

# Palliative Care Education in the Acute-care Setting

REBECCA PIEKNIK, CST, CSA, MS, FAST

## LEARNING OBJECTIVES:

- Demonstrate an understanding of the meaning of palliative care
- Develop an understanding of the important issues related to palliative care
- Distinguish the types of education related to palliative care and the different staff levels
- Summarize the findings of the palliative care survey
- Demonstrate an understanding of a patient's prognosis and ways to coordinate communication between a patient and family.

The end-of-life phase is gaining recognition as an important aspect of life that is ignored until it is too late. This is a period in which individuals have the right to expect quality of life, pain and symptom control, and support for decisions about death and the effect it has on family members. Recommendations by the Institute of Medicine emphasize the need for action by clinicians, educators, researchers, policy makers and the public to strengthen the knowledge base for palliative care and treatment of symptoms common during the end of life.<sup>15</sup>

## Background

An exploratory study was done to assess the knowledge level of nursing staff and medical residents regarding palliative care. A questionnaire was developed that was distributed to several units within the acute-care hospital. These units included oncology, SICU and MICU, as well as pulmonary, patient safety and from the director of the palliative-care consultation service.

The major observation by the researcher was that 72% of the respondents felt there was not any formal or written material for staff regarding palliative care; although 24% of the staff acknowledged written material concerning hospice care. Over 83% of those surveyed identified a lack of education regarding pain management; however, 43% affirmed the acute-care hospital offered a half hour to one hour in-service concerning pain management. When queried, staff stated they were very comfortable in consulting residents and attending staff for pain management.

The study revealed several important factors that should be considered as planning for palliative-care services begins. The implementation of palliative care should include a core disciplinary team that consists of a physician, nurse, social worker, pharmacy and pastoral care. Consultations among these team members should focus on current and future treatment of patients identified for palliative care. This would aid patients in being transitioned to appropriate levels of care,

thereby reducing lengths of stay, especially in ICU. According to the data collected, pain management should be an essential component of any form of palliative care. It would be essential for the physician to work with pharmacy and nursing education to develop pain management protocol for writing orders. Through joint efforts between the physician, pharmacy and nursing education, pain relief can be addressed.

Through the choice of descriptors and qualitative data, respondents identified there was continuity in the use of bereavement support in every unit of patient care. Although staff could not identify any specific guidelines in the policy manuals, a referral to pastoral care by staff was commonplace to aid the patient in spiritual counseling or provide their family with bereavement support.

Significance was noted in the respondents' views on whether communication was appropriate between all disciplines that are involved in a patient's goals for care. Although nursing staff felt communication was appropriate, the director of patient safety felt attending physicians did not do as good of a job as the house staff in communication across the different disciplines. The findings of this study can be used to explore ways to improve the education process of palliative care and ways to implement outcomes for education regarding palliative care in the acute-care setting.

## Methodology

### *Scope and limitations*

This study was limited to the following units: staff from oncology (ONC), the medical intensive care unit (MICU), the surgical intensive care unit (SICU), the director of the palliative-care consultation service, medical director of patient safety and head of pulmonary medicine. Staff was randomly selected to answer the questionnaire. To facilitate the questionnaire's response, only those who expressed an interest or willingness to answer the questions were approached. Participants were assured they would be anonymous and that no specific patient information would be collected. It was assumed the questionnaire was completed honestly and accurately, and the participants did not feel intimidated, since their job performances were not being evaluated.

### *Selection of the survey tool*

As with any new procedure or drug used in medicine, education is the key factor in successfully implementing proper

protocol. The knowledge base of staff nurses, residents, as well as attending physicians would need to be identified in order to develop educational outcomes for the incorporation of palliative care to the acute-care hospital in the study. This data could provide valuable information regarding the knowledge level of staff in the different units who provide direct patient care in the hospital.

#### **Development of the questionnaire**

The survey selected was an open-ended questionnaire written by the researcher. It was chosen because of its straightforward method to obtain data. A 10-question survey was designed and used to collect data. (See sidebar.) As most patient-care providers are familiar with hospice care, a brief explanation of the difference between palliative and hospice care was provided. Staff nurses were asked to answer the questions as they related to their area of patient care. Physicians were asked to answer the questions as they related to the residents on their rotation.

