

5-1-2015

## Increasing Comfort With End-of-Life Discussions

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# INCREASING COMFORT WITH END-OF-LIFE DISCUSSIONS

By

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2010

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A doctoral project submitted in partial fulfillment  
of the requirements for the

Doctor of Nursing Practice

School of Nursing  
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May 2015

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entitled

**Increasing Comfort with End-of-Life Discussions**

is approved in partial fulfillment of the requirements for the degree of

**Doctor of Nursing Practice**

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**May 2015**

## Abstract

End-of-life discussions and advanced care planning are part of the healthcare process, and within the scope of practice for providers. Despite the evidence supporting the effectiveness of these conversations, the system falls short. Talking about death is never easy. At times, it is difficult for healthcare providers to approach the topic with patients who are living with serious life-limiting illness. Reports in the end-of-life literature reveal that healthcare professionals avoid discussions about preparations for end-of-life care due to feeling unprepared, and a lack of framework for such discussions. **Purpose:** The purpose of this doctoral project was to improve the quality of end-of-life care for patients with life-limiting illnesses by increasing provider comfort with end-of-life conversations. **Method:** This project was a Quazi-experimental pre and post intervention design. A pre-intervention baseline assessment of healthcare providers comfort with end-of-life discussions through a self-assessment survey and retrospective chart audits was conducted. An educational intervention was completed implementing an evidenced-based tool to guide end-of-life discussions. Healthcare providers were instructed to utilize the tool for sixty days to guide them in end-of-life discussions on appropriate patients. Post intervention data was collected to include a repeat of the self-assessment survey and retrospective chart audits to determine changes in comfort level. **Conclusion:** Providers reported increases in level of comfort and demonstrated an increase in conversations from baseline.

Key Words: end-of-life

## **Acknowledgments**

This doctoral project would not have been possible without the love, support, and encouragement of my husband and children. I thank them for the sacrifices they have made and the encouragement they have provided during my graduate studies.

*Dedicated to my son Alonzo Thomas Berton~  
My Inspiration  
Forever in my Heart*

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## **Chapter I**

### **Introduction**

Communication at the end-of-life stage is imperative to patient outcomes such as relief from distress, improved coping, and satisfaction. Successful palliative care is dependent on the healthcare provider's ability to elicit and comprehend the problems of the dying patient, and have an understanding of the patient's end-of-life care goals. The primary goal of end-of-life discussions is to ensure that treatments are consistent with patient preferences. However, many people, including healthcare providers, are uncomfortable talking about dying (Rizzo et al., 2010).

Few would deny that addressing and discussing end-of-life care planning is an essential component of healthcare provider-patient communications. So, why do healthcare providers avoid this important component of patient care? Findings in the end-of-life literature reveal that healthcare professionals avoid discussions about preparation for end-of-life care for a multitude of reasons (Heyland et al., 2009; Duke, 2010; Rizzo et al., 2010; Seymour, Almack, & Kennedy, 2010; Abarshi et al., 2011; Boyd, Merkh, Rutledge, & Randell, 2011; You, Fowler, & Heyland, 2013).

Reasons why end-of-life discussions do not occur as often as they should are related to healthcare providers feeling unprepared, and a lack of structured framework to have such discussions (Rizzo et al., 2010; Sharp, Morar, Kuhn, & Barclay, 2013). Other identified reasons as to why these crucial communications do not occur include providers feeling unable to articulate patient care choices, feeling pressured for time, allowance for distractions, and providers' lack of ability to acknowledge patients' emotions. In addition, many providers offer false reassurance before the main problems

have been identified (Schapira, Tulskey, Buckman, & Pollack, 2008). Despite death being a certain outcome, patients and their families may be told the prognosis is poor, that the patient is seriously ill, the disease is progressing, or that the patient is failing to respond. Very seldom do patients hear that they are dying or likely to die (Workman, 2010).

Providing compassionate end-of-life care in accordance with patient preferences is an essential component of healthcare. Patients benefit greatly from having their end-of-life wishes defined; however, until healthcare professionals are more comfortable with initiating these discussions, many patients will continue to have life-sustaining treatments that prolong suffering, and in many cases are unwanted. Providers who are experienced and comfortable with end-of-life discussions are more likely to engage in communication and assessment strategies that facilitate end-of-life decision-making.

