

University of San Diego

Digital USD

---

Doctor of Nursing Practice Final Manuscripts

Theses and Dissertations

---

Spring 5-23-2020

## Utilization of Peer-Led Education to Enhance Advance Care Planning and Advance Directive Completion

Jenna Juenger

University of San Diego, [jjjuenger@sandiego.edu](mailto:jjjuenger@sandiego.edu)

Follow this and additional works at: <https://digital.sandiego.edu/dnp>



Part of the [Nursing Commons](#)

---

### Digital USD Citation

Juenger, Jenna, "Utilization of Peer-Led Education to Enhance Advance Care Planning and Advance Directive Completion" (2020). *Doctor of Nursing Practice Final Manuscripts*. 122.

<https://digital.sandiego.edu/dnp/122>

This Doctor of Nursing Practice Final Manuscript is brought to you for free and open access by the Theses and Dissertations at Digital USD. It has been accepted for inclusion in Doctor of Nursing Practice Final Manuscripts by an authorized administrator of Digital USD. For more information, please contact [digital@sandiego.edu](mailto:digital@sandiego.edu).

PEER-LED EDUCATION FOR ADVANCE DIRECTIVE COMPLETION

UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF NURSING PRACTICE

Utilization of Peer-Led Education to Enhance Advance Care Planning  
and Advance Directive Completion

by

Jenna Juenger, BSN, RN, FNP-DNP Student

A Doctor of Nursing Practice Portfolio presented to the

FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE

UNIVERSITY OF SAN DIEGO

In partial fulfillment of the

requirements for the degree

DOCTOR OF NURSING PRACTICE

May 2020

### Abstract

**Background:** The integration of advance care planning (ACP) and palliative care (PC) into oncology plays a critical role in symptom management and quality of life. Studies reveal a large subset of oncology patients with unmet needs regarding ACP and advance directive (AD) completion. Successful ACP helps to promote congruent medical treatment with patients' values and preferences and motivates patients to complete ADs.

**Objective:** An evidence-based practice project was conducted to assess the effectiveness of peer-led education to nursing staff to improve ACP and AD completion among inpatient oncology and PC patients

**Design:** A standardized survey created from the Knowledge, Attitudinal, and Experiential Survey on Advance Directives (KAESAD), was utilized to assess nursing staff knowledge and comfort of ADs and ACP prior to education course. Data outcomes of AD completions, ACP conversations, KAESAD survey results, and code status changes were recorded quarterly.

**Setting/Subjects:** 42 nursing staff at a local medical center, inpatient oncology, and PC patients.

**Results:** A total of 42 nursing staff attended in person education, online education was disseminated to approximately 20 remaining staff. A total of 633 patient records were reviewed from July 2019 to December 2019 to assess for AD completion. An increased proportion of comfort care codes could suggest a potential link between education and ACP conversations initiated by nursing staff. AD completion rates decreased post intervention but were not statistically significant. Pre-course standardized survey revealed varying levels of knowledge and comfort in discussing ADs.

**Conclusions:** ACP and ADs are pivotal components of the PC continuum. Timely ACP discussions and completion of ADs can improve patient and family satisfaction, decrease symptom burden, and improve quality of life. Recommendations call to educate across all interdisciplinary teams to verify sustainability and further improvements in AD completion and ACP conversations.

*Key words: advance care planning, advance directive, peer-led education, nursing, oncology, palliative care,*

## Utilization of Peer-Led Education to Enhance Advance Care Planning and Advance Directive Completion

In the United States, cancer has a substantial effect on society, with approximately 1,735,350 new reported cases in 2018, and is one of the leading causes of death in the United States; an estimated 609,640 deaths in 2018 (National Cancer Institute, 2017). The 2017 national expenditure for cancer care was estimated at \$147.3 billion in the (National Cancer Institute, 2018). The Institute of Medicine (2014) report, *Dying in America*, discussed end-of-life (EOL) care in the United States and the inconsistency between patient preferences and provided treatments. This signifies the importance of advance care planning (ACP) among oncology and palliative care (PC) patients. ACP, as defined by the IOM report, is an ongoing discussion between patient and clinician regarding EOL care goals over time (Institute of Medicine, 2014).

