

University of Louisville

ThinkIR: The University of Louisville's Institutional Repository

Doctor of Nursing Practice Papers

School of Nursing

8-2020

Evaluating family satisfaction on an advanced certification palliative care unit.

Ruby Aebersold

Follow this and additional works at: <https://ir.library.louisville.edu/dnp>



Part of the [Nursing Commons](#)

Recommended Citation

Aebersold, Ruby, "Evaluating family satisfaction on an advanced certification palliative care unit." (2020).

Doctor of Nursing Practice Papers. Paper 72.

Retrieved from <https://ir.library.louisville.edu/dnp/72>

This Doctoral Paper is brought to you for free and open access by the School of Nursing at ThinkIR: The University of Louisville's Institutional Repository. It has been accepted for inclusion in Doctor of Nursing Practice Papers by an authorized administrator of ThinkIR: The University of Louisville's Institutional Repository. This title appears here courtesy of the author, who has retained all other copyrights. For more information, please contact thinkir@louisville.edu.

Evaluating Family Satisfaction on an
Advanced Certification Palliative Care Unit

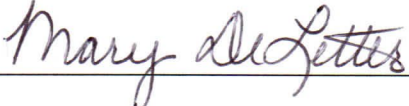
by

Ruby Aebersold

Paper submitted in partial fulfillment of the
requirements for the degree of
Doctor of Nursing Practice

School of Nursing, University of Louisville

August 6, 2020



Signature DNP Project Chair

8-6-2020

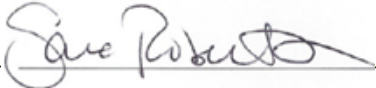
Date



Signature DNP Project Committee Member

8-6-20

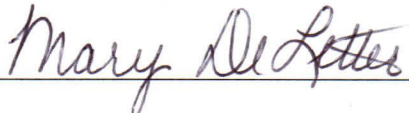
Date



Signature Program Director

8-6-20

Date



Signature Associate Dean for Academic Affairs

8-6-2020

Date

Acknowledgements

I would like to thank the staff at the hospital for assisting me throughout this project's journey, especially the time and effort from Ruth Hofmann, Danielle Lyons, Megan Breitenstein, the palliative care unit nursing staff, and the hospital's Nursing Research Oversight Team.

I would also like to thank my DNP project chair, Dr. Mary DeLetter, who pushed me to achieve higher than I thought possible, and for countless hours of feedback and revisions. Also, to my DNP project committee member, Dr. Beverly Williams Coleman, whose support and assistance is greatly appreciated.

Lastly, I would like to acknowledge my colleagues in palliative care. It is not an easy specialty but caring for the patients is rewarding and makes everything we do worth it. I have learned so much from different providers in this specialty and I am happy to have the opportunity to contribute to the literature for palliative care.

Dedication

I would like to dedicate this work to my father and uncle who were large proponents in my pursuance of higher education from a young age, and the driving factor for my passion in palliative care. I know that they would be proud.

Table of Contents

<i>Title Page</i>	1
<i>Acknowledgements</i>	2
<i>Dedication</i>	3
<i>LIST OF FIGURES</i>	5
<i>LIST OF TABLES</i>	5
<i>Advanced Certification Palliative Care Unit Introduction</i>	7
Significance of the Problem	7
Review of Literature.....	8
<i>Theoretical Framework</i>	9
<i>Setting and Organizational Assessment</i>	10
<i>Purpose</i>	11
<i>Intervention</i>	12
Survey Participants	14
Data Collection	15
Measurement.....	16
<i>Results</i>	17
<i>Discussion</i>	20
Interpretation	20

Limitations	23
Conclusion	23
References	25

LIST OF FIGURES

<i>Figure 1. Survey Distribution.....</i>	<i>13</i>
<i>Figure 2. Data Management.</i>	<i>14</i>
<i>Figure 3. April-June 2019 and 2020: Mailing Addresses as Nursing Facilities.....</i>	<i>18</i>
<i>Figure 4. Survey Response Rate Pivot Table.....</i>	<i>19</i>
<i>Figure 5. Survey Item Responses Pivot Table.</i>	<i>19</i>

LIST OF TABLES

<i>Table 1</i>	<i>17</i>
----------------------	-----------

Abstract

Inpatient palliative care programs with The Joint Commission (TJC) Advanced Certification for Palliative Care are accountable for evaluating multiple health outcomes, including family satisfaction. A midwestern urban hospital's palliative care unit received certification in January 2019. To comply with TJC standards, a clear data management and evaluation plan for family satisfaction data was needed. Investigation of the previous family satisfaction measure processes revealed areas in need of improvement in the satisfaction survey distribution, data collection, and evaluation processes. Satisfaction surveys were often unable to be distributed to families of deceased patients because the documented mailing address was a nursing facility. Survey data that were collected were entered in multiple spreadsheets, making data management and evaluation cumbersome. This project's purpose was to implement an improved satisfaction survey distribution process and an evaluation plan for family satisfaction data for a Palliative Care Inpatient Unit with TJC Advanced Certification. The new distribution process identified and documented family addresses so the staff can mail surveys to the intended participant rather than the deceased patient's nursing facility. A new data management plan utilizes pivot tables for data collection and evaluation. Over a three-month period, the survey distribution rate increased from 80.5% in 2019 to 88% in 2020. Survey data for 2019 were entered into the pivot tables. The process change strengthened the unit's distribution and data management processes to improve family satisfaction data collection, evaluation ability, ease of dissemination, and use of data to improve palliative care. Future evaluation should assess the impact of the process change on survey response rates.