#### **Selection of the sample**

This study is based on a selected representative sample of hospital employees who provide care to patients with progressive illnesses. They were selected on the following bases:

1. Five staff nurses were selected from the MICU.
2. Five staff nurses were selected from the SICU.
3. The medical director for the palliative-care consultation service was selected due to her contact with a variety of patients that request palliative as well as hospice care.
4. Seven staff nurses in the ONC unit were selected based on their knowledge regarding patients being supported with end-of-life care.
5. The medical director of patient safety works with house residents and fellows that oversee patient care in the hospital.
6. The medical director of pulmonary care oversees a patient base with respiratory problems.
7. The medical director for the palliative-care consultation service is spearheading the initiative to incorporate palliative care at the study hospital.

#### **Distribution of the questionnaire**

The questionnaire utilized in this research dictated the use of a combination of personal interview and respondent anonymity. Research approval for the questionnaire was obtained by the Human Investigation Committee (HIC) and approved by Nursing Development and Educational Resources

### **Palliative Care Questionnaire**

Palliative care concentrates on the quality of life for the patient and that of the family. It is planned treatment to relieve, rather than cure, symptoms caused by cancer or other terminal illnesses.

Palliative care is a comprehensive approach to treating serious illnesses that focuses on the physical, psychological, and spiritual needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, controlling pain and symptoms, and enabling the patient to achieve maximum functional capacity. Respect for the patient's culture, beliefs, and values are an essential component. Palliative care is sometimes called comfort care or hospice-type care.

Hospice care is an individualized program of support for people within the final stages of a terminal illness and their families. Hospice care may take place in the patient's home or in a hospice facility. The emotional, psychological, and spiritual care also includes the family, who continues to receive ongoing support even after the patient dies.

Hospice care is defined as a coordinated program for meeting the special physical, emotional, social and spiritual needs of dying individuals, by providing palliative and supportive services during the illness and bereavement to and on behalf of individuals who have no reasonable prospect of cure and, as estimated by a doctor, have a life expectancy of less than six months.

#### **What type of education is available at various staff levels regarding palliative care?**

1. How many hours of education are given to address pain management for patients?
2. What topics are covered during grand rounds or in-services regarding alternative therapies?
3. Is there training/guidelines established to assist staff in recognizing the patient's need for psychosocial counseling?
4. Is there an in-service or guidelines in place to assist staff in offering respite care? Does your staff know the difference in respite or palliative care?
5. What criteria/guidelines have been established to assist staff in writing orders for pain management? With whom would the staff confer if they have questions? Is your staff comfortable in writing orders for pain management?
6. What information is given to staff to assist in offering spiritual counseling and support in the hospital? Is your staff aware of spiritual counseling that is offered in the hospital?
7. How does the staff handle cultural sensitivity training when dealing with terminal and end-of-life patient issues?
8. What guidelines have been established to assist staff in offering bereavement support? Does your staff follow through with ways to offer bereavement support?
9. What means have been established to facilitate communication between the different disciplines with a patient's treatment goals? Does your staff aid in facilitation of communication regarding treatment goals?
10. What criteria/guidelines are available to assist staff in facilitating the transfer to hospice or palliative care? Is your staff comfortable in facilitating the transfer to hospice or palliative care?

