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A Clinical Practice Guideline: Hospice Care in the Emergency Room

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This is to certify that the doctoral study by

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Walden University
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Abstract

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MSN, Walden University, 2019

BSN, American Military University, 2017

Project Submitted in Partial Fulfillment

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Abstract

Hospice patients use the emergency department (ED) for the management of symptoms, making it necessary for ED nurses to be equipped with the knowledge and skills to care for hospice patients. EDs should have staff specially trained to address end-of-life needs due to ED staff's minimal knowledge of treating and managing hospice patients. When healthcare organizations fail to provide clinical practice guidelines (CPG) and collaborate with significant stakeholders adequately, gaps in care delivery can occur, and hospice care is often not delivered safely. Standardized guidelines on end-of-life care in the ED should provide adequate guidance for ED nurses in bridging the gap to improve end-of-life care in the ED. Based on peer-reviewed articles from Cochrane Database of Systematic Reviews, PubMed, and MEDLINE and the AGREE II model, the DNP student addressed the gap in practice by creating a CPG following Walden University's CPG manual and the AGREE II model, answering the practice-focused questions and providing ED nurses with resources to improve hospice care in the ED. A panel of three content experts with experience in both hospice and emergency medicine evaluated the newly developed CPG finding it of high quality with no revisions needed. Domain scores ranged from 90% for rigour of development and 98% for scope and practice with an overall domain score of 100% usable CPG. These newly developed guidelines should provide a positive social change through improved hospice care in the ED thus putting the patients and families at ease and allowing them to focus on themselves and their loved ones. Furthermore, cost-savings are anticipated due to the reduced uncertainty in care practice and a more efficient discharge process from the ED.

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Section 1: Nature of the Project

Introduction

Lack of knowledge of emergency department (ED) nurses in hospice care has increasingly become an issue, especially with the aging populace. According to the Merck Institute of Aging and Health (MIAH, 2019), there is overwhelming evidence regarding hospice care's efficacy, but ED staff do not adequately manage those patients. There have been up to seven hospice patients in the target clinical setting in one day seeking care within the ED with an average stay between 6 to 8 hours, and sometimes more, with symptoms not always controlled. Appropriate delivery of hospice care in the ED improves patient outcomes, patient and family satisfaction, and is cost-effective (Levine et al., 2019). ED staff lack the knowledge and skills needed to provide best practices in end-of-life care (Clark et al., 2015).

Chronic diseases are indicators for palliative, and eventually, hospice care (Clark et al., 2015). The MIAH (2019) predicted that by 2030, the number of aging Americans over 65 years will account for 20% of the population impacting healthcare in the United States. The MIAH (2009) stated that 15-20% of the current older adults suffer from chronic issues and are on five or more prescribed daily medications. Approximately 157,000,000 Americans live with a severe and life-threatening illness, and seven out of 10 Americans will expire from a chronic disease (Levine et al., 2019).

Patients under the care of hospice sometimes use the ED, which provides care to patients presenting with various symptoms, offering access to the hospital's specialists 24 hours a day, 7 days a week, 365 days a year, to manage their symptoms (Weng et al., 2017). The services provided by the ED are critical for patients with ongoing symptoms who cannot obtain relief at home. The ED staff is trained for diagnostics, treatment, and quick patient transition to appropriate settings. Hospice patients generally present with complex issues not amenable to rapid changes. They often leave the ED with many needs unmet, suggesting that ED staff are not adequately trained to care for the hospice patient (Weng et al., 2017). Shearer (2014) agreed, stating that evidence is overwhelming regarding hospice care's efficacy, but ED staff do not adequately manage those patients. MIAH (2019) argued that all EDs should have staff trained to effectively care for hospice patients. Weng et al. (2017) agreed, stating that with the increase in the elderly population, the additional need for hospice training will become apparent as ED teams are frequently confronted with complex patients requiring end-of-life care.

Weng et al. (2017) reported that appropriate delivery of hospice care in the ED improves patient outcomes, patient and family satisfaction, and is cost-effective and exceptional care can be provided to hospice patients by ED staff if the staff is adequately equipped with the knowledge, skills, and appropriate attitudes toward end-of-life care. Through this Doctor of Nursing Practice (DNP) clinical practice guideline (CPG) project, I provided a template for nurses to adopt in leading the way to providing quality hospice care within the ED. This newly developed CPG will positively affect social change by improving quality of life and care for the dying patient and increase family satisfaction while also improving nurse technique and knowledge, leading to increased job satisfaction (Batchelor, 2015).

Problem Statement

The director of the local ED where this project was implemented shared that, since 2015, about 3,300 patients have been evaluated for terminal illness symptom management, with 70% being transferred to a contracted facility because of the inconsistencies in the quality of care provided within the ED (ED Director, personal conversation, July 13, 2020). The director also stated that in 2017, the end-of-life team administered a needs assessment to the 175 nurses in the ED, revealing about 75% of nurses had not had any additional training on death and dying outside of nursing school, and 85% had minimal experience with hospice patients, illustrating the need for increased knowledge about hospice care. Those same nurses verbalized not knowing how to care for hospice patients in the ED effectively and lacked the skills to confront and comfort families during grief. An understanding of hospice care is absolute to quality care for the family and the patient with a terminal illness nearing end-of-life (Sangeeta & Tammie, 2011).

Although all sick patients should be treated with compassion and respect, hospice patients should receive an overwhelming amount of support, compassion, and respect (Sangeeta & Tammie, 2011) while receiving safe, appropriate care. Researchers have indicated that ED staff members function under their own sets of knowledge and beliefs regarding end-of-life care. This suggests the need for increased evidence-based protocols to improve ED nurses' competencies regarding end-of-life care (Clark et al., 2015). Unfortunately, hospice patients tend to have unmet needs when treated in the ED and, sadly, are discharged home with unresolved symptomatic relief or treatment (Clark et al., 2015). This doctoral project provided the opportunity to bridge the gap in lack of knowledge related to hospice care in ED nurses and the literature supporting hospice trained ED staff (MIAH, 2019). This project holds significance to the field of nursing practice by providing a template for nurses to adopt in leading the path to provide quality hospice care within the ED, while also translating evidence into practice.

Purpose Statement

The gap in practice identified for this DNP CPG project was that while MIAH (2019) argued that EDs should have staff specially trained to address end-of-life needs and goals, providers in the ED where this project was implemented had minimal knowledge on treating and managing hospice patients. Many deficiencies can be linked to the ED's low prioritization of end-of-life care and the inability to perform an evidence-based approach towards hospice (Pesut & Greig, 2018). Management of symptoms, unrelieved within the home environment, is the primary reason hospice patients seek help from the ED, making it necessary for ED nurses to be equipped with the knowledge and skills to care for hospice patients. The practice-focused questions that drove this project were: What evidence from the literature supported the need for standardized guidelines for hospice care in the ED and What evidence from the literature was available for the development of a CPG related to hospice care in the ED? Standardized guidelines on end-of-life care in the ED provide resources for ED nurses on end-of-life care and bridged the gap to improve end-of-life care in the ED. I anticipated that the findings would provide for a welcoming and safer practice environment for hospice patients while improving ED nurses' knowledge of hospice care. Although too early to realize the gains, responses to date indicate early success.

Nature of the Doctoral Project

For an exhaustive search of the literature for this DNP project, I continued to search Walden's Library, Cochrane Database of Systematic Reviews, PubMed, and MEDLINE for current peer-reviewed articles addressing hospice care in the ED until the CPG was approved. Search terms included *hospice*, *attitudes*, *knowledge*, *ED*, *hospice care in the ED*, *caring for the dying*, *practice guidelines for ED*, *practice patterns*, *nurse attitudes*, and *attitudes about end-of-life care*. The selected literature was graded according to Melnyk et al.'s (2010) grading criteria and placed in a literature matrix (Appendix A).

Following *Walden University Clinical Practice Guideline Manual* and the Appraisal of Guidelines Research and Evaluation (AGREE) II model (Brouwers et al., 2010), the analysis phase was completed. The problem was determined to be a lack of knowledge related to hospice care in ED nurses; after discussing the problem with leadership, they agreed to support the project. The development of a CPG was determined to be the best design to address the gap.

The development phase continued after Institutional Review Board (IRB) approval, with the literature search continuing until the guideline was completed. From the current peer-reviewed, evidence-based literature, I developed a CPG. The implementation phase included evaluation, revision, and approval by content experts. No modifications were recommended; the newly developed CPG was shared with end-users, ED nurses, and will be shared with the ED administration for final approval after the 2021 Knowledge Initiative Conference. The evaluation phase included AGREE II evaluations completed by the content experts and a formative evaluation by the content experts and practitioners.

