mind, body and spirit, being present and allowing for a spiritual connection between the nurse and the patient (Watson, 2008, 2012).

The use of Watson’s caring theory and the Caritas process as a foundation to promote the atmosphere of the ED into an environment that places comfort about cure, the nurse prepares to allow her presence to transform the environment into a place where caring, compassion, and spiritual connection increase trust and understanding of the trajectory of care. In order to follow the protocol and the guideline, the nurse must first enter into self-refection that moves the nurse into a manifestation of being and knowing of their own beliefs, values, and self-care associated with the idea of death, preparation for death, and the caring for the dying in order to be open to the beliefs and values of the patient (see Watson, 2012).

As the nurse accepts the care of the patient in the ED, the initial introduction conveys the nurses as a professional and places the nurse in a unique position to administer care on a professional level and as the assessment becomes more comprehensive to include cultural beliefs as a foundation to build a relationship with the patient and the family in which trust can be built to uphold the patient’s care as a personal expression of desires for holistic care (Beckstrand et al., 2017). As the nurse has previously explored their inner perspective of own thoughts around caring for patients with palliative care needs, the promotion of a healing and caring environment can be employed through the Caritas Process to promote environment of comfort to discuss this topic. The following description is the basis for building a caring environment using the Caritas rocess (see Appendix D).

Some studies suggest providing a space that is dedicated to the palliative or dying patient that provides privacy for patients and families and to be subjected to the chaos of the ED (Bradley et al., 2013, Basol et al., 2015, Tse et al., 2016). However, some institutions are unable to provide a private space and therefore, using the core concepts of the Caritas process the nurse finds that the chaotic environment of the ED can become a place where caring relationships and compassion build trust between the nurse and the patient. Watson's theory (2008, 2012) and Caritas process provided a foundation that was used to promote an environment that is agreeable for the nurses to support a presence and atmosphere to discuss goals of care in the ED. Providing the nurse with the resources to engage with patients makes it more likely that the more patients will identify and document their goals of care as the first step in providing palliative care in the ED. As the nurse is able to understand and incorporate evidence based resources into the routine engagement with the patient, it empowers the nurse to be an advocate for patient directed shared-decision making and educate patients and families when needed. The nursing scope of practice identifies education of patients and families related to all aspects of life including end of life care. Watson differentiates curative factors as the "aim at curing the patient of disease, carative factors aim at the caring process that helps the person attain (or maintain) health or die a peaceful death" (Watson, 1985, p.7). The following interpretation of the Caritas Process was used as a framework to base the project in the ED (Watson, 2008).

Integrating the Caritas Process (The Nurse as the Environment)

Practicing loving-kindness and equanimity increases the connection between providing basic care and providing care that is founded in empathy and compassion. Maintaining poise through basic interaction such as healing touch and active listening has a profound effect on promoting healing in patients. Taking the time to sit down and listen to their concerns helps to build trust and promotes the sense of the nurse as being present, establishing an atmosphere of care.

Being authentically present and enabling, and sustaining the deep belief system and subjective life world of self and one-being-cared-for. Watson's theory believes the act of being authentically present enables the belief that others are unique individuals. As the nurse is authentically present, emotions and spirituality become evident and are able to be experienced by the nurse and the patient within the environment. The encounter is about making spiritual connections with patients and families understanding and experiencing a deep connection. Building trusting relationships between the nurse and the patient is the building block that allows for the discussion of fears, concerns, and goals of care.

Cultivating one's own spiritual practices and transpersonal self, going beyond ego self. Watson describes meditation and centering as a spiritual practice that helps the nurse to be in the present moment with the patient. She believes that deep breathing exercises during hand washing or bed making are examples of being in the Caritas

Consciousness (ie, being present, accepting the patient as a being, and connecting with the patient). Encouraging the nurse to practice these principles increases the ability of the nurse to transform any environment into a caring environment.

Developing and sustaining a helping-trusting, authentic caring relationship. Through open and honest communication, the nurse maintains a safe, ethical, and mature relationship where the patient is able to openly discuss issues without feeling judged or coerced.

Being present to, and supportive of the expression of positive and negative feelings. The nurse maintains a safe environment for the patient to express concerns and fears. Acknowledges that the patient is uncertain about what experiences lay ahead. The nurse encourages open discussion, sharing own experiences and allowing the patient and family to express thoughts and understanding of events and education.

Creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices. The nurse is aware of how he/or she creates a healing environment is integrated through the use of healing touch, tone of voice, appropriate eye contact, smiling and active listening. Through this approach, the nurse is able to engage the patient in a caring moment that allows trust and sharing.

Engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within other's frame of reference. Through active listening and engagement with the patient, the nurse enters into an experience of sharing information for the purpose of educating the patient based on what the patient’s current understanding is. The nurse must remain open to the worldview of the patient and take this into consideration when educating the patient regarding decision making and goal setting.

Creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated. Watson's beliefs that a healing environment is also important is grounded in the works of Florence Nightingale (1946) as she noted the benefits of a healing environment. Natural light, beauty of nature, quietness, sound, soothing decorations, thermal regulation are important elements conducive to comfort in an environment of spiritual healing. As the ED is not necessarily able to provide these elements, it is the role of the nurse to use creative ideas to promote a caring environment to endorse palliation in the ED.