### **Problem Statement**

Due to different cultural, societal, and individual expectations, combined with advances in technology and extraordinary procedures, death has become a medical event rather than an expected part of life (Institute of Medicine [IOM], 2013). The IOM, in its report entitled *Approaching Death: Improving Care at the End of Life* (1997), identified four deficiencies in the care of people with life-threatening and incurable illnesses. One of the findings of that report was

“The education and training of physicians and other healthcare professionals fail to provide them with the attitudes, knowledge, and skills required to care well for the dying patient” (Institute of Medicine [IOM], 1997).

More than fourteen years later, the progress is slow. Too many Americans spend the last days of their lives in a way they would never choose; in a hospital bed enduring the best that modern technology has to prolong life (Meier, 2010). This is true, in part, due to healthcare providers' lack of comfort with initiating end-of-life discussions. End-of-life communication is becoming one of the most widely discussed issues in healthcare. There are multiple organizations with initiatives to assist providers and patients with tools to have these necessary discussions, including the Institute for Healthcare Improvement and Coalition for Compassionate Care of California. Despite this emphasis, patients continue to receive care that is futile, and over 60% of patients do not have advanced care planning documented (Coalition for Compassionate Care of California, 2012). This leads to family members and healthcare teams struggling to make decisions surrounding care.

The recognition of a problematic practice in end-of-life discussions is not new. In fact, the historical beginnings of focus on this topic date back decades in our practice. The *Study to Understand Prognoses and Preferences Outcomes Risk of Treatment* (SUPPORT), published in 1995, was a landmark study that set the stage for contemporary research about end-of-life decision-making. Phase I of the SUPPORT study, a multisite investigation into the delivery of end-of-life care, demonstrated that poor communication about end-of-life issues resulted in many patients receiving life-sustaining care that they did not want (Adams, Bailey, Anderson, & Docherty, 2011).

So, why focus on this problem now? The healthcare industry is experiencing unprecedented changes in which the importance of end-of-life care is underscored (Frost, Cook, Heyland, & Fowler, 2011). According to the Institute for Healthcare

Improvement, an estimated one million people in the United States die each year without important palliative care services. Despite both federal and state laws that advocate for these conversations, and that healthcare consumers routinely have their preferences for end-of-life ascertained, this component of care continues to be a challenge in the United States healthcare system, leading to spiraling costs and declining patient satisfaction (Institute for Healthcare Improvement [IHI], 2011).

A key element of high quality care at end-of-life is communication through end-of-life discussions. According to Cherlin (2005), multiple studies have examined what is important to patients at their end-of-life stage, and having a clear understanding of their illness and treatment options is frequently mentioned. As a patients' death approaches, truth-telling by healthcare providers may assist patients and families with a movement toward closure and discussion of end-of-life care preferences. It is well documented in the literature that these discussions do not occur as frequently as they should, and when they do occur, patients often express dissatisfaction with healthcare provider performance and with the quality of the interaction. Performance issues are related to a lack of specific communication techniques such as establishing a rapport with the patients, devoting time to explanations, and not addressing emotions (Schapira et al., 2008; Heyland et al., 2009; Frost, Cook, Heyland, & Fowler, 2011).

The foundation of this project is an educational intervention for healthcare providers on how to communicate end-of-life discussions with a goal of increasing the frequency of this imperative component of patient care. In order to increase healthcare provider comfort with end-of-life discussions, training on how to communicate with patients who have poor prognosis and require end-of-life care is necessary (Gordon,

2003; Schwartz, Goulet, Gorski, & Selwyn, 2003; Duke, 2010; Frost et al., 2011; Smith & Hough, 2011; Rose & McDonald, 2012; You et al., 2013).

## Chapter II

### **Literature Review Supporting Education in End-of-life Discussions**

An Internet search was conducted using nursing (Cumulative Index of Nursing and Allied Health Literature (CINAHL), medical (MEDLINE, PUBMED) and Google Scholar databases. Research articles and systematic reviews of end-of-life discussions were identified using various combinations of the key words: end-of-life communication, end-of-life discussions, healthcare practitioners, healthcare providers, palliative care, physician order for life-sustaining treatment, end-of-life decision-making, end-of-life education, patient-centered care, and advanced care planning. The search produced thousands of publications on this topic. Although there is documentation in the literature to support the problem statement dating back to more than a decade, inclusion criteria were publications from January 2006 through January 2014, to obtain a more current status of the problem. Articles were chosen if they: (1) addressed end-of-life discussions between healthcare providers and patients; (2) were published in English; and (3) focused on adult (versus pediatric) populations.

