SOUTHERN CALIFORNIA CSU DNP CONSORTIUM

CALIFORNIA STATE UNIVERSITY, FULLERTON
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SUPPORTIVE CARE NURSING CLINICAL PROTOCOL
FOR A PUBLIC ACUTE CARE HOSPITAL

A DOCTORAL PROJECT
Submitted in Partial Fulfillment of the Requirements
For the degree of
DOCTOR OF NURSING PRACTICE

By
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May 2017
ABSTRACT

Seriously ill patients may require palliative nursing care that may be offered independently or in collaboration with palliative medical care. World-wide, approximately 40 million people require palliative care but only about 14% of those individuals receive it (World Health Organization, 2015). In a public 670-bed acute care hospital, palliative care consultation requires a physician's order and thus may arrive late in an illness trajectory. Acute care nurses may not be confident or proficient in providing palliative care. A palliative care knowledge survey in the local setting confirmed nurses’ knowledge deficit.

A Supportive Care Nursing Clinical Protocol (SCNCP) was developed as a knowledge tool to meet the needs of acute care nurses providing care for seriously ill patients. The term “supportive care” is used instead of palliative care to avoid the stigma of palliative care and its potential tie with end-of-life (Cherny, 2009). The SCNCP is based upon national guidelines and scientific evidence. The SCNCP guides nurses to assess physiological, psychosocial, and spiritual factors commonly experienced by patients living with serious illness. Evidence-based nursing interventions in the SCNCP include using select complementary interventions including a thirst bundle, hand-held fan for dyspnea, and the use of mobile phone applications (apps) are suggested for mindfulness, relaxation, distraction, and coping. Approvals for the protocol have been
made by the Nursing Protocol Committee, Professional Practice Committee, and the Nursing Executive Council. Implementation of the SCNCP is projected for Spring 2017.
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ACKNOWLEDGMENTS

Special thanks to Dr. Dana Rutledge and Dr. Sue Robertson for all the support and encouragement that made this work possible. Their wisdom and enthusiasm for scholarship guided a DNP journey that is rich with inquiry and discovery.

Thanks also goes to the palliative care clinical nurse specialist, Eve Cruz, who provided clinical expertise to the project. Her genuineness as a nurse and a friend made the DNP project a clinically meaningful experience.

There would not be today without my parents. Mumsy, thank you for my nursing genes and for being a creative role model. Dadsy, thank you for the gift of perseverance and for never doubting me. Most of all, thanks go to my husband, Bill, without whom my life would be fragmented and incomplete.
BACKGROUND

Palliative care is specialized care for people living with serious illness which focuses on providing relief from the symptoms and stress of a serious illness. Palliative care provision likely results in a higher quality of life (Institute of Medicine [IOM], 2014). At a public university-affiliated hospital in Los Angeles, palliative care consultation requires a physician referral. However, physician referral to palliative care services is often slow (Humphreys & Harman, 2014) and acute care nurses lack palliative care knowledge (Shea, Grossman, Wallace, & Lange, 2010; White, Roczen, Coyne, & Wiencek, 2014).

The terms palliative care, hospice care, and end-of-life (EOL) care are sometimes used interchangeably. While there are similarities among the terms, the differences are important in a discussion of care delivery. Palliative care is both a philosophy of care, and an organized, highly structured system for delivering care ("National Consensus Project for Quality Palliative Care: Clinical Practice Guidelines for Quality Palliative Care, Executive Summary," 2004). Palliative care conveys the comprehensiveness of care of the person and family as a unit of care once complex health problems of serious illness arise (Hanks, 2008). Such care can begin as soon as the patient with a serious or life-limiting illness enters an advanced stage (Hui et al., 2013).

End-of-life care often reflects a disease-centered perspective based on a period when there is irreversible decline towards death (Hui et al., 2014). In the United States, hospice care is specialized care that Medicare beneficiaries (Medicare Hospice Data, 2016) are qualified to receive once a physician certifies a patient to have a prognosis of six months or less to live (Stevenson, 2012). Hospice care usually takes place at home or
in the community and includes care of the bereaved (Hui et al., 2013). Palliative care can be provided concurrently from the time of diagnosis up until the end-of-life (see Figure 1). Provision of usual care occurs without restriction in tandem with palliative care. As illness progresses, more palliative care and less usual care may be needed to optimize quality of life (QOL). End-of-life care begins when the irreversible decline towards death occurs and aggressive interventions are futile.

Figure 1. Palliative care continuum in the acute care setting. Adapted from (Bakitas, 2010).

An estimated 40 million people require palliative care, but only 14% of those who need palliative care receive it (World Health Organization, 2015). In most developed countries, hospitals provide a part of palliative care (Robinson, Gott, & Ingleton, 2014). Palliative care focuses on improving QOL for patients and families who face serious illness (Kelley & Morrison, 2015) and should ideally start at the time of diagnosis of a serious illness. Palliative care provides an added layer of attention to usual care providing patient and family support as an illness trajectory progresses. However, the myth that
palliative care is only provided for the dying continues to be a barrier to palliative care services (Radbruch & Kern, 2014). In 2011, Advanced Palliative Care Certification became available to recognize formal, organized inpatient palliative care programs (The Joint Commission, 2016). The Joint Commission posits that quality palliative care that focuses on patient and family-centered care brings quality of life to the seriously ill. A Joint Commission-certified Palliative Care program means that patients have access to palliative care services 24-hours a day. Currently, fewer than 100 hospitals hold the Advanced Palliative Care Certification (The Joint Commission, 2016).

While nurses, family members and patients themselves are often aware that illness is severe, and death is approaching (Lokker, van Zuylen, Veerbeek, van der Rijt, & van der Heide, 2012), EOL advance care planning is often delayed. The National Physician Order for Life-Sustaining Treatment (POLST) Paradigm suggests that health care professionals consider advance care planning when a serious illness or frailty will likely result in death within one year. However, the average time between POLST completion and death is 6.4 weeks (Zive, Fromme, Schmidt, Cook, & Tolle, 2015).

Repeated hospitalizations due to serious illness during the last year of life is not uncommon for many patients. Many of the seriously ill will die in the hospital. The lack of adequately trained staff is a barrier to the provision of patient-centered palliative care in hospitals (Pringle, Johnston, & Buchanan, 2015). When QOL issues present as a medical management problem, a palliative care consult may be initiated. Evidence indicates that palliative care consultation positively affects patient satisfaction (Chand, Gabriel, Wallace, & Nelson, 2013) as well as facilitates family communication and decision-making (Enguidanos, Housen, Penido, Mejia, & Miller, 2014).
Seriously ill patients in need of palliation for symptom burden often welcome complementary therapies (Anderson & Taylor, 2012; Dorfman, Denduluri, Walseman, & Bregman, 2012). Complementary interventions are not currently supported by strong research evidence for efficacy. However, low cost, non-harmful interventions that may help ease suffering may be well worth considering as part of care delivery. The National Consensus Project’s Clinical Practice Guidelines for Quality Palliative Care include the use of complementary interventions as an important dimension of symptom management (National Consensus Project, 2013), with the caveat that these interventions lack strong empirical evidence (Greenlee et al., 2014).

In the clinical setting for this doctor of nursing practice project, nursing clinical protocols (NCP) provide standards for practice in caring for patients with a specific problem. Developing these protocols is a formal and ongoing process involving the nursing staff: from the staff nurse level to organizational leadership. Multidisciplinary collaboration is included in the approval process as needed. Nursing clinical protocols address nursing management for a variety of patient care needs. Nursing Clinical Protocols may involve independent nursing actions or may require interprofessional collaboration. The NCP content is based on evidence which includes standard textbooks, clinical practice guidelines, standard community practice, expert opinion, and research evidence.

**Problem Statement**

Providing palliative care in a busy tertiary care public hospital is difficult. In a Los Angeles public hospital affiliated with a large medical school, advanced medical knowledge and skill are readily available to provide cutting edge life-saving
interventions. Seriously ill patients may feel silenced, ignored, and misunderstood in such an environment (IOM, 2004). Provision of medical care includes diagnostic workup, tests, and procedures (Maani-Fogelman & Bakitas, 2015). However, tests and treatments may not change patient outcomes for many conditions.

At the project hospital, referrals to the Palliative Care Consultation Service (PCCS) must be ordered by physicians on the primary treatment team, often when medical treatments are futile, or when EOL symptom management is problematic. Consult requests are often late in patients’ lives, leading to short lengths of service by the PCCS. Brousseau et al. (2012) reported an effort to expand palliative care services in public hospitals in California. Approximately 40% of patients seen by the PCCS in that study were recommended to receive hospice care indicating a probable life length of six months or less. However, a portion of those individuals was too ill to return home, and there were others who must wait for fiscal resources to receive hospice care in the community. The wait for community hospice care may give the family hope, but often life ends in the acute care setting. In the project hospital setting, a minority of patients face the end-of-life without PCCS intervening. These individuals remain in the acute care setting without the offer of systematic palliative care. Identifiable care needs exist for this group of patients even though they may or may not have had palliative care consultation.

Unfortunately, palliative care competencies are not a part of basic nursing education (Ferrell, Virani, Paice, Coyle, & Coyne, 2010). Budgetary and staffing constraints hinder formal palliative care for nursing staff training. Patients who need palliative care in the acute care setting can be very ill and often have symptoms, psychological stressors, social challenges, and spiritual distress that are poorly managed.
Acute care nurses may struggle with conflicting thoughts and feelings about palliative care (O'Shea, 2014). They do not necessarily recognize the dying process and may continue aggressive interventions (Bloomer, Endacott, O’Connor, & Cross, 2013). Acute care nurses also may not be comfortable with applying specialized palliative care skills and knowledge to provide care for the seriously ill or dying (Frey et al., 2013)¹ including patients suffering from many chronic conditions. Acute care nurses' lack of palliative knowledge and competencies affect their confidence to provide quality care (Frey et al., 2013). This lack of knowledge may translate to care provision that is less than ideal.

Practice guidelines for palliative care exist. Evidence-based nursing interventions in palliative care are increasing (Kraft, 2012; Mansky & Wallerstedt, 2006; O'Kelly, 2002; Williams & Kabat-Zinn, 2011). Bringing practice guidelines and evidence into the care of these patients is a challenge of a large public acute care hospital.

Currently, the hospital has a PCCS which is made up of two board-certified palliative care physicians, clinical nurse specialist (CNS), nurse practitioner, staff nurse, licensed clinical social worker, and chaplain. Each year the PCCS receives over 450 consults. In addition to the initial consultation, the PCCS provides follow-up visits with patients and their families during hospitalization. The PCCS visits an average of 15-25 patients per day. There are no PCCS services during the night or weekends. The PCCS may recommend a comfort care physician order set (CCPO) to address medical symptom management. However, the CCPO does not guide the day-to-day nursing care for palliative care patients. A knowledge tool that guides practice at this hospital is needed to remedy this knowledge - practice gap.
The purpose of this doctoral project is to assess nurses’ palliative care knowledge and to develop a Nursing Clinical Protocol (NCP) to guide palliative nursing care for a public acute care hospital. This NCP will bring evidence to action, close the knowledge – practice gap and serves as a guide for nurses who provide palliative care for patients and their families. The label of palliative care carries a stigma that is associated with end-of-life (Dalal et al., 2011). When the term supportive rather than palliative is used to convey the same concept, health care providers respond in a more positive manner (Dalal et al., 2011). By using the term supportive, the protocol distinguishes itself from physician driven care that is provided by the PCCS. Thus, the purpose of this DNP project is to develop a protocol titled “Supportive Care Nursing Clinical Protocol” (SCNCP). Hospitalized patients with serious illness, life-threatening, or life-limiting illness may receive SCNCP regardless of where they are on the trajectory of illness. Implementation of the SCNCP may prompt the need for inter-professional collaboration that may result in PCCS consultation or advance care planning (see Figure 2).
Figure 2. Decision to Apply SCNCP.

Supporting Framework

The development and implementation of the SCNCP involves knowledge translation and bringing evidence to practice. Processes involved in the knowledge translation can be complex and challenging in a large health care organization. There are many knowledge translation frameworks (Field, Booth, Ilott, & Gerrish, 2014; Rogers, 2003; Straus, Tetroe, & Graham, 2011). Moving evidence to practice and embedding it
into everyday practice in a large public health care organization requires systems thinking and consideration of the interrelatedness of different elements within the system.