Assisting with basic needs, with an intentional caring consciousness, administering 'human care essentials,' which potentiate alignment of mind-body-spirit, wholeness in all aspects of care. Views the patient as a being and not as a disease process or a task. Supports and encourages others to reduce anxiety and respects the privacy of the patient. The nurse is careful to involve the family in the care of the patient if the patient permits and encourages the patient and the family to speak openly.

Opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being-cared-for; "allowing and being open to miracles". The nurse encourages the patient and family to explore their feelings openly without judgement about death, dying, and the afterlife. The nurse allows the caring moment to happen and supports the patient and family in their hope.

The nurse will must incorporate the Caritas process into the routine of the ED to promote the transition from curative to comfort. The nurse will identify potential palliative care patients in need of care discussion using the existing palliative care assessment screening tool and will follow up with the initiation of the palliative care discussion to define goals of care using the CPG (Appendix B. Wang (2016), suggested that early palliative care intervention such as identification of goals of care and initiation of advance directives early may directly impact patient quality of life and the utilization of healthcare such as futile admissions and treatments.

Strengths and Limitations of the Project

One important strength of the local setting included the recent focus on evidence-based nursing practice. This facility had already begun providing evidence based resources for nurses to increase the quality of care and patient satisfaction at the inception of care. The protocol and the guidelines as well as the interpretive guidelines for the NDPCD will provide a framework for nurses to provide patients with the opportunity to have palliative care discussions and identify what their preferences for treatment that provides them with the dignity to choose the way they want to live and to die. Another strength of the environment was that medical and nursing schools are beginning to integrate palliative care in their curricula, although this education continues to be inconsistent across programs and there is little standardization in the definitions and the languages that are used throughout the healthcare system; this can also be con. This leads to confusion and mistrust. My recommendation is to standardize the education and language for palliative and end-of-life care. Although this project addressed only one aspect of palliative care at one local setting, there is much more work to do in this space to provide quality of care and patient satisfaction for patients with serious and life-limiting illnesses and those who are imminently dying. Recommendations for future projects will address issues that recognize palliative care discussions as part of the initial assessment for patients entering the ED. Further recommendations may include palliative care discussions to bridge the gap between curative and hospice care earlier in the disease trajectory.

Limitations of the project is that staff have been practicing palliative care in the ED based on life experience and may be reluctant to change their mindset. According to the nursing educator, the staff in the ED feel having goals-of-care discussions is out of their scope of practice, noting they have a palliative care department for this approach, and the ED is not a place for patients in need of comfort care. Another limitation was getting the staff together for educational activities.

My plan is to disseminate this work is to provide the draft CPG and a resource booklet that contains palliative care discussion resources and current evidence-based articles to support the nursing staff in implementing the change in clinical practice throughout the institution. The new protocol and guidelines should be discussed in the unit-based meetings, placed on the hospital intranet, and posted in all staff-access-only rooms, if approved by leadership. Other clinical personnel such as the medical staff and the community nurse would benefit from this information as well. My ultimate recommendation would be to advance the protocol to all nursing staff internal and ancillary to the hospital. I would also recommend that the institution use follow up chart audits to collect data for Quality Assurance Performance Improvement (QAPI) to provide insight in to the number of patients that are provided the opportunity for palliative discussions and those that are provided a palliative care consult prior to discharge.

Summary

It is expected that upon implementation, the institution will experience an increase in palliative care discussions. A positive result will provide a ripple effect in the use of the protocol and nursing guidelines within to include the participation of ancillary departments and community outreach programs promoting shared-decision making and advance directive development. In the next section, I focus on dissemination and analysis of self at the completion of the program.

Section 5: Dissemination Plan

Dissemination

I selected the emergency department as my study setting because this area has been overlooked as an area appropriate for advance directives discussions and palliative care planning (ENA, 2019). The gap in the literature clearly showed that there is a robust number of seriously-ill patients who could benefit from early identification of goals of care and completion of advance directives. The practice guideline for this project was developed and will be used by the nursing staff at an inner-city emergency department to meet the needs of the patients of the community.

My initial plans for disseminating this project included providing the nursing education department with the draft CPG and the resources to educate the nursing staff. I also provided a resource booklet with references and articles that will promote understanding of the need for the CPG and the use of Watson’s caring theory for the nursing staff to have onsite. There is the possibility the institution will expand the project to other areas in the hospital. Beyond the initial presentation and implementation of the CPG, I would recommend that the institution incorporate this project into the new hire orientation and as an annual competency for the ED nursing staff. I believe that this project closed the gap to improve the early completion of advance directives by seriously-ill patents and for all patients. My plan is to submit a manuscript for publication to a peer-reviewed journal for emergency nurses and possibly close the gap between ED nursing and palliative care. Another possibility is to submit an abstract to the Emergency Nurses Association (ENA) annual conference to be able to reach a much larger audience.