With the needs identified, it was unfortunate that today's literature lacked the available guidelines, educational opportunities, and resources for ED staff to acquire the needed knowledge to care for hospice patients properly. The anticipated increase in skills should provide the staff members with valuable skills to better care for the dying. Pesut and Greig (2018) explained that while positive attitudes toward caring are a nurse's nature, increased education programs, to include CPGs, are needed to aid in effective strategies for coping, removing barriers of care, and developing hospice competencies, which increase the proficiency of hospice care. Changing the attitude and culture of the ED staff regarding the care of hospice patients is being accomplished through the implementation of a CPG.

Significance

The stakeholders impacted by this project included the nurses, the patients, the families, employers and insurance companies, and the providers. Increased knowledge and skills, especially in the ED, satisfied many stakeholders' concerns; for example, expanded knowledge will positively impact patient care due to increased confidence and work satisfaction of the nurses (Batchelor, 2015). A uniform, systematic method of treating hospice patients guides the providers in providing appropriate care, following approved guidelines (Quest et al, 2011). Additionally, this improved level of care puts the patient at ease and more able to focus on themselves rather than what is going on around them. Family satisfaction also increases when their sick loved ones are being cared for appropriately by qualified nurses educated in end-of-life care. Payors will be satisfied as to faster turnaround of hospice patients in the ED rather than holding them due to the uncertainty with their care (Batchelor, 2015).

The newly developed CPG is transferable to any setting that end-of-life patients visit because they all have the same needs of knowledgeable care by providers, no matter the environment. Highlighting the physiological, emotional, and medical conditions, and differences of the dying patient will allow for a more fluent transition of care and increased focus on holistic care while including what is essential to the patient (Quest et al., 2011). A positive social change is being realized as quality care of the dying patient provides a smooth transition of care, improved quality of life, and support and assisting families adjust to the needs of their dying loved ones (Quest et al., 2011). This CPG contributes to nursing practice by elevating the level of care provided to end-of-life patients by adopting a guideline in leading the way to providing quality hospice care within the ED.

Summary

Researchers have suggested that ED nurses' lack of hospice care knowledge poses obstacles to providing quality care to the hospice patient (Clark et al., 2015). Included in these barriers is a lack of knowledge and time in the fast-paced ED. Furthermore, healthcare professionals have a difference in understanding regarding hospice care in the ED due to inconsistencies in beliefs, practice and care delivery, and education. While

MIAH (2019) argued that EDs should have staff specially trained to address end of life needs and goals, providers in the ED had minimal knowledge of treating and managing hospice patients.

A CPG project was determined to be the best method of addressing the practice-focused questions, What evidence from the literature supported the need for standardized guidelines for hospice care in the ED and What evidence from the literature was available for the development of a CPG related to hospice care in the ED? Providing standardized guidelines better prepares the staff to address the unique needs of the end-of-life clients they are called upon to care for. This doctoral project served to bridge the gap in ED nurses' knowledge of hospice care. By providing a practical CPG the identified needs were addressed to help the dying population better. Models that will inform the project are discussed in Section 2. Local background and context are identified, as well as the role of the DNP student.

Section 2: Background and Context

Introduction

ED nurses lack the proper knowledge and skills related to adequate end-of-life care (Clark et al., 2015). Through this project, I answered the practice-focused questions: What evidence from the literature supported the need for standardized guidelines for hospice care in the ED? and What evidence from the literature was available for the development of a CPG related to hospice care in the ED? I developed a CPG to address the lack of ED nurses' knowledge related to hospice care better preparing them to provide quality end-of-life care. In Section 2, I highlight concepts, relevance to nursing practice, local and background context, and the role of the DNP student.

Concepts, Models, and Theories

The model that guided the DNP CPG project was the AGREE II model (Brouwers et al., 2010). The AGREE II model addresses variability in the quality of practice guidelines and can be used by practice guideline developers, policymakers, health administrators, management, and stakeholders (Brouwers et al., 2010). The AGREE II model has been validated and tested in developing evidence-based CPGs, addressing six quality domains: scope and purpose, stakeholder involvement, the rigor of development, clarity of presentation, applicability, and editorial independence (Brouwers et al., 2010). Each quality domain targets different parts of the CPG quality used as the appraisers evaluate the guidelines. The AGREE II tool continues with two final assessment items requiring an overall appraisal of the CPG (Brouwers et al., 2010). The appraisers are also asked whether they would advocate the use of the practice guideline within the ED.

Guidelines of recent acne treatment protocols were assessed using the AGREE II model to evaluate the effect of quality of treatment (Eady et al., 2017). During this assessment, eight guidelines were considered, with two of them needing significant updating. The AGREE II evaluation identified that applicability and rigour scored the lowest amongst all domains (Eady et al., 2017). Also highlighted during the review was a potential bias within the guidelines. The use of the AGREE II assessment demonstrated there is significant room for improvement in treating acne and the guidelines provided for the treatment of acne need revision (Eady et al., 2017).

The AGREE II model was also used to appraise the World Health Organizations' (WHO) guidelines in maternal health, evaluating the transparency and the overall quality of methodological rigour of four different guidelines published by WHO between 2007 and 2011 (Polus et al., 2012). The results showed higher scores amongst the newest of guidelines, published between 2010 and 2011, suggesting the higher quality of care (Polus et al., 2012), demonstrating the guidelines had been improved over time.

Relevance to Nursing Practice

Researchers have indicated that ED staff members function under their own sets of knowledge and beliefs regarding end-of-life patient care (Clark et al., 2015). The literature was exceedingly suggestive of the need for increased evidence-based guidelines to improve ED nurses' competencies regarding end-of-life care (Clark et al., 2015).

According to the MIAH (2019), in 2011, approximately 1.6 million patients were diagnosed with a chronic, terminal illness. Additionally, the ED experience suggested that patients suffering from terminal illnesses or in hospice care are often stuck in a repetitive emergency care pattern, wasting resources, and failing to have their needs met (Clark et al., 2015). The average length of stay in an ED for hospice patients was about 8 hours, which could be significantly reduced if the staff was adequately trained on end-of-life symptom management (Clark et al., 2015). Hospice care is appropriate when nearing end-of-life and is a service that can begin in any setting, including the ED. Therefore, providing end-of-life clinical guidelines for nurses in the ED improved the level of hospice care delivered.

The Agency for Healthcare Research and Quality (2009) presented four key areas exclusive to nursing roles in providing end-of-life care. These areas were education and training, attitudes toward the dying, current practice beliefs, and ED as a venue for hospice patients. ED nurses are highly skilled nurses specializing in the quick response to patients' need for care; in contrast, there is a relaxed attitude regarding caring for those patients nearing end-of-life (Batchelor, 2015). The issue was not a lack of caring by the ED nurses but a lack of understanding of hospice care and the dying process. Practice guidelines addressing hospice care are crucial to successfully care for such patients. Increased knowledge can be implemented using a CPG to highlight practice guidelines and clinical practice (Batchelor, 2015). Increased knowledge and education showed to be not only cost-effective but resulted in increased patient and family satisfaction. When quality care is being provided, patients and their families can focus on what is important to them, rather than the burden of their illness (Levine et al., 2019).

ED nurses have expressed that they feel awkward surveying and coordinating care as a patient nears end□of□life and were uncertain of the part that the ED plays during this time (Quest et al., 2011). Only as of late has hospice consideration been introduced in the emergency medical writing through quality markers and competencies, for example, realizing how to oversee quality hospice care in the ED and how best practices are characterized (Levine et al., 2019). Theoretical advancements have shown improvement in public health arenas and have developed infrastructure to deliver better care, which allows the terminally ill to live much longer (Haverhals et al., 2019). While many of these individuals are nearing end-of-life, few will die suddenly. In contrast, most will die of predictable illness advancements, bringing many individuals to the ED for symptomatic treatment (Haverhals et al., 2019). Given the nature of the emergency nurse role in the ED, there was a need to expand on end-of-life care knowledge in the ED setting, with a focus on better understanding the effect of education and clinical guidelines (Quest et al., 2011).

End-of-life care globally has recently started to be defined as a quality outcome; unfortunately, the integration of care of the ED patient has not been formally established. Quest et al. (2011) reported that the Palliative Care Workgroup, a leading workgroup of emergency medicine providers, geriatric specialists, and hospice medicine experts, identified four needs to better assure end-of-life care concerning quality and safety to include those who need end-of-life care in the ED, the role of the emergency medical staff in caring for an end-of-life patient, how end-of-life education in the ED affects healthcare delivery, and what educational priorities for providers working with end-of-life patients are (Quest et al., 2011).

Research is needed across the hospice care platform to better optimize quality care for the patients nearing end-of-life (Giles & Miyasaki, 2009). The focus should gear towards the end-of-life period where discomfort and pain from disease increase, increasing ED visits are noted, hospitalized care can be observed, and a large portion of related medical expenses are spent. Integrating quality end-of-life care in the ED will need a paradigm shift in the way care is performed and where comprehensive ED hospice care is a core element of practice (Quest et al., 2011).