**Table 1: Palliative-care questionnaire data, summarized by department**

Questions	MICU Nurses	SICU Nurses
What type of education is available at various staff levels regarding palliative care?		
No formal education for staff regarding palliative care	Two nurses stated there was none, only written info for hospice	One nurse identified an in-service
How many hours of education are given to address pain management?		
30 minute in-service for pain management	0 nurses recalled any in-service	Four nurses recalled a 30 minute session
Ongoing in-service for pain management	Four nurses agreed there was ongoing education	One nurse identified education in pain control
What topics are covered during in-services regarding alternative therapies?	Only three nurses knew of alternative therapy	Four nurses felt informed on alternative therapy
Healing touch therapy or massage therapy	One nurse had knowledge of touch therapy	
Is your staff comfortable in writing orders for pain management?		
Comfortable consulting residents and attending physicians for pain management		All surveyed were at ease in consults
Refer pain management to physicians	Staff preferred to refer to physicians	
Is there training established to assist staff in recognizing a patient's needs for psychosocial counseling?		
No specific training to recognize a patient's need for psychosocial counseling	Three nurses did not know of any training	All five nurses felt untrained
Patients were assessed upon admission to the unit on needs for psychological counseling	One nurse assessed patients upon admission	This unit did not assess patients
Are there guidelines in place to assist staff in offering respite care? Is it available?		
Are not aware of any respite care or guidelines	Only one nurse knew of respite guidelines	Four nurses were not aware of guidelines
What information is given to staff to assist in offering spiritual counseling and support? Are you aware of counseling offered in the hospital?		
Aware of pastoral care services and were comfortable referring patients to pastoral care.	Three nurses aware of services	Only two nurses referred patients to pastoral care
What guidelines have been established to assist in offering bereavement support? Does staff follow through with bereavement support?	All four knew established guidelines	All five nurses knew guidelines
No specific guidelines for bereavement except to contact pastoral care.		
What means have been established to facilitate communication between the different disciplines with a patient's treatment goals? Does your staff aid with facilitation of communication regarding treatment goals?	All four nurses aid in patient's goals	All five nurses aid in patient's goals
Nursing staff felt that communication was appropriate between all involved in a patient's care.		
What criteria /guidelines are available to assist staff in facilitating the transfer to hospice or palliative care? Is your staff comfortable in facilitating the transfer to hospice or palliative care?		
Hospital needs to offer more in house service and promoting the policies and procedures when it comes to hospice and palliative care. Staff is not comfortable.		One nurse felt there should be more education
Staff is comfortable in referring patients to hospice. The hospice representatives facilitate the transfer.	All four nurses knew guidelines in the transfer of care	All five nurses knew of guidelines for the transfer of care

<b>ONC Nurses</b>	<b>Director of Pulmonary</b>	<b>Director of Patient Safety</b>	<b>Director of Palliative Care</b>
	Not available for residents	Not sure	Not available for residents
One nurse identified an in-service			
	Rounds once a year	Informal verbal education	None regularly
Five nurses recalled a 30 minute in-service			
Two staff stated there was a pain control in-service			
Three nurses felt informed on alternative therapy	No alternative therapies discussed	Informal discussion held on options	No alternative therapies discussed
Four nurses knew of touch therapy			
	Comfortable using individual formulary	Residents use published algorithms	Residents use individual formulary
Only two nurses felt at ease to consult			
Five nurses referred patients to physicians			
	Residents not familiar with any training	Staff used some guidelines	None known
Four nurses did not recognize any training			
Four nurses used admission for assessing patient			
	Not aware of any	Staff refers patient to hospice	Residents call care counselor
Five nurses did not know of any respite care			
	Works closely with pastoral care	Residents offer pastoral care	Works with pastoral care
Six nurses referred patients to pastoral care			
All seven nurses knew of guidelines			
	Residents follow through by contacting pastoral care	Staff follows through by contacting pastoral care	Works closely with pastoral care
All seven nurses aid in patient's goals			
	There are no set standards for communication	House staff communicates better than attending physicians	
	Physicians do not discuss with patients. Usually a nurse handles the discussion	Consult director of palliative care/ lack of continuity of care for patient	Staff is aware of guidelines and work with director to transfer patients
One nurse felt there should be more education			
All seven nurses knew of guidelines for the transfer of care			

(NDER). As time was a factor, the survey was hand delivered to staff in the patient care units on March 31, 2005. Nurses were randomly selected by management to complete the survey. Surveys were mailed back through interdepartmental mail. There was an 80% return rate on surveys that were distributed in SICU and a 100% return rate from MICU and ONC patient care units. The questionnaire was presented to physicians who oversee residents that offer patient care. This allowed the opportunity for more detailed verbal feedback on the questions. Primary data was collected through the questionnaire.

### **Analysis of data**

The researcher summarized the data by utilizing a table for easy visualization of the information for comparison across the units (See Table 1).

### **Summary**

The findings of this study can and should be used to determine what kind of education is necessary for initiating palliative care as part of standard care within the study hospital and the value of that education in ensuring patient-care continuity across the different units at that hospital. The nature of the interviews varied. Face-to-face interviews were held with the physicians who supervise staff residents in these areas. The remaining questionnaires were answered and returned through interdepartmental mail.