Keywords: palliative, palliative care, inpatient, family satisfaction, survey distribution

Evaluating Family Satisfaction on an Advanced Certification Palliative Care Unit

Terminal illnesses include a wide range of diseases, such as cancer, heart disease, chronic obstructive pulmonary disease, and dementia. Palliative care focuses on improving the quality of life for patients with life-threatening illnesses and their families. Treatment is aimed at preventing and relieving physical, psychosocial, and spiritual suffering (World Health Organization [WHO], 2018b). Approximately 6,000,000 people in the United States could benefit from palliative care services (Center to Advance Palliative Care [CAPC], 2014). However, only 14% of those in need of palliative care currently receive it (WHO, 2018a). According to the Centers for Disease Control and Prevention (CDC, 2017a), the United States' death rate is 844 deaths per 100,000 population, with cancer being second place to heart disease as the leading causes of death. Over 700,000 of those people die in the hospital, with the majority being over the age of 85 years (CDC, 2017b). In the acute care setting, inpatient palliative care teams are responsible for providing treatment to terminally ill patients and their families. These interdisciplinary teams manage uncontrolled symptoms, address goals of care, and facilitate discharge planning and caregiver support, thus, improving the quality of life and satisfaction of patients and their families.

Significance of the Problem

Palliative care has increased in the inpatient setting over the past 16 years, with a growth from 25% to 75% of hospitals offering palliative care services (CAPC, 2018). Although 53.1% of Kentucky hospitals have a palliative care program prior to 2016 (Dumanovsky et al., 2016), only three Kentucky hospitals have The Joint Commission (TJC) Advanced Certification for Palliative Care (TJC, 2019). The project hospital received TJC certification in January 2019.

Maintaining TJC certification requires multiple performance measures to be collected, one of which is family satisfaction.

Review of Literature

Patient/family satisfaction is a frequently measured health outcome. Satisfaction is defined as a perceived experience of the care received from a variety of factors, including communication, respect and dignity, emotional support (Larson et al., 2019), quality of life factors, such as fatigue, (Lis et al., 2009), quality of care of nurses, and information exchange (Engel et al., 2018). The hospital's palliative care coordinator uses date stamps on surveys so they can be linked to the month and year of the patients' deaths.

Satisfaction and experience are meaningful patient-reported outcomes that are typically collected via mailed, phone, or interview surveys (Fiscella et al., 2011). A review of the literature was conducted to determine the best method for distributing a family satisfaction survey in a palliative care setting (Aoun et al., 2010; Carter et al., 2011; Follwell et al., 2009; Lo et al., 2009; McDonald et al., 2017; Pidgeon et al., 2018, Zimmermann et al., 2014). Since the hospital's staff uses a self-created satisfaction survey used only in their own facility, a commonly used satisfaction survey instrument in palliative care was the focus of the literature review. Survey nonresponse was higher in studies utilizing in-person (Follwell et al., 2009; Lo et al., 2009; McDonald et al., 2017) and computer (Carter et al., 2011) survey methods. Therefore, the project continued use of a paper survey method (Aoun et al., 2010; McDonald et al., 2017; Pidgeon et al., 2018, Zimmermann et al., 2014) as the most efficient modality in palliative care satisfaction assessment.

In the first half of 2019, 373 satisfaction surveys were sent to addresses of patients who passed away on the palliative care unit. Of these, 93 surveys were completed, 36 were returned

to sender unopened, and the remaining 244 were unaccounted for. Surveys of 100 deceased patients were not distributed because the patients' addresses were listed as a nursing facility (D. Lyons, personal communication, November 7, 2019). The focus of the current project was to enhance the survey distribution process with an intent of improving survey distribution and response rate, improving the evaluation plan for survey data, and meet TJC standards. This approach is consistent with the hospital's mission statement.

Theoretical Framework

Ruland's and Moore's (1998) middle-range theory, Peaceful End of Life, contains five thematic outcomes: not being in pain, experience of comfort, experience of dignity/respect, being at peace, and closeness to significant others/persons who care. Each outcome has two to five summary concepts which are nursing interventions to achieve the outcome (Ruland & Moore, 1998). Because of the consistency with the agency's core values, the hospitals's palliative care satisfaction survey items and the Peaceful End of Life theory, this theory was used as the guiding framework for this project. The family's reported satisfaction reflects the staff's ability to provide a peaceful end of life for the palliative care patient and their family.