This DNP project used Promoting Action on Research Implementation in Health Services integrated framework (iPARIHS) by Kitson and Harvey (2016) to facilitate the movement of evidence to practice. The systems perspective of the iPARIHS with its descriptive role of the facilitator makes the framework a practical one for this project. The complexity of a large public organization require meticulous systems assessment and well planned interventions to project management.

As shown in Figure 3, the core constructs of the iPARIHS are facilitation, innovation, recipients, and context (Kitson & Harvey, 2016). The framework identifies the facilitator’s skills and experience; the novice facilitator, the experienced facilitator, and the expert facilitator. The novice facilitator builds the beginning skills of comparing organizational context, culture, processes, networking, and how to sustain and spread innovation across the system. An experienced facilitator has an in-depth understanding the contextual complexities of a large organization, individual and team motivation, and competing priorities can facilitate an innovation through processes leading to practice change. The expert facilitator coordinates facilitation networks, work across academic and service systems. The expert facilitator also works to generate and evaluate new knowledge. Detailed systems assessment and actions by the facilitator are delineated in the iPARIHS framework. The facilitator focus and activities are central in bridging knowledge translation and moving innovation to practice.

In this DNP project, the SCNPCP is the evidence-based innovation. Recipients of the project are acute care nurses and the patients in their care. The context is a large
public university-affiliated acute care hospital. The facilitator needs to understand the project focus and implement identified facilitator activities to bring innovation to practice. The DNP scholar assumes the role of facilitator in the iPARIHS framework of knowledge translation.
Figure 3. The Promoting Action on Research Implementation in Health Services integrated framework (i-PARIHS framework): facilitation as the active ingredient (reprinted with permission from Kitson & Harvey, 2016).
REVIEW OF LITERATURE

Barriers to Palliative Care in Acute Care Hospitals

Using search terms “palliative care” and “acute care,” OR “hospitals,” OR “inpatient,” AND “barriers,” PubMed and CINAHL were searched for articles published between 2010 to 2016. Articles selected were in English. The search identified 76 articles (see Figure 4) which were examined for relevance. To ensure that evidence focused on barriers was found in contexts similar to the California hospital in this project, the following exclusion criteria were used:

- barriers in home settings
- long-term care facilities and outpatient settings
- foreign studies that identified nation specific health care system barriers
- specific medication or specific cancer types as barriers
- studies of foreign origins that identified nursing attitude and behaviors as barriers
- opinions and letters to the editor
Evidence demonstrates that palliative care affords cost-savings in acute care hospitals (Binney, Quest, Feingold, Buchman, & Majesko, 2014; May et al., 2016; May, Normand, & Morrison, 2014). Cost-savings are measured in patient days which is translatable into dollar amounts. Most hospitals over 300-bed capacity have palliative care services (Dumanovsky et al., 2016), yet barriers to palliative care exist. Patients may enter a tertiary university-affiliated medical center looking for a cure. Physicians are
focused on applying the best of modern medicine. The hospital is designed for the acutely ill, those who will soon recover and go home. However, for some patients, cure is not an option; supportive or palliative care is needed. Barriers to palliative care in inpatient settings can be divided into three themes, health care personnel as barriers, patient/family factors as barriers, and resource allocation as barriers.

**Health Care Personnel as Barriers**

Current clinical practice in acute care often fails to support dignified care at the end-of-life. Inadequate staff training in symptom control, staff sense of time constraints, motivation, personality, attitudes, and beliefs are identified as personnel-related barriers to providing dignified palliative care in inpatient settings (Antunes, Harding, & Higginson, 2014; Pringle et al., 2015).

Provision of competent nursing care requires knowledge, skills and appreciation of the patient experience. Nurses in acute care settings may lack knowledge regarding the scope and role of palliative care in symptom management for seriously ill patients (Autor, Storey, & Ziemba-Davis, 2013; Ritchie, 2014; Rocque et al., 2015). Nurses working in acute care may not readily recognize signs and symptoms that require palliative care (Bookbinder & McHugh, 2010; Mellor, McCabe, Davison, Goldhammer, & Hallford, 2013; Nunn, 2014). This lack of knowledge poses a barrier to competent supportive care, and also may contribute to nurses’ moral distress (Espinosa, Young, Symes, Haile, & Walsh, 2010; McCourt, James Power, & Glackin, 2013; Reinke et al., 2010).

Hospital-based health care providers may misunderstand what palliative care involves and often think that it is related to EOL care (Dalal et al., 2011; Ouimet Perrin &
Kazanowski, 2015; Rhodes, Tindall, Xuan, Paulk, & Halm, 2015). The misunderstandings contribute to late referrals or failure to initiate PCCS consultation.

Health care provider attitudes toward palliative care are another barrier. Physician attitudes towards palliative care can be a barrier to communicating the need for advance care planning with their seriously ill patients (Smith et al., 2014). A lack of physician knowledge and training in palliative care may contribute as a barrier to the discussion of EOL matters (Eriksson, Andersson, Olsson, Milberg, & Friedrichsen, 2014; Litauska et al., 2014; T. Ryan, Gardiner, Bellamy, Gott, & Ingleton, 2012). Many physicians can feel inappropriately confident in their abilities to manage symptoms without palliative care consultation (Hui, Kapo, & Akgün, 2016; Kamel, Paniagua, & Uppalapati, 2013). The combination of knowledge gap and this overconfidence may not be optimal for high-quality patient care. Physician perceptions about palliative care may not directly impact the development of the SCNCP. However, plans should be in place to educate stakeholders (including physicians) as they may impact the approval and implementation of the SCNCP.

**Patient and Family Factors as Barriers**

Patient and family perceptions about palliative care can be a barrier to optimum inpatient palliative care. Like providers, patients and families also hold misconceptions about palliative care thinking that palliative care is associated with EOL decisions (Metzger, Norton, Quinn, & Gramling, 2013; Ouimet Perrin & Kazanowski, 2015; Robinson et al., 2014). Cultural and linguistic factors may also affect family decisions about palliative care in seriously ill patients (Cruz-Oliver, Talamantes, & Sanchez-Reilly, 2014; Silva et al., 2016). In fact, seriously ill African-Americans and Hispanics have
been found to be less likely than whites to complete advance directives. These ethnic and
cultural groups acknowledge terminal illness and use hospice care, yet are more likely to
use aggressive medical interventions (Drisdom, 2013; Sacco, Deravin Carr, & Viola,
2013; Yancu, Farmer, Graves, Rhinehardt, & Leahman, 2015). Although patient-centered
factors may not affect creating of the SCNCP, considerations should be placed on
eliciting and understanding patient preferences. Cultural and linguistic considerations
must be considered in patient-centered care planning.

**Resource Allocation as a Barrier**

Barriers to inpatient palliative care include inadequate resource allocation.
Organizational structures and processes can be a hindrance in implementing practice
changes. Hospitals have typically not allocated resources (staff and others) that allow
care for the seriously and chronically ill that is appropriate to many illness trajectories
(Grudzen, Richardson, Morrison, Cho, & Morrison, 2010; Lamba, Nagurka, Zielinski, &
Scott, 2013). More than 60% of Maryland hospitals recently surveyed had plans to
expand palliative care services, yet less than half had plans to increase their palliative
care budget (Gibbs Jr., Mahon, Truss, & Eyring, 2015). However, palliative care is cost
effective and therefore should be supported (Binney et al., 2014; May et al., 2016).
Patients with palliative care needs may enter the hospital from the emergency
department. Emergency physicians know the futility of treatment for many of these
clients (DeVader, Albrecht, & Reiter, 2012). However, palliative care consultation is not
available around the clock, and those who need palliative care in the emergency
department suffer as a consequence (Lamba et al., 2013; Norton, Hobson, & Kulm,
2011).
Hospitalized patients who require palliative care may be more dependent on nursing care. Staffing patterns for palliative care services should be examined as more nursing time is spent on patient-centered care activities (Roberts & Hurst, 2013).
METHODS

The goals of this DNP project were to assess acute care nurses’ palliative care knowledge and to develop an evidence-based knowledge tool to facilitate the provision of supportive care for seriously ill patients in a large public university-affiliated hospital in southern California.

The iPARIHS framework was used as a roadmap for the DNP role as a facilitator to move research evidence into clinical practice. The iPARIHS deliniates the facilitator perspective and activities necessary in bringing knowledge to action (Kitson & Harvey, 2016). Each iPARIHS construct and facilitator role were considered individually and as integrated into the framework. The iPARIHS suggests that the innovation should be considered before the recipient. However, this author found it important to simultaneously consider recipients and the innovation. Recipients’ motivation, values, skills, and knowledge can impact the trialability of the innovation. Recognizing and appreciating recipients as the end user of the innovation enables the facilitator to consider clinical consensus and unwritten power and authority that may help or hinder the project. While developing the innovation, contextual factors were also considered. Context at the organization level was considered prior to the launch of the DNP project to secure formal and informal leadership support. Without organizational leadership support, project success cannot be achieved. There is an interrelatedness between the innovation, context, and recipients. It was critical that the project facilitator understood this interrelatedness. The DNP project integrates the DNP competencies of scientific underpinnings, clinical scholarship, organizational leadership, systems thinking, and health care policy to the iPARIHS framework in the knowledge translation process. As suggested in Figure 3, the
iPARIHS framework is not linear in nature, the swirl originating from the core and the arrow suggests an outward movement that encounters and involves other constructs in the system. This methods section will discuss each iPARIHS core construct and how this author’s role as facilitator was applied to the DNP project.

**Recipients**

The recipients in this DNP project include acute care nurses and the patients in their care. The area surrounding the hospital carries one of the county’s highest Economic Hardship Indices (Los Angeles County Department of Public Health, 2013). Over 75% of the patient population is Hispanic, 9.5% African-American, 6.9% Caucasian, and 6.2% Asian/Pacific Islander (Los Angeles County Department of Health Services, 2016). Cultural and linguistic factors among Latino patient population may be barriers in decisions about palliative care as this patient population prefer aggressive treatment (Silva & Baca, 2017; Smith, Sudore, & Pérez-Stable, 2009).

This author engaged acute care nurses in conversation about palliative care. During the summer of 2016, the hospital planned to open Comfort Care Rooms (CCR) on select medical-surgical wards. Patients facing their last days of life would be admitted to the CCR which are designed to be home-like and include furniture for family members. Nurses working on the wards with the planned CCR felt ill-prepared to care for those admitted to the CCR. Some nurses were unsure about the rationale for why their particular wards were selected. Overall, acute care nurses wanted to learn more about palliative and end-of-life care.

An interview with the PC CNS in summer of 2016 revealed the probability of a knowledge deficit among hospital acute care nurses caring for the seriously ill. The PC
CNS planned to compile a three-inch binder with resources for the acute care wards that house the CCR. This author suggested that a NCP that can be accessed in the local computer work station may be more effective. Acute care nurses engaged in discussion of SCNCP development welcomed the idea of having a knowledge tool to guide care for this patient population. However, the extent of actual nursing knowledge gap among hospital nurses was unknown. The literature supports the existence of such a knowledge and practice gap (Autor, Storey, & Ziemba-Davis, 2013; Dalgaard, Bergenholtz, Nielsen, & Timm, 2014).

To determine whether a palliative care knowledge deficit existed, a survey of nurses’ knowledge was performed. The doctoral student and the PCCS nursing team (CNS and registered nurse) reviewed the Palliative Care Quiz for Nurses (PCQN) developed by Ross, McDonald, and McGuinness (1996) and modified it based upon relevance and currency of the items. Eleven items were selected, and three items were modified from the original PCQN. The item from the original PCQN that states, "In the terminal stages of illness, drugs that can cause respiratory depression are appropriate for treatment of severe dyspnea" was modified to exclude the phrase "in the terminal stages of an illness." The other item from the original PCQN, "Suffering and physical pain are synonymous" was modified to, "Suffering and physical pain are the same." The PCQN item, "Manifestation of chronic pain are different from those of acute pain" was modified to read, "Manifestation of chronic and acute pain are the same." The modifications were made with the intention to improve readability of the items.