### **Background and Significance/Description of the Clinical Problem**

ACP is a key component of PC treatment, as stated in the National Comprehensive Care Network guidelines as well as the American Society of Clinical Oncology (ASCO, 1998; Levy, Weinstein et al., 2001). ACP involves ongoing EOL care discussions and advance directive (AD) completion. Many studies have shown there is a large subset of oncology patients with unmet needs regarding AD completion and ACP discussions with their provider (Houben et al., 2014; Pfirstinger et al., 2014; Yadav et al., 2017). The Patient Self Determination Act of 1990 implores health care providers to inform patients of their right to make health care decisions and to determine if they have a completed AD (Gazarian et al., 2019). This alone enhances the importance of ADs and ACP in oncology and palliative medicine.

Early initiation of ACP is important because many patients are unable to express their wishes at EOL. Successful ACP promotes congruent medical treatment with patients' values and

preferences and motivates patients to complete ADs. Approximately one-third of adults in the United States have a documented AD on file (Centers for Disease Control and Prevention, 2017; Yadav et al., 2017).

Ongoing efforts have highlighted the need to improve ACP and AD completion among PC and oncology patients. Phase 1 of an evidence-based practice (EBP) project, a screening tool to promote early PC consults, was implemented on a medical oncology unit of a local hospital in 2018. Results demonstrated an increase in PC consults and a decrease in symptom burden among this subset of patients. Subsequently, the PC team addressed the need for improved AD completion and earlier ACP with patients to decrease unnecessary aggressive treatment and respect patients EOL wishes. As a result, Phase 2 of this PC project focused on increasing ACP discussions and AD completion through peer-led education to nursing staff and patient-education portals.

### **Description of EBP Project & Facilitators**

This EBP project aimed to increase AD completion and ACP among hospitalized patients on an oncology and PC unit. The need for increased AD and ACP compliance among this population emphasized intensive cancer interventions that might not correlate to improved outcomes or quality of life. Often, vulnerable oncology and PC patients lack documented wishes in an AD and the EOL discussion with oncologists, thereby leading to unwanted treatment despite patient wishes and goals of care.

Multimodal interventions included education to staff nurses, patient education handouts, and a standardized survey of knowledge for this EBP project. Educational material in the form of a PowerPoint presentation and handouts were provided to nurses and other staff upon request. Discussions included ordering and documenting online patient-education videos, *EMMI*

*modules*, to assist with patient questions and concerns regarding ADs. This education reinforced baseline knowledge of ADs and ACP among multidisciplinary teams. ACP materials (e.g., *Go Wish, Five Wishes, Make Your Wishes Known*) were available for patient to review and displayed in family waiting areas.

Key facilitators of this project included the director of PC, bedside nurses, the unit nurse manager, social workers, and a faculty advisor. The project was approved by the director of PC at a large, teaching hospital, inpatient unit nurse manager, and ACP committee. A letter of approval and hospital Institutional Review Board addendum were approved to review patient data. Approval through the University of San Diego's (USD) Institutional Review Board was also approved for project implementation (Appendix A).

### **Evidence-Based Interventions**

A literature review of relevant studies underscored the importance of peer-led education to nursing staff to increase ACP discussions and AD completion. Keywords (e.g., *ACP, PC, oncology, solid tumor, goals of care, provider education, nursing education, PC screening, interventions*) were used for PubMed, CINAHL, and Cochrane database searches. Articles included randomized controlled trials, clinical practice guidelines, systematic reviews, meta-analysis, and quantitative studies. A total of 16 articles were reviewed from 1998 to 2018. A hierarchy of evidence table was utilized to grade the quality of evidence on a scale of I-V (John's Hopkins Nursing Evidence-Based Practice, 2017).

A Phase-1 project on the utilization of a PC screening tool aided in identifying the need for an intervention to increase AD completion and ACP. The PC screening tool was constructed from PC criteria developed by the National Comprehensive Cancer Network recommending that all patients with cancer be screened for PC needs (Levy, Smith et al., 2016). Once PC has been

initiated, EOL wishes needed to be aligned with treatment options. A randomized control trial conducted in Canada demonstrated significant improvement in the quality of life and patient satisfaction after 3 months of symptom management, monthly telephone follow-up, and PC training for nurses (Zimmerman et al., 2014).