Family satisfaction with inpatient palliative care is affected by a multitude of factors, many of which are influenced by the agency's staff, such as quality of care provided by nurses, communication and information exchange between staff and patients and their families, receiving emotional support, and feeling respected and dignified even while in the hospital and at the end of life (Engel et al. 2018; Larson et al., 2019). A family's reported satisfaction during palliative care often reflects the staff's ability to provide a peaceful end of life, physically and emotionally, for patients and their families. The hospital's palliative care staff are trained to identify physical and emotional discomfort and intervene. Nursing interventions for patients can

include medications, repositioning, oral care, feeding, and toileting to alleviate physical distress. Interventions for patients and families, such as praying and conversing address emotional discomfort. Since patient and family needs are unique to individual situations, staff adapt interventions and care to provide comfort and improve satisfaction.

The hospital's staff provide care congruent with six agency faith-based core values: integrity, respect, compassion, excellence, collaboration, and joy. Several palliative care satisfaction survey items reflect these values.

Setting and Organizational Assessment

The project was implemented at an acute care hospital located in an urban, highly populated area of a midwestern city, on the 24-bed palliative care unit/medical-surgical overflow unit. Five registered nurses (RNs) provided the 24-hour patient care with additional support staff, including a palliative care coordinator, palliative care social worker, case manager, and chaplains. In addition, hospice nurses, chaplains, and social workers are available for patients who also receive contracted hospice services from an outside agency. The average length of stay on the inpatient palliative care service from January to September 2019 was 3.48 days (R. Hofmann, personal communication, October 16, 2019). Patients were admitted to the palliative care unit from other hospital units, the emergency department, an outpatient office, or home.

Key stakeholders in the project included patients and families, palliative care coordinator, patient relations coordinator, unit RNs, unit nurse manager, IT specialist, the palliative care division director of nursing, palliative care medical director, chief nursing officer (CNO), and chief executive officer (CEO). The unit RNs, manager, palliative care coordinator, and patient relations coordinator contributed to the project with participation in the newly developed process. The IT specialist enabled the visibility of family addresses on the survey mailing list.

The project benefits the agency's fulfillment of TJC standards, thus upholding specialty certification which helps to attract more patients and staff. Patient care can be improved when family's satisfaction with the end of life care is evaluated and relevant practice changes are implemented.

Discussions with the palliative care coordinator and patient relations coordinator identified areas for improvement in the previous survey distribution, data management, and evaluation processes. A large number of patients' families were not receiving surveys, the data management process was difficult, and the evaluation plan was cumbersome. The new process addresses these three areas and facilitates adherence with TJC standards for the Advanced Certification for Palliative Care. An initial barrier at implementation was a miscommunication of instructions to staff. Clarification was provided to staff by the project leader after implementation began. Additional barriers that emerged during project implementation were decreased patient census, visitor restrictions, and low staffing, all related to COVID-19 pandemic policies.

Purpose

The purpose of the quality improvement project described in this article was to implement an improved satisfaction survey distribution process and an evaluation plan for family satisfaction data for a Palliative Care Inpatient Unit with TJC Advanced Certification. The project's aims were to: (a) increase the number of recipients receiving the palliative care satisfaction survey, (b) establish an analysis plan of satisfaction data from families, (c) create a process for regular data reporting and staff discussions to determine action items to maintain or improve satisfaction, and (d) identify areas for improvement for the inpatient palliative care program.

Intervention

In this project, the project leader implemented a new process for palliative care satisfaction survey distribution, created a data management system for efficient satisfaction data collection, and developed a systematic analysis and evaluation plan for the satisfaction data. New distribution methods focused on collecting accurate family addresses rather than patient addresses, coupled with education about the purpose and use of family addresses. Reporting graphics and pivot tables will now be used to manage data. These methods are intended to increase survey distribution, response rate, and data management.

Approval for the project was obtained from the unit-based shared governance council, the unit management, and the hospital's Nursing Research Oversight Team as a quality improvement project. The project also received approval from the University of Louisville Institutional Review Board.

The project leader informed all registered nurses on the project unit of the planned intervention with an email two weeks prior to the intervention start date. In the email, the project leader explained the project's purpose and aims, its effect on the unit's staff and patients' family members, and detailed, step-by-step instructions for a new procedure of documenting family addresses. This included illustrated directions of where and how to document the family's address in the electronic health record (EHR). The email instructions were also printed and placed at the nurse's station as a "read & sign" document, which is mandatory for all unit nurses to view and sign.

Distribution

The previous and revised processes for distributing the palliative care satisfaction surveys to family members are illustrated in Figure 1. In the original process, the mailing address in the

EHR was the patient's address at the time of admission. In many cases, this was a nursing facility address. After the patient expired, the family member's address was written on the envelope of a sympathy card that was to be mailed by the palliative care coordinator to the family. Because the family member's address was not entered into the EHR, it was not available to the patient relations coordinator at the time she mailed the satisfaction surveys to families.