The PCCS nursing team wanted to assess additional potential knowledge deficits in order to assist planning of future educational activities regarding supportive and
palliative care. They had noticed that imminently dying patients are often under-medicating for pain and sedation despite orders for medicatations to be given as needed. Three new items were created and added to survey:

- A high dose of opioid causes life to end for the imminently dying (item #8)
- Patient/family’s medical decision-making is influenced by culture (item #10)
- Spiritual assessment is within the scope of nursing practice (item #11)

The modified survey consisted of 14 items (Appendix C).

The hospital Institutional Review Board was consulted regarding administering the PC survey and determined that this activity was exempt from institutional review (Appendix G). Permission to administer the PC survey was granted by the Chief Nursing Officer (CNO). The CNO specified nursing units where the PC survey could be administered during late fall 2016. The rationale given for limited access to nurses was that there were other projects underway on several units and additional surveys might have added stress to nursing staff. The units selected are also under the same division of the nursing organizational leadership structure.

The plan to administer the quiz was announced at the nurse manager meeting October 19, 2016. This author communicated directly with nurse managers about PC survey administration. Copies were distributed on three 32-bed medical-surgical units November 1-2, 2016 in order to capture staff during both day and night shifts for 48 hours.

Characteristics of the Innovation (Practice Change)

The SCNCP is the innovation that would guide practice change. The SCNCP (Appendix D) was constructed using national guidelines on palliative care. Assessment
elements were selected based upon common symptoms identified by the National Guidelines (National Quality Forum, 2016). National guidelines suggest the consideration of complementary interventions in palliative care. Complementary interventions included in the SCNCP are based upon current evidence. A table of evidence (TOE) for each intervention was constructed in the process of reviewing the available evidence in the literature. Interventions in the SCNCP are those that are possibly beneficial with unlikely harm (e.g., use of a hand-held fan for dyspnea, the use of computer application for meditation, music, and peppermint lip balm).

The issue of trialability was considered. The fans for dyspnea that were described in the literature were battery operated and handheld (Galbraith, Fagan, Perkins, Lynch, & Booth, 2010). A battery operated handheld fan would potentially be a safety hazard in the context of acute care. The provision of batteries for handheld fans may pose added costs. The handheld fans described in the SCNCP (and to be made available in the hospital with SCNCP implementation) are made of paper with a wooden handle. This handheld fan is safe and low-cost. A beeswax peppermint lip balm was selected as a part of the thirst bundle (Puntillo, Arai, Cooper, Stotts, & Nelson, 2014) with the consideration that petrolatum based products are potentially flammable and may interfere with enriched oxygen therapy. The thirst bundle suggested the use of oral and lip moisturizer. Per correspondence with the principle investigator, Kathleen Puntillo, the protocol used mentholated lip moisturizer. This author procured peppermint lip balm based upon evidence that peppermint aroma may reduce salivary cortisol, which is an marker of stress (Toda & Morimoto, 2011). Available oral swabs can be submersed in ice to provide a refreshing feeling for the thirsty without added cost. The use of cold water
spray from the thirst bundle was not included as spray bottles would add cost and may bring epidemiological regulatory challenge. Music is available on a designated channel at the project hospital. The music channel is included as a reminder to staff to select the channel if the patient is unable to select a channel. The SCNCP suggest the use of computer apps *Breathe2Relax* and *Virtual Hope Box*. These computer apps were developed by the United States military and are available for free use by both military and civilians. The apps may be used for those with smartphones. According to the Pew Research Center, 77% of adults in the United States own smartphones (http://www.pewinternet.org/chart/mobile-phone-ownership/). The SCNCP includes a reference section addressing signs of imminent dying and suggested interventions; these resources were noted to be a helpful tool for nurses working with patients exclusively receiving end-of-life comfort care. Risk management nurse was consulted for any possible legal implication that may incur related to the application of the SCNCP. No risks were identified.

Strategies for assessment were discussed to help the acute care nurse assess novel questions that some nurses may not be used to asking (Table 1). Rationale for each assessment is included. These strategies will be presented as a part of the protocol launch staff education.
Table 1

**Strategies for Assessments in SCNCP**

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<th>Symptom/patient need</th>
<th>Specific Strategy</th>
<th>Rationale</th>
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| **Spiritual distress** | Ask how has the illness has influenced the meaning of work, role function, family, relationships, inner strength, and hope.  
Listen closely to patient response, providing non-judgmental feedback  
Listen for the need for referral to chaplaincy or social work | It is not easy to incorporate questions about spirituality in a secular patient care environment (Orr, 2015), yet spirituality is a part of the holism of humans |
| **Mental/emotional status** | Mental status encompasses more than orientation  
Ask “how are you feeling overall today?”  
If the presence of stress is known, ask about the level of stress  
Listen for cues of anxiety, fear, and depression  
Support the use of breathing exercise for relaxation  
Assess for the need for interdisciplinary collaboration to manage variance in mental status | Anxiety and depression are common in patients experiencing serious illness (Wilson et al., 2007)  
Deep slow breathing can positively influence pain perception, decrease sympathetic activity, decrease tension, and improve mood (Busch et al., 2012). |
| **Discomfort other than pain** | Ask about presence or experience of “discomfort other than pain”  
Allow patient to discuss a range of unmet needs  
If the discomfort is dyspnea, assess breath sounds, position for comfort, and offer a hand-held fan. Family members can participate in caring by the use of the hand-held fan | Many factors can produce suffering. The discomfort suffered by the seriously ill is likely related to psychological discomfort (Tony Ryan et al., 2013).  
Seriously ill patients may experience psychological distress from repeated thinking of negative thoughts related to their illness (Galfin, Watkins, & Harlow, 2010).  
A hand-held fan can alleviate the subjective sensation of dyspnea (Booth, Galbraith, Ryan, Parker, & Johnson, 2016) |
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<td>Identify food and fluid preferences to meet need unless contraindicated by disease or trajectory of illness</td>
<td>Food has multiple meanings other than nutrition (Arbit, Ruby, &amp; Rozin, 2017)</td>
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<td>If patient cannot have anything by mouth (NPO) or has a fluid restriction, offer ice cold oral swabs and apply lip moisturizer (preferably peppermint)</td>
<td>Thirst sensation and thirst distress can be alleviated by use of a thirst intervention bundle (Puntillo, Arai, Cooper, Stotts, &amp; Nelson, 2014)</td>
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<td>May allow staff to organize care activities in a way that conserves patient energy</td>
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<td>Sleep pattern</td>
<td>Assess sleep pattern during both day and night shifts</td>
<td>Given their disease process and medication side-effects, patients with serious illness may not sleep well (Mercadante et al., 2015)</td>
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<td>Inquire about both sleep amount and sleep quality</td>
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<td>Support the use of meditation</td>
<td>Mindfulness meditation can diminish stress and improve sleep (Brand, Holsboer-Trachsler, Naranjo, &amp; Schmidt, 2012)</td>
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<td>Suggest the use of the computer application “Virtual Hope Box” to help with meditation/relaxation</td>
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<td>Altered coping with the illness condition</td>
<td>When assessing patient coping, combine queries with active listening</td>
<td>May help staff understand a unique patient narrative. Listening to patient narratives is a part of holistic nursing care (Alicea-Planas, 2015)</td>
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During protocol development (Fall 2016), the hospital opened two CCR in the acute care units. The CCR are dedicated for hospitalized patients who are facing the last days of life. The rooms were designed with a home-like environment. The CCR are located away from busy hallways. They are equipped with furniture such that family
members can stay over-night. Admission to the CCR does not trigger a PCCS consultation. The opening of the CCR heightened the staff awareness for the need for the SCNCP.

**Inner Context**

The setting for this doctoral project was a 670-bed University-affiliated public hospital in East Los Angeles. The hospital accepts patients regardless of their ability to pay. The hospital is one of three acute care public hospitals serving Los Angeles County, which has a population of over 10 million residents.

As an organization, the hospital has many levels of leadership and management. The author interviewed the Chief Operations Officer (COO) to identify organizational relationships and priorities. The author then engaged the Chief Nursing Officer (CNO) and presented the DNP project product (SCNCP) as an intervention that can impact the organizational priority of improving the patient experience and possibly increase palliative care as a paradigm of care to improve quality of life and afford cost savings (Witt Sherman & Jooyoung, 2012). The CNO was receptive to the DNP project and directed clinical directors and nurse managers to support it.

The PC CNS reports to medical hierarchy rather than to the CNO. The PC CNS not reporting to the CNO causes a disconnect between PC activities and functions from nursing’s oversight. The CNO lines of communication do not include the PC CNS. The DNP scholar acted as a liaison between the PC CNS and nursing leadership. Liaison work is an example of facilitation activity in the promoting action process. Understanding the organizational structure and the interactive culture of the setting allowed the DNP scholar to appropriately facilitate the progression of the innovation to practice.
Moving the SCNCP into practice required a formal approval process. Approvals had to be obtained from the Protocols and Standards Committee, Professional Practice Committee, and the Nursing Executive Council. In September 2016, the DNP scholar engaged the chairperson of each committee, communicating the DNP project aims and how the SCNCP could potentially improve patient experience. Engaging organizational leaders helped to move the innovation forward. Presenting the project in terms of how it aligns with organizational priorities drew the attention of leaders to the project. Future plans to collaborate with the other acute care hospitals regarding implementation of the SCNCP was discussed.
RESULTS

The aim of this DNP project was to develop a Supportive Care Nursing Clinical Protocol (SCNCP) to guide quality nursing practice for a public acute care hospital. Results of the palliative care knowledge survey which assessed baseline nurse palliative care knowledge will be presented as well as the process of SCNCP approval.

Palliative Care Quiz Results

Results from the palliative care knowledge survey affirmed that a knowledge deficit exists at the local context. Thirty out of 45 eligible nurses completed the 14-item PC survey as did five clerks and three nursing attendants. The RN survey results were tabulated (see Figure 5). Responses from clerks and nursing assistants were not tabulated due to the potential for lack of confidentiality. The demographic characteristics of respondents were not gathered to maintain anonymity. The mean percentage of correct responses to the survey for RNs was 64.28%. Seven items received <75%. The item that received the lowest correct response was item #9 (The philosophy of palliative care is compatible with that of aggressive treatment). Seventeen out of the 30 nurses (56.67%) erroneously thought that the method of pain treatment is determined by the extent of the disease. Sixteen saw drug addiction as a major problem when morphine is used on a long-term basis for pain management (53.33%). Items #5, #6, and #14 surveyed knowledge symptom recognition and management; 23.33% of nurses had correct responses to these. However, all RNs surveyed correctly identified that patients receiving opioids should be assessed and treated for constipation. Of the items added to the original PCQN, item #8 (A high dose of opioid causes life to end for the imminently dying) received 60% correct
responses. The other two new items (#10 and #11) received correct responses above 75%.

**Protocol Approval Process**

The SCNCP final review by the palliative care nursing team was completed October 20, 2016. On November 1, 2016, the SCNCP was presented for review and approval at the hospital Protocol and Standards Committee, consisting of nurse educators, nursing quality manager, and staff nurses identified as clinical resources in their areas of practice. The SCNCP was well received by the Committee. The staff nurses on the Committee felt that the SCNCP will empower nurses to use interventions that can alleviate suffering when medicine cannot offer treatment options. The Protocols and Standards Committee approved the SCNCP with minor revisions. The SCNCP does not contain any pharmaceutical interventions and thus, did not need review by the Pharmacy and Therapeutics Committee.

On November 15, 2016, the SCNCP was presented for review and approval at the Professional Practice Committee (comprised of Clinical Directors, Assistant Nursing Directors, Clinical Nurse Specialists, and Nurse Managers). The Professional Practice Committee viewed that the measurement scales included in the SCNCP will require electronic health records (eHR) modifications that is not feasible at this time. A modification of the eHR requires approval at the corporate level which will require agreement with all the hospitals in the system. The Professional Practice Committee approved the protocol with a revision to link the SCNCP protocol to the Pain Management Protocol and omitting the measurement scales.
Note. $n = 30$

*Figure 5. Palliative Care Quiz Results*
The SCNCP was reviewed by the Nursing Executive Council December 16, 2016. The Nursing Executive Council, comprised of Clinical Directors, Director of Nursing Quality, Director of Nursing Informatics, and Chief Nursing Officer is holding the SCNCP for further review due to competing priorities at the hospital.