Local Background and Context

According to the local ED director, there have been about 3,300 patients seen for terminal illness symptom management since 2015. Out of those seen, 70% were transferred to third party facilities for quality hospice care. Lack of end-of-life care knowledge has been the primary reason for less than optimal hospice care in the ED. There was no education in place for hospice care in the ED within the institution this DNP project was conducted. The hospice care provided in the ED was not meeting the mission statement of the hospital, providing healthcare services excelling in caring, quality, and innovation. The newly implemented staff guidelines provide nurses and providers in the ED with a standardized plan of care as they provide end-of-life care. There are no regulations in Florida regarding hospice care in the ED, and although recommendations were found on the national level for hospice care, none were found specific to hospice care within the ED.

Due to the aging populace of the geographical area and discussions with the ED director related to the lack of quality end-of-life care being provided in the local ED, I determined this to be a concern that needed addressing. Sarasota County has an aging population with hospice patients seen in the ED regularly. Hospice care is a specific clinical specialty that centers around caring for patients determined to have severe sicknesses at any phase of existence with alleviation from side effects, torment, and worry of such ailments (Quest et al., 2011). Further consideration of hospice care is fundamental in limiting low-quality care and undesirable consequences.

Role of the DNP Student

As a nurse practitioner student, I had the privilege of working with the local hospice group, providing care in many different settings including the ED. As a student practitioner, I focused heavily on the medical care of the patients but noted a lack of knowledge by the ED nurses when working with end-of-life patients in the ED. One nurse told me that she is always happy and grateful to see hospice nurses helping with care in the ED because she did not know what to do for the hospice patient and was uncomfortable caring for end-of-life patients. This is when I realized that there is a significant lack of knowledge of ED nurses caring for end-of-life patients.

As the DNP student, I had the privilege of and responsibility for organizing and executing all parts of this CPG undertaking with guided help from my faculty. After an exhaustive literature review, I developed the literature matrix, analyzed the literature, developed the CPG, made guideline revisions based on the context experts' evaluations, and developed a summary of findings from evaluations provided by the panel. A packet of information was provided for the expert panel, including an introduction letter, AGREE II scoring instrument, and the CPG. Due to my experience as a student practitioner in the ED, there was a possibility for personal bias based on my experiences. My education in gerontology has provided me with golden standards of care, which were not met in my clinical setting by the ED nurses. With this in mind the CPG was developed based on the peer-reviewed literature, decreasing the bias of my opinion.

Summary

My intentions in carrying out this DNP CPG project were to bridge the gap of ED nurses' knowledge toward providing quality hospice care in the ED and the literature supporting hospice trained nurses in the ED (Quest et al., 2011). With the AGREE II model (Brouwers et al., 2010), a group of content experts evaluated the newly developed CPG for quality and rigor. The CPG provided evidence-based guidelines to provide quality care for the patient nearing end-of-life in the ED. In Section 3, I provide an overview of the practice-focused questions and sources of evidence along with methods I used to collect and analyze the evidence for this DNP project.

Section 3: Collection and Analysis of Evidence

Introduction

The purpose of this DNP project was to develop a CPG for ED nurses working with hospice patients as there was a lack of education in place for hospice care in the ED. While Sarasota County has an aging population and must be ready to provide end-of-life care within the ED, the local ED failed to meet its mission statement of providing healthcare services excelling in caring, quality, and innovation. I developed an evidence-based CPG to increase ED nurses' knowledge related to quality care for hospice patient. In Section 3, I highlight the practice-focused questions, sources of evidence, and analysis and synthesis of the evidence gathered.

Practice-Focused Questions

Hospice care is critical in relieving symptoms that patients experience when progressing through a terminal illness. The ED has been noted as the first-line of treatment for patients with chronic illnesses, yet many institutes lack the appropriate guidelines to care for the dying patient properly (Quest et al., 2011). To address this gap, I answered the practice-focused questions: What evidence from the literature supported the need for standard guidelines for hospice care in the ED and What evidence from the literature was available for the development of a CPG related to hospice care in the ED? By developing an evidence-based CPG, ED nurses have guidance when providing care for a hospice patient in the ED. The AGREE II model (Brouwers et al., 2010) provided direction for me and the content experts in the development and evaluation of the CPG.

Sources of Evidence

I developed a CPG based on the literature and recommendations from professional organizations obtained from the literature review. For this project, only evidence-based, peer-reviewed literature was used. The other sources of evidence used to address the practice-focused questions were the AGREE II results provided by the content experts along with their formative evaluation. This evaluation provided expert and clinical feedback on the CPG, which allowed for modifications to best provide quality end-of-life care in the ED.

Participants

An expert panel was identified to evaluate the newly developed CPG following the AGREE II model (Brouwers et al., 2010) recommendations. This panel included a hospice advanced practice registered nurse with her Master of Science in Nursing (MSN) and Adult Nurse Practitioner certification, an advanced practice registered nurse educator who has an MSN and Family Nurse Practitioner certification, and a hospice nurse with her MSN. This panel was selected because of their expertise, ability to speak to the practice-focused questions, knowledge of the research literature, and the fact they provide direct patient care to end-of-life patients.

Procedures

After a thorough review of the literature, I developed a literature matrix (see Appendix A), grading the selected articles using Melnyk et al.'s (2010) grading criteria (see Appendix B). Once I developed the CPG based on the evidence-based literature, a packet of information was presented to the expert panel, including a preapproved

Disclosure to Expert Panelist form (see Appendix C) along with an introductory letter, the AGREE II scoring instructions, the AGREE II tool, the literature matrix, and the CPG. I asked the expert panel participants to review the CPG (see Appendix E) using the AGREE II tool (see Appendix D) to assess the quality of the guidelines, provide feedback, and return the packet to me within 2 weeks. After revisions were made and a consensus was reached, a group of end-users (ED nurses) reviewed the CPG for content and useability within the facility. After the completion of the project evaluation by the expert panel, they were each asked to complete a summary evaluation of the project, process, and my leadership. The approved CPG was presented to the administration for final approval and implementation.

Protection

There were no identified ethical risks involved in completing the CPG for hospice care in the ED. Ethics approval from Walden's IRB (612-312-1210) as well as approval from the facility was obtained to show compliance with the IRB requirements. Each expert panelist received the preapproved Disclosure to Expert Panelist form with an accompanying letter introducing them to the AGREE site. The reviews remained anonymous with all paperwork identified with numbers rather than names. Electronic records will be stored in a password-protected file for 5 years and then deleted. The site name and location remained masked.

Analysis and Synthesis

The expert panel provided the scores on the AGREE trust site (https://www.agreetrust.org/). The scores were tabulated through the site and I received a report which provided an overall assessment of the guideline. This assessment displayed a percentage for each of the 6 domains within the AGREE II model and identified any limitations. Once all the results were compiled, the scores were assessed and synthesized, and modifications were made to the CPG as needed. The completed AGREE II tool results were saved in the AGREE II website.

Summary

The above section reviewed the practice-focused questions: What evidence from the literature supported the need for standard guidelines for hospice care in the ED and What evidence from the literature was available for the development of a CPG related to hospice care in the ED? The evidence compiled for this DNP CPG was obtained through an exhaustive literature review and an expert panel completing the AGREE II tool. The expert panel's responses were provided on an AGREE II report and provided an overall assessment of the CPG. Modifications to the CPG were made as necessary to reflect the expert panel's AGREE II assessment. In Section 4, I will discuss the findings and implications of the interpreted data.

Section 4: Findings and Recommendations

Introduction

The local problem that was addressed in this project was ED nurses lack the knowledge to provide best practice in end-of-life care. The gap in practice was identified as a lack of standardized guidelines on end-of-life care in the ED. Standardized guidelines on end-of-life care in the ED should provide adequate guidance for ED nurses on hospice care and bridge the gap to improve end-of-life care in the ED. The newly developed CPG serves to answer the practice-focused questions: What evidence from the literature supported the need for standardized guidelines for hospice care in the ED, and What evidence from the literature was available for the development of a CPG related to hospice care in the ED?

Using Walden's Library, I used peer-reviewed articles from the Cochrane Database of Systematic Reviews, PubMed, and MEDLINE to address the gap in practice and create a CPG. The CPG was assessed by a panel of three content experts using the AGREE II website and data were scored for each domain. The numbers were reported using appraiser numbers instead of names, email addresses, or any identifying characteristics, maintaining the experts' confidentiality.

Findings and Implications

Three expert panelists used the AGREE II tool to provide an evaluation of the CPG (see Appendix F). The results show data from 23 items, and six individuals domains tabulated a percentage within each domain. Per the AGREE II tool (Brouwers et al., 2010), any domain scoring a percentage of 50% and above is considered acceptable, however, any domains scoring under 75% should be reviewed.

- Domain I, scope and practice, scored 98%;
- Domain II, stakeholder involvement, scored 94%;
- Domain III, rigour of development, scored 90%;
- Domain IV, clarity of presentation, scored 96%;
- Domain V, applicability, scored 92%;
- Domain VI, editorial independence, scored 96%;
- Overall domain scored 100%, usable CPG.