The new process includes five steps. The registered nurse assigned to the patient when expiration occurred was instructed to (a) ask for the family member's address, (b) educate the family that the address would be used for the patient relations coordinator and palliative care coordinator to distribute the palliative care satisfaction survey, sympathy card, and the memorial service invitation, (c) and document the address in a temporary address section in the EHR's demographics area. The agency's Information Technology specialist allowed visibility of the temporary address on the survey mailing list.

Previous Process:



Current Process:

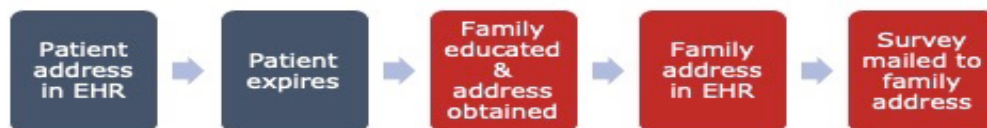


Figure 1. Survey Distribution.

Data Management & Evaluation

The previous data management and evaluation plan consisted of separate Microsoft Excel™ spreadsheets for each year. The use of multiple spreadsheets made data management

and evaluation cumbersome. In this intervention, the project leader created pivot tables within Microsoft Excel™ so that the palliative care coordinator can record all same-type data (survey response rate and survey item responses) from multiple years in the same spreadsheet. The pivot tables organize the data by months and years. With the new data management plan (Figure 2), the palliative care coordinator will be able to evaluate trends in survey response data over time.

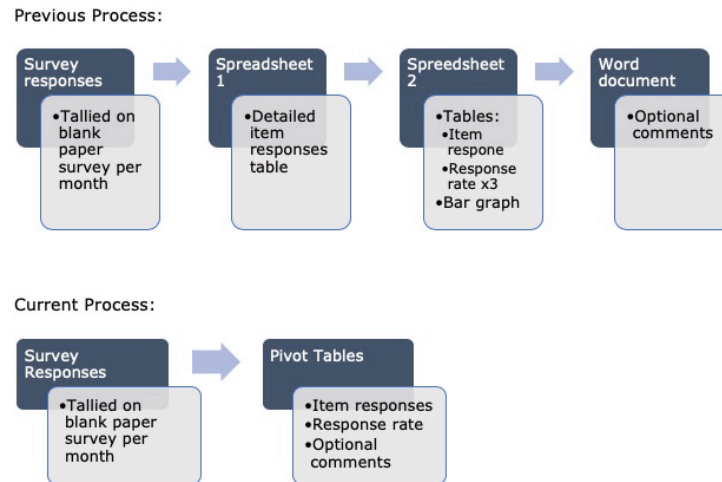


Figure 2. Data Management.

Survey Participants

Participants in the satisfaction assessment were adult family members of terminally ill patients that expired on the palliative care unit at the hospital. All participants were 18 years of age or older, had a family member who received inpatient palliative care service prior to their death on the hospital's palliative care unit. Palliative care service was defined as the receipt of comfort care measures rather than aggressive curative treatment for a serious, life-threatening illness. Family members unable to read English and those without a US mailing address on file were excluded.

Data Collection

The anticipated data collection process involved the patient relations coordinator's ability to mail the palliative care satisfaction survey to the family address within two weeks of the patient's death. As a consequence of the COVID-19 pandemic, surveys from the latter half of March to early July were not mailed until late July. Once families return completed surveys, the patient relations coordinator will record response rates and survey responses into the two Microsoft Excel™ spreadsheets for the palliative care coordinator to review. The palliative care coordinator can edit the initial pivot tables to include newly obtained data.

Distribution

An EHR report generated by the patient relations coordinator showed the number of family addresses of deceased patients that were documented by the unit's nurses in the EHR's temporary address section per month. The patient relations coordinator recorded how many addresses were valid family addresses and how many continued to be documented as nursing facilities. The project leader collected the number of eligible participants based from patient death totals, family addresses documented, and surveys mailed.

Data Management & Evaluation

The project leader entered all 2019 survey data collected by the patient relations coordinator in the pivot tables. The data for 2020 was not available subsequent to COVID-19 delays, therefore the 2020 data will be entered into the pivot tables by the palliative care coordinator when it becomes available. The project's plan for sustainability includes education of pivot table creation and management of future data by the palliative care coordinator with input from the project leader.

Measurement

Palliative Care Satisfaction Survey

The palliative care satisfaction survey is a nine-item survey, designed by the palliative care coordinator for distribution to families. The nine items assess the families' perception of information accessibility, timeliness of care, staff competence, goals of care planning, symptom management, spiritual needs, and emotional needs. Items are rated on a five-point (1-5) Likert-scale with responses: very poor, poor, fair, good, and very good.

Distribution

Monthly data were evaluated via EHR reports for the number of eligible participants, family addresses documented, and surveys mailed. The frequency and percentage of participants who were mailed a survey was calculated for April-June 2020 and compared to 2019.