On January 27, 2017, the CNO called a meeting consisting of pain management CNS, oncology CNS, PC CNS, the oncology ward nurse manager, a clinical director, and this author. The purpose of the meeting was to discuss a clinical incident involving a terminally patient who was not medicated per physician orders. It was concluded that the nurse may have not had sufficient knowledge regarding EOL care. The SCNCP was brought up in the discussion as a valuable knowledge tool and reference. The CNO mentioned that the SCNCP can be applied to any seriously ill patient and not limited to those who may need palliative or end-of-life care.

**Summary**

The PC CNS suspected that acute care nurses at the project hospital had a palliative care knowledge deficit. The nurses’ palliative knowledge survey results confirmed the lack of knowledge. The findings validate the need to close the knowledge gap. Most severe knowledge deficits clustered around pain management and end-of-life symptoms.

The facilitation function as described in the iPARIHS framework was critical in bringing the SCNCP through the approval process. Systems thinking was crucial in identifying key organizational stakeholders. Leadership support of the project was brought about by consistent communications which connected the value of the SCNCP
with organizational priorities. Engaging key approval committee leaders laid the groundwork for the SCNPCP approval.
DISCUSSION

At the conclusion of this DNP project, the SCNCP was developed and formally approved. The SCNCP is the first protocol at this hospital that was developed incorporating the holistic care process. References supporting each recommended intervention are included as a part of the protocol. The approval of the protocol with in-text references is an indication that hospital administration places value in holism and evidence-based practice. Moreover, inclusion of references in the SCNCP allows the end user of the protocol to access these sources of evidence as needed.

Dissemination, embedding, and sustaining the SCNCP within the project hospital and other hospitals in the network will need further facilitation. Plans for future facilitation activities are presented here to guide future champions of the SCNCP.

Protocol Launch Plans: Recommendations

New and revised protocols are usually announced at the monthly Nurse Manager meetings, which are chaired by the CNO. Following this, electronic dissemination of new and revised protocols is accessible to all hospital staff members. There is a time lag between the final approval of a protocol and when it appears electronically on the point of care computers. During this time, plans for educational activities surrounding the new SCNCP may be developed and implemented. The nursing in-service department will be engaged in the educational activities if continuing education units can be awarded.

The current method used by the organization for protocol development does not encourage the end user to interact with the change process. It is recommended that staff nurse champions who are enthusiastic about supportive care will be identified and mentored to serve as a Supportive Care (SC) resource for other staff. Champions from
each nursing unit would be identified and educated on the specific details of the SCNCP and palliative care. Special designation should be made for these SC champions to identify them as unit-based SC resource nurses. The SC nurses would then educate their peers about supportive care. Currently, there are unit-based skin care resource nurses who have additional training in pressure ulcer management. Similarly, the SC resource nurse will provide peer facilitation when caring for patients needing supportive care.

Promoting awareness of the SCNCP is a part of knowledge tool dissemination. An information table will be set up in the staff cafeteria to introduce the SCNCP and the concept of palliative care. The information table will be presented by members of the multi-disciplinary PCCS. A multi-disciplinary presentation will likely draw multi-disciplinary attention. A video clip should be created to introduce the new protocol. The video clip may be embedded in the hospital’s intranet for easy access.

The DNP project hospital is one of four in a public health care system. Agreement to implement the SCNCP in all four hospitals should be sought. This agreement is essential in modifying the electronic documentation of the SCNCP. At such a time, triggers for supportive care may prompt coordination of a palliative care plan in a timely manner.

**Evaluation Plan**

Knowledge to action must be sustainable. Monitoring the use of the SCNCP will need to be planned with the Nursing Quality Manager. Nurses’ response to the new SCNCP should be monitored by Nursing Quality Management quarterly. Input from staff nurses would be vital to evaluate the effectiveness of the protocol and allows modifications to be considered. The literature should be reviewed every year to determine
a need for protocol change. Revisions of other policies and protocols may affect the SCNCP. Thus, monitoring other protocol changes will be a part of the continual evaluation of the SCNCP.

Monitoring the effectiveness of the SCNCP is critical. Data reflecting the quality of care before and after protocol implementation will bring validity to the project. These measures may include, but not limited to numbers of PCCS referrals, patient and family satisfaction ratings, and the number of live discharge among PC patients which would indicate early establishment of palliative care.

A re-deployment of the nurses’ palliative care knowledge six months after SCNCP launch will document knowledge changes related to the SCNCP and educational activities surrounding the protocol launch plans.

**Implications for Practice**

Palliative care is a specialty practiced by few, but a service needed by many. The SCNCP is an independent nursing protocol that guides holistic assessment that may lead to identifying the need for specialized palliative care. The SCNCP brings focus to possibly unaddressed symptoms often suffered by the seriously ill and their families.

Acute care nurses are often ill-equipped to meet these specific needs of patients facing serious and life-limiting illness. Using a tool like the SCNCP adds evidence-based strategies that can be used by nurses caring for seriously ill patients. The SCNCP’s holistic assessment approach encourages acute care nurses to know patients as persons and appreciate their experiences of living with serious illness. In the process of appreciating patient experiences, nurses are led into identifying meaningful unmet needs of the seriously ill as persons beyond a disease. Understanding the patient experiences
and narratives brings meaning and a caring quality that may not be often measured (Dy et al., 2015).

Incorporating the appropriate use of technology of computer application for relaxation, distraction, and mindfulness activities can enhance the patient experience. The select computer applications suggested in the SCNCP are free and can be used by patients, families, and health care providers in and outside the hospital.

The SCNCP content promotes quality and safe nursing care (Cronenwett et al., 2009). The SCNCP assessments embrace patient-centered care and personhood. Prompts for inter-professional collaboration encourages teamwork. For nurses applying the SCNCP to the care of patients facing life-limiting illness, inter-professional collaboration may start needed conversations that move care decisions toward advance care planning earlier in the trajectory of the illness than the current norm.

The SCNCP interventions are low-cost and unlikely to be harmful. The low-cost nature of the SCNCP interventions are attractive to any budget-minded administration. With the SCNCP’s potential to improve patient satisfaction and add value to nursing service, a similar protocol should be welcomed in other health care settings.

Unlike EOL tools and resources, the SCNCP tries to eliminate the stigma of palliative care and the suggestion of terminality of life. Conversely, the SCNCP can potentially help those who suffer silently while living with serious illness without definitive curative outcomes or prognostication of death. The application of the SCNCP need not be limited to the acute care setting. Assessments and interventions in the SCNCP may be adapted for used in community and ambulatory care settings.
SUMMARY

The DNP project was a journey that brought evidence to practice. Although the journey has not ended, many lessons were learned, many solutions revealed, and many relationships were forged in the process. This author is not a palliative care specialist, but through the application of DNP competencies and close collaboration with the PC nursing team, acute care nurses on the oncology ward, and nurses who will care of the imminently dying, she led the DNP project to bring an evidence-based innovation (SCNCP) into the workplace. Working across the local and organizational contexts allowed for a broadened perspective of problem solving.

Medical science may have delivered health care with technological advances in recent years, but the need for nursing care remains constant. The SCNCP attempts to give acute care nurses a concrete tool to guide care for patients facing life-threatening and life-limiting illness.

Evidence-based practice is now common in professional nursing. Increasing evidence in the literature validates the value of nursing action. However, research evidence is not the only source of evidence for practice. Clinical experience, expertise, and patient preference may be sources of evidence (Mackley, Bollinger, & Lynch, 2012). Practices that may not have strong scientific evidence should be reviewed by clinical scholars for their trialability, relative advantage, and possible benefits to patient care. Facilitating the translation of evidence into practice is an important role of the clinical scholar. Developing the SCNCP and bringing it through the organizational approval process is a promising first step in officially delivering evidence-based practice into nursing practice at a large public hospital.
The DNP project grew out of the need to have a knowledge tool that would help nurses care for patients and families requiring palliative care. Based upon the holistic care process, the SCNCP was developed and is congruent with palliative care. A poster showcasing the project will be presented at the National Nursing Ethics Conference, the American Holistic Nursing Association Convention (2017), and the Western Institute of Nursing Research Conference (2017). A manuscript will be submitted to the *Holistic Nursing Practice Journal*. This wide acceptance and interest in the project lends credence to the need for dissemination of this important work. From a protocol developed for a specific patient population, the SCNCP became a protocol that can guide nursing care for seriously ill patients in most settings.
REFERENCES


Medicare Hospice Data (2016). Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Medicare_Hospice_Data.html


doi:http://dx.doi.org/10.1016/j.jpainsymman.2006.07.016


doi:http://dx.doi.org/10.1016/j.jpainsymman.2015.06.004
Supportive Care Nursing Clinical Protocol Incorporates Holism in a Public Acute Care Hospital

Abstract
Patient care requires holism of the human experience. The Supportive Care Nursing Clinical Protocol (SCNCP) guides acute care nurses to integrate holistic care process when caring for the seriously ill. The SCNCP marks formal recognition of holistic nursing values as the standard of care at a public acute care hospital.

Introduction: While patients with serious life-limiting or chronic progressive illness may want to receive care at home, many will receive care at acute care public hospitals. At a large university affiliated public hospital, patients living with serious, life-limiting or chronic progressive illness receive fragmented care as curative medical procedures dominate the hospital stay. The Supportive Care Nursing Clinical Protocol (SCNCP) was developed to facilitate a holistic nursing perspective in caring for this patient population. This clinical protocol includes low-cost, low-risk, independent nursing interventions that may alleviate patient suffering. The purpose of this article is to describe the process of creating and gaining approval for the SCNCP.

Background: Holism involves the “interrelationships of a person’s bio-psycho-social-spiritual dimensions, recognizing that the whole is greater than the sum of its parts.” According to the American Holistic Nursing Association (2013), the holistic approach
looks for ways to integrate conventional nursing interventions and to use complementary modalities for promotion of healing, peace, comfort and a subjective sense of well-being. This approach is not always possible in a busy public acute care hospital. However, seriously ill hospitalized patients need to be cared for holistically as all aspects of their personhood may be affected by their condition. The SCNCP was developed with a goal of bringing holism to care.

The SCNCP grew out of nurses’ frustration of not being able to help patients when medical care had reached its limit of interventions. Interviews with acute care nurses made it clear that a guideline for independent nursing interventions that might alleviate suffering would be helpful. Because this frustration stemmed from nurses caring for the dying, the Palliative Care Consultation Services clinical nurse specialist (CNS) was consulted. A knowledge survey established a need for a palliative care practice guide. However, in the process of SCNCP development, the CNS and the first author saw that the SCNCP might be applied to a broader range of hospitalized patients than just those at the end of life.

The SCNCP development is based upon a holistic caring process. The various dimensions of personhood are considered in the recommended assessments and interventions. Patients living with serious and chronic progressive illness who need relief from symptom burden often welcome complementary therapies.\textsuperscript{5,6} While complementary interventions are used in palliative care,\textsuperscript{7-9} use of complementary interventions with seriously ill patients in acute care settings is not well documented. Despite the low quality level of evidence supporting most complementary interventions, low cost, non-
harmful interventions that may help ease suffering may be well worth considering as part of care delivery.

**Laying the Groundwork for a Protocol:** Key stakeholders, such as the Chief Operations Officer, Chief Nursing Officer; Clinical Director; nurse managers, staff nurses; and the three CNS for palliative care, pain management, and oncology, discussed the need for a clinical protocol that would be used by acute care nurses as a knowledge tool to guide holistic care of seriously ill patients. The need to enhance nurses’ palliative care knowledge was heightened by the opening of two Comfort Care rooms (*Figure 1*), which were designed for patients in their last days. When these rooms were introduced, nurses on the medical-surgical units where the rooms were housed reported frustration regarding their limited contribution to caring for the dying.