Analysis of Self

As a scholar, I believe I have identified a specific need in the continuum of care from curative to end-of-life. I was able to investigate the gap in the care and provide evidence-based remediation in this area of professional nursing practice. I was able to identify a theoretical framework along with evidence that supported the creation and implementation of a new protocol and CPG that will improve quality of care for patients with palliative care needs. Research of this area was inspirational and frustrating at times due to the lack of research in this specific area. This project has fostered my interest in palliative care delivery, the need for early discussions regarding preferences and goals of care, and the need for consistent education for all health care workers in this area. I believe this project nurtured my personal growth as an educator, a patient advocate, a leader, and a mentor.

As a project manager, I found that time management and communication with the institution and my mentor increased my ability to meet goals on a timely manner. However, there were many challenges as this project is only a small part of a much bigger need for improvement in palliative, end-of-life, and advance care planning. I have grown in personal and professional insight, I have developed more confidence in my ability as a scholar and a project manager. I have been able to identify a holistic approach to providing better outcomes for patients through providing better resources for nurses.

Developing and implementing this project honed my skills in the establishment of EBP, application of a theoretical model to ground nursing practice, and leadership in organizational change. Moreover, I was able to help the staff nurses to realize their own ability to identify gaps in clinical practice and use EBP to increase quality outcomes.

Summary

The implementation of a practice guideline for the nursing staff to conduct initial discussions around goal planning and advance directive completion will improve patient satisfaction and improve patient outcomes. Future research and potential projects should include the development and implementation of comfort protocols for patients that come to the ED and initiating palliative care in the community and community outreach.

To conclude, the purpose of this DNP CPG development project was to provide ED nurses with evidence-based resources to initiate the palliative care discussion around goals of care and advance directives for patients with serious and life-limiting illnesses. The anticipated outcomes for this project (EB protocol, clinical guidelines, and interpretive guidelines) will be an increased perceived preparedness that will be evaluated by the nursing educator using the standard evaluation tool for used by the institution. Providing resources to prepare nurses to successfully implement the protocol, will improve care delivery and patient outcomes. As an added benefit, perhaps the trust between the community and the health care system will improve. In the future, the CPG may be extended to other areas of the institution and in community outreach; if decided by executive leadership.

References

AGREE Research Trust. (2019). Appraisal of guidelines for research and evaluation (AGREE). Retrieved from http://www.agreetrust.org

Aldridge, M. D., Hasselaar, J., Garralda, E., van der Eerden, M., Stevenson, D., McKendrick, K., Centeno, C., & Meier, D. E. (2016) Education, implementation, and policy barriers to greater integration of palliative care: A literature review. *Palliative Medicine*, *30* (3), 224-239. doi: 10.1177/0269216315606645

Al-Mohaimeed, A. A., & Sharaf, F. K. (2013). Breaking bad news issues: A survey among physicians. *Oman Medical Journal*, *28*, 20–25. Retrieved from https://doi.org/10.5001/omj.2013.05

Alqahtani, A. J., & Mitchell, G. (2019). End-of-life care challenges from staff viewpoints in emergency departments: Systematic review. *Healthcare*, *7*(3), 83. doi:10.3390/healthcare7030083

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. Retrieved from www.aacn.nche.edu/DNP/pdf/Essentials.pdf

American Nurses Association. (2016). *Nurses' roles and responsibilities in providing care and support at the end of life* [position statement]. Retrieved from https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/endoflife-positionstatement.pdf

American Nurses Association Professional Issues Panel. (2017). *Call for action: Nurses lead and transform palliative care*. Retrieved from http://nursingworld.org/CallforAction-NursesLeadTransformPalliativeCare

Anderson, W. G., Puntillo, K., Cimino, J., Noort, J., Pearson, D., Boyle, D., & Grywalski, M. (2017) Palliative care professional development for critical care nurses: A multicenter program. *American Journal of Critical Care*, *26*(5), 361–371. doi:10.4037/ajcc2017336

Aslakson, R. A., Curtis, J. R., & Nelson, J. E. (2014). The changing role of palliative care in the ICU. *Critical Care Medicine, 42*(11), 2418-2428. doi:10.1097/CCM.0000000000000573

Bailey, C. J., Murphy, R., & Pordock, D. (2011). Dying cases in emergency places: Caring for the dying in emergency departments. *Social Science & Medicine*, *73*(9), 1371-1377. doi:10.1016/j.socscimed.2011.07.036

Basol N., Celenk Y., & Okan, I. (2015) Thoughts of emergency physicians about palliative care: Evaluation and awareness. *The Journal of Academic Emergency Medicine*, *14*, 75- 78. doi:10.5152/jaem.2015.32767

Bayuo, J. (2018) Application of Watson's theory of human caring to end of life care in the burns intensive care unit: A case report. *International Journal of Human Caring 21*, 142-144. doi:10.20467/HumanCaring-D-17-00017

Beckstrand, R. L., Rohwer, J., Luthy, K. E., Macintosh J. L., & Rasmussen, R. J. (2017). Rural emergency nurses' end-of-life care obstacle experiences: Stories from the last frontier. *Journal of Emergency Nursing*, *43*, 40–48. doi:10.1016/j.jen.2015.08.017