One consistent theme in the literature pertaining to end-of-life discussions was the opportunity that exists for healthcare providers to improve their communicative ability when having these essential conversations with patients with life-limiting illness. Areas for communication improvement identified were providers' ability to articulate patient care choices, conversation structure, ability to cope with emotional reactions of patients and families, and timing of conversations (Furman, et al., 2006 ; Heyland et al., 2009; Rizzo et al., 2010; Workman, 2010; Fine, Carrington-Reid, Shengelia, &

Adelman, 2010; Duke, 2010; Abarshi et al., 2011, Frost et al., 2011, Rose & McDonald, 2012; You et al., 2013 & Sharp et al.s, 2013).

Seriously ill patients and their healthcare providers often avoid discussing prognosis due to healthcare providers' inability to communicate available patient care choices, which compromises optimal end-of-life care. Healthcare providers' lack of training or knowledge in specific treatment modalities at end-of-life and fear of inability to answer patient questions related to choices, cause provider discomfort with end-of-life discussions (Workman, 2010; Duke, 2010; Frost et al., 2011; Rose & McDonald, 2012; You et al., 2013).

Workman (2010) discusses how the language that providers often unconsciously use contributes to the inappropriate care that patients frequently receive at their end-of-life stage. For example, a provider might use phrases like, "doing badly" when the provider really means, "you are dying." Inappropriate care, or care that does not match the prognosis, is a result of providers not communicating clearly that treatment will not prevent the patient from dying. The lack of clarity often leaves patients with false hope, and opting for treatments at end-of- life that are futile. Workman further discusses how euphemism-free communication will assist patients in better understanding their prognosis and choices. According to Workman, healthcare providers should clearly communicate ineffectiveness related to treatments, explaining that treatments will not or are not going to allow for survival.

At the end-of-life stage, communications around important decisions, such as resuscitation are not always done well. According to Duke (2010) this is, at times, due to the providers' limited knowledge in life-sustaining treatment modalities, or lack of

ability to articulate them. Healthcare providers must educate themselves on choices related to advanced directives and goals of care. Furman et al. (2006) conducted a study on improving providers' ability to articulate advanced directives. The foundation for their study resulted from research findings that demonstrated only 41% of fourth-year medical students recognized the importance of having the ability to discuss an advanced directive. They also found that a mere 27% had ever had the opportunity to have such a discussion with a patient. Due to the small sample size of providers trained in the study, statistical significance was not achieved; however, the study did illustrate the fact that patients at end-of-life are often not having advanced directive discussions.

Conversation structure is another topic in the literature. Rizzo and associates (2010) reported that the reluctance of providers to initiate end-of-life discussions was based on feeling unprepared to have the discussion because of personal discomfort and lack of training with the task. Their study demonstrated how the use of a structured framework in initiation of end-of-life discussions assisted healthcare providers with opening the door to deeper end-of-life conversations. Advanced Illness Coordinated Care Program, a controlled intervention trial, involved training healthcare providers how to counsel, educate, and assist with coordination of care for patients at end-of-life. The intervention was delivered primarily in the outpatient setting, and focused on healthcare provider influence with patients' ambivalence to end-of-life discussions through structured communication techniques (Rizzo et al., 2010).

Frost et al. (2011) provided a systematic review of the literature, examining 6,259 publications, which focused on professional factors influencing end-of-life discussions during critical illness. Publications were chosen if they were controlled



trials, surveys, or observational studies that addressed associations among patient and healthcare team characteristics with end-of-life discussions. The main finding of their review demonstrated that patients and healthcare providers approach end-of-life discussions with different expectations and preferences that are influenced by a number of factors.