Looking into the results, I was shocked to see the high percentages. No reviewers offered comments or requested clarification. When discussing these findings with the expert panelists, they showed great appreciation for any type of hospice guidelines within the ED and were impressed at the level of care required for quality end-of-life care. They did not recommend any changes at this time; additionally, they strongly encouraged the CPG to be presented at the facility's 2021 Knowledge Initiative, advocating for the increased knowledge on end-of-life care within the ED.

The feedback from the expert panelists and end-users of the over-all assessment supported a well written CPG, useful in the care of hospice patients in the ED. Implementation of this CPG should have a positive impact on hospice patients seeking symptomatic treatment within the ED by ensuring staff is adequately equipped with the knowledge, skills, and appropriate attitudes toward end-of-life care. This CPG provides a template for nurses to adopt in leading the way to providing quality hospice care within the ED. The CPG will positively affect social change by improving the quality of care for the hospice patient, increasing family satisfaction, and improving nurse technique and knowledge, leading to increased job satisfaction. Cumulatively, the expert panelists agreed that the process of the project was seamless. My leadership assured their ability to use the grading tool, as well as submitting their evaluations on time.

Recommendations

The gap in practice was addressed by providing a CPG regarding the process of hospice care through a recommended practice guideline. MIAH (2019) argued that EDs should have staff specially trained to address end of life needs and goals, providers in the ED where this project was implemented had minimal knowledge on treating and managing hospice patients. After gaining leadership approval, I recommend implementing the CPG throughout the hospital system's EDs with follow up surveys on quality of care scores after 6 months of implementation.

Strengths and Limitations of the Project

Strengths of this project directly related to the positive feedback and willingness of the expert panelists who expressed the clinical benefits of this CPG when treating hospice patients in the ED. The panelists expressed the usefulness of having a guideline to promote best practice in end-of-life care in the ED. Management of symptoms unrelieved within the home environment is the primary reason hospice patients seek help from the ED (Quest et al., 2011), making it necessary for ED nurses to be equipped with the knowledge and skills to care for hospice patients. The facility showed great support and interest in the CPG and encouraged the entry of this project within the 2021 Knowledge Initiative Conference, held in Sarasota, Florida in June of 2021.

A limitation to using the AGREE II tool was the time needed for appraisers to register and complete the appraisal. The registration process proved more challenging than the appraisal itself. The organizer should plan on consistent follow-up with the participants within the tool as navigating the tool site proved challenging. One panelist needed consistent reminders to get registered and complete the appraisal, as it was getting very close to the anticipated deadline.

The COVID epidemic also presented challenges by simply limiting communications. During this project, much of the communication within the facility was conducted through emails, phone calls, and Zoom meetings. These proved a challenge due to scheduling conflicts, internet connectivity problems, and other various technical difficulties. Several times, Zoom meetings were time-limited, with most of the meeting time dedicated to establishing connectivity and usability of the app.

Summary

The findings for this project were centered around the anonymous use and analysis of the AGREE II appraisal tool by a panel of three clinical experts. The panel of experts AGREE II tool results highly favored the use of the CPG and also provided recommendations to include this CPG within the facilities 2021 Knowledge Initiative Conference. The practice gap was addressed and the practice-focused questions answered, with plans for dissemination after graduating from Walden University. The facility intends to implement the newly developed CPG throughout the system in the upcoming year. In section 5, I will be providing a self-analysis and summary of this project to include challenges, solutions, and insights gained from this DNP endeavor.

Section 5: Dissemination Plan

Many factors exist when presenting a new CPG for implementation within this organization, made up of three hospitals, each having an ED. The organization heavily favors a systematic approach to patient care, meaning all the different sites use the same policies and procedures and guidelines. There is a collaboration within the EDs of these organization called T-Collab, standing for trauma collaborations committee. The committee is made up of emergency room physicians, nurse practitioners, physician assistants, ED staff nurses, managers, and the education department from the three different hospitals, working together to ensure systematic implementation of new clinical practice changes within the organization. I plan on emailing the CPG to the director of the ED to bring the CPG to the ED collaborative group for implementation. The CPG will be used as a guideline within this hospital system to guide the ED nurses to provide appropriate care to hospice patients. The CPG will be presented at the 2021 Knowledge Initiative at the facility and may also be presented to the National Hospice and Palliative Care Organization for possible dissemination on a broader nursing platform, reaching the staff members providing direct patient care to end-of-life patients. The CPG will be submitted to the *Journal of Emergency Nursing* for publication consideration in hopes of highlighting the importance of end-of-life care within the ED nursing realm.

Analysis of Self

I started my nursing career as a licensed practical nurse in an ED in Chesapeake, Virginia. I found my passion for not only educating my patients but my peers as well. As a care provider, I found it an obligation to continue my education to provide the best care to my patients. This sense of duty led to the successful completion of my registered nurse education, and soon after, my bachelor of science in nursing. I found this still was not fulfilling enough, and soon I achieved a lifetime goal, becoming a board-certified nurse practitioner and now a DNP. Providing my patients, peers, and community with the best care by changing factors beyond the bedside was a crucial factor in pursuing higher education. Choosing to develop a CPG, I found I could adapt uniformed evidence-based patient care into practice.

Practitioner

As a practitioner with both ED and hospice experience, I was able to identify the project focused problem. My drive to remain within patient care has allowed me to understand the issues needing attention within this field of practice. After the experiences that this project has provided, it is abundantly clear how important it is to have nurses educated in end-of-life care, especially the front-line ED nurses. There is a lack of doctorate-prepared nurses within the organization, and those with DNPs do not provide direct patient care. I, however, will have the honor and privilege of serving my patients firsthand, even after graduating with my DNP. The DNP Essentials that guided this DNP CPG were:

1. Scientific Underpinning for Practice
    - Using science-based concepts of hospice care to make a CPG.
    - Development and evaluation of a new practice approach based on evidence.
2. Organizational and Systems Leadership for Quality Improvement

  - Development of clinical practice guidelines related to cost-effective, ethical, improved quality of care.
  - Designing evidence-based interventions.
  - Evaluating practice outcomes.

3. Clinical Scholarship and Analytical Methods for Evidence-Based Practice
    - Facilitate meaningful organization changes.
    - Identify the gap.
    - Accountability of quality care and patient safety.
4. Health Care Policy for Advocacy in Health Care
    - Critically analyzing policies to advocate for social justice within the hospice realm.
    - Improve care policies for the hospice patient seeking care in the ED.
5. Advanced Nursing Practice
    - Improving practice outcome of hospice patients in the ED.
    - Delivery of evidence-based care.
    - Comprehensive needs assessments.
    - Guiding nurses through complex situations.

Scholar

The rigors of completing a DNP project have been a great experience, but an exhausting one. As a scholar, I focused on my courses and learning objectives and tried learning everything to make me a better DNP. This journey has changed how I view the work that I do from day to day and allows me to identify problems, conduct research, formulate a plan, and implement and evaluate changes. The education I received has helped me recognize alternative avenues in changing nursing to align with current evidence-based practice and research.

Project Manager

As a leader for this project, I was able to successfully manage the project and the members of the expert panel. I completed a literature review matrix, including researched literature that helped support this project. Appropriate panelists were selected to grade and appraise the project for content and usability. The panel members' degree levels, position within the organization, experience, and patient involvement were all considered regarding hospice patient care. The panel members are very excited and eager to have a CPG tailored specifically to hospice care within the ED. As the project manager, it was a stressful undertaking but incredibly rewarding as the end-results will benefit a very vulnerable and under-managed population.

Challenges, Solutions, and Insights Gained

I faced personal and academic challenges during this project. Time management seemed always to be an issue, especially with the requirements of the program. Challenges were further staggered with full-time work responsibilities and a very active family. Tending to the family, work, and the project proved to be very difficult, but with my mentor's help, I was able to push through. The most significant academic challenge was completing my literature review matrix, which was relatively foreign to me. Another challenge was using the AGREE II website for the first time, as the website instructions are not very clear. The coordination of the project has provided me with a very gratifying experience, as now I understand how invested one must be to achieve organizational change.

Summary

During this DNP project, I created a CPG addressing a gap in practice regarding hospice care in the ED to improve the quality of end-of-life care within the ED. This project addressed the gap in practice related to hospice care within the ED, providing a guideline for the ED nurse to care for these end-of-life patients in a setting that is more geared toward rapid treatment and discharge or transfer. This project's positive social change of improved end-of-life care in the ED allows patients and family members to focus on themselves, not having to worry if their dying loved ones are being cared for appropriately. As patient-centered care and safety are priorities, our duties as professionals are to deliver the best, most appropriate patient care by supporting the bedside staff members in providing high-quality care to a vulnerable population. The newly developed CPG should increase nurses' knowledge, patient satisfaction, and quality of care, providing quality care to a vulnerable population.