Black, A., Balneaves, L., Garossino, C., Puyat, J., & Qian, H. (2015). Promoting evidence-based practice through a research training program for point-of-care clinicians. *Journal of Nursing Administration*, *45*,14-20. doi:10.1097/NNA.0000000000000151

Bon Secours Health System. (2017). *Fact sheet and profile*. Baltimore, Maryland. [online] Retrieved September 26, 2018 from https://bonsecours.com/library/about-us/baltimore/fact_sheet-fy2017.pdf?la=en

Bradley, V., Burney, C., & Hughes, G. (2013) Do patients die well in your emergency department? *Emergency Medicine Australasia, 25,* 334- 339. doi:23911024 10.1111/1742-6723.12099

Brouwers, M. C., Kerkvliet, K., & Spithoff, K. (2017). The AGREE reporting checklist: A tool to improve reporting of clinical practice guidelines. *British Medical Journal*, *52 354.* Retrieved from http://dx.doi10.1136/bmj.i1152

Cara, C. (2003). A pragmatic view of Jean Watson’s caring theory. Retrieved from www.humancaring.org

Cevik, B., & Kav, S. (2013). Attitudes and experiences of nurses toward death and caring for dying patients in Turkey. *Cancer Nursing, 36*, E58–E65. doi:10.1097/NCC.0b013e318276924c

Committee on Approaching Death, Institute of Medicine. (2015). Dying in America: Improving quality and honoring individual preferences near the end of life. *Military Medicine*, 180, 365–367.

Community Health Needs Assessment. (2016). Bon Secours Health System. [online] Baltimore. Retrieved September 26, 2018 from: https://bonsecours.com/library/community-involvement/baltimore/bsbhs-community-health-needs-assessment.pdf?la=en

Comprehensive Cancer Information. (n.d.). Retrieved July 13, 2019 from https://www.cancer.gov /

Dame, L., & Hoebeke, R. (2016). Effects of a simulation exercise on nursing students' end-of-life care attitudes. *Journal of Nursing Education*, *55*(12), 701-705. doi: 10.3928/01484834-20161114-07

Emergency Nurses Association. (2011). *Emergency nursing scope and standards of practice*. Des Plaines, IL: Author.

Emergency Nurses Association. (2019). *Palliative and end-of-life care* [position statement]. Retrieved December 12, 2019 from ENA:https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/palliativeendoflifecare.pdf?sfvrsn=1777bb45_6

End-of-Life Care. (2012) *Medical Dictionary for the Health Professions and Nursing*. Retrieved July 7 2019 from https://medical-dictionary.thefreedictionary.com/end-of-life+care

Fernández-Sola, C., Cortés, M. M. D., Hernández-Padilla, J. M., Torres, C. J. A., Terrón, J. M. M., & Granero-Molina, J. (2017). Defining dignity in end-of-life care in the emergency department. *Nursing Ethics*, *24*(1), 20–32. Retrieved from https://doi.org/10.1177/0969733015604685

Foss -Durant, A., McDermott, S., Kinney, G., & Triner, T. (2015). Caring science: Transforming the ethic of caring-healing practice, environment, and culture within an integrated care delivery system. *The Permanente Journal*, 19(4), e136–e142. doi:10.7812/tpp/15-042

Goldsmith J., Ferrell B., Wittenberg-Lyles E., Ragan S.L. (2013). Palliative care communication in oncology nursing. *Clinical Journal of Oncology Nursing*, 17:163–167. doi:10.1188/13.CJON.163-167

Gloss, K. (2017). End of life care in emergency departments: A review of the literature. *Emergency Nurse*. 25, 2, 29-38. doi:10.7748/en.2017.e1707

Grudzen C, Richardson L, Johnson P, Hu, M., Wang, B. Ortiz, J. M., et al. (2016) Emergency department–Initiated palliative care in advanced cancer: A randomized clinical trial. *Journal of the American Medical Association (JAMA) Oncology*. 2016 ,2(5),591–598. doi:10.1001/jamaoncol.2015.5252

Hartjes, T. M. (2015). Predicting which patients will benefit from palliative care. *Critical Care Nursing Clinics of North America*, 27(3), 307-314. doi:10.1016/j.cnc.2015.05.003

Hollyday, S.L., & Buonocore, D. (2015). Breaking bad news and discussing goals of care in the intensive care unit. *American Association of Critical-Care Nurses (AACN) Advanced Critical Care*, 26, 131–141. https://doi.org/10.1097/ NCI.0000000000000082

Institute of Medicine. (2010). *Leading change: Advancing health.* [Report brief]. Retrieved from http://www.nationalacademies.org

Jamison, T., & Vulaj, K. (2015). Courageous conversations in the end of life: implications. *American Research Journal of Nursing, 1*(3), 23-33. Retrieved September 6, 2019 from https://www.arjonline.org/papers/arjn/v1-i3/5.pdf

Johnson, K. (2013) *Journal of Palliative Medicine*. 16(11): 1329–1334. doi: 10.1089/jpm.2013.9468

Kettner, P. M., Moroney, R. M., & Martin, L. L. (2013). *Designing and managing programs: An effectiveness-based approach* (4th ed.). Thousand Oaks, CA: Sage.