Discussions with the medical-surgical nurses regarding the development of the SCNCP indicated the protocol would be well received. A nurse stated, “I may do certain things to help, but I don’t necessarily know if the nurse on the next shift is going to do the same thing. The protocol would help continuity.” Another nurse said, “We have needed something like this for a long time.”

**Protocol Development:** National guidelines consistently suggest that seriously ill patients should be monitored for common symptoms, and that a holistic approach to care is needed.\textsuperscript{10,11} For the seriously ill, pain management, thirst, anxiety, dyspnea and sleep pattern should be monitored daily.\textsuperscript{12} To add to the understanding of the patient, assessment of an illness’ influence on life meaning needs to be included. Physiologic, psycho-social, and spiritual assessments are included in the SCNCP in appreciation of the totality of individuals.
Interventions for the SCNCP were selected based upon available evidence in the literature with consideration of trialability, relative benefit, and minimum risk. Where appropriate, the intervention was modified to fit the local context. For the dyspnea intervention, a cardboard hand-held fan was selected as opposed to electrical fans; it was thought that electrical fans might complicate an acute care environment (Figure 2).

Listed in Table 1 are assessments and interventions in the SCNCP. Also included in the protocol is a suggestion for use of guided imagery as a strategy to alleviate chronic non-cancer pain.\textsuperscript{13} Active listening, another intervention, need not correspond to a symptom or identified need; listening to the patient narrative can provide insight into the patient experience and break down barriers to the path to healing.\textsuperscript{14}

**Protocol Approval Process:** This nurse-driven supportive care protocol is the first nursing protocol focused upon holistic assessments and complementary interventions for seriously ill patients at the hospital. The protocol approval process involved multiple committees: Protocol and Standards Committee, Professional Practice Committee, Nursing Executive Council. Using the integrated Promoting Action on Research Implementation in Health Services (iPARIHS) model \textsuperscript{15} (Figure 3), the first author assumed the role of facilitator and carefully planned an approach to approval based upon understanding of the system functions within a large organization. Taken into account were needs and idiosyncrasies of known key stakeholders and approval bodies. This was crucial in facilitating practice change. In all presentations during the approval process, the SCNCP was presented as a practice guide or knowledge tool that would help nurses deliver evidence-based, quality holistic care and improve patient satisfaction. The SCNCP was well received and was approved in February 2017. One interesting
anecdote: a staff nurse member attending the Protocols and Standards Committee broke into tears when she heard the SCNCP presentation, stating, “I wished I had this the other day. My patient was very sick and there was nothing the doctor could do for her. This protocol gives me things that I can do for my patient.”

The SCNCP is the first nursing protocol at this hospital to include complementary interventions and in-text references showing supporting evidence. The approval to include these is an acknowledgment that those granting approvals value evidence-based practice. It is hoped that nurse users of the protocol will seek out the references to further their knowledge.

Evidence-based practice is now common in professional nursing. Supportive evidence in the literature validates the value of nursing action. Developing the SCNCP and bringing it through the approval process is a promising step in officially bring evidence-based practice and holism into nursing practice at a large public hospital.

**Implications for practice:** On a busy hospital unit, managing technology and time limitations may compete with meeting patients’ true nursing care needs. It is the responsibility of nurses to try to understand complex patients and family experiences of illness and to find ways to contribute to their healing, peace, and sense of well-being. The holistic care process has nurses consider all elements of patient experiences while focusing on individual patients. It also leads nurses to examine the interconnectedness of the patient needs, the external environment, and the local care context for each individual. This project and the SCNCP resulted from nurses looking at the interconnections of individuals and the system of a large hospital.
With the protocol’s approval, it is now more likely that nurse-driven holistic interventions will alleviate the suffering of seriously ill hospitalized patients. This public hospital joins other hospitals by including complementary interventions as a part of their value added services (AHNA, 2013). While barriers exist to bringing about change in large health care organizations, the use of a framework like the iPARIHS can be helpful in systematically approaching change implementation.

There is increasing evidence that shows the efficacy of complementary modalities that holistic nurses can incorporate in acute care settings. However, some of these practices do not have strong convincing scientific evidence. Such interventions are not considered mainstream but should be evaluated for their trialability, relative advantage, and possible benefits within the context of care settings.

**Summary:** Nurses are instruments of healing. The SCNCP brings nurses back to the core values of holistic caring, and may support patients along their illness trajectory. Use of the SCNCP should allow nurses to appreciate the holism of nursing, find greater satisfaction in being an instrument of healing, and self-reflect on the meaning and value of nursing. Finally, when the protocol is established as the standard of care, holism will have taken root in a public acute care hospital.
References


http://www.qualityforum.org/Projects/Palliative_Care_and_End-of-Life_Care.aspx.


11. Chanques G, Nelson J, Puntillo K. Five patient symptoms that you should 

12. Lewandowski W, Jacobson A. Bridging the Gap Between Mind and Body: A 
Biobehavioral Model of the Effects of Guided Imagery on Pain, Pain Disability, 

13. Alicea-Planas J. Listening to the Narratives of Our Patients as Part of Holistic 

14. Kitson AL, Harvey G. Methods to Succeed in Effective Knowledge Translation in 


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<td>Allow patient to discuss a range of unmet needs</td>
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Figure 1.
Comfort Care Room
Figure 2.
Hand-held fan
Figure 3
iPARIHS model

Facilitator Focus and Activity
What the Facilitator Looks at
What the Facilitator Does

Characteristics of the Innovation
- Underlying knowledge sources
- Clarity
- Degree of fit (compatibility or contestability)
- Degree of novelty
- Value boundaries
- Trialability
- Relative advantage

Problem identification
- Acquiring/appraising evidence
- Baseline context & boundary assessment
- Stakeholder mapping

Recipients
- Motivation
- Values & beliefs
- Clinical consensus
- Local opinion leaders
- Existing data sources
- Skills & knowledge
- Time & resources
- Learning environment
- Collaboration & teamwork
- Power & authority
- Professional boundaries & networks

Inner Context: Local Level
- Formal & informal leadership support
- Culture
- Past experience of change
- Mechanisms for embedding change
- Evaluation & feedback processes

Local context assessment
- Communication & feedback
- Networking
- Boundary assessment & spanning
- Negotiating & influencing
- Policies & procedures
- Structuring learning

Inner Context: Organization
- Organizational priorities
- Structure
- Leadership & senior management support
- Systems & processes
- Culture
- History of innovation & change
- Absorptive capacity
- Stakeholder engagement
- Communications & feedback
- Marketing & presentation
- Networking
- Boundary spanning
- Negotiating & influencing
- Policies & procedures

Outer Context
- Policy drivers & priorities
- Incentives & mandates
- Regulatory frameworks
- Environmental incitability
- Inter-organizational/networks & relationships
- Political awareness & influence
- Communication
- Marketing
- Networking
- Boundary spanning
- Sustainability & spread

PERMISSION TO USE THE iPARIHS MODEL

Jutharatana Srivali Teal <jutara@csu.fullerton.edu> Mar 28 (5 days ago)

to sue, Gillian, Dana

Dr. Harvey,
I will be submitting a Manuscript for publication in the Holistic Nursing Practice journal. I would like your permission to use the iPARIHS and corresponding figure in the manuscript. Applying the iPARIHS in my practice change project brought the multi-faceted nature of each construct and the multi-layered process of the system to life. Thank you in advance for your kind consideration.
Sincerely,
Jutara Srivali Teal, RN
DNP Candidate

Gillian Harvey Mar 28 (5 days ago)

to me, Dana, sue

Dear Jutara
Yes very happy to grant permission – good luck with the manuscript submission.
With best wishes,
Gill
Gill Harvey| Professorial Research Fellow
Adelaide Nursing School| Adelaide Health & Medical Sciences Building, Level 6| The University of Adelaide| SA 5005 Australia|
Tel: +61 8 8313 0267
Email: gillian.harvey@adelaide.edu.au
CRICOS Provider Number 00123M

http://health.adelaide.edu.au/nursing/

--------------------------------------------

APPENDIX B

AUTHOR GUIDELINES FOR HOLISTIC NURSING PRACTICE
Holistic Nursing Practice
Online Submission and Review System

Instructions for Authors (this page)
Copyright Transfer (PDF)
Submission Form (Doc)
Permissions Requests
Reprints

JOURNAL INFORMATION

About the Journal. The primary focus of *Holistic Nursing Practice* (*HNP*) is to explore holistic models of nursing practice and to emphasize the complementarity of traditional and holistic nursing and health care practices. *Holistic Nursing Practice* seeks articles on holistic nursing models and theory-based interventions and their outcomes. The term holistic is not restricted to complementary, alternative, and integrative health interventions but is rather an umbrella term that may occasionally encompass best practices of the medical model particularly when combined with a specific holistic nursing intervention.

Articles sought for publication in *HNP* include the following themes: innovations in holistic nursing practice, exploration of controversies inherent in holistic nursing practice and health care; empirical and historical research related to holistic nursing practice, health care and policy, and values and ethical-legal issues related to holistic nursing practices. The holistic approach is a worldview that emphasizes the potential for health and healing in human systems rather than on disease process and deficit. Projected topics for future publication are listed on the front of each issue. These topics should not limit submission of articles on other topics by prospective authors. As the scope of the journal may change from time to time, the Editor reserves the right to reject articles not deemed a good fit before sending out for full peer review.

**Research and theory articles:** All types of *empirical research*, including descriptive, quasi-experimental, experimental, basic, and applied. Research articles should include a clear and concise summary of the purpose and problem, a statement of the hypothesis tested, background and significance, theoretical framework, design, methods and procedures, analyses of data, findings, conclusions, and implications for further research and nursing practice. *Historical research* articles dealing with the history of holistic theory, holistic nursing and health care practices, policy, or related health care issues.

**Theory articles:** Analyses of holistic concepts and theories germane to nursing intervention and health care. Such articles should include concise classic and modern literature reviews of the concept or theory and implications for nursing practice or research.

**Nursing practice, education and leadership articles:** Articles on innovative or best practices in nursing/holistic care or related fields.

Articles on integrating holistic care concepts in care delivery, management of care and teaching.

**Creative pieces:** Poetry or brief creative essays or thought pieces related to holistic nursing care or human experiences related to health care such as self-healing.
INSTRUCTIONS FOR AUTHORS

Manuscript Preparation

Manuscripts must be formatted according to the following instructions or they will be returned for corrections before undergoing peer review:

Abstract. The Abstract should briefly summarize the major issue, problem, or topic being addressed, and the findings and/or conclusions of the manuscript. No more than 50 words. Do not cite references in the abstract. Spell out abbreviations and acronyms.

Title page. The title page must be submitted as a separate file when you are instructed to attach files to your submission. This allows Editorial Manager to generate a reviewer copy that contains no author identification. Also, be sure to include on the title page: (a) Complete manuscript title; (b) all contributing authors' information, including full names, highest academic degrees and any honorary degrees in order of bestowal, any organization affiliations; (c) name and address for correspondence, including fax number, telephone number, and e-mail address; and (d) any acknowledgements, credits or disclaimers. Note: HNP will not publish degree candidacies such as PhD(c).

Disclosure. All sources of funding and possible conflicts of interest must be disclosed on the title page, including consultant, institutional, and other relationships that might lead to bias or a conflict of interest. If there is no conflict of interest, this should also be explicitly stated as none declared.

Please list this information with the heading "Conflicts of Interest and Source of Funding." For example:

Conflicts of Interest and Source of Funding. A has received honoraria from Company Z. B is currently receiving a grant (#12345) from Organization Y, and is on the speaker's bureau for Organization X - the CME organizers for Company A. For the remaining authors none were declared.

Please be sure to specify all funding from any of the following organizations: National Institutes of Health (NIH); Wellcome Trust; Howard Hughes Medical Institute (HHMI); and other(s) who may require open public access to the article after publication.

Main Manuscript: The manuscript will be submitted as a separate file when you are instructed to attach files to your submission. Please note the following guidelines for preparing your manuscript:

- Prepare the manuscript double spaced in Microsoft Word. Leave a 1-inch margin on all sides. Allow a ragged right margin for text — not justified.
- Type all headings on a separate line. Do not number headings.
- Number all manuscript pages consecutively in the upper right-hand corner (text and references, followed by illustrations on separate pages).
- All legends for Tables and Figures are to be included at the end of manuscript after the list of references. Tables and Figures are attached as separate files when
you reach "attach files" in the submission process. Further instructions for preparing figures are given below.