### **Findings**

Nineteen percent acknowledged a one-hour workshop regarding the palliative-care concept, yet no indication of how it would or could impact their patients. This corresponds with findings of the 1995 Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT), which concluded that the utilization of specially trained nurse clinicians to facilitate communication with patients produced no statistical change in the patient's pattern of care.<sup>15</sup>

The nursing staff, as well as residents, could not identify any formal education in the hospital regarding palliative care. A general lack of knowledge about palliative care is hindering communication and discussion about care preferences for patients with progressive illnesses.

Palliative care is event and patient driven. It can be initiated at the time of diagnosis of a life threatening or debilitating condition, yet without staff being adequately informed about palliative care, initiation of palliative care is a challenge. Eighty percent of the staff in MICU could not identify any education regarding pain management, while 80% in SICU recalled a 30 minute in-service. Seventy two percent of the ONC unit that provides end-of-life care stated they had a 30 minute in-service and 28% felt there was on-going education regarding pain management.

The staff in MICU, SICU and oncology that answered the survey all stated they often referred the patient for pain management, although residents only received education during grand rounds once a year. MICU preferred to refer patients to physicians for pain management. Coincidentally, the SUPPORT study findings stated that 50% of hospitalized dying patients experienced moderate to severe unrelieved pain up to their deaths.<sup>15</sup> If nurses and physicians are to be advocates for their patients, failure to aid in pain and symptom control can be seen as failure to meet a patient's physiological needs.

Palliative care includes addressing a patient's psychosocial needs as it supports patients and families through a life-threatening illness. The statistics acknowledge that one out of every eight patients is identified for psychosocial counseling. This ratio falls far below expected rates for patient satisfaction. Forty-three percent of staff surveyed in MICU felt they had training in recognizing a patient's need for psychosocial counseling and only one nurse stated an assessment was done upon admission to the unit. Although 100% of the staff surveyed in SICU recognized a patient's need for counseling, only half of the ONC unit felt they could recognize the need for psychosocial counseling.

The Palliative Task Force at the acute-care hospital identified that pastoral care would be an important entity to any palliative-care service that might be offered. It has been recognized that "keystone rounds," which involve the residents, attending physicians and nursing staff, offer the opportunity for communication between the different disciplines regarding a patient's goals for care.

The ability to communicate between the different disciplines and family members ensures there is a commonality for each patient regarding treatment goals. This is accomplished through keystone rounds that take place daily on the units. However, the medical director of pulmonary care felt there was lack of communication in regard to the patient's goals of treatment. Residents and attending physicians are uncomfortable discussing end-of-life issues. According to the Reuters study, family end-of-life orders often exist for hospice patients, and feedback from the questionnaire supports that nursing staff is very comfortable calling for referrals to the hospice unit.<sup>3</sup>

The initial phase of palliative care for the study hospital will be based on a consultation service headed by the director of the palliative-care consultation service. According to a study done in 2002, the hospital would best be supported by an educational model of palliative care. This would include residents and fellows who would be supervised by the palliative-care physician. Currently, physicians are not adequately trained to handle the complexities of end-of-life care and pain management. The education model for palliative care should be multifaceted and include physicians, nurses, medical and nursing students, pastoral care and social workers.



Resources for education can be obtained from Education for Physicians in End of Life Care (EPEC) and include fundamental skills in communicating, ethical decision making, palliative care, psychosocial considerations, and pain and symptom management.<sup>11</sup> By identifying specific objectives, essential skills to palliative care can be learned. Core curricula should be established with ethical conferences that include end-of-life care, advance directives, limitation of treatment, futility, quality of life, as well as assisted suicide/euthanasia.

According to the National Institutes of Health, patients with progressive illness experience many symptoms and syndromes, such as difficulty breathing (dyspnea), and transient episodes of confusion and loss of concentration, nausea, fatigue, and depression.<sup>16</sup> These symptoms add considerably to the suffering of patients and their families, and to the cost and burden of medical care. Studies from the Center to Advance Palliative Care have documented patient demands regarding palliative care:

- Patients want vigorous treatment of their pain and symptoms.
- Patients want relief from worry, anxiety and depression.
- Patients want communication about their care over time.
- Patients want coordinated care throughout the multiple-year course of an illness.