Klarare A., Hagelin C. L., Fürst C. J., Fossum, B. (2013). Team interactions in specialized palliative care teams: A qualitative study. *Journal of Palliative Medicine*.;16:1062–1069. doi:10.1089/jpm.2012.0622

Kristensen, N., Nymann, C., & Konradsen, H. (2016). Implementing research results in clinical practice- the experiences of healthcare professionals. *BMC Health Services Research*, 16, 48. doi:10.1186/s12913-016-1292-y

Kurian, M.J., Sulata, D., James, A., James, C., Joseph, L., Malecha, A.T.et al. (2014). Intensive care registered nurses' role in bereavement support. *Journal of Hospice and Palliative Care Nursing*, 16(1), 31-39. doi:10.1097/NJH.0000000000000018

Marcus, J. , & Mott, F. (2014). Difficult conversations: from diagnosis to death. *The Ochsner Journal*, *14*(4), 712–717. PMID: 25598738

McEwen M. & Wills, E. (4th ed.). (2014). Learning Theories in Theoretical Basis for Nursing. Philadelphia, PA: Wolters Kluwer

Melnyk, B., & Fineout-Overholt, E. (2015). Evidence-based practice in nursing & healthcare: A guide to best practice (3rd ed.). Philadelphia: Wolters Kluwer.

Mierendorf, S., & Gidvani, V. (2014). Palliative care in the emergency department. *Permanente Journal*, *18*(2), 77-85. http://dx.doi.org/https://doi.org/10.7812/TPP/13-103

Mishelmovich, N., Arber, A., & Odelius, A. (2016). Breaking significant news: The experience of clinical nurse specialists in cancer and palliative care. *European Journal of Oncology Nursing*, 21, 153–159. https://doi.org/10.1016/j.ejon.2015.09.006

Nightingale, F. (1946). *Notes on nursing: What it is, and what it is not*. Philadelphia, PA: Stern & Company.

Norton, C. K., Hobson, G., & Kulm, E. (2011). Palliative and end-of-life care in the emergency department: Guidelines for nurses. *Journal of Emergency Nursing*, *37*(3), 240–245. doi:10.1016/j.jen.2010.02.019

Pagano, M. P. (2016). Learning about dying and living: An applied approach to end-of-life communication, *Health Communication*, 31:8, 1019-1028, doi:10.1080/10410236.2015.1034337

Revels, A., Goldberg, L., & Watson, J. (*20*16). Caring science: A theoretical framework for palliative care in the emergency department. *International Journal for Human Caring*, 20(4), 206-212. doi:10.1177/0969733011436027

Ryan, D., & Jezewski, M.A. (2012). Knowledge, attitudes, experiences, and confidence of nurses in completing advanced directives: A systemic synthesis of three studies. *The Journal of Nursing Research*, 20(2), 131-140. doi:10.1097/jnr.0b013e318256095f

Salmond, S. W., & Echevarria, M. (2017). Healthcare transformation and changing roles for nursing. *Orthopedic Nursing*, *36*(1), 12–25. http://doi.org/10.1097/NOR.0000000000000308

Teoli, D. (2019). Patient Self-Determination Act. Retrieved December 15, 2019 from https://www.ncbi.nlm.nih.gov/books/NBK538297/#article-26769.s6

Tse J, Hung M, Pang S (2016) Emergency nurses' perceptions of providing end-of-life care in a Hong Kong emergency department: A qualitative study. *Journal of Emergency Nursing.* 42, 3, 224- 232. 27033338 10.1016/j.jen.2015.10.025

Verma, J. Y., Rossiter, M., Kirvan, K., Denis, J. L., Samis, S., Phillips, K., et al. (2013). Going far together: Healthcare collaborations for innovation and improvement in

Canada. *International Journal of Healthcare Management*, *62*(2), 66-76. http://dx.doi.org/10.1179/2047971913y.00000000029

Walden University. (2017). Social Change. Retrieved from https://www.waldenu.edu/about/social-change

Wang, S. , Aldridge, M. , Gross, C. , Canavan, M., Cherlin, E., & Bradley, E. (2017). End-of-life care transition patterns of Medicare beneficiaries. *Journal of the American Geriatrics Society*, *65*(7), 1406–1413. doi:10.1111/jgs.14891

Watson, J. (1985). *Nursing: The philosophy and science of caring*. Colorado, CO: Colorado Associated University Press.

Watson, J. (2007). Watson’s theory of human caring and subjective living experiences: Carative factors/caritas processes as a disciplinary guide to the professional nursing practice. *Texto Contexto Enferm,Florian ´ opolis*, 16, 129–135.

Watson, J. (2008). *The philosophy and science of caring* (revised ed.). Boulder, CO: University Press of Colorado.

Watson, J. (2012). *Human caring science: A theory of nursing*. Sudbury, MA: Jones & Bartlett Learning.

Wolf, L. A., Delao, A. M., Perhats C., Clark, P. R., Moon, M. D., Baker, K. M., Carman, M. J., Zavotsky, K. E., & Lenehan, G. (2015). Exploring the management of death: Emergency nurses’ perceptions of challenges and facilitators in the provision of end-of-life care in the emergency department. *Journal of Emergency Nursing, 41*, e23–e33. doi:10.1016/j.jen.2015.05.018.