The review found that a lack of training and conversation structure for end-of-life discussions were contributing factors in the initiation of conversations. They reported that the provider specialty, place of training, and experience affected their ability to conduct end-of-life discussions. For example, they found that physician factors associated with discussions of forgoing treatment in the Intensive Care Unit was practiced by providers that had American training compared to European training. American-trained providers had these discussions with twenty-two of twenty-nine patients whereas European-trained providers had discussions with just three of sixteen patients (Frost et al., 2011). Provider specialty also had an influence on end-of-life discussions with nephrologists more likely than internists to offer cardiopulmonary resuscitation to dialysis patients who were critically ill. Patients managed by oncologists were more likely to undergo chemotherapy, and spend greater than fourteen days at the end-of-life stage in a hospital. More experienced residents were significantly less likely to recommend aggressive measures during end-of-life discussions, and staff intensivists were more likely to discuss advanced directives including “Do Not Resuscitate” orders. Appreciating all of these factors associated with end-of-life care may raise awareness, facilitate communication, and guide healthcare providers with end-of-life discussions (Frost et al., 2011).

Rose and McDonald (2012) recognized that the residents and medical students at their facility were often uncomfortable with end-of-life discussions. Through direct observation from nursing leadership, it was determined that these individuals required additional or supplementary training on communication structure with patients at their end-of-life phase. Baseline data of current attitudes, confidence levels, and therapeutic communications being utilized by providers was gathered through a self-evaluation questionnaire. Once that data was collected, their intervention was to teach the residents and medical students how to have end-of-life discussions in the critical care setting utilizing a tool to assist with communication structure. The tool is a conversation framework for end-of-life or prognosis discussions entitled SPIKES (*see Appendix F*). SPIKES is an acronym outlining the steps of the conversation as follows: (S) setting up the interview; (P) assessing patient perception; (I) obtaining an invitation to give information; (K) giving knowledge; (E) addressing emotional response with empathy; and (S) strategy and summary. Post intervention evaluation included utilizing the same self-evaluation questionnaire with an additional question on how the participants could change their practice based on the educational curriculum provided. Data demonstrated increased confidence in the medical students and residents in having end-of-life discussions.

Similarly, a lack of confidence and conversation structure as a communication barrier in end-of-life discussions was identified in a literature review conducted by You, et al. (2013). The publication also identifies and implements the SPIKES protocol as a tool for providers to use in the initiation of such discussions. To identify patients that are in need of this communication, You et al. (2013) recommends that providers ask

themselves “the surprise question,” which is “Would I be surprised if this patient died in the next year?” If the answer is no, an end-of-life conversation is to be initiated using the SPIKES protocol.

Additional communication opportunities exist in healthcare providers’ ability to address patient and family emotional issues at end-of-life (Shapira, et al., 2008; Fine et al., 2010). According to Shapira et al. (2008), the best way to support a patient emotionally during an end- of-life discussion is to demonstrate a genuine and caring presence. Having the ability to analyze a patient’s emotional reaction, and respond appropriately, is the key to successful end-of-life communication. For example, if a patient is deeply distressed or panicked, that should be acknowledged with validating statements such as “you seem frightened.” Part of the reason that healthcare providers are not skilled at dealing with emotional responses of patients at end-of-life is that they are medically-oriented, not psychologically-oriented (Shapira et al., 2008).

Fine et al. (2010) provided a systematic review of the literature pertaining to studies where patient-physician end-of-life discussions were directly observed. Of the twenty articles reviewed, a common theme was that providers tend to avoid emotional issues during the discussion. Moreover, providers need more instruction on how to interact with patients during conversations about poor prognosis, and how to process the host of emotions that these discussions raise. They also found that patient satisfaction proved to be higher when providers used supportive statements acknowledging patients and families feelings.

Conversation timing was another opportunity identified to improve end-of-life communication. Timing encompassed not only the time of initial communications, but

the time allowed for the discussion to take place. Earlier discussions about end-of-life care are associated with less aggressive care, and increased utility of palliative services in the last days of life (Mack et al., 2012). Failure to discuss end-of-life communications in a timely manner greatly affects the quality of palliative care for the dying patient.

A nationwide study among general practitioners discussing end-of-life issues, conducted by Abarshi et al. (2011), concluded that general practitioners often wait until very close to death before they discuss end-of-life issues with patients. The reasons for the delayed timing in discussions were a level of discomfort with the discussion as well as an inability to determine appropriate patients that require these discussions. Recommendations to remedy this issue were to implement a systematic needs assessment to determine appropriate timing for end-of-life discussions.