The cornerstone of palliative care is to ensure that patients do not suffer from uncontrolled symptoms. Hospitals accredited by the Joint Commission on Accreditation of Health-care Organizations (JCAHO) are required to meet national standards for effective pain treatment. By instituting palliative care in the acute-care setting, the study hospital will be successful in meeting pain management and other quality standards set by JCAHO.<sup>16</sup>

Today's health care system can be very fragmented and complex as it attempts to meet the needs of the chronically ill, while at the same time strives to offer sophisticated care that requires tremendous coordination of time and staff. Palliative-care programs allow for staff to provide high-quality coordinated care to their patients.

### Recommendations

Based on the study the following recommendations can be made:

1. The director of the palliative-care consultation service will take calls for palliative-care consultations and bring in other team members as necessary. The core disciplinary team should consist of a physician, nurse, social worker, pharmacy and pastoral care. Consultations among these team members will focus on current and future treatment of patients identified for palliative care. Patients would be transitioned to appropriate levels of care. This will translate to reduced lengths of stay, especially in the ICU units. The consultation will serve

## Palliative care plan checklist

### Address short term medical progress and goals.

- Assess whether specific criteria toward progress have been met (eg mental status or ventilator needs). Has there been improvement, stability, or worsening in the past 24 hours?
- Are there clinical changes (eg new gastrointestinal bleeding) that will impact the patient's ability to meet desired clinical goals?
- Review interventions that may be needed in the next 48 hours and set overt criteria to measure progress (eg objective indicators of progress toward ventilator weaning).
- Use this information to review goals and determine whether changes in the prognosis can guide you, the patient, or the family in decision making.

### Address patient symptoms and psychosocial needs.

- Review progress in managing the current symptoms and psychosocial needs (patient and family).
- Identify existing or new physical symptoms and psychosocial needs (eg patient depression, family stress) and discuss among team members.
- Develop a treatment plan for each symptom/need for the next 24 hours.
- Identify both ICU and non-ICU resources (eg palliative care nurse, clinical psychologist, etc) to assist in the care plan and clarify roles for members of the interdisciplinary team.

### Clarify understanding of prognosis and coordinate patient/family communication.

- Review patient/family understanding and concerns about diagnosis, prognosis, possible outcomes, and details of the above items.
  - Inquire if the patient or significant others have new information or new perspectives that can help clarify the understanding of the patient's goals and preferences.
  - Decide if the goals of care need to be refined or changed.
  - Agree on specific criteria for the reassessment of clinical responses and goals.
- Determine what new information needs to be communicated within the next 24 hours.
- Agree on who and how the team will communicate with the family/patient today (eg the attending physician will meet with family at 3 pm; the resident will attend, then call out-of-town relative after meeting).

### Document care plan and coordinate the follow-up and the next day's assessment.

- Document the clinical status, symptoms, and daily goals of care with the details of the decision-making process.
- Change orders as necessary (eg new do-not-resuscitate order).
- Schedule next meeting for interdisciplinary team that includes the patient (if able) and family to update the goals, medical evaluation, responses to current therapy, and future plans.

as a forum to educate medical and nursing staff about palliative care and decision making for individual patients. Creating a pathway for care would be the next step to palliative care that meets the patient's needs.

- Phase I: Patient with terminal diagnosis. The attending physician discusses treatment options with the patient and family.
  - Phase II: The care coordinator contacts palliative care. The RN consults the social work and pastoral care departments. The patient makes a decision on care based on his or her own value system.
  - Phase III: Continue treatment.
2. Pain management is an essential component of palliative care. The physician will work with the pharmacy and the nursing education department to develop pain management protocol for writing orders. Through joint efforts between the physician, pharmacy and nursing education, pain relief can be addressed. Analgesia includes not only drug therapy, but also non-pharmacological interventions such as imagery, massage, therapeutic touch, music therapy and meditation. The goal of therapy is to keep the patient comfortable, without clouding mental or cognitive functions. Teaching pain management to the nursing staff can alleviate many fears they have (eg causing respiratory depression in patients in order to address their pain symptoms or creating narcotic addictions in tenuous patients).
  3. From the results of the study, it would be beneficial to develop a bereavement care flow plan with pastoral care. This will aid in the coordination of treatment for patients within the palliative-care service leading to improved patient and family satisfaction. Spiritual needs should be addressed on a broad scale. A patient or family member may experience any or all of these convictions:
    - the need for meaning and purpose
    - the need for love and relatedness
    - the need for forgiveness<sup>18</sup>