World Health Organization. (2019) *WHO definition of palliative care*. Available from http://www.who.int/cancer/palliative/definition/en/

Worldwide Palliative Care Alliance. (2014). *Global atlas of palliative care at the end of life.* Retrieved from http://www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf.

Yankovsky, A., Gajewski, B. J., & Dunton, N. (2016). Trends in nursing care efficiency from 2007 to 2011 on acute nursing units. *Nursing Economic$,* 34(6), 266-276.

Zaleski, M. (2018, September 8). RN DNP Emergency Department Educator. (S. Landefeld, Interviewer)

Zhang, X., Zhao, K., Bai, Z., Yu, J., & Bai, F. (2016). Clinical practice guidelines hypertension: Evaluation of quality using the AGREE II instrument. *American Journal of Cardiovascular Drugs, 16,* 439-451. Retrieved from http://doi.10.1007/s40256-016

Appendix A: Nurse Directed Palliative Care Discussions

POLICY

It is the policy of [redacted] to establish procedure/protocols to be followed as an internal quality check for patients receiving initial palliative care discussions about goals of care in the Emergency Department by nurses.

SCOPE

This is a system-wide protocol that applies to the Emergency Departments at [redacted]

RATIONALE

This protocol provides a course of action to provide a standard of care integrating high-quality, family-centered compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients, families, and surrogate decision makers. This policy also addresses nursing staff's ability to provide support to patients and families in need of discussing goals of care pertaining to their serious and life-limiting illness in the Emergency Department.

DEFINITION(S)

Imminently Dying - specifies the period of a patient's illness when death can reasonably be expected to occur within 7 days. Common signs/symptoms of imminent death include: sedation or delirium, death rattle (upper airway secretions that the patient cannot clear), no oral or artificial nutrition/hydration, and no plans for further life-sustaining treatments.

Life-limiting illness- is a term used to describe an incurable condition that will shorten a person's life, though they may continue to live active lives for many years.

Serious illness- is defined by is a health condition that carries a high risk of mortality AND either negatively impacts a person's daily function or quality of life, OR excessively strains their caregivers.

The Five Wishes- an advance directive document that provides clear guidance to help the patient discuss what matters to them and what their wishes are in advance; many people find it challenging to bring up the conversation with their family members, loved ones, and their doctor.

Wish 1: The Person I Want to Make Care Decisions for Me When I Can't
Wish 2: The Kind of Medical Treatment I Want or Don't Want
Wish 3: How Comfortable I Want to Be

Wish 4: How I Want People to Treat Me
Wish 5: What I Want My Loved Ones to Know

PROCEDURES

The nurse will provide care to the patient that includes:

Promotion of an environment of caring that is conducive to discussing palliative goals of care.

Providing and reviewing with the patient, family, or surrogate decision maker the *'Five Wishes'* pamphlet for identifying what matters to the patient.

Communication with the patient, family and surrogate decision makers regarding goals of care, respecting the patient's privacy, values, religion, culture, and philosophy.
Educating/counseling patients and families concerning the treatment options that are offered.

Collaboration with medical staff to manage pain and other physical/psychological symptoms effectively.

Referral to the Palliative Care Team if the patient requires intense pain or symptom management (see 'Referral Process').

Provision of care for the imminently dying (see 'Care of the Imminently Dying')
Documentation of the '*Five Wishes'* discussion and the goals of care in the medical record.

Resource to hospital staff:

The Palliative Care team acts as a resource for clinicians. This may include support to address moral distress, burnout, post-traumatic stress disorder and trauma that can result from repeated exposure to stressful situations. Interventions may include de-briefings after patient deaths and access to spiritual and psychosocial resources.

REFERENCES

Center to Advance Palliative Care. Policies and Tools for Hospital Palliative Care Programs. A Crosswalk of National Quality Forum Preferred Practices. New York, NY, 2007.

National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care. Second Edition. Pittsburgh, PA, 2009.

National Quality Forum, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report*, 2007.
"'Five Wishes:'" An Easy Advance Directive Promotes Dialogue on End-of-Life Care, Robert Wood Foundation.

Ferrel BR, Coyle N. *The Experience of the Nurse in End-of-Life Care in the 21st Century*. The Textbook of Palliative Nursing. Chapter 26. New York: Oxford University Press, 2006.

Kelley, A. S., & Bollens-Lund, E. (2018). Identifying the population with serious illness: The “denominator” challenge. Journal of Palliative Medicine, 21(S2), S-7.