A mixed methods study by Price et al. (2017) reported the need for further nursing education related to PC and symptom management. Gaps in education for nursing staff included knowledge on communication strategies as well as symptom management evaluation. Interventions focused on communication skills and training included information on ADs, ACP, and strategies for EOL care communication. These aided in increasing EOL care discussions between patient and health care providers (Hanson et al., 2017). A study conducted by Ferrell et al. (2000) found similar conclusions related to nurse's foundational education, knowledge, and comfort in discussing ADs and ACP. The key points highlighted that nurses need further education on EOL care, specifically ADs and ACP.

Jezewski, Meeker et al. (2003) surveyed a random group of 900 oncology nurses in four states (i.e., CA, IL, NY, TX). This survey revealed an overwhelming response for needed education on ACP and ADs. Collectively, AD education averaged 1.3 hours of their nursing program and only one-half of nurses received formal education at their place of employment. Nurses sought detailed, concrete information on ACP and ADs with opportunities for case discussions, role playing, and communication strategies. Annual in-services and patient education pamphlets were areas noted to enhance practice among oncology patients (Jezewski, Meeker et al., 2003).

A mainstay of AD intervention is the use of patient education. Support and education is also needed for ACP. Several resources have been created to enhance patient participation in

ACP. Many of these resources have been evaluated for their effect on patient outcomes and offer suitable guidance to patients for ACP. Such resources include *Making Your Wishes Known*, *Five Wishes*, and *PREPARE for Your Care*. These educational resources offer values, goals, and care wishes to stimulate discussions and clarify patients' views (Gazarian et al., 2019).

### **Anticipated Project Benchmarks**

The anticipated outcomes of this EBP project of peer-led education for ACP and AD promise significant benefits to the oncology and PC specialties. The primary goal was a 10% increase in the portion of documented ADs from unit baseline. The secondary goal was earlier ACP discussions; less than 5 days after admission. Other variables included length of stay, code status changes, and Physician Orders for Life-Sustaining Treatment (POLST) form documentation. Long term goals focused on sustainability and reducing confounding factors in data collection during specific times of the year.

### **Project Development and Implementation Timelines**

As a Phase 2 pilot project on an oncology and PC floor, sustainable buy-in from key stakeholders and bedside nurses was vital. The pilot project was conducted from July 2019 to December 2019. During the first quarter of the project, July 2019 to September 2019, a nurse practitioner and oncology staff nurse conducted a 1-hour educational course on ADs and ACP. Nurses were encouraged to attend at least one of the sessions during 6 weeks of offerings. Education included information regarding the registered nurse's role in the ACP process, appropriate documentation of AD and ACP conversations, and patient education resources. The education course was primarily didactic and incorporated the *Go Wish* activity to personalize the importance of this topic and encourage class discussion.



A pre-course survey, created from the Knowledge, Attitudinal, and Experiential Survey on Advance Directives (KAESAD), a standardized survey, was administered to assess baseline knowledge, comfort, and attitudes towards ACP and ADs (Jezewski, Brown et al., 2005). During the education course, nurses were encouraged to motivate patients to discuss their goals of care early on in their course of treatment by asking questions (e.g., “Who would make decisions for you if you were unable to?”). Nurses who were unable to attend the education course received the presentation electronically and were asked to review the material independently. Patient education pamphlets were developed and displayed in patient and family lounge areas to foster earlier patient initiation and engagement of goals and wishes. The post intervention data collection process began in the second quarter of this project, from October 2019 to December 2019.

### **Theoretical Model: Iowa Model**

The Iowa Model was chosen as the best fit for this EBP project. Marti Titler, a registered nurse at the University of Iowa Hospitals and Clinics, developed this model in the 1990s because she believed the use of evidence-based medicine was imperative for generating sustainable practice change (Iowa Model Collaborative et al., 2017). The first step of the Iowa model was to identify the problem or need for practice change; the lack of AD completion and ACP discussions among oncology and PC patients. Many knowledgeable physicians, nurse practitioners, nursing staff, and faculty assisted in the creation of this project, ensuring the necessary steps were completed to support this practice change. Throughout the project, modifications were made as appropriate. Finally, data were collected and evaluated for outcomes. The Iowa model allowed for adjustments when necessary to align nursing and patient care needs, serving as an excellent tool for evidence-based practice changes. Further changes