Duke (2010) spoke to finding the right moment to initiate, and allowance for ample time to have the conversation. Identifying the right time to begin conversations is essential to facilitate an open dialogue. Sharp et al. (2013) conducted a systematic review of the literature surrounding advanced care planning discussions with frail patients. Their findings also included time challenges as a barrier to end-of-life discussions. Sharp et al. (2013) reports that healthcare providers feel the pressure to see a large number of patients daily. This creates a conflict for them as they feel the time necessary to hold these conversations is not possible with the amount of patients they must see each day, which greatly reduces their ability to have them.

### **Significance to Advanced Nursing Practice**

According to the American Association of Colleges of Nurses (AACN) and the Robert Wood Johnson Foundation (RWJF), the United States is facing the realization of an aging population, recognition of the limits and inappropriate use of technological resources, and concerns about the capabilities of healthcare providers (AACN, 1998). As America moves into the 21<sup>st</sup> century, an issue of focus is how people die in this country. Improving care at the end-of-life phase is a concern of many healthcare disciplines; however, the nursing profession is particularly well suited to lead these efforts. An Advanced Practice Nurse (APN) with a Doctorate of Nursing Practice (DNP) has a significant role in the patient population requiring end-of-life care. Their role is one aligned with leadership, requiring systems thinking; the implementation of evidenced-based practice, healthcare policy advocacy, and interprofessional collaboration to improve care provided to patients at their end-of-life.

Specific to this project, the APN is significant to the identification of a practice that is in need of improvement, and implementing evidenced-based research in an attempt to improve practices. Peterson (2011) suggests that the bleak outlook of healthcare in the United States, related to an anticipated shortage of healthcare providers and access to quality care, necessitates rapid evolution of advanced practice nursing to a station of leadership. The Institute of Medicine (IOM) and The Joint Commission (TJC) in collaboration with AACN, is calling for advanced nursing practitioners to reconceptualize health professional's education and development to meet the evolving needs of the healthcare system.

The role of the APN is recognized at a national level. The Institute of Medicine's (2010) *The Future of Nursing* report calls for the need to transform nursing education.

APNs are critical to the success of healthcare reform, including changing current practice surrounding end-of-life care. Another national institution that recognizes the role of the APN in palliative care and end-of-life care is the Robert Wood Johnson Foundation (RWJF). In 2001, the Foundation led *Promoting Excellence in End-of-Life Care*—a program designed to identify, promote, and institutionalize care practices that allow seriously ill patients and their families to approach end-of-life comfortably from physical, psychological, spiritual, and emotional perspectives (RWJF, 2009). The RWJF assembled a group of APNs to discuss the state of palliative care advanced practice nursing in the United States. The group was challenged to identify gaps in current practice, and to develop a strategic plan for the future. Three objectives of this initiative were facilitation of conversation among nursing leaders about improving the state of palliative care advanced practice nursing; illustrating successful models in advanced practice nursing; and promoting the advanced practice nurse's role in providing palliative care. Key results of this project included the creation of new models in the delivery of palliative care including within-hospital intensive care units.

The role of the APN in end-of-life care was established more than a decade ago. It is time for the APNs to take their rightful place, not only as leaders in the professional practice of nursing, but leaders in the practice of healthcare. They must practice to their fullest ability, and collaborate with other healthcare professions to improve care for this vulnerable patient population at their end-of-life stage (Giovanni, 2012).

### **Needs Assessment and Description of the Project**

End-of-life care has been a topic of research from a quality perspective for decades (Giovanni, 2012). The need for this project was identified through an

assessment of the population affected by the problem of healthcare providers' inability to communicate with patients at end-of-life. This was achieved in the review of demographic data from public sources, internal organizational data in the form of retrospective chart reviews, and interviews with healthcare providers at the clinic.

For purposes of this project, a needs assessment was completed identifying the population affected by the problem, identification of key stakeholders, conducting an organizational assessment, project team selection, presentation of a cost-benefit analysis, and defining the scope of the project.

### **Population Identification**

The first step of the needs assessment was to identify the affected population specific to the institution. The project leader conducted a