Moral Distress in Palliative Care:
http://www.capc.org/seminar/phoenix/Modules/Module4MoralDistress/Presentation/Module4MoralDistress_Presentation_Summary.pdf

Making the Case for ICU Palliative Care Integration:
http://www.capc.org/ipal-icu/monographs-and-publications/ipal-icu-making-the-case-for-icu-palliative-care-integration.pdf

Appendix B: Clinical Practice Guidelines

Standard Operating Procedure- Emergency Department

Title: Guidelines for Nurse Directed Palliative Care Discussions

Original Publication Date: *Draft* – 11/08/2019

Revision Dates: update annually

Purpose: To provide a standard of care integrating high quality, family-centered compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients, families, and surrogate decision makers by:

- Providing and reviewing with the patient, family, or surrogate decision maker the *'Five Wishes ™'* booklet for identifying what matters to the patient
- Promoting an environment of caring that is conducive to discussing palliative goals of care.
- Communicating with the patient, family and surrogate decision makers regarding goals of care, respecting the patient's privacy, values, religion, culture, and philosophy Educating/counseling patients and families concerning the treatment options that are offered.
- Collaborating with medical staff to manage pain and other physical/psychological symptoms effectively, referral to the Palliative Care Team if the patient requires intense pain or symptom management (see 'Referral Process').
- Providing care for the imminently dying (see 'Care of the Imminently Dying')
- Documenting the '*Five Wishes'* discussion and the goals of care in the medical record.

Associated Procedures: *Nurse Directed Initial Palliative Care Discussions in the Emergency Department*

Appendix: (A) Five Wishes ™ Pocket Card reference

(B) Caritas Process adapted for the ED nurse

Resources:

Center to Advance Palliative Care. Policies and Tools for Hospital Palliative Care Programs. A Crosswalk of National Quality Forum Preferred Practices. New York, NY, 2007.

National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care. Second Edition. Pittsburgh, PA, 2009.

National Quality Forum, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report*, 2007.

"Five Wishes:" An Easy Advance Directive Promotes Dialogue on End-of-Life Care, Robert Wood Foundation.

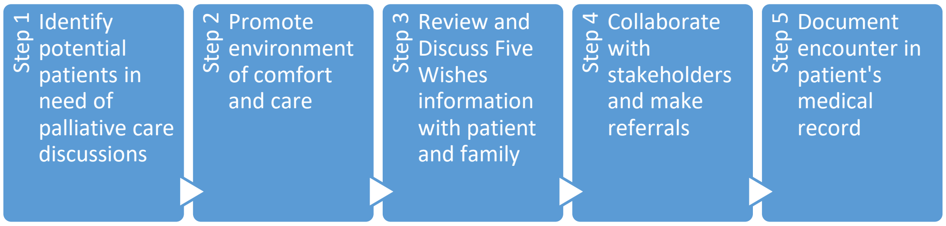
Ferrel BR, Coyle N. *The Experience of the Nurse in End-of-Life Care in the 21*st *Century*. The Textbook of Palliative Nursing. Chapter 26. New York: Oxford University Press, 2006.

Watson J. Nursing: The Philosophy and Science of Caring. New rev ed. Boulder, CO: University Press of Colorado; 2008.

Watson J. Human Caring Science: A Theory of Nursing. Sudbury, MA: Jones & Bartlett; 2012.
Draft: November 8, 2019

General Procedures:

NURSE DIRECTED PALLIATIVE CARE DISCUSSIONS –



Step 1: Identify potential patients in need of palliative care discussions

- Ask patient if they have an advanced directive
- Assess if the patient has discussed goals of care with their provider
- Provide a Five Wishes information booklet to patient if desired

Step 2: Promote an environment of comfort

- Nurse to explore inner perspective of own thoughts around caring for patients with palliative care needs
- Promote environment of comfort
  - Provide privacy
  - Decrease noise
  - Use therapeutic touch
  - Maintain Consistent language

- Provide adequate lighting
- Involve family and spokesperson in discussion if patient approves

Step 3: Review and discuss Five Wishes information with patient and family

- Wish 1: The Person I Want to Make Care Decisions for Me When I Can't
- Wish 2: The Kind of Medical Treatment I Want or Don't Want
- Wish 3: How Comfortable I Want to Be
- Wish 4: How I Want People to Treat Me
- Wish 5: What I Want My Loved Ones to Know

Step 4: Collaborate with stakeholders and make referrals

- Report discussion and goals of care summary to the emergency department physician caring for the patient
- Attach advanced directive document to the patient’s medical record
- Make appropriate referrals

Step 5: Document encounter in patient’s medical record to include the following

- *Wish 1*: Spokesperson (include contact information and document in the point of contact section of the medical record)
- *Wish 2*: Treatment Preferences
- *Wish 3*: Comfort
- *Wish 4*: Cultural values
- *Wish 5*: What does the patient want to share about his/her condition?
- Referrals/consults:

Step 1: Identify potential patients in need of palliative care discussions: Upon initial nursing assessment provided by the nursing staff, the nurse will identify potential palliative care patients in need of care discussion using the existing screening assessment used by the institution (includes information about disease state and chronic co-morbidities, current advanced directives, previous palliative care consultations, previous hospice admissions, and readmission within the last 30 days Patients that meet the patients that do not have advanced directives documented, and those patients that not discussed goals of care with their physician or their family. In the event the patient meets the above description and is interested in receiving a Five Wishes™ booklet about identifying advanced directives, the nurse will provide written information for the patient in the language of their choice (if available). If the patient has an advanced directive, the nurse will make a copy for the patient's chart and document the encounter in the medical record.