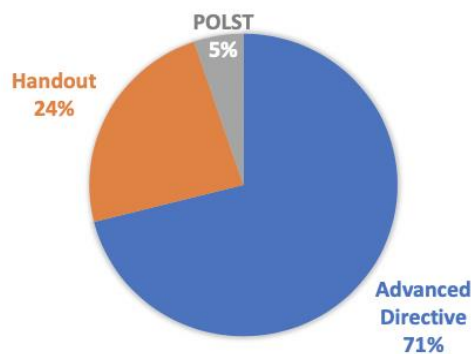
could be made to expand this project hospital wide to create a larger practice change within a large hospital system.

## Results

For inpatients in the oncology and PC units from July 2019 to December 2019, 633 patients were identified for analysis, with some patients having multiple admissions in the same time period. Figure 1 below shows the distribution of AD and POLST documentation in patient charts.

### Figure 1

*Total Completion of Advance Directives and POLST Forms*

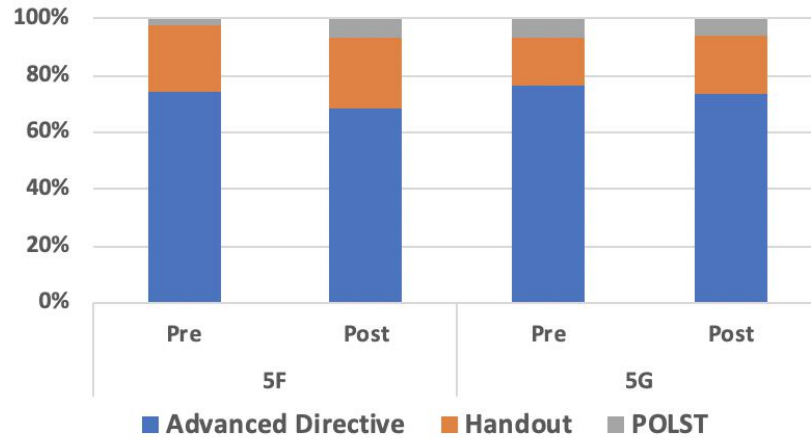


From July 2019 to September 2019, 408 admissions on the units yielded 309 unique patient identifiers and 408 admissions. This represents 99 admissions for patients with multiple admissions within the pre intervention period. During the post intervention period, October 2019 to December 2019, 324 unique patients has 413 admissions; 89 admissions represented a second, third, fourth, or fifth admission within the period. Figure 2 shows the results after extracting and analyzing the data for documented ADs, POLST forms, and AD education handout. In the pre intervention phase, 73.8% of individuals had a documented AD on file versus the 68.5% post intervention. Although there was a slight decrease in documented ADs, it was not be statistically

significant. There was a slight increase in AD education handouts between pre and post intervention, (21.4% vs. 25.9%). Unit- specific data reflected a small decrease in AD completion among both units.

**Figure 2**

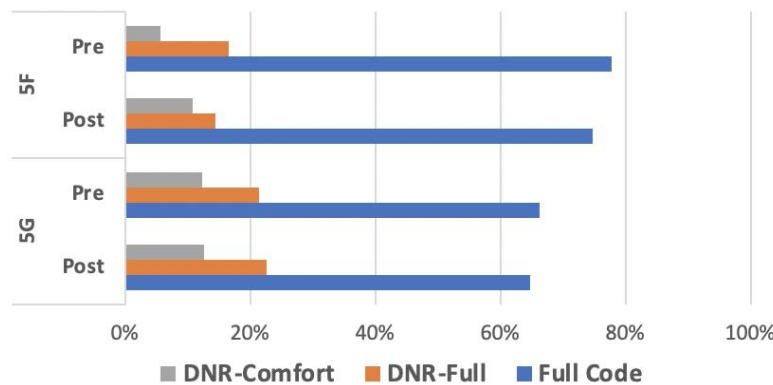
*Unit Based Advance Directive, POLST, and Advance Directive Handout Completion*



Analyzing pre- and post code status changes, there was a notable increase in DNR comfort care code status changes on the oncology unit, 5F. This could suggest a correlation between education received and ACP conversations initiated by nursing staff. *Figure 3* shows the distribution of code status changes among 5F, the oncology unit, and 5G, the PC unit.