Data Management & Evaluation

The palliative care coordinator is now capable of entering survey data monthly as responses are received. The project leader provided the palliative care coordinator with an instruction manual for pivot table creation, editing, and management, and the two pivot tables for survey response rate data and survey item responses data. Survey data for 2019 were entered into the pivot tables that were provided to the palliative care coordinator. The pivot tables will be updated with 2020 data by the palliative care coordinator once the patient relations coordinator receives completed surveys and enters data into the spreadsheets. The data will be evaluated quarterly using pivot tables to compare survey response rates and survey item responses to the previous months and years. The palliative care coordinator will use the pivot tables to evaluate trends overtime. The nine areas that the survey assesses will be monitored for satisfaction reduction or improvement using the pivot table. Evaluation will determine which

areas the staff have improved in and which areas have lower satisfaction scores. Areas with lower satisfaction scores will be investigated by the unit's management to identify possible reasons and develop a plan of action to address areas in need of improvement. The results and interpretations will be routinely disseminated at the following staff meetings. Satisfaction data will be reported to the TJC to fulfil the Advanced Certification for Palliative Care requirements.

Results

Distribution

The survey distribution rate in April-June increased from 80.5% in 2019 to 88% in 2020. The results of frequencies and percentages of eligible participants and mailed surveys in April-June 2019 and 2020 are presented in Table 1.

Table 1

Survey Distribution Data

2019	Eligible	Mailed	Percent
April-June	221	178	80.5%
2020	Eligible	Mailed	
April	60	54	90%
May	70	56	80%
June	63	60	95%
Total	193	170	88%

Eligible participants who were not mailed a survey because the address was documented as a nursing facility decreased from 43/221 (19.4%) in April-June 2019 to 23/193 (11.9%) in April-June 2020 (Figure 3). The rate of ineligible mailing addresses in April-June decreased by 38.7% from 2019 to 2020.

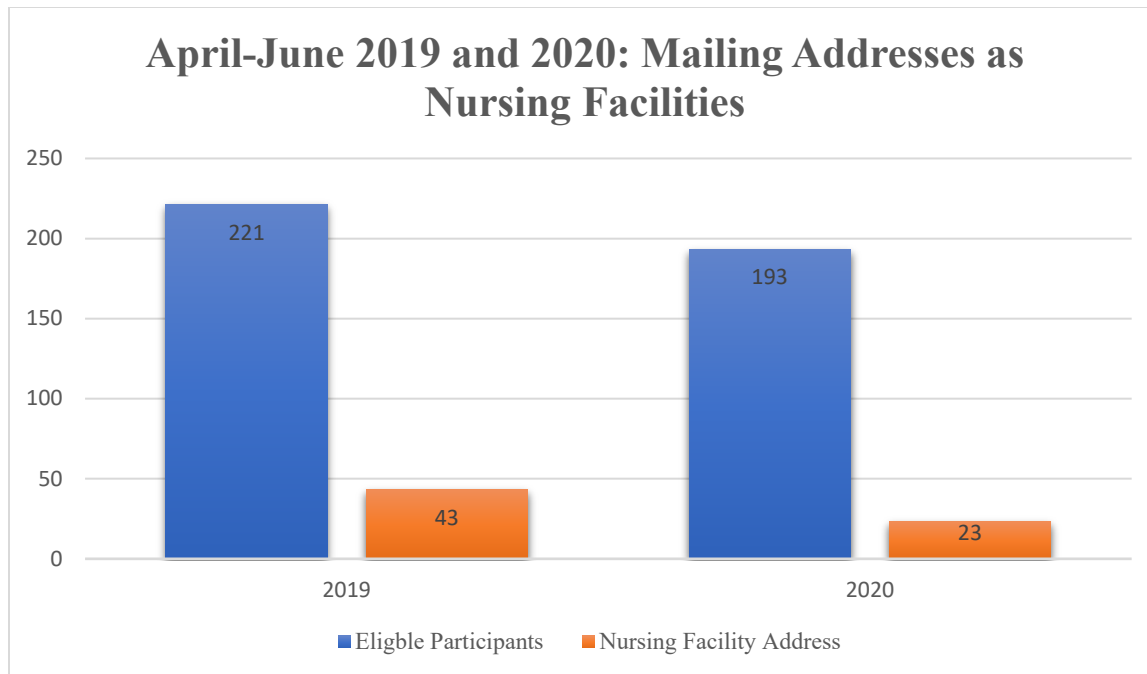


Figure 3. April-June 2019 and 2020: Mailing Addresses as Nursing Facilities.

Data Management & Evaluation

The new data management plan addresses those areas identified as in need of formative change: data collection, evaluation, and dissemination. The new plan used two pivot tables to collect survey response rate and survey item response data, presented in Figures 4 and 5. The patient relations coordinator will continue to enter data into Microsoft Excel™ spreadsheets. However, the new data management plan established a new process for the palliative care coordinator to update pivot tables with the spreadsheet data. Survey data from 2019 were entered into the pivot tables and provided to the palliative care coordinator. Although data were not available at that time, 2020 and 2021 areas were included in the pivot tables so evaluation with the new data management plan could incorporate multiple years and not be limited to a monthly evaluation within the same year. The project leader conducted an educational session with the palliative care coordinator via phone conference to provide hands-on learning and determine the feasibility and sustainability of the pivot tables. The palliative care coordinator

was able to demonstrate proper use and understanding of the pivot tables. The satisfaction data can be easily submitted to TJC for the Advanced Certification for Palliative Care standards with the new management plan. The dissemination strategy established for the new data management plan recommended a quarterly evaluation of data, identification of areas with lower satisfaction levels, and dissemination at management meetings first, followed by dissemination to staff at a monthly staff meeting thereafter.