- Although *HNP* does not specify a font or point size, in general a 12-point serif or 11-point sans serif font will result in the preferred manuscript length.
- No identifying information (authors' names) should be included on the manuscript. However, if you cite your own works, please list them just as you would any other reference.
- Write out the full term for each abbreviation or acronym at its first use unless it is a standard unit of measure. Include the acronym in parentheses after the full term; thereafter, please use the acronym consistently.
- Please refer to the *American Medical Association Manual of Style*, 10th edition, copyright 2007, for citations and references. See examples for citations and references below.

**References, Citations & Examples:** The authors are responsible for the accuracy of the references. Key the references (double-spaced) at the end of the manuscript.

In accordance with AMA Style, cite the references in text in the order of appearance. Cite unpublished data—such as papers submitted but not yet accepted for publication and personal communications, including e-mail communications in parentheses in the text. Personal communications may require written permission; please specify whether the communication is oral or written.

Citation generators available online may be helpful if you are unfamiliar with AMA style or if the references are already in another style such as APA. Papers submitted in APA style will be returned to the author for reformatting before peer reviewers are invited. Examples of citations within the text and reference list style are as follows:

**Citation:** Reliability has been established previously.1,2-8,19

**Citation following a quote:** Jacobsen concluded that "the consequences of muscle strength..."5(pp3,4)

**Reference list: Books**

**Reference list: Journal articles (with abbreviated journal names)**

**Reference list: unpublished material**

**Reference list: dissertation and thesis**
Reference list: World Wide Web

Reference list: Journal using DOI numbers

Reference list: Online Journal with parallel print presence

Reference list: Online-only Journal (no page numbers, no DOI)

Tables and Figures:
A) Creating Digital Artwork
1. Learn about the publication requirements for Digital Artwork: http://links.lww.com/ES/A42
2. Create, Scan and Save your artwork and compare your final figure to the Digital Artwork Guideline Checklist (below).
3. Upload each figure to Editorial Manager in conjunction with your manuscript text and tables.

B) Digital Artwork Guideline Checklist
Here are the basics to have in place before submitting your digital artwork:
- Artwork should be saved as TIFF, EPS, or MS Office (DOC, PPT, XLS) files. High resolution PDF files are also acceptable.
- Crop out any white or black space surrounding the image.
- Diagrams, drawings, graphs, and other line art must be vector or saved at a resolution of at least 1200 dpi. If created in an MS Office program, send the native (DOC, PPT, XLS) file.
- Photographs, radiographs and other halftone images must be saved at a resolution of at least 300 dpi.
- Photographs and radiographs with text must be saved as postscript or at a resolution of at least 600 dpi.
- Each figure must be saved and submitted as a separate file. Figures should not be embedded in the manuscript text file.

Remember:
- Cite figures consecutively in your manuscript.
- Number figures in the figure legend in the order in which they are discussed.
Upload figures consecutively to the Editorial Manager web site and enter figure numbers consecutively in the Description field when uploading the files.

**Tables:** Create tables using the table creation and editing feature of your word processing software; do not use Excel or comparable spreadsheet programs. Cite tables consecutively in the text, and number them in that order. Each table should appear on a separate page and should include the table title, appropriate column heads, and explanatory legends (including definitions of any abbreviations used). Do not embed tables within the body of the manuscript. They should be self-explanatory and should supplement, rather than duplicate, the material in the text.

**Supplemental Digital Content**
Authors may submit certain types of Supplemental Digital Content (SDC) via Editorial Manager to *HNP* to be considered for online posting. SDC is subject to editorial approval and, if approved, will be included with the manuscript when it undergoes peer review. Materials may include text documents, graphs, audio, or video files that meet formatting requirements. For a list of all available file types and detailed instructions, please visit [http://links.lww.com/A142](http://links.lww.com/A142).

On the Attach Files page of the submission process, please select Supplemental Audio, Video, or Data as appropriate before uploading the file as the Submission Item. If an article with SDC is accepted, production staff will create a live URL in the article linking to the SDC file. The URL will be placed in a call-out within the article. SDC files are not copy-edited by LWW staff and will be presented digitally as submitted and approved by editorial staff.

**SDC Call-outs**
Supplemental Digital Content must be cited consecutively in the text of the submitted manuscript. Citations should include the type of material submitted (Audio, Figure, Table, etc.), be clearly labeled as "Supplemental Digital Content," include the sequential list number, and provide a description of the supplemental content. All descriptive text should be included in the call-out as it will not appear elsewhere in the article.

**Example:** We performed many tests on the degrees of flexibility in the elbow (see Video, Supplemental Digital Content 1, which demonstrates elbow flexibility) and found our results inconclusive.

**List of Supplemental Digital Content**
A listing of Supplemental Digital Content must be submitted at the end of the manuscript file. Include the SDC number and file type of the Supplemental Digital Content. This text will be used by production staff and removed from the article before publication.

**Example:** Supplemental Digital Content 1. wmv

**SDC File Requirements**
All acceptable file types are permissible up to 10 MBs. For audio or video files greater than 10 MBs, authors should first query the journal office for approval. For a list of all available file types and detailed instructions, please visit [http://links.lww.com/A142](http://links.lww.com/A142).
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FAQ for open access
http://www.wkopenhealth.com/openaccessfaq.php

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Acceptance
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## APPENDIX C

### PALLIATIVE CARE QUIZ

<table>
<thead>
<tr>
<th>Items</th>
<th>True</th>
<th>False</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration</td>
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<tr>
<td>2. The extent of the disease determines the method of pain treatment</td>
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<tr>
<td>3. Adjuvant therapies are important in managing pain</td>
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<tr>
<td>4. Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain</td>
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<td>5. During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation</td>
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<tr>
<td>6. Drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnea</td>
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<tr>
<td>7. Individuals taking opioids should be assessed and treated for constipation</td>
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<tr>
<td>8. A high dose of opioid causes life to end for the imminently dying</td>
<td></td>
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<tr>
<td>9. The philosophy of palliative care is compatible with that of aggressive treatment</td>
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<tr>
<td>10. Patient/family's medical decision-making is influenced by culture</td>
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<td></td>
<td></td>
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<tr>
<td>11. Spiritual assessment is within the scope of nursing practice</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>12. Suffering and physical pain are the same</td>
<td></td>
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<tr>
<td>13. Manifestation of chronic pain and acute pain are the same</td>
<td></td>
<td></td>
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<tr>
<td>14. The pain threshold is lowered by anxiety and fatigue</td>
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</tbody>
</table>
APPENDIX D

SUPPORTIVE CARE PROTOCOL

COUNTY OF LOS ANGELES  LAC+USC MEDICAL CENTER  DEPARTMENT OF HEALTH SERVICES
NURSING CLINICAL PROTOCOL

SUPPORTIVE CARE

PURPOSE: To outline the nursing management of seriously ill patients in adult acute care. This Protocol may be implemented for patients who have potentially life-limiting, life-threatening, or chronic progressive illnesses.

SUPPORTIVE DATA: Supportive care is care that focuses on relieving symptoms caused by serious illnesses. Serious illness can affect a patient’s physical, emotional, and spiritual well-being. Supportive care can be provided at any point during an illness to help the patient feel more comfortable.

There are evidence-based independent nursing interventions that can provide comfort for patients and families experiencing serious illness.

ASSESSMENT: 1. Assess the following upon admission and with significant change in condition or diagnosis:
   - Patient and/or family’s personal perception of current illness
   - Anxiety and subjective depression
   - How has the illness influenced the meaning of:
     - Work and/or role function
     - Family and/or relationships
     - Inner strength and hope

2. Assess the following a minimum of every shift:
   - Mental status (including mood and presence of delirium)
   - Presence of dyspnea and breathing pattern
   - Appetite/thirst
   - Discomfort/pain (Ryan et al., 2013)
   - Energy level/fatigue (Patterson, Wan, & Sidani, 2013)
   - Sleep pattern
   - Bowel function
   - Coping with illness/progression/prognosis

MANAGEMENT: 3. Provide active listening to patient and family regarding response to illness and treatment plan.
4. Support patient in the use of breathing exercise as needed (Ducloux, Guisado, & Pautex, 2013)
5. Offer music and/or guided imagery. (McConnell, Scott, & Porter,
7. Provide mouth care with ice cold oral swabs and apply lip moisturizer for dry mouth/lips or thirst. (Puntillo, Arai, Cooper, Stotts, & Nelson, 2014)
8. Offer a hand-held fan to patient/family for discomfort related to dyspnea. (Booth, Galbraith, Ryan, Parker, & Johnson, 2016)
9. Position for comfort based upon patient preference. (Corcoran, 2013)
10. Alter standard turning schedule when imminent death is established (e.g. minimize turning if it causes discomfort. (Langemo, Haesler, Naylor, Tippett, & Young, 2015)
11. Cluster night time nursing activities to promote sleep (Ritmala-Castren, Virtanen, Leivo, Kaukonen, & Leino-Kilpi, 2015)

COLLABORATION: 12. Collaborate with
- Chaplain regarding spiritual support
- Dietitian regarding food preference and nutrition support
- Skin care resource nurse regarding support surfaces for comfort
- Social worker regarding:
  - individual and/or family distress
  - grief and/or bereavement support
  - subjective depression and anxiety
- Palliative Care nurse regarding need for advance care planning
- Physician regarding need for Palliative Care consultation and/or Comfort Care Orders

PATIENT/FAMILY TEACHING 13. Instruct on the following:
- Purpose of interventions
- Importance of reporting the effects of interventions
- Importance of reporting worsening symptoms and/or distress

ADDITIONAL PROTOCOLS: 14. Refer to the following as indicated:
- Pain Management

DOCUMENTATION: 15. Document in accordance with documentation standards.
16. Document assessment findings and interventions applied
17. Document patient/family response to interventions
<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
<th>Score</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dyspnea Scale</strong></td>
<td>Not at all breathless</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td><strong>Thirst Intensity</strong></td>
<td>Not thirsty at all</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td><strong>Fatigue</strong></td>
<td>No fatigue</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td><strong>Subjective Depression</strong></td>
<td>Not depressed at all</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>
**Bowel Function Index** (Ueberall, Müller-Lissner, Buschmann-Kramm, & Bosse, 2011)

1. **Ease of defecation**
   - No Problem
   - Maximum Difficulty
   
<table>
<thead>
<tr>
<th>No Problem</th>
<th>Maximum Difficulty</th>
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<tbody>
<tr>
<td>0</td>
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2. **Feeling of incomplete evacuation**
   - Complete
   - Severely Evacuation
   - Incomplete

<table>
<thead>
<tr>
<th>Complete</th>
<th>Severely Evacuation</th>
<th>Incomplete</th>
</tr>
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<tr>
<td>0</td>
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<td>10</td>
</tr>
</tbody>
</table>

3. **Personal judgement of constipation**
   - No Problem
   - The worst constipation

<table>
<thead>
<tr>
<th>No Problem</th>
<th>The worst constipation</th>
</tr>
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<tbody>
<tr>
<td>0</td>
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</tbody>
</table>
### COMMON SIGNS AND SYMPTOMS OF IMMINENT DEATH

<table>
<thead>
<tr>
<th>Assessment finding</th>
<th>Suggested interventions</th>
</tr>
</thead>
</table>
| Anxiety/Agitation                | Talk to patient  
Collaborate with physician regarding sedation needs                                                                                                                                                                  |
| Increasingly anorexic            | Avoid force feeding the patient  
Reinforce to family that nutritional needs diminish due to decreased level of activity                                                                                                                                 |
| Confusion                        | Orient to the environment                                                                                                                                                                                                  |
| Delirium                         | Collaborate with physician regarding need for sedation                                                                                                                                                                    |
| Dysphagia                        | Collaborate with physician regarding medication route and need for oral intake                                                                                                                                              |
| Dyspnea                          | Position upright; prop with pillows  
Use hand-held fan  
Explain to family that oxygen is not likely to help when patient is nearing death                                                                                                                                   |
| Pain                             | Offer music and/or guided imagery  
Pain Management Protocol  
Medicate as indicated                                                                                                                                                                                                     |
| Perceptual variance/hallucinations (seeing and talking to people who have died) | Explain to family that this is common and expected.  
Assess for agitation and presence of fear  
Ensure safety                                                                                                                                                                                                               |
| Respiratory secretions (gurgling/rattling sound) | Position patient with head of the bed up and side-lying  
Suctioning is rarely needed  
Gentle suctioning of the mouth, throat and nasopharynx may be appropriate  
Collaborate with physician regarding medication for secretion management                                                                                                                                            |