**Figure 3**

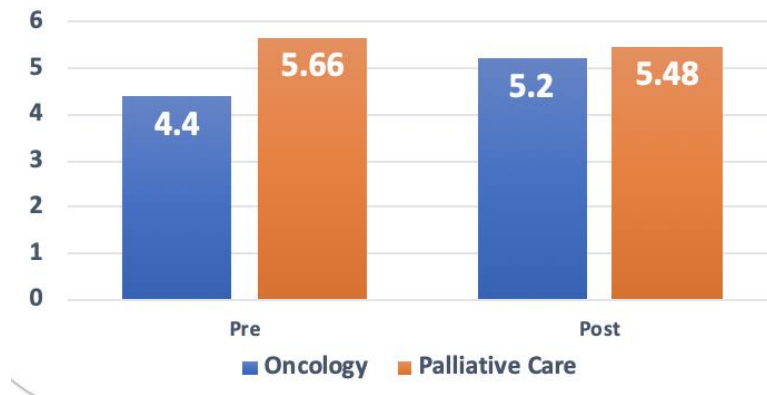
*Unit Based Code Status Changes Pre and Post Intervention*



The average length of stay (LOS) for patients on the oncology and PC units are displayed in *Figure 4*. LOS increased on the oncology unit; however, this difference was not statistically significant.

**Figure 4**

*Length of Stay Pre and Post Intervention*



Survey results from pre intervention revealed that 100% of those surveyed *agreed* or *strongly agreed* that all patients with decision-making capacity should complete an advance directive. Sixty-nine percent of individuals felt slight or moderate confidence in implementing institutional policies and procedures for advance directives, 62% had moderate-to-high confidence in answering questions about ADs, and 66% had moderate-to-high confidence in initiating AD discussions with patients. When openly asked, “What do oncology nurses need most to increase their ability to assist patients with advance directives?” most wanted more time and education on the proper documentation of ADs.

### **Discussion and Limitations**

The primary goal of a 10% increase in AD documentation was not met. ACP is a process throughout a patient’s continuum of care that is sensitive and requires answers to vulnerable questions. Patients might not feel comfortable answering such questions during an urgent

admission where trust and rapport have not been built between them and their inpatient provider. Dube et al. (2015) reported a positive correlation between length of time knowing the provider and the amount of ACP conversations; therefore, inpatient nurses may find it challenging to initiate these conversations with patients in a single visit. This warrants further education and training to nurses as well as motivation for outpatient providers to complete ADs. An increase in AD education handouts from pre and post intervention could suggest that nurses were initiating ACP conversations with patients. However, patients were unwilling to complete an AD during that hospitalization. Many of these patients with documented ADs that could have potentially been captured in the outpatient setting; a topic to explore in future studies. Other areas to investigate could be differences in proportion by gender in the completion of ADs as well as the average LOS for those with or without ADs.

Despite the evidence suggesting that participation in ACP significantly reduced treatment intensity, increased patients' quality of life, and promoted congruency between treatment and patient goals, there was still a gap in completion. Different strategies should be pursued to bolster the adoption of ADs. Other opportunities include adding a prompt in the electronic medical record as well as awareness in the community. The Narang et al. (2015) study reported an 80% increase in AD completion rates achieved by community awareness campaigns and prompts in the electronic medical record system for all patients reaching age 55. These interventions encouraged providers to discuss EOL care preferences with each patient.

Surveys collected pre intervention revealed data that was relevant to future educational courses regarding ADs and ACP. An identical survey was transmitted electronically 6 weeks post intervention; however, compliance via email revealed no respondents post intervention. This highlights the importance of in-person education, training, and follow-up to ensure compliance

among all interdisciplinary teams. The 1-hour educational session was offered once a week for 6 weeks to allow more flexibility with the nurses' schedule. However, approximately 30% of the nursing staff did not attend in-class sessions. Scheduling the educational course to differing times of the day would have potentially captured those nurses who did not attend.