Documentation of encounter: Advanced directive information received and placed on the patient chart, ED physician made aware of advanced directive, specifically, [enter details related to resuscitation orders, intubation, and point of contact if patient is unable to communicate). In addition, the nurse will document other information that will be pertinent for patient's treatment options and note the written information provided to the patient and in what language, for patient to review.

Step 2: Promote an environment of comfort using the Caritas Process

Nurse to explore inner perspective of own thoughts around caring for patients with palliative care needs by promote environment of comfort

1) Assess and identify patients who will benefit from palliative care discussions;

2) Promote a caring environment that increases trust between the nurse and patient by using evidence-based palliative-care communication strategies based on the Caritas Process (see appendix D).

3) Develop a person-centered plan of care using the Five Wishes (advance directive) patient information booklet;

4) Document the encounter using consistent language and terminology for clarity of patient goals and preferences of care using the Five Wishes pocket care for reference (Appendix C); and

5) Refer patient for palliative care consult if warranted.

Step 3: ***Review and discuss Five Wishes information with patient and family.*** The nurse will discuss an overview of the information provided in the booklet with the patient and assist the patient and family or spokesperson in identifying information related to goals of care.

Step 4: ***Follow up with all stakeholders and make appropriate referrals*****.** When the nurse has completed the discussion with the patient and family and identified their preferences and goals of care, the nurse will document the encounter in the medical record, alert the emergency physician on duty, and submit appropriate referrals to palliative care services or social work as ordered by the physician. The nurse will also provide the patient with a copy of the Five Wishes booklet that includes the initial discussion points documented and dated in the booklet.

Step 5: Document the encounter and discussion in the medical record. Include documentation of the five topics for discussion from the Five Wishes™ booklet (use the pocket card for reference if needed located in Appendix C) and make pertinent referrals if needed to palliative care services, social work, etc.

Appendix C: Five Wishes Pocket Card Reference

The Five Wishes

- *Wish 1*: The Person I Want to Make Care Decisions for Me When I Can't
- *Wish 2*: The Kind of Medical Treatment I Want or Don't Want
- *Wish 3*: How Comfortable I Want to Be
- *Wish 4*: How I Want People to Treat Me
- *Wish 5*: What I Want My Loved Ones to Know

Do	Don't
• Listen and let the patient do most of the talking	• Wait until death is imminent
• Break information into small chunks	• Qualify treatment as
• Check frequently for understanding	• Ask patients if they want
• Provide empathy and support	• Tell patients there is
• Emphasize what can be done	• Focus solely on preferences for procedures
• Offer your recommendation(s) based on their goals and values	• Exclude surrogate decision-makers from the discussion

Appendix D: Caritas Process: Adapted for the Emergency Department Nurse

	Caritas Factor	Nurse’s Role	Examples
1	humanistic-altruistic system of values	cultivate a personal/professional practice of loving-kindness, compassion, and equanimity with self/other in the emergency department	Be open to understanding own feelings about death and caring for patients with palliative needs
2	installation of faith-hope	promote faith and hope/belief system that honors inner life world of self/other to be the foundation of the encounter	Be available to the patient to discuss their beliefs about faith and their spiritual beliefs without judgement
3	cultivation of sensitivity to one’s self and to others	cultivate personal growth and spiritual practices, beyond ego-control	Be open to explore and understand the spiritual values and practices of others
4	development of a helping-trust relationship	promote the foundation for loving, trusting, caring relationships with self, peers, and patients	Be open to promoting a personal connection with the patient to build trust and promote caring
5	promotion and acceptance of the expression of positive and negative feelings	authentically use active listening to engage in another person’s story	Allow the patient to openly express concerns and feeling about what they are feeling and what their fears are
6	systematically using a scientific problem-solving method for decision making	promote the full use of artistry of self, embracing all ways of knowing/being/doing/Becoming	Be open to thinking outside the box, to engage with patients to meet their needs and achieve their goals. Be open, be in the now to connect with patients and families
7	promotion of interpersonal teaching-learning	engage in coaching or mentoring with patients for health and wellness consider the cultural and environmental preferences and limitation for health/wellness	Educate patients and families using language and understanding on a level they can understand. Offer information in their native language , in large print or offer to read it to them for understanding
8	promoting a provision for a supportive,	incorporate comfort and caring into the healing environment, attending to	Support the patient and family holistically to addressing physical,

	protective and /or corrective mental, physical, socio-cultural and spiritual environment	energetic caring healing field consciousness.	emotional, socio-cultural, and spiritual concerns
9	assisting with the gratification of human needs	sustain human dignity by incorporating care into routine nursing tasks such as making beds, physical assessment, feeling, providing comfort, etc.	Provide care and compassion in the nursing tasks. Offer comforting words, therapeutic touch and a peaceful environment. Provide the patient with undivided attention while providing nursing duties
10	allowing for existential-phenomenological forces to promote spiritual and emotional healing	promote healing from all forces valued by the patient, allow for the presence of “miracles”	Be open to allow the patient to explore spiritual manners. Allow for emotional and spiritual healing to occur

*The use of the Caring Science Caritas Process ™ was adapted to promote the role of the nurse in the emergency department when actively working with palliative care patients.