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Appendix A: Literature Review Matrix

A Clinical Practice Model: Hospice Care in the Emergency Room

Author/ Date	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Methodology**	**Analysis & Results**	**Conclusions**	**Implications for Future research/practice**	**Grading the Evidence**
Bacci, M., Harland, K., Schlichting, A., & Nugent, A. (2015). 219 The recognition of hospice-eligible patients in the emergency department: A missed opportunity. *Annals of Emergency Medicine*, 66 (4), 81. https://doi-org.ezp.waldenulibrary.org/10.1016/j.annemergmed.2015.07.252.	Recognizing hospice eligibility.	What is hospice eligibility and how to recognize it?	A retrospective chart review.	- There are minimal assessment tools available for hospice patients being transferred to the ED from an outpatient setting. - Findings propose hospice patients are assessed the same as the elderly/frail elderly population with little emphasis on hospice needs. - Reviewed 1886 patients admitted to the ED. - Only 12.7% of reviewed patients met hospice eligibility criteria.	- There is a great need for assessment tools specific to the hospice patient's needs. - Assessment tools are needed to better address level of care needed within the urgent care center. - 92.5% of adults 65 years of age who are eligible for hospice are not recognized within the emergency department. -Early discussion of palliative care and hospice services can maximize benefits and potentially decrease ED visits by these patients.	-Assessment tools are needed. -Early discussion of palliative care and hospice services.	Level VII
Barnett, M. D., Reed, C. M., & Adams, C. M. (2020). Death attitudes, palliative care self-efficacy, and attitudes toward care of the dying among hospice nurses. *Journal of Clinical Psychology in Medical Settings*, 1-6.	Death attitudes, palliative care self-efficacy, and attitudes toward care of the dying among nurses.	How does death attitudes, hospice care self-efficacy and attitudes towards dying link to the hospice nurse?	Qualitative.	- Positive mentalities toward care of the dying leads to higher neutral and escape acceptance. -Positive attitude towards the care of dying has been noted to harbor increased confidence when asking hospice-type questions, but not responding to hospice-type symptoms.	-Better end-of-life care can be achieved by targeting attitudes about death and improving self-efficacy in discussing end-of-life care.	-Clinical interventions are needed to better equip nurses with positive outlook on caring for the dying patient.	Level VI
Batchelor, N. H. (2015). A quality improvement assessment of emergency department visits by hospice home care patients. *Journal of*	Quality improvement.	What can be improved within the emergency department for hospice patients? determine reasons	Qualitative.	- Emergency room continuous educational requirements should include hospice care within the emergency department.	- There is minimal hospice educational requirements for emergency room continuous education. -Emergency medical providers have minimal knowledge	Revision of educational materials and development of strategies to address the needs of this population should impact future projects.	Level VI

Hospice & Palliative Nursing, *17*(5), 442.		for and prevalence of hospice home care patients who access emergency departments for symptom management near the end of life and to explore factors that may influence patients' decisions to do so.		- 147 hospice patients were seen in one ED in 2011 for symptoms related to end-of-life.	regarding end-of-life care and are unable to properly communicate with the patient and family regarding hospice specifics. - Although many hospice patients and family members know the symptoms of end-of-life, many seek ED help due to anxiety. - Patients and family members may have written material regarding end-of-life care but family still seek emergency care because of anxiety.		
Chan, G. K. (2006). End-of-life and palliative care in the emergency department: A call for research, education, policy and improved practice in this frontier area. *Journal of Emergency Nursing*, *32*(1), 101-103.	Advancing research in emergency department regarding end-of-life care.	Although medical staff deal with death regularly, especially in the ED, why is end-of-life care identified as poor in quality?	Needs assessment.	- American Nurses Association has identified good end-of-life care as a core value for nursing. - American Medical Association has identified good end-of-life care as a core value of medicine. -End-of-life care as a specialty has been neglected with lack of research conducted into the issue.	- There remains a significant lack of research and education dedicated to refining end-of-life care.	-ED setting should be considered a frontier area for future study because little is known about how people die and about the care provided to patients at the end-of-life in the ED.	Level VII
Clark, P. A., Drain, M., & Malone, M. P. (2015). Addressing patients' emotional and spiritual needs. *Joint Commission Journal on Quality and Safety*, *29*(12), 659–670. https://doi.org/10.1016/s1549-3741(03)29078-x.	Whether or not hospitals and addressing emotional and spiritual needs of the patient.	- Are hospitals assessing emotional and spiritual needs and effectively addressing those needs? - What strategies can guide improvement of emotional and spiritual needs?	A comprehensive systematic literature review.	- Patients receiving hospice care have different spiritual and emotional needs than the general public. - Holistic approach to caring for the end-of-life patient is crucial. - Data analysis confirmed a strong relationship between emotional and spiritual care by staff and overall patient satisfaction.	- Three subgroups measure highly when correlating with measure of emotional and spiritual needs of a patient: 1) staff response to concerns and complaints of the patient and family 2) including patients in the decision making process 3) sensitivity of staff regarding the inconvenience of the illness and hospital stays have on the patient.	Holistic assessments are needed for every patient, particularly those nearing end-of-life.	Level V

Davies, N., Maio, L., Vedavanam, K., Manthorpe, J., Vernooij-Dassen, M., Iliffe, S., & IMPACT Research Team. (2014). Barriers to the provision of high-quality palliative care for people with dementia in England: A qualitative study of professionals' experiences. *Health & social care in the community*, *22*(4), 386-394.	Barriers to providing high-quality end-of-life care.	What are the barriers to providing high-quality end-of-life care?	Semi-structured individual face-to-face interviews/ Qualitative.	- High-quality care can be affected by but not limited to the following four factors: 1) uncertainty toward synchronization of end-of-life care 2) miscommunication, lack of communication and disconnect between services 3) different avenues of thoughts about training 4) Negotiation of risk.	The four mentioned barriers must be understood to better establish pathways tailored to patients nearing end-of-life.	Overcoming barriers to providing high-quality care of the dying patient.	Level VII
Eady, E. A., Layton, A. M., Sprakel, J., Arents, B. W. M., Fedorowicz, Z., & van Zuuren, E. J. (2017). AGREE II assessments of recent acne treatment guidelines: How well do they reveal trustworthiness as defined by the US Institute of Medicine criteria?. *British Journal of Dermatology*, *177*(6), 1716-1725.	To determine the quality of recently published acne treatment guidelines.	Given the apparent low adoption rate of the AGREE II instrument and the uncertainty of its impact on quality, what steps can be taken to improve acne treatment guidelines?	Expert opinion, committee report.	-Two guidelines were identified as needing updating out of eight. -Lowest scoring domains across all guidelines were applicability and rigour. -No guideline fully met the Institute of Medicine criterion. -Potential bias was noted in all guidelines.	-AGREE II model did not provide the anticipated quality measures of the guidelines. -Significant room for improvement is available regarding acne treatment.	Acne treatment guidelines need to be updated to reflect Institute of Medicine criteria of trustworthiness.	Level VII
Giles, S., & Miyasaki, J. (2009). Palliative stage Parkinson's disease: Patient and family experiences of health-care services. *Palliative Medicine*, *23*(2), 120-125.	Patient and family experience of end-of-life healthcare services.	What is it like being a patient and family member when receiving palliative care?	Qualitative.	Three main themes where noted to effect phenomenological analysis: 1) patient missing information 2) independent vs. dependent on others 3) wanting and not wanting to know all the information.	- Findings are similar to many other conducted research in that end-of-life care is not being met within the current health-care system. - End-of-life care should be multi-disciplinary in nature with a team based approach.-End-of-life care should heavily focus on supporting the patient and family.	Comprehensive quantitative-based multi-disciplinary health-care needs assessment of the hospice patients with goals to expand end-of-life services.	Level VI
Haverhals, L. M., Manheim, C. E., Mor, V., Ersek, M., Kinosian, B., Lorenz, K. A., Faricy-Anderson, K. E. Gidwani-Marszowski, R. A.,	Identify, describe and explain factors influencing care of the VA patient	What are factors influencing care of the veteran population with terminal cancer?	Qualitative.	- Concurrent care helps preserve hope and relationships with patient is transitioning to hospice care.	- Concurrent care is an option used by VA hospital staff to bridge patients to hospice care.		Level VI