### **Project Impact and Sustainability**

Upon completion of EBP projects, it is important to consider sustainability in the practice setting. There are a few steps to ensure sustainability after completion of this ACP and AD EBP project. The first step for sustainability will be the continuation of annual education on ACP and ADs. Providing this education to new staff nurses and providers will also be vital in the sustainability. The second step for sustainability will be to obtain early buy-in from providers in the first phase of the ACP and AD project. Therefore, providers will see the continued benefit within their practice during Phase 2 of project implementation. The third step in sustainability will be the continued support from staff nurses and clinical mentors. These nurses and providers will be champions of this practice change and are key in the sustainability of ACP and AD completion.

### **Conclusions**

Early ACP conversations and AD completion ensure patients values, goals, and wishes are respected in treatment decisions. This is especially vital in patients with advanced cancer and those under PC services. PC improves the quality of life of patients and families who are experiencing a life-threatening illness. Not only does PC address the physical symptoms of chronic disease management but also a holistic approach to patient care (World Health Organization, n.d.). ACP and ADs are pivotal components of the PC continuum. Proper educational support for bedside nurses who are uniquely integrated into patient care plans is key

to the initiation and earlier adoption of ADs. Providing nurses with the necessary tools and resources will allow them to advocate for patients during critical EOL care. This will in turn improve patient satisfaction, decrease symptom burden, and enhance patients' quality of life while ensuring consistent knowledge across all multidisciplinary teams.

### References

- American Society of Clinical Oncology (1998). Cancer care during the last phase of life. *Journal of Clinical Oncology*, *16*(5), 1986–1996. <https://doi.org/10.1200/JCO.1998.16.5.1986>
- Centers for Disease Control and Prevention. (2017). *Give peace of mind: Advance care planning*. <http://www.cdc.gov/aging/advancecareplanning>
- Dube, M., McCarron, A., & Nannini, A. (2015). Advance care planning complexities for nurse practitioners. *The Journal for Nurse Practitioners*, *11*(8), 766–773. <https://doi.org/10.1016/j.nurpra.2015.05.011>
- Ferrell, B., Virani, R., Grant, M., Coyne, P., & Uman, G. (2000). Beyond the Supreme Court decision: Nursing perspectives on end-of-life care. *Oncology Nursing Forum*, *27*(3), 445–455.
- Gazarian, P. K., Cronin, J., Dalto, J. L., Baker, K. M., Friel, B. J., Bruce-Baiden, W., & Rodriguez, L. Y. (2019). A systematic evaluation of advance care planning patient educational resources. *Geriatric Nursing*, *40*(2), 174-180. <https://doi.org/10.1016/j.gerinurse.2018.09.011>
- Hanson, L. C., Collichio, F., Bernard, S. A., Wood, W. A., Milowsky, M., Burgess, E., Creedle, C. J., Cheek, S., Chang, L., Chera, B., Fox, A, & Lin, F.-C. (2017). Integrating palliative and oncology care for patients with advanced cancer: A quality improvement intervention. *Journal of Palliative Medicine*, *20*(12), 1366–1371. <https://doi.org/10.1089/jpm.2017.0100>
- Houben, C. H. M., Spruit, M. A., Groenen, M. T. J., Wouters, E. F. M., & Janssen, D. J. A. (2014). Efficacy of advance care planning: A systematic review and meta-analysis.



*Journal of the American Medical Directors Association, 15(7), 477–489.*

<https://doi.org/10.1016/j.jamda.2014.01.008>

Institute of Medicine (2014). *Dying in America: Improving quality and honoring individual preferences near the end of life*. National Academies Press.

Iowa Model Collaborative, Buckwalter, K. C., Cullen, L., Hanrahan, K., Kleiber, C., McCarthy, A. M., Rakel, B., Steelman, V., Tripp-Reimer, T., Tucker, S., & Authored on behalf of the Iowa Model Collaborative. (2017). Iowa Model of evidence-based practice: Revisions and validation. *Worldviews on Evidence-Based Nursing, 14(3), 175–182.*

<https://doi.org/10.1111/wvn.12223>

Jezewski, M. A., Brown, J., Wu, Y.-W. B., Meeker, M. A., Feng, J.-Y., & Bu, X. (2005).

Oncology nurses' knowledge, attitudes, and experiences regarding advance directives.