Row Labels	Sum of Sent			Sum of Received			Sum of Returned to Sender			Total Sum of Sent	Total Sum of Received	Total Sum of Returned to Sender
	2019	2020	2021	2019	2020	2021	2019	2020	2021			
January	71			6			6			71	6	6
February	63			19			5			63	19	5
March	61			16			6			61	16	6
April	64			17			7			64	17	7
May	57			20			6			57	20	6
June	57			15			6			57	15	6
July	67			26			6			67	26	6
August	56			16			5			56	16	5
September	61			17			6			61	17	6
October	69			20			10			69	20	10
November	50			10			2			50	10	2
December	62			17			8			62	17	8
Grand Total	738			199			73			738	199	73

Figure 4. Survey Response Rate Pivot Table.

Row Labels	Sum of January			Sum of February			Sum of March		
	2019	2020	2021	2019	2020	2021	2019	2020	2021
1. Information provided about the palliative care program at Baptist Health Louisville meet your needs.	6	0	0	19	0	0	16	0	0
Very Good	5	0	0	17	0	0	15	0	0
Good	1	0	0	1	0	0	1	0	0
Fair	0	0	0	1	0	0	0	0	0
Poor	0	0	0	0	0	0	0	0	0
Very Poor	0	0	0	0	0	0	0	0	0
Not Answered	0	0	0	0	0	0	0	0	0
2. The timeliness of the palliative care consult.	6	0	0	19	0	0	16	0	0
Very Good	5	0	0	16	0	0	15	0	0

Figure 5. Survey Item Responses Pivot Table.

Discussion

Interpretation

Distribution

The new survey distribution process included a change in address collection at the time of each patient's death. Nurses successfully captured family addresses that would not have been identified and documented with the previous distribution process. The number of surveys unable to be mailed because only a nursing facility was listed as an address in April-June decreased by 38.7% after implementation of the new distribution process. Survey distribution rates increased from 80.5% to 88%, respectively. While there was an increase in the number of patients that had a family address documented for distribution, only 23/193 (11.9%) family addresses were documented in the temporary address section in April-June 2020, indicating not all family members' addresses were documented by the RN.

Although the number of family addresses documented for mailing purposes increased, there is room for improvement. Nurses need to consistently document each family address in the temporary address section of the EHR. Initial findings from April 2020 showed that nurses documented only six family addresses out of 60 eligible participants (10%). As a formative intervention, the project leader sent a second email to unit nurses in late May to clarify that every deceased patient should have a family address documented in the temporary address section, even if the patient's primary address matched the family's address. The email also clarified that nursing facilities should remain in the primary address section if already documented. Follow-up revealed that June 2020 was the month with the most documented family addresses at 12 out of 63 eligible participants (19%), which was a 47.4% increase from April. Studies have shown that bereaved family members of palliative care patients generally respond to mailed surveys

assessing their satisfaction with care (Mayland et al., 2017; Miyashita et al., 2015; Stajduhar et al., 2017). Therefore, it is important that the distribution process captures family addresses so all families can receive a satisfaction survey.

The project leader's second email sent to unit nurses contained a reminder to enter the family address. This process helps confirm that families are being asked and the correct addresses are being recorded in the EHR. Each month showed that some family addresses were the same as the patient's primary address, indicating that the nurses were documenting the matching addresses correctly in the EHR.

Further evaluation of barriers to family address entry is warranted. The death of a patient requires the nurse's attention for families, hospital procedures, and care of the deceased. Remembering a new process during this busy time can be difficult. The second email may have served as a reminder to nurses, possibly contributing to the reason for the family address EHR entries to double in June compared to April and May 2020. It would not be feasible for an email to be sent every month to nurses, but ongoing monitoring by the patient relations coordinator with periodic reminders would be beneficial.

The project leader recommends that the family address documentation be incorporated into the required patient death navigator. The patient death navigator is a section in the EHR that the RN is required to complete after each patient death. It serves as a checklist for the RN to ensure that the appropriate postmortem interventions, such as declaring time/date of death, paging physicians, calling the organ donation agency and the coroner if applicable, removing lines and catheters, and placing the body bag, are completed before discharging the deceased patient from the unit. Some items are yes/no boxes. A yes/no item field on the patient death navigator asking "Has the family's address been entered into the temporary address section?"

would serve as a reminder. A comment box could require a reason when the family address is not entered in the EHR. This information could be used to identify barriers to obtaining family addresses and prompt discussion for improved procedures.