Resources: Decedent Affairs: (323) 409-7161
References


## APPENDIX E

### TABLES OF EVIDENCE

**Barriers to Palliative Care in the Acute Care Setting**

<table>
<thead>
<tr>
<th>Title, Author(s), Year</th>
<th>Methodology</th>
<th>Sample &amp; Setting</th>
<th>Findings</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effects of Palliative Care Consultation on DNR Status of African-American in a Safety-net Hospital, (Joseph Sacco, Carr, &amp; Viola, 2013)</td>
<td>Retrospective review, Descriptive</td>
<td>N= 1999, 1113 African-Americans, 886 Hispanics, Bronx Lebanon Hospital, NY</td>
<td>Patients elects DNR at a higher rate when received Palliative Medicine Consultation</td>
<td>Socioeconomic disadvantage, Social disparity, Cultural factor, Deceptive title, Similar local context as Project</td>
</tr>
<tr>
<td>Patient and Family Perceptions of Palliative Care in Heart Failure (Metzger et al., 2013)</td>
<td>Qualitative, Descriptive</td>
<td>Purposeful sampling, Large tertiary academic medical center in upstate NY</td>
<td>Themes identified: 1. Lack of knowledge of PC, 2. PC is supportive, 3. Participants had a sense of prognosis, 4. Confusion of PC and hospice is a barrier</td>
<td>Might be a problem across settings, Staff, providers, and patients</td>
</tr>
<tr>
<td>Palliative care referral among patients</td>
<td>Correlational, Retrospective chart review</td>
<td>N = 2001</td>
<td>Low PC referral rate (6%)</td>
<td>Physician reluctance to talk was based on other studies</td>
</tr>
<tr>
<td>Title, Author(s), Year</td>
<td>Methodology</td>
<td>Sample &amp; Setting</td>
<td>Findings</td>
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</tbody>
</table>
| Palliative Care Provision in Emergency Department: Barriers Reported by Emergency Physicians (Sangeeta Lamba, Roxanne Nagurka, Adrian Zielinski, & Sandra R. Scott, 2013) | Anonymous survey of ED physicians 23 statements 5 point Likert scale          | N = 30 Urban, tertiary teaching hospital Newark, New Jersey | Lack of 24-hour PC team  
Lack of access to complete medical records  
Physicians lack education & training  
Communication  
ED physicians would like to initiate PC consult for hospice patient in 
respiratory distress, massive intracranial bleed, sudden traumatic arrest, and metastatic cancer | Small convenient sample  
Survey constructed by author – not tested for reliability/validity  
Institution - similar to DNP Project local context |
| Barriers to the Detection and Management of Depression by Palliative Care Professional Carers Among their Patients: Perspectives from Professional Carers and Patients’ Family members | Qualitative Focus groups Semi-structured interviews | 10 family members 18 professionals working in palliative care Melbourne, Australia | Themes:  
Lack of knowledge training, confidence to recognize depression  
Professional care givers reluctant to go into the discussion of end-of-life related depression | Australia  
Considered due to family as unit of care  
Evidence may be very similar, in the US  
Lack of knowledge in EOL care is documented in older literature |
<table>
<thead>
<tr>
<th>Title, Author(s), Year</th>
<th>Methodology</th>
<th>Sample &amp; Setting</th>
<th>Findings</th>
<th>Notes</th>
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<tbody>
<tr>
<td>(Mellor, McCabe, Davison, Goldhammer, &amp; Hallford, 2013)</td>
<td></td>
<td></td>
<td>Physical concerns, time constraints</td>
<td>Lack of collaboration with family to find out about emotional concerns</td>
</tr>
<tr>
<td>Association Between a Name Change from Palliative to Supportive Care and the Timing of Patient Referral at a Comprehensive Cancer Center (Dalal et al., 2011)</td>
<td>Retrospective chart review before and after name change</td>
<td>N = 4,701 charts reviewed all who received a PC consult</td>
<td>Perception of Palliative Care as the same as Hospice care</td>
<td>Stigma in the name “Supportive care” made it less distressing</td>
</tr>
<tr>
<td>Overcoming Barriers to Palliative Care Consultation, (Ouimet Perrin &amp; Kazanowski, 2015)</td>
<td>Review</td>
<td>NA</td>
<td>• Misunderstanding both patient and HCP about Palliative Care • Reluctance of HCP to bring up conversation about PC • Cultural issues – ICU culture - Patient/family - linguistic barriers • Moral distress among ICU nurses due to lack of involvement in decision making</td>
<td>Expert opinion Suggests strategies Using triggers to initiate PC consult as nursing advocacy</td>
</tr>
<tr>
<td>Title, Author(s), Year</td>
<td>Methodology</td>
<td>Sample &amp; Setting</td>
<td>Findings</td>
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<tr>
<td>ICU Nurses’ Experiences in Providing Terminal Care, (Espinosa et al., 2010)</td>
<td>Descriptive phenomenology</td>
<td>N = 18 ICU nurses</td>
<td>Barriers to optimal care: lack of involvement, philosophical difference, disagreement among physicians, perception of futile care, unrealistic expectation from the family, and lack of education</td>
<td>Identified the need for protocols or guidelines for nursing care</td>
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<tr>
<td></td>
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<td>Internal conflicts by the nurse</td>
<td>Education</td>
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<td></td>
<td></td>
<td></td>
<td>• Relieved when PC starts</td>
<td>Possible need for staff support</td>
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<td></td>
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<td></td>
<td>• Wants pt to be comfortable and family to have good memories</td>
<td>Better communication</td>
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<td></td>
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<td></td>
<td>• Guilty to withdraw tubes</td>
<td>Encouraging positive coping</td>
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<td></td>
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<td>• Uncomfortable giving large doses of meds</td>
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<td>• Difficult if patients are young</td>
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<td></td>
<td>Effective and ineffective coping</td>
<td></td>
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<tr>
<td>Interpreting at the EOL: A systematic Review of the Impact of Interpreting on the delivery of PC Services to Cancer Patients with LEP, (M. D. Silva et al., 2016)</td>
<td>Systematic review</td>
<td>10 articles from 3 English speaking countries</td>
<td>Using professional and bilingual staff interpreters improved QOL for LEP patients receiving PC</td>
<td>Using family members distressed the family members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>United States</td>
<td>Not using professional interpreter</td>
<td>Using children resulted in maladaptive behaviors for the children</td>
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<td></td>
<td></td>
<td>England</td>
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<td>Australia</td>
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<td>Title, Author(s), Year</td>
<td>Methodology</td>
<td>Sample &amp; Setting</td>
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<tr>
<td>Knowledge of Palliative Care: An Evaluation of Oncology, Intensive Care and Heart Failure Nurses, <em>(Autor, Storey, &amp; Ziemba-Davis, 2013)</em></td>
<td>Survey using the PCQN RN Groups were divided to Oncology nurses, ICU nurses, and heart failure nurses</td>
<td>N = 143 Large tertiary hospital in Indiana, USA</td>
<td>Nurses overall did not fully understand PC Misconception Nurses did not know when PC was appropriate Did not know that PC is compatible with aggressive treatment Oncology nurses scored better, yet scores indicate misconceptions about PC</td>
<td>PCQN is standardized (20 item T/F)</td>
</tr>
<tr>
<td>Palliative Care Needs of Seriously ill, Older Adults Presenting to the Emergency Department <em>(Grudzen et al., 2010)</em></td>
<td>Cross-sectional structured survey</td>
<td>N = 50 &gt; 65 years old With at least 1 of seven select serious illness and functional deficit Large urban tertiary hospital</td>
<td>Older patients seen in the ED have unmet PC needs - Physical symptoms - Finances - Mental health - Access to care ED lacks resources for PC provision Presence of moderate to severe fatigue, dyspnea, pain and depression</td>
<td>Process barrier Resource allocation</td>
</tr>
<tr>
<td>Title, Author(s), Year</td>
<td>Methodology</td>
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<td>Communication About Advance Directives and EOL Care Options Among Internal Medicine Residents, (Rhodes et al., 2015)</td>
<td>Cross sectional survey</td>
<td>N = 83</td>
<td>Residents felt confident that they can communicate with patients and families about EOL</td>
<td>Setting has established inpatient and outpatient PC services</td>
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<td></td>
<td>2 Cohorts comparison (2006 &amp; 2013)</td>
<td>Internal medicine residents</td>
<td>Residents thought that the barrier is the patients not fully understanding their illness and futility of resuscitation</td>
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<td></td>
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<td>Large urban tertiary hospital Texas</td>
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<tr>
<td>Early intervention of palliative care in hospitals: A systematic review of methods, barriers, and outcomes (Dalgaard, Bergenholtz, Nielsen, &amp; Timm, 2014)</td>
<td>Systematic review</td>
<td>44 articles between 2002 – 2012</td>
<td>Poor physician prognostication skills (COPD, CHF, and cancer)</td>
<td>Early integration of PC combined with EOL care discussions resulted in less aggressive treatments and better QOL</td>
</tr>
<tr>
<td></td>
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<td>Articles from US, UK, Europe, Australia</td>
<td>Clinicians reluctance to communicate prognosis</td>
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<td></td>
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<td></td>
<td>Staff misconception of PC as “terminal care”</td>
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<tr>
<td>Identifying the Barriers and Enablers to Palliative Care Nurses’ Recognition and Assessment of Delirium Symptoms: A Qualitative Study, (Hosie, Lobb, Agar, Davidson, &amp; Phillips, 2014)</td>
<td>Qualitative study</td>
<td>N = 30</td>
<td>Erroneous beliefs</td>
<td>Nurses in the study were PC nurses – may not be good for generalization to local context</td>
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<tr>
<td></td>
<td>Semi-structured interviews</td>
<td>PC inpatient Australia</td>
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<td></td>
<td>Lack of time</td>
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<td>Nursing workload pressures</td>
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<td>Lack of training</td>
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<td>Lack of delirium guide tools</td>
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<tr>
<td>Title, Author(s), Year</td>
<td>Methodology</td>
<td>Sample &amp; Setting</td>
<td>Findings</td>
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<tr>
<td>Feasibility and Economic Impact of Dedicated Hospice Inpatient Units for Terminally Ill ICU Patients’, (Binney et al., 2014)</td>
<td>Retrospective chart review</td>
<td>N = 358 charts</td>
<td>Nurses did not feel respected by other clinicians for their clinical assessment of delirium</td>
<td>Dedicated Hospice rooms are planned at project’s locale</td>
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<tr>
<td></td>
<td></td>
<td>Patients transferred to Dedicated Hospice Inpatient Unit</td>
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<td>&gt; 18-year-old</td>
<td>Feasible</td>
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<td>United States</td>
<td>There is cost savings</td>
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<td>Transfer did not shorten life</td>
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<td></td>
<td>Lack of staff knowledge</td>
<td></td>
</tr>
<tr>
<td>Palliative Care Teams’ Cost-Saving Effect is Larger for Cancer patients with Higher Numbers of Co-morbidity, (May et al., 2016)</td>
<td>None random assignment to control group (usual care) and PC consult</td>
<td>N = 906</td>
<td>Patients with more co-morbidities who receive PC consultation</td>
<td>Cost-savings</td>
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<tr>
<td></td>
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<td>193 (21%) of patients were seen by PC services</td>
<td></td>
<td>Suggests Policy change for workforce allocation</td>
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<tr>
<td></td>
<td></td>
<td>Large academic metropolitan hospital</td>
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<tr>
<td>Barriers to Using Palliative Care, (Drisdom, 2013)</td>
<td>Review of Literature</td>
<td></td>
<td>African-Americans are culturally cared for by family</td>
<td>Opinion</td>
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<td></td>
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<td>Trusts family to make EOL decisions</td>
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<td></td>
<td>Mistrust of medical establishment</td>
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<td></td>
<td>Physician communication</td>
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</tr>
<tr>
<td>Title, Author(s), Year</td>
<td>Methodology</td>
<td>Sample &amp; Setting</td>
<td>Findings</td>
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<tr>
<td>Assessment of Hospital-based Palliative Care in Maryland: Infrastructure, Barriers, and opportunities, (Gibbs Jr et al., 2015)</td>
<td>Survey of hospitals</td>
<td>N = 28 hospitals In Maryland</td>
<td>Plans to expand PC services were not planning to increase budget</td>
<td>Laws in Maryland require PC Resource allocation is a barrier</td>
</tr>
</tbody>
</table>