Protocol for referring patients to respite care should be incorporated into the care plan. This will facilitate help for family members if it becomes necessary.
  4. The needs of seriously ill patients and their families are typically complex and multidimensional. Staff skills should include: medical evaluation and decision making, pain and symptom management, patient and family communications, a capability to address difficult decisions about the goals of care, sophisticated discharge planning, and the ability to deliver continuity of care.<sup>7</sup> Support services to the core team include: patient advocates, anesthesia pain experts, rehabilitation therapists, and psychiatry consultants. The interdisciplinary team

should have special training and/or work experience in palliative medicine, hospice or nursing home settings. There should be an understanding of the standards of the acute-care setting as well.<sup>7</sup>

5. Psychosocial counseling was identified through the study to be an inconsistent or unrecognizable component of needed care. A standardized approach to psychosocial counseling can be obtained through a suggested practice guideline. In addition to the various symptoms associated with a disease process, common problems may include: anxiety, depression, insomnia and financial difficulties. Improved communication and decision making can help alleviate some of the psychosocial stress that occurs for many patients and family members.<sup>2</sup>
6. Through the questionnaire, staff acknowledged that a protocol should be developed along with educational in-services to address criteria for staff in order to facilitate the transfer to hospice. The information should be recorded on video or DVD for training of new personnel to the unit. This protocol would be implemented by both hospice and palliative-care services, working together to ensure a smooth transition.

#### ***Clinical assessments***

Ongoing clinical assessments are important when planning care for chronically ill patients. When developing a care plan, it is essential to evaluate functional ability in daily activities and correlate the physical signs and symptoms.<sup>6</sup> Creating prognostication tools will help health care professionals determine when functional and physical decline occurs and a patient has entered the terminal phase.<sup>21</sup> This would have been especially helpful in the care plan for Mrs G.

When Mrs G's condition deteriorated after her abdominal surgery, her son and daughter began to wonder if consenting to surgery was a wise decision. It was suggested the family consider hospice and a do-not-resuscitate (DNR) order. Pain and symptom management were addressed in the care plan. The family was asked to switch from curative treatment to hospice and end-of-life care.<sup>6</sup> Those who cared for Mrs G grieved over the loss of their patient of the last seven years. If upon admission, goals were identified with the patient and family, a care plan based on palliative care may have created the understanding and communication to allow staff as well as the patient and family transition to hospice care. If palliative care been part of the care plan, the family, patient and staff may have had more time to accept the prognosis and emotionally prepare for the ultimate outcome.

#### ***Palliative care plan checklist***

A care plan checklist should be utilized at admission to begin communication between staff, family and the patient about

care and goals. A daily care plan checklist can also be used to facilitate palliative care, simultaneously with curative or life-prolonging therapies if so desired. A user-friendly algorithm aids in identifying goals of care to ensure the patient's needs are being met (see sidebar). This daily care plan can be initiated in general units as well as units that may not be familiar with end-of-life care. This checklist can help clarify the goals of care for the staff, ICU team, consultants, patients, and family, as well as provide a medium for quality improvement.<sup>10</sup>

As a patient is admitted to the hospital, it is important to determine patient-centered goals of care and then decide if ICU care or palliative care will help support these goals or distract from them. With a documented strategy upon admission, the patient can benefit from a care plan that integrates palliation into the daily agenda.<sup>10</sup> Different models of care should not exclude any of the others; each may be useful at different stages of the disease process.<sup>11</sup>

#### **Patient centered and family centered care**

"Respect for persons is an ethical ideal that states it is wrong to use people as a means to an end. People should be treated as an end to themselves."<sup>12</sup> For example, the health care clinician should reflect on whether there is benefit to that particular intervention.<sup>12</sup>

Potential benefits of hospital-based palliative care include:

- Reduction in symptom burden
- Care concordant with patient-family preferences
- Patient-family/professional consensus on the goals of medical care
- Improved patient and family satisfaction
- Improved (or no adverse) utilization outcomes (length of stay, ICU days, readmission rate, rate of hospice use, emergency department use).