Data Management & Evaluation

The new data management plan introduced pivot tables to the palliative care coordinator as a useful tool for data collection, management and evaluation. The palliative care coordinator was provided with a blank template of the pivot tables, pivot tables with 2019 data entered with areas for future 2020/2021 data, a real-time educational session, and an instruction manual to sustain the process after the project's conclusion in the event that the palliative care coordinator has new questions or a change in roles leads to a different person managing the data and pivot tables.

The previous data management plan separated data into multiple spreadsheets per year, each containing five different tables and two graphs across four spreadsheets tabs for that year's data. This plan did not provide congruency between data from different years for thorough analysis and evaluation. The newly constructed pivot tables provide a centralized location for data collection and evaluation. The new data management plan successfully combines and organizes yearly survey data. Satisfaction data entry in one spreadsheet decreases the number of files the palliative care coordinator must manage and store. Prior to this new plan, several spreadsheets had to be opened and manual calculations made during evaluation. The new data management plan uses one spreadsheet for each type of data (survey response rate and survey item responses). The pivot tables automatically generate calculations and applies them in side-by-side comparisons. The pivot tables are visually appealing. Graphics, such as bar or line graphs can be generated automatically to display the data on the same spreadsheet as the pivot

tables. Evaluation and dissemination efforts were positively impacted from the new data management plan. These tables and graphics are intended to be used at staff meetings to share data and discuss strengths and areas in need of improvement. The organized data demonstrates compliance with TJC standards to continue certification status.

Limitations

Changes in hospital policies, procedures, and staffing related to the 2020 coronavirus (COVID-19) pandemic forced several delays in this project. First, there were fewer admissions, resulting in staff reduction. Secondly, the previously unrestricted number of visitors and visiting hours were significantly limited, which decreased the nurses' ability to retrieve family addresses for survey distribution. Thirdly, surveys normally mailed to families within two weeks of the patient's death by the patient relations coordinator were delayed for several months.

Conclusion

Family satisfaction is a frequently measured health outcome. TJC requires certified programs to collect and evaluate outcome data. It is imperative for an inpatient palliative care unit with a new TJC certification, such as this unit, to have a feasible process for data collection and evaluation. This quality improvement project developed a new process for palliative care satisfaction survey distribution to increase the number of surveys mailed to family members and created a data management plan to centralize data collection to a single location and allow for evaluation and dissemination to staff and TJC. The project was useful in identifying and addressing areas in need of improvement in the survey distribution process and data management and evaluation plans. Implications of the project proved beneficial to the agency by strengthening the unit's distribution and data management processes to improve family

satisfaction data collection and evaluation requirements. Future evaluation should assess the impact on survey response rates.

The new process and plan are sustainable through the cooperation of the patient relations coordinator and palliative care coordinator. The distribution process changed steps in the unit's patient death protocol. The family addresses are now a permanent addition to the EHR mailing list. Positive feedback was received from the educational session with the palliative care coordinator and a typed instruction manual about pivot tables can be used for education in the event of data management role changes.

Although family satisfaction is a commonly measured health outcome in the palliative care setting, this quality improvement project is an evidence-based practice project developed for use strictly at this hospital on the palliative care unit. Many factors influencing the project process are specific to the hospital, such as operating system for data, instruments and methods used to collect satisfaction data, palliative care setting, and individually assigned roles and workloads. Other inpatient palliative care units with the need for adequate address identification for satisfaction survey distribution could benefit from a quality improvement project to examine areas needing improvement in their processes and develop a new distribution process and data management plan.

Next steps should include staff debriefings to understand barriers the nurses encountered during implementation, development of a checklist for family address documentation in the EHR's patient death navigator, ongoing evaluation of survey response rates, continued monitoring of survey distribution, thorough analysis of survey data, dissemination of data to nursing staff, and discussion of strategies for improving palliative care.

References

- Aoun, S., Bird, S., Kristjanson, L. J., & Currow, D. (2010). Reliability testing of the FAMCARE-2 scale: measuring family carer satisfaction with palliative care. *Palliative Medicine, 24*(7), 674-681. doi: 10.1177/0269216310373166
- Carter, G. L., Lewin, T. J., Gianacas, L., Clover, K., & Adams, C. (2011). Caregiver satisfaction with out-patient oncology services: utility of the FAMCARE instrument and development of the FAMCARE-6. *Support Care Cancer, 19*(4), 565-572. doi: 10.1007/s00520-010-0858-1
- Center to Advance Palliative Care. (2014). Palliative care facts and stats. Retrieved from https://media.capc.org/filer_public/68/bc/68bc93c7-14ad-4741-9830-8691729618d0/capc_press-kit.pdf
- Center to Advance Palliative Care. (2018). Growth of palliative care in U.S. hospitals: 2018 snapshot (2000-2016). Retrieved from https://media.capc.org/filer_public/27/2c/272c55c1-b69d-4eec-a932-562c2d2a4633/capc_2018_growth_snapshot_022118.pdf
- Centers for Disease Control and Prevention. (2017a). Deaths and mortality. Retrieved from <https://www.cdc.gov/nchs/fastats/deaths.htm>
- Centers for Disease Control and Prevention. (2017b). Trends in inpatient hospital deaths: National hospital discharge survey, 2000-2010. Retrieved from <https://www.cdc.gov/nchs/products/databriefs/db118.htm>
- Dumanovsky, T., Augustin, R., Rogers, M., Lettang, K., Meier, D. E., & Morrison, R. S. (2016). The growth of palliative care in U.S. hospitals: A status report. *Journal of Palliative Medicine, 19*(1), 8-15. doi: 10.1089/jpm.2015.0351