*Oncology Nursing Forum, 32(2).*

<https://pdfs.semanticscholar.org/e59e/9a24ada5db36c88eb3d129fe7b72f9899f67.pdf>.

Jezewski, M. A., Meeker, M. A., & Schrader, M. (2003). Voices of oncology nurses: What is needed to assist patients with advance directives. *Cancer Nursing, 26(2), 105–112.*

John's Hopkins Nursing Evidence-Based Practice (2017). *Appendix D: Evidence level and quality guide*. [https://www.hopkinsmedicine.org/evidence-based-](https://www.hopkinsmedicine.org/evidence-based-practice/_images/EBP%20Tool%20Samples/2017_Appendix%20D_Evidence%20Level%20and%20Quality%20Guide_Page_1.png)

[practice/\\_images/EBP%20Tool%20Samples/2017\\_Appendix%20D\\_Evidence%20Level%20and%20Quality%20Guide\\_Page\\_1.png](https://www.hopkinsmedicine.org/evidence-based-practice/_images/EBP%20Tool%20Samples/2017_Appendix%20D_Evidence%20Level%20and%20Quality%20Guide_Page_1.png)

Levy, M., Smith, T., Alvarez-Perez, A., Back, A., Baker, J. N., Beck, A. C., Block, S., Dalal, S., Dans, M., Fitch, T. R., Kapo, J., Kutner, J. S., Kvale, E., Misra, S., Mitchell, W., Portman, D. G., Sauer, T. M., Spiegel, D., Sutton, L., . . . Scavone, J. L. (2016). Palliative

- Care Version 1.2016. *Journal of the National Comprehensive Cancer Network*, 14(1), 82-113. <https://doi.org/10.6004/jnccn.2016.0009>
- Levy, M. H., Weinstein, S. M., Carducci, M. A., & NCCN Palliative Care Practice Guidelines Panel. (2001). NCCN: Palliative care. *Cancer Control: Journal of the Moffitt Cancer Center*, 8(6 Suppl 2), 66–71.
- Narang, A. K., Wright, A. A., & Nicholas, L. H. (2015). Trends in advance care planning in patients with cancer: Results from a national longitudinal survey. *JAMA Oncology*, 1(5), 601–608. <https://doi.org/10.1001/jamaoncol.2015.1976>
- National Cancer Institute (2018). *Cancer statistics*. <https://www.cancer.gov/about-cancer/understanding/statistics>
- National Cancer Institute (2017). *Cancer stat facts: Cancer of any site*. <https://seer.cancer.gov/statfacts/html/all.html>
- Pfirstinger, J., Kattner, D., Edinger, M., Andreesen, R., & Vogelhuber, M. (2014). The impact of a tumor diagnosis on patients' attitudes toward advance directives. *Oncology*, 87(4), 246–256. <https://doi.org/10.1159/000363508>
- Price, D. M., Strodtman, L., Montagnini, M., Smith, H. M., Miller, J., Zybert, J., Oldfield, J., Policht, T., & Ghosh, B. (2017). Palliative and end-of-life care education needs of nurses across inpatient care settings. *Journal of Continuing Education in Nursing*, 48(7), 329–336. <https://doi.org/10.3928/00220124-20170616-10>
- World Health Organization. (n.d.). *WHO definition of palliative care*. <https://www.who.int/cancer/palliative/definition/en/>
- Yadav, K. N., Gabler, N. B., Cooney, E., Kent, S., Kim, J., Herbst, N., Mante, A., Halpern, S. D., & Courtright, K. R. (2017). Approximately one in three US adults completes any type of

advance directive for end-of-life care. *Health Affairs (Project Hope)*, 36(7), 1244–1251.

<https://doi.org/10.1377/hlthaff.2017.0175>

Zimmermann, C., Swami, N., Krzyzanowska, M., Hannon, B., Leighl, N., Oza, A., Moore, M., Rydall, A., Rodin, G., Tannock, I., Donner, A., & Lo, C. (2014). Early palliative care for patients with advanced cancer: A cluster-randomised controlled trial. *The Lancet*, 383(9930), 1721–1730. [https://doi.org/10.1016/S0140-6736\(13\)62416-2](https://doi.org/10.1016/S0140-6736(13)62416-2)