#### **Conclusion**

Since completing the study, a number of advancements have occurred at the acute-care hospital. The findings of the study validated the algorithm that had been presented to the End of Life Steering Committee at the hospital. A core disciplinary team that consists of a physician, nurse, social worker, pharmacy and pastoral care was put in place. The hospital received approval for an in-house palliative care unit, which will be designed with the idea of meeting the individual needs of each patient. The End of Life Steering Committee is working directly with pharmacy to update policies to ensure proper pain management. Bereavement cards have been integrated as part of the protocol for a patient that does expire. Every staff member who was directly involved with the patient's care during his or her stay in the hospital signs each card.

The study raised awareness as to what patient needs the hospital is not meeting. To close this gap, it will be necessary to educate staff and furnish resources that can be utilized

when caring for the critically ill patient. The End of Life Steering Committee formed an education subcommittee that will initiate a step plan to educate those who are or who may be involved with chronically ill patients. The importance of education in any care flow plan can not be stressed enough. Although this program is in its infancy, it illustrates that the hospital does respect patient autonomy and the importance of quality patient care.

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#### **About the Author**

Rebecca Pieknik, CST, CSA, MS, FAST, earned a bachelor of health service administration from Baker College in 2002 and a masters of science in bioethics from Albany Medical College, Graduate College of Union University in May 2005.

She is currently working as the manager of Central and Sterile Supply at Pontiac Osteopathic Regional Medical Center in Pontiac, Michigan.

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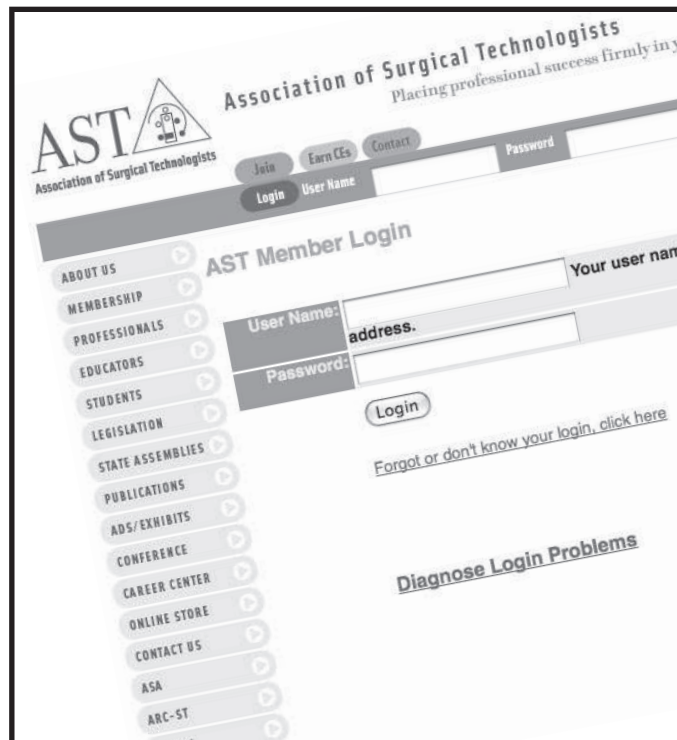


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**Additional resources**

- American Medical Association (AMA), [www.ama-assn.org/](http://www.ama-assn.org/)
- American Nurses Association (ANA), <http://nursingworld.org/>
- Education for Physicians on End of Life Care (EPEC), [www.epec.net](http://www.epec.net)
- Hospice Association of America (HAA), [www.hospice-america.org/](http://www.hospice-america.org/)
- Human Investigation Committee (HIC) Yale University School of Medicine, <http://info.med.yale.edu/hic/>
- National Hospice and Palliative Care Organization (NHPCO), [www.nhpc.org](http://www.nhpc.org)
- Patient Self Determination Act (PSDA), [www.dgcenter.org/acp/pdf/psda.pdf#search=Patient%20Self%20Determination%20Act](http://www.dgcenter.org/acp/pdf/psda.pdf#search=Patient%20Self%20Determination%20Act)
- The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), <http://jama.ama-assn.org/cgi/content/abstract/274/20/1591>



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