- Engel, M., Brinkman-Stoppelenburg, A., Nieboer, D., & Heide, A. V. (2018). Satisfaction with care of hospitalised patients with advanced cancer in the Netherlands. *European Journal of Cancer Care*, 27, 1-14, doi: 10.1111/ecc.12874
- Fiscella, K., Ransom, S., Jean-Pierre, P., Cella, D., Stein, K., Bauer, J. E., Crane-Okada, R., Gentry, S., Canosa, R., Smith, T., Sellers, J., Jankowski, E., & Walsh, K. (2011). Patient-reported outcome measures suitable to assessment of patient navigation. *Cancer*, 117(15), 3603-3617. doi: 10.1002/cncr.26260
- Follwell, M., Burman, D., Le, L. W., Wakimoto, K., Seccareccia, D., Bryson, J., Rodin, G., & Zimmermann, C. (2009). Phase II study of an outpatient palliative care intervention in patients with metastatic cancer. *Journal of Clinical Oncology*, 27(2), 206-213. doi: 10.1200/JCO.2008.17.7568
- Larson, E., Sharma, J., Bohren, M. A., & Tuncalp, O. (2019). When the patient is the expert: measuring patient experience and satisfaction with care. *Bull World Health Organization*, 97, 563-569. doi: <http://dx.doi.org/10.2471/BLT.18.225201>
- Lis, C. G., Rodeghier, M., Grutsch, J. F., & Gupta, G. (2009). Distribution and determinants of patient satisfaction with a focus on health related quality of life. *BMC Health Services Research*, 9(109), 1472-83. doi: 10.1186/1472-6963-9-190
- Lo, C., Burman, D., Hales, S., Swami, N., Rodin, G., & Zimmermann, C. (2009). The FAMCARE-Patient scale: measuring satisfaction with care of outpatients with advanced cancer. *European Journal of Cancer*, 45(18), 3182-3188. doi: 10.1016/j.ejca.2009.09.003
- Mayland, C. R., Mulholland, H., Gambles, M., Ellershaw, J., & Stewart, K. (2017). How well do we currently care for our dying patients in acute hospitals?: The views of the bereaved

- relatives? *BMJ Supportive & Palliative Care*, 7(3), 316-325. doi: 10.1136/bmjspcare-2014-000810
- McDonald, J., Swami, N., Hannon, B., Lo, C., Pope, A., Oza, A., Leighl, N., Krzyzanowska, M. K., Rodin, G., Le, L. W., & Zimmermann, C. (2017). Impact of early palliative care on caregivers of patients with advanced cancer: Cluster randomised trial. *Annals of Oncology*, 28(1), 163-168. doi: 10.1093/annonc/mdw438
- Mitsunori, M., Morita, T., Sato, K., Tsuneto, S., & Shima, Y. (2015). A nationwide survey of quality of end-of-life cancer care in designated cancer centers, inpatient palliative care units, and home hospices in Japan: The J-HOPE study. *Journal of Pain and Symptom Management*, 50(1), 38-47. doi: 10.1016/j.jpainsymman.2015.01.007
- Pidgeon, T. M., Johnson, C. E., Lester, L., Currow, D., Yates, P., Allingham, S. F., Bird, S., & Eagar, K. (2018). Perceptions of the care received from Australian palliative care services: A caregiver perspective. *Palliative and Supportive Care*, 16(2), 198-208. doi:10.1017/S1478951517000177
- Ruland, C. M., & Moore, S. M. (1998). Theory construction based on standards of care: A proposed theory of the peaceful end of life. *Nursing Outlook*, 46(4), 169-175.
- Stajduhar, K., Sawtzky, R., Cohen, S. R., Heyland, D. K., Allan, D., Bidgood, D., Norgrove, L., & Gadermann, A. M. (2017). Bereaved family members' perceptions of the quality of end-of-life care across four types of inpatient care settings. *BMC Palliative Care*, 16(1), 1-12. doi: 10.1186/s12904-017-0237-5
- The Joint Commission. (2019). Quality check. Retrieved from <https://www.qualitycheck.org/search/?keyword=#advancedcertification=Advanced%20Palliative%20Care&pg=2>

World Health Organization. (2018a). Palliative care. Retrieved from

<https://www.who.int/en/news-room/fact-sheets/detail/palliative-care>

World Health Organization. (2018b). WHO definition of palliative care. Retrieved from

<http://www.who.int/cancer/palliative/definition/en/>

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. *Lancet*, 383(9930), 1721-1730. doi: 10.1016/S0140-6736(13)62416-2