& Levy, C. (2019). The experience of providing hospice care concurrent with cancer treatment in the VA. *Supportive Care in Cancer*, *27*(4), 1263-1270.	with terminal cancer.			- Signified the importance of dedicated liaisons, care coordinators, and educators. - Staff argue that current Medicare guidelines obstruct the use of concurrent care.	- VA hospice staff claimed that concurrent care improved coordination of care.		
Hogan, T. M., Losman, E. D., Carpenter, C. R., Sauvigne, K., Irmiter, C., Emanuel, L., & Leipzig, R. M. (2010). Development of geriatric competencies for emergency medicine residents using an expert consensus process. *Academic Emergency Medicine*, *17*(3), 316-324.	Development of geriatric competencies for ED providers.	Why does emergency medicine fail to provide high-quality care for elder ED patients?	An inductive, qualitative, multiphase method.	The domains that hinder high-quality care of the dying within the ED are: 1) trauma 2) falls 3) cognitive and behavioral disorders 4) emergent intervention modifications 5) medication management 6) transitions of care 7) pain management and palliative care 8) effects of comorbid conditions.	-The Geriatric Competencies for EM Residents provides a reasonable foundation for emergency medicine residency curricula and assessment to meet the demands of our aging population.	Determine the minimum geriatric competencies needed by emergency medicine.	Level VI
Levine, S., Malone, E., Lekiachvili, A., Briss, P., (2019). Health care industry insights: Why the use of preventive services is still low. https://www.cdc.gov/pcd/issues/2019/18_0625.htm.	Lack of preventative use for chronicle ill patients.	-What are barriers to preventative care for the chronically ill patient? -Clinical and community linkage focusing on chronic disease prevention.	Qualitative.	Review concluded four major level of influence of preventative medicine: 1) financial and economic consideration 2) metrics to drive change in the healthcare system 3) changes within the reimbursement models 4) role of the healthcare professionals.	-Most healthcare workers are away of recommended preventative care measure. -Most healthcare workers understand the benefit of preventative care. -Implementation gap rather than informative gap is the driving reason for lack of preventative services. -Preventative care is not prioritized, although prevention can reduce the burden of chronic illnesses.	Multipronged approach including but not limited to: 1) strong structural direction 2) institutional culture shift 3) team-based care 4) Preventative services accommodated within the systems of care 5) Patients engaging in preventive healthcare.	Level VI

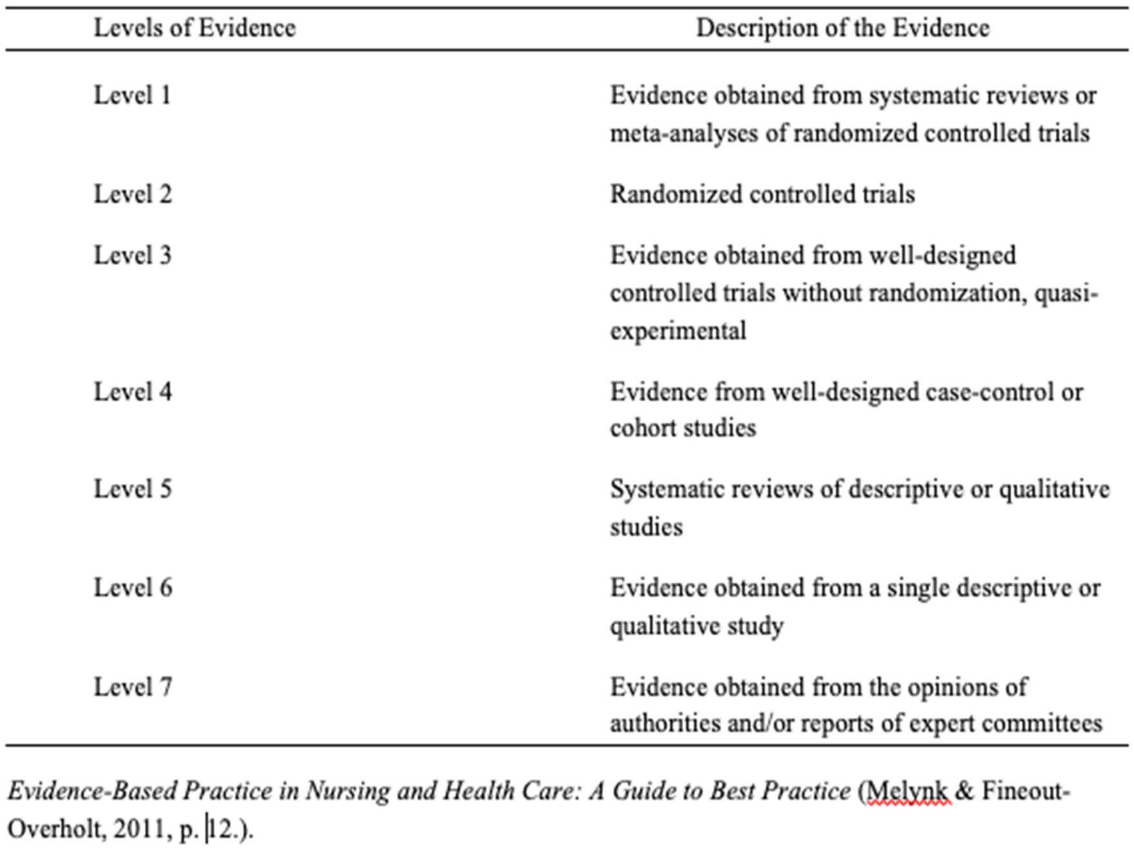
McKeown, A., Cairns, C., Cornbleet, M., & Longmate, A. (2010). Palliative care in the intensive care unit: An interview-based study of the team perspective. *International Journal of Palliative Nursing*, *16*(7), 334-338.	Palliative care in the ICU.	-Non-malignant conditions are gaining increased focus regarding end-of-life care. -Palliative care is expanding into acute settings, giving recognition for quality end-of-life care within the ICU.	Qualitative.	-Intensive care unit nurses advocated for end-of-life care within the ICU. -ICU staff nurses reported issues regarding training and education, how to better identify palliative care patients, and aggressive management as barriers to providing best quality-care.	-ICU and palliative care specialist must collaborate to better identify and meet the required needs of the dying patient. -An understanding between the two specialties is crucial to expand provision of end-of-life care.	Promotes the need for collaboration between specialties to provide best care for the dying patient.	Level VI
Pesut, B., & Greig, M. (2018). Resources for educating, training, and mentoring nurses and unregulated nursing care providers in palliative care: A review and expert consultation. *Journal of Palliative Medicine*, *21*(S1), S-50.	Review models and guides to hospice and palliative care.	What model is best to provide quality care for patients needing end-of-life care?	Expert opinion.	- Overall understanding of hospice care in the ED plays a critical role in feedback. - Introducing hospice care to providers in acute settings may help decrease lack in care, increase patient satisfaction and increase family satisfaction. - Integrating hospice care into the existing healthcare facility and the community is key to global hospice care progress and sustainability.	- A network of holistic care can be achieved by increasing acute care staff education on the needs of the chronic needs of a dying patient. - There has been a failure in discussing end-of-life care as an individualized topic even though millions of people need this service globally.	- Implication to improved evidence base and analyses the available guidelines. - Increase awareness to leadership and accountability is needed regarding end-of-life care.	Level VII
Polus, S., Lerberg, P., Vogel, J., Watananirun, K., Souza, J. P., Mathai, M., & Gülmezoglu, A. M. (2012). Appraisal of WHO guidelines in maternal health using the AGREE II assessment tool. *PloS one*, *7*(8), e38891.	Evaluate the quality of methodological rigour and transparency of four different WHO guidelines published between 2007 and 2011.	What are the AGREE II assessment findings of quality of methodological rigour and transparency of the four different WHO guidelines	Tool assessment, committee report.	-Higher scores to the most recent developed guidelines suggesting higher quality. -Lower scores were noted to guidelines developed prior to 2007, although not much lower.	-Studies from 2010 and 2011 received the highest AGREE II score compared to guidelines developed earlier in 2007 and 2009.	-Potential for improvement regarding stakeholder views, transparency of guidelines and roles of funding body. -Suggested improvement to quality of identified guidelines by AGREE II method.	Level VII

		published between 2007 and 2011?					
Quest, T. E., Asplin, B. R., Cairns, C. B., Hwang, U., & Pines, J. M. (2011). Research priorities for palliative and end□of□life care in the emergency setting. *Academic Emergency Medicine*, *18*(6), e70-e76.	Priorities for caring for end-of-life patients within the emergency setting.	What are priorities for palliative and end-of-life care in the emergency department?	Qualitative.	Four categories of questions were developed to better improve quality and efficiency of end-of-life care within the ED: 1) who is at greatest need for palliative care services 2) what is the best role for emergency providers to play when caring for the terminally ill 3) how does training of end-of-life care within the emergency department affect health-care utilization 4) what are educational priorities for emergency providers to better provide end-of-life care?	The previously discussed questions can help strengthen the evidence utilizing six classes of analysis: 1) descriptive 2) attitudinal 3) screening 4) outcomes 5) resource allocation 6) education of clinicians.	Using the six classes of analysis in real time.	Level VI
Sangeeta, L., & Tammie E., Q. (2011). Hospice care and the emergency department: Rules, regulations, and referrals. *Annals of Emergency Medicine*, *3*, 282.	Rules and regulations regarding hospice care in the emergency setting.	What are the rules and regulations amongst emergency department providing hospice care; is there a pattern of rules and regulation, or a lack of?	Expert opinion, committee report.	-A lack of specifics of care is present when caring for the hospice patient. -Traditional ED training does not address hospice as a system of care. -Many emergency professionals are not familiar with the hospice model. -Misinformation of inaccurate information may lead to failure to guide appropriate patient	-Review of several emergency department rules and regulation regarding geriatric care, hospice care, palliative care, care of the dying and death shows a lack of specifics regarding those mentioned services.	Systematic rules and regulation to drive the care of the dying patient.	Level VII