*Notes: NY = New York; PC = Palliative care; ED = Emergency Department; HCP = Health care provider; EOL = End-of-Life; LEP = Limited English Proficiency; QOL = Quality of Life; PCQN = Palliative Care Quiz for Nurses*
### Palliative Care Clinical Practice Guidelines

<table>
<thead>
<tr>
<th>Title, Author(s), year</th>
<th>Methodology</th>
<th>Country/Sponsor</th>
<th>Assessment</th>
<th>Intervention/Management</th>
<th>CIH interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>(National Quality Forum, 2016)</td>
<td>Expert consensus, Systematic review, Rating of Evidence</td>
<td>United States, Public-private partnership</td>
<td>Pain screening, Physical symptoms, Psychological, Social, Spiritual</td>
<td>None specified</td>
<td>Cultural aspect of care: Preferred Practice 24 – Assess for the desire for supportive measure such as complementary and alternative medicine</td>
</tr>
<tr>
<td>Palliative care for adults</td>
<td>Systematic reviews</td>
<td>United States</td>
<td>Criteria to initiate PC, Common symptoms, Food preferences, Psychological, Risk for suicide</td>
<td>Make referrals</td>
<td>Low quality often strong Recommendation Need for further studies</td>
</tr>
<tr>
<td>Institute for Clinical Systems Improvement, (2013)</td>
<td>Systematic reviews, RCT, Meta-analysis</td>
<td>United States</td>
<td>Criteria to initiate PC, Common symptoms, Food preferences, Psychological, Risk for suicide</td>
<td>Make referrals</td>
<td>Low quality often strong Recommendation Need for further studies</td>
</tr>
<tr>
<td>A Model to Guide Hospice Palliative Care, Canadian Hospice Palliative Care Association (2013)</td>
<td>Expert consensus, Review of other US guidelines</td>
<td>Canada</td>
<td>Assessment of each of the eight Domains per National Consensus Project</td>
<td>Inter-professional responsibility to share info about Palliative Care Care planning is person and family centered</td>
<td>None mentioned</td>
</tr>
<tr>
<td>Title, Author(s), year</td>
<td>Methodology</td>
<td>Country/Sponsor</td>
<td>Assessment</td>
<td>Intervention/Management</td>
<td>CIH interventions</td>
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<td></td>
<td>Palliative Care Physicians</td>
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<td>3. Psychological and psychiatric</td>
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<td>Physical Psychological</td>
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<td>4. Social aspects</td>
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<td>5. Spiritual, religious, and existential</td>
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<td>6. Cultural aspect</td>
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<td>7. Care at the End-of-life</td>
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<td>8. Ethical and legal</td>
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</table>

*Note: CIH = Complementary and Integrative Health PC = Palliative Care, RCT = Randomized Controlled Trial, NIH = National Institutes of Health, CACP = Center to Advance Palliative Care, NINR = National Institute of Nursing Research*
## Complementary and Integrative Interventions

<table>
<thead>
<tr>
<th>Title, Author(s), year</th>
<th>Methodology</th>
<th>Sample &amp; Setting</th>
<th>Measures</th>
<th>Results</th>
<th>Author Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A random clinical trial of an intervention to relieve thirst and dry mouth in ICU patients (Puntillo et al., 2014)</td>
<td>Randomized clinical trial</td>
<td>N = 252</td>
<td>NRS 0-10</td>
<td>TI and TD scores decreased between pre-procedure and post-procedure significant p &lt; 0.05</td>
<td>Simple</td>
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<tr>
<td></td>
<td>Single blinded</td>
<td>ICU tertiary medical center in urban California</td>
<td>Thirst intensity (TI)</td>
<td>Thirst distress (TD)</td>
<td>Inexpensive</td>
</tr>
<tr>
<td></td>
<td>DV: Thirst intensity</td>
<td>Thirst distress</td>
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<td></td>
<td>Safe</td>
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<td>IDV</td>
<td>Thirst bundle</td>
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<td></td>
<td></td>
<td>- Oral swab wipes</td>
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<td>- Sterile ice water spray</td>
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<td>- Lip moisturizer</td>
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<tr>
<td></td>
<td>Expert advisement</td>
<td>NIH - sponsored</td>
<td>Dyspnea</td>
<td>Massage, music therapy, relaxation techniques</td>
<td>Dyspnea:</td>
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<td>Thirst</td>
<td>Positioning</td>
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<td>Fan</td>
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<td>Cold cloth on face</td>
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<td>Thirst:</td>
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<td></td>
<td>Frozen gauze pads w/saline, olive oil, xylitol, artificial saliva</td>
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<td>Thirst intervention bundle</td>
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<tr>
<td>Does the Use of a Handheld Fan Improve Chronic Dyspnea? A Randomized Controlled, Crossover Trial</td>
<td>Randomized controlled crossover trial</td>
<td>N = 49</td>
<td>Dyspnea</td>
<td>Not significant</td>
<td>Low cost</td>
</tr>
<tr>
<td></td>
<td>DV - Dyspnea</td>
<td>Inpatient wards</td>
<td>VAS (1-10 cm)</td>
<td>Not a long enough wash out period</td>
<td>Self-directed</td>
</tr>
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<td></td>
<td></td>
<td>Outpatient</td>
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<td></td>
<td>Practical</td>
</tr>
<tr>
<td>Title, Author(s), year</td>
<td>Methodology</td>
<td>Sample &amp; Setting</td>
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<td>Results</td>
<td>Author Conclusion</td>
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</tr>
<tr>
<td>(Galbraith, Fagan, Perkins, Lynch, &amp; Booth, 2010)</td>
<td>IDV Battery operated fans</td>
<td>Patient homes</td>
<td>Dyspnea</td>
<td>Low power</td>
<td>Safe</td>
</tr>
<tr>
<td></td>
<td>Fan to leg then face</td>
<td>England</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fan to face then leg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The importance of the feasibility study: Lessons from a study of the hand-held fan used to relieve dyspnea in people who are breathless at rest. (Booth et al., 2016)</td>
<td>Observational</td>
<td>N = 31</td>
<td>Inpatient and outpatient</td>
<td>Moderate effect size</td>
<td>Low cost</td>
</tr>
<tr>
<td></td>
<td>Fanned then no fan</td>
<td>England</td>
<td>VAS NRS</td>
<td>VAS and NRS dyspnea measurements were different</td>
<td>Self-directed</td>
</tr>
<tr>
<td></td>
<td>Wait until back to baseline (wash out)</td>
<td></td>
<td></td>
<td>VAS ES = -0.47</td>
<td>Practical</td>
</tr>
<tr>
<td></td>
<td>Then fanned until relief plateau</td>
<td></td>
<td></td>
<td>NRS ES = -0.48</td>
<td>Safe</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Established washout period</td>
<td></td>
</tr>
<tr>
<td>Meditative Therapies for Reducing Anxiety: A Systematic Review and Meta-analysis of Randomized Controlled Trials. (Chan et al., 2012)</td>
<td>Systematic review and meta-analysis</td>
<td>N = 36 RCT</td>
<td>Anxiety as a secondary concern – not as clinical diagnosis</td>
<td>25/36 had statistically better outcomes in anxiety</td>
<td>Studies are small</td>
</tr>
<tr>
<td></td>
<td>DV: Anxiety</td>
<td>United States</td>
<td></td>
<td>Low cost</td>
<td>Safe</td>
</tr>
<tr>
<td></td>
<td>IDV: Meditation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meditation Programs for Psychological Stress and Well-being: A Systematic Review and Meta-analysis. (Goyal et al., 2014)</td>
<td>Systematic review and meta-analysis</td>
<td>N = 47 trials</td>
<td>Outcomes: - Anxiety</td>
<td>ES: Anxiety 0.38</td>
<td>Long programs</td>
</tr>
<tr>
<td></td>
<td>Funded by Agency for Healthcare Research and Quality</td>
<td>United States</td>
<td>- Depression</td>
<td>Depression 0.22</td>
<td>Low cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Pain</td>
<td>Pain 0.23</td>
<td>Safe</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Stress/distress</td>
<td></td>
<td>Stress/distress low evidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Health-related QOL</td>
<td></td>
<td>Health-related QOL – low evidence</td>
</tr>
<tr>
<td>Title, Author(s), year</td>
<td>Methodology</td>
<td>Sample &amp; Setting</td>
<td>Measures</td>
<td>Results</td>
<td>Author Conclusion</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Evaluation of Effects of Lavender and Peppermint Aromatherapy Using Sensitive Salivary Endocrinological Stress markers (Toda &amp; Morimoto, 2011)</td>
<td>Randomize controlled trial</td>
<td>N = 21 Osaka University students</td>
<td>Salivary Cortisol A marker for stress Chromogranin A A marker for eustress</td>
<td>Peppermint group had lower salivary cortisol and higher Chromogranin A levels (p &lt; 0.05)</td>
<td>Small sample size Safe Low-cost</td>
</tr>
</tbody>
</table>

**Note:** Pts = Patients; PC = Palliative Care; DV = dependent variable; IDV = independent variable; CV = Confounding variable; RCT = Randomized Controlled Trial; NRS = Numeric Rating Scale; VAS = Visual Analog Scale; QOL = Quality of Life; CIN = Chemotherapy induced nausea; ES = Effect size
APPENDIX F

PERMISSION TO USE iPARIHS FIGURE

Jutharatana Srivali Teal <jutara@csu.fullerton.edu>
5/25/16
to alison.kitson
Dear Dr. Kitson,

I am a nursing doctoral student at California State University, Fullerton. I am creating a palliative care protocol for an acute care setting. I would like to have your permission to use the i-PARIHS framework figure in my project.

Figure 1 in your article published in the Journal of Nursing Scholarship (Kitson, A., & Harvey, G., 2016) is exactly what my project needs to navigate and facilitate a practice change in a large health care organization.


Thank you in advance for your kind consideration.
Sincerely,
Jutara Srivali Teal, RN, LAc, MSN, MTOM
DNP Student
Alison Kitson <alison.kitson@adelaide.edu.au>

5/25/16
to Gillian, me
Dear Jutara,
Very happy for you to use the framework – if you need any help let us know!

Best wishes,
Alison and Gill.
APPENDIX G

IRB EXEMPTION

From: Phillip L. Moore
Sent: Tuesday, June 21, 2016 8:33:51 AM
To: Jutara Srivali Teal; Doris DeHart
Subject: RE: IRB Procedure & Forms

ok that would not be an IRB study, that is just an assessment. Are you working with the new Director over Palliative Care?

From: Jutara Srivali Teal
Sent: Tuesday, June 21, 2016 8:25 AM
To: Phillip L. Moore <phmoore@dhs.lacounty.gov>; Doris DeHart <ddehart@dhs.lacounty.gov>
Subject: Re: IRB Procedure & Forms

OK. Just want to make sure.
I am proposing to create a Palliative Care Protocol for nurses. The literature shows that nurses are not sufficiently knowledgeable on the topic of Palliative Care. I want to see if our nurses' knowledge levels at LAC+USC are similar. If they too lack the knowledge, then it would be necessary to remedy the situation by giving them tools to help them care for palliative care patients.

Jutara

From: Phillip L. Moore
Sent: Tuesday, June 21, 2016 6:16:28 AM
To: Jutara Srivali Teal; Doris DeHart
Subject: RE: IRB Procedure & Forms

Giving nurses a quiz would not constitute an IRB study.

1. ELNEC Fact Sheet. 2016.