				referrals, leading to poor outcomes.			
Shearer, F. M., Rogers, I. R., Monterosso, L., Ross-Adjie, G., & Rogers, J. R. (2014). Understanding emergency department staff needs and perceptions in the provision of palliative care. *Emergency Medicine Australasia : EMA*, *26*(3), 249–255. https://doi.org/10.1111/1742-6723.12215.	Understanding the needs of staff when providing end-of-life care.	What are the needs and perception of the staff members providing end-of-life care within the emergency department?	Quantitative.	-66 participants reported only working knowledge of palliative care. -Participants stated proficiency in symptom control. -Confidence in palliative care provision was lower among nursing than medical staff but educational needs were similar.	-ED staff expressed confidence regarding symptom management in palliative care. -ED staff lacked understanding of the patients in whom a palliative approach could be applied and sought further education in areas, such as end-of-life communication and ethical issues.	ED specific training and clinical interventions in palliative care provision is needed and justified.	Level VI
Weng, T.-C., Yang, Y.-C., Chen, P.-J., Kuo, W.-F., Wang, W.-L., Ke, Y.-T., Hsu, C.-C., Lin, K.-C., Huang, C.-C., & Lin, H.-J. (2017). Implementing a novel model for hospice and palliative care in the emergency department: An experience from a tertiary medical center in Taiwan. *MEDICINE*, *96*(19). https://doi-org.ezp.waldenulibrary.org/10.1097/MD.0000000000006943.	Although end-of-life care has been deemed an essential part of ED medicine, there lacks consensus on best practice model in providing best quality end-of-life care.	Why is there a lack of consensus on best practice regarding end-of-life care within the ED?	Quasi-experimental.	-ED staff suggested additional need for resources regarding end-of-life care. -ED staff advocated for additional educational specific to the dying patient. -With additional knowledge and understanding, medical services can enhance patient satisfaction, while improving quality of the visit.	Additional staff knowledge regarding hospice care in the ED is needed to optimize hospice patient’s emergency room visits.	Implementation of Systematic approach to caring for the dying patient.	Level III

Evidence-Based Practice in Nursing and Health Care: A Guide to Best Practice (Melynk & Fineout-Overholt, 2011, p. 12.)

Appendix B: Melynk & Fineout-Overholt Levels of Evidence



Levels of Evidence	Description of the Evidence
Level 1	Evidence obtained from systematic reviews or meta-analyses of randomized controlled trials
Level 2	Randomized controlled trials
Level 3	Evidence obtained from well-designed controlled trials without randomization, quasi-experimental
Level 4	Evidence from well-designed case-control or cohort studies
Level 5	Systematic reviews of descriptive or qualitative studies
Level 6	Evidence obtained from a single descriptive or qualitative study
Level 7	Evidence obtained from the opinions of authorities and/or reports of expert committees

Evidence-Based Practice in Nursing and Health Care: A Guide to Best Practice (Melynk & Fineout-Overholt, 2011, p. 12.).

Appendix C: Disclosure for Anonymous Questionnaires

Questionnaires

To be given to an expert panelist prior to collecting questionnaire responses—note that obtaining a “consent signature” is not appropriate for this type of questionnaire and providing respondents with anonymity is required.

Disclosure to Expert Panelist

You are invited to take part in an expert panelist questionnaire for the doctoral project that I am conducting.

Questionnaire Procedures

If you agree to take part, I will be asking you to provide your responses anonymously, to help reduce bias and any sort of pressure to respond a certain way. Panelists’ questionnaire responses will be analyzed as part of my doctoral project, along with any archival data, reports, and documents that the organization’s leadership deems fit to share. If the revisions from the panelists’ feedback are extensive, I might repeat the anonymous questionnaire process with the panel of experts again.

Voluntary Nature of the Project

This project is voluntary. If you decide to join the project now, you can still change your mind later.

Risks and Benefits of Being in the Project

Being in this project would not pose any risks beyond those of typical daily professional activities. This project’s aim is to provide data and insights to support the organization’s success.

Privacy

I might know that you completed a questionnaire, but I will not know who provided which responses. Any reports, presentations, or publications related to this study will share general patterns from the data, without sharing the identities of individual respondents or partner organization(s). The questionnaire data will be kept for a period of at least 5 years, as required by my university.

Contacts and Questions:

If you want to talk privately about your rights in relation to this project, you can call my university’s Advocate via the phone number 612-312-1210. Walden University’s ethics approval number for this study is (Student will need to complete Form A in order to obtain an ethics approval number).

Before you start the questionnaire, please share any questions or concerns you might have.

Appendix D: AGREE II Tool

Domain 1. Scope and Purpose

1. The overall objective(s) of the guideline is (are) specifically described.

2. The health question(s) covered by the guideline is (are) specifically described.

3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

Domain 2. Stakeholder Involvement

4. The guideline development group includes individuals from all the relevant professional groups.

5. The views and preferences of the target population (patients, public, etc.) have been sought.

6. The target users of the guideline are clearly defined.

Domain 3. Rigor of Development

7. Systematic methods were used to search for evidence.

8. The criteria for selecting the evidence are clearly described.

9. The strengths and limitations of the body of evidence are clearly described.

10. The methods for formulating the recommendations are clearly described.

11. The health benefits, side effects, and risks have been considered in formulating the recommendations.

12. There is an explicit link between the recommendations and the supporting evidence.

13. The guideline has been externally reviewed by experts prior to its publication.

14. A procedure for updating the guideline is provided.

Domain 4. Clarity of Presentation

15. The recommendations are specific and unambiguous.

16. The different options for management of the condition or health issue are clearly presented.

17. Key recommendations are easily identifiable.

Domain 5. Applicability

18. The guideline describes facilitators and barriers to its application.

19. The guideline provides advice or tools on how the recommendations can be put into practice.

20. The potential resource implications of applying the recommendations have been considered.

21. The guideline presents monitoring or auditing criteria.

Domain 6. Editorial Independence

22. The views of the funding body have not influenced the content of the guideline.

23. Competing interests of guideline development group members have been recorded and addressed.

Appendix E: Clinical Practice Guideline

Purpose

The purpose of this guideline is to provide direction to ED nursing staff on the management of hospice and/or end-of-life care patients in the ED.

Procedure

- The CPG will be reviewed with all ED nurses on implementation.
- The CPG will be included in the nurses' orientation to the ED.
- The CPG will be included in the annual HealthStream training.
- The CPG will be included in the policy and procedure manual on the PULSE page, available for review as needed.
- The CPG will be used to direct hospice care in the ED.

Question

What information do ED nurses need to provide quality hospice care in the ED?

Target Population

The CPG will be a tool to address lack of knowledge related to hospice care in the ED setting for ED nurses.

Recommendations

There is a lack of knowledge on caring for hospice patients in the ED, while the literature shows that education and guidelines can help nurses provide quality care.

- ED nurses lack proper knowledge, skills, and appropriate delivery of end-of-life care (Clark et al., 2015).
- Research indicates that ED staff members function under their own sets of knowledge and beliefs regarding end-of-life patient care (Clark et al., 2015).
- The literature is exceedingly suggestive of the need for increased evidence-based guidelines to improve ED nurses' competencies regarding end-of-life care (Clark et al., 2015).
- Integrating quality end-of-life care in the ED will need a paradigm shift in how care is performed and where comprehensive ED hospice care is a core element of practice (Quest & Lamba, 2020).

Key Evidence

- Experience in the ED suggests that patients suffering from terminal illnesses or in hospice care are always stuck in a repetitive pattern of emergency care, wasting resources and failing to have their needs met (Clark et al., 2015).
- Hospice care is appropriate when nearing end-of-life and is a service that can begin in any setting, including the ED. Therefore, providing an end-of-life clinical guideline for nurses in the ED should improve the level of hospice care delivered.
- Practice guidelines addressing hospice care are crucial to quality care for such patients. Quality care can be implemented using a CPG to highlight practice guidelines and clinical practice (Batchelor, 2015).
- Increased hospice practice guidelines and education is showing to be not only cost-effective but resulting in increased patient and family satisfaction. When quality care is

being provided, patients and their families can focus on what is important to them, rather than their illness (Levine et al, 2019).

Guideline Monitoring

- The guideline should be reevaluated every 3 years or when new hospice care recommendations within the ED are published.
- Barriers to applying this guideline should be addressed as they arise by the nurses and before implementation.

Hospice Care in the ED: A Clinical Practice Guideline

This guide is intended for ED nurses to provide non-biased, quality hospice care to patients being seen in the ED.

- Why is hospice care provided in the ED?
    - Patients with chronic, severe, or life-threatening conditions would benefit from hospice care interventions present to the ED when symptoms cannot be managed within the home setting.
    - ED nurses should engage patients and their families in conversations about hospice services.
        - Early recognition and referrals from the ED to hospice medicine, when indicated, can provide benefits to both quality and quantity of life.
- Why is the integration of hospice care so important in the ED?
    - Early integration of hospice care can substantially improve patient care by involving hospice clinicians early in the decision-making process. The ED can ensure the patients and families make decisions with the best available information.
    - Early integration of hospice care is linked with a better quality of life, better understanding of the illness, improved access to home care, improved emotional and spiritual support, increased patient well-being and dignity, improved care oat the time of death, and decrease symptom burden.
- Hospice care skills expended of ED nurses:
    - Content areas and competencies for the primary-level practice of hospice care includes:
        - Recognition of hospice needs in patients.
        - Primary-level provider skills in hospice care.
        - Logistic understanding of hospice care in the ED.
- Hospice conditions commonly managed in the ED:
    - Older adults with dementia or multimorbidity.
        - Frail elderly with advanced dementia or multiple morbidities are generally transferred from long-term facilities with unstable vital signs, acute decline, precipitous decline, and unclear care goals that contribute to a significant population of patients treated in the ED.
    - Advanced malignancy.
        - Metastatic cancers often present with high symptom burden on patients, especially the burden of pain.
    - Severe or incurable neurologic conditions.
        - Stoke and intracranial bleeds are common reasons to initiate conversations in the ED about goals of end-of-life care.
        - Irreversible hypoxic brain injuries and chronic conditions diminish the quality of life.
    - Resuscitations/cardiac arrests.
        - When the prognosis of prolonged cardiopulmonary resuscitation (CPR) is low, involving hospice care may be appropriate for care goals.
    - Organ failure.

        - End-stage heart failure, chronic obstructive pulmonary disease (COPD), liver disease, and/or renal disease benefit from end-of-life care, although the trajectory of functional decline in these patients can be erratic and unpredictable.
- Why do patients come to the ED with known advanced illness?
    - New or worsening of chronic symptoms
        - Pain
        - Dyspnea
        - Constipation
        - Nausea
        - Vomiting
        - Weakness
    - Reduced functional status
        - Increased frailty
    - Altered mental status
        - Delirium
    - Psychological distress
    - Social issues
        - Lack of caregiver
        - Caregiver distress
        - Poor or lack of care coordination
    - Social concerns
        - Financial
        - Employment
        - Housing
    - Clarity
        - Questions about prognosis or treatment options
- General guidance:
        - Do not use vague language.
        - Avoid the use of medical jargon.
        - Avoid delays in delivering bad news, if possible.
        - Do not delegate end-of-life tasks to those without sufficient experience.
        - Avoid abrupt ends or premature ends to discussions when possible.
        - Consider having a social worker accompany you to provide support, especially if needed to leave the room.
- Common symptom management
    - Dyspnea
        - Supplemental oxygen
            - If hypoxic on room air
        - Opioids are first-line drugs
            - 5-10mg morphine parenteral route
            - It can be redosed 5-15 mins IV or 60 mins oral.
        - Dyspnea can trigger anxiety
            - Administer benzodiazepines
        - Use of cold air toward their face may help alleviate symptoms
        - Noninvasive ventilation

- May be considered as an end-of-life measure in the dying patient who has severe dyspnea.
- Severe pain
  - Choose a treatment algorithm
    - Obtain past and present opioid use history.
      - What opioids have been taken?
      - How many opioids have been taken?
    - Patients who have not taken opioids regularly should be considered naïve, and long-acting opioids should be avoided.
  - Select a medication and dose
    - Morphine is usually the drug of choice.
    - Past and present opioid use history will help to dose ranges.
  - Route of administration
    - IV is generally best for controlling severe nociceptive pain that is new or getting worse.
    - Oral pain medication can manage mild or moderate chronic pains if the patient can swallow.
  - Perform pain reassessment
    - Reassessment should be done 10 to 15 minutes to achieve adequate pain control safely.
- Constipation
  - All opioids cause constipation-hospice patients generally take opioids at home.
    - Verify no evidence of bowel obstruction
    - Rectal therapy
      - Bisacodyl
      - Glycerin
    - Osmotic laxative
      - Polyethylene glycol
      - Magnesium hydroxide
      - Magnesium citrate
- Nausea/Vomiting
  - Often multifactorial, especially in patients with cancer
    - Antiemetics
      - Prokinetics
        - Ondansetron
        - Granisetron
      - Dopamine antagonists
        - Haloperidol
      - Histamine antagonists
        - Cyclizine
      - Muscarinic antagonists
        - Hyoscine butylbromide

GENERAL GUIDANCE
Don’t use vague language
Avoid medical jargon
Don’t delay bad news
Don’t delegate end-of-life tasks to those without experience
Avoid disruptions when talking with the patient
Consider having a social worker accompany you to provide support
DYSPNEA
Supplemental Oxygen
Opioids
Benzodiazepines
Noninvasive ventilation
PAIN
What have they been on?
How much are they taking?
Start low and go slow
Reassess pain every 10-15 minutes
CONSTIPATION
Verify NO BOWEL OBSTRUCTION
Rectal therapy (Bisacodyl/Glycerin)
Laxatives
NAUSEA / VOMITING
Antiemetics
WEAKNESS/REDUCED FUCNTIONAL STATUS
Review medications
Assess strength
Discuss progression of disease vs. stage of dying
ALTERED MENTAL STATUS
Review meds
Discuss medication optimization/reconciliation
PSYCHOLOGICAL DISTRESS
Respite referral
Social service referral
CLARITY
Explain
Discuss disease process/symptomatic control
Answer questions
Refer to spiritual advisors if needed

Staff Signature:____Date:____________________

Educator Signature:______________________________________Date:_____________________

References

Batchelor, N. H. (2015). A quality improvement assessment of emergency department visits by hospice home care patients. *Journal of Hospice & Palliative Nursing*, *17*(5), 442.

Clark, P. A., Maxwell, D., & Malone, M. S. (2015). Addressing patients' emotional and spiritual needs. *Joint Commission Journal on Quality and Safety.* https://pubmed.ncbi.nlm.nih.gov/14679869/

Levine, S., Malone, E., Lekiachvili, A., & Briss, P., (2019). Health care industry insights: Why the use of preventive services is still low. https://www.cdc.gov/pcd/issues/2019/18_0625.htm

Quest, T. E., & Lamba, S. (2020). Palliative care for the adults in the emergency department (ED). https://www.uptodate.com/contents/palliative-care-for-adults-in-the-emergency-department-ed

Appendix F: AGREE II Group Appraisal

APPRAISAL OF GUIDELINES RESEARCH & EVALUATION

AGREE II

A critical group appraisal of:
A Clinical Practice Guideline: Hospice Care in the Emergency Room using the AGREE II Instrument

Created with the AGREE II Online Guideline Appraisal Tool.

Coordinator: Sam Saad, MSN, APRN, AGNP-BC

Date: 14 January 2021

Email: samer.saad@waldenu.edu

URL of this appraisal: http://www.agreetrust.org/group-appraisal/14113

Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6	OA 1	OA 2
98%	94%	90%	96%	92%	92%	100%	Yes - 3, Yes with modifications - 0, No - 0

Guideline URL:

Domain 1. Scope and Purpose			
	Appraiser 2	Appraiser 1	Appraiser 3
Item 1	7	7	7
Item 2	7	7	7
Item 3	7	7	6
Domain 2. Stakeholder Involvement			
	Appraiser 2	Appraiser 1	Appraiser 3
Item 4	6	7	7
Item 5	7	6	7
Item 6	7	7	6

Domain 3. Rigour of Development			
	Appraiser 2	Appraiser 1	Appraiser 3
Item 7	6	6	7
Item 8	7	6	7
Item 9	6	7	6
Item 10	7	7	7
Item 11	6	5	7
Item 12	6	6	6
Item 13	7	7	6
Item 14	5	7	7
Domain 4. Clarity of Presentation			
	Appraiser 2	Appraiser 1	Appraiser 3
Item 15	7	6	7
Item 16	7	7	7
Item 17	6	7	7

Domain 5. Applicability			
	Appraiser 2	Appraiser 1	Appraiser 3
Item 18	6	6	6
Item 19	6	7	7
Item 20	6	7	7
Item 21	7	7	6
Domain6. Editorial Independence			
	Appraiser 2	Appraiser 1	Appraiser 3
Item 22	7	6	7
Item 23	6	6	7
Overall Assessment			
	Appraiser 2	Appraiser 1	Appraiser 3
OA1	7	7	7

Created online at www.agreetrust.org 14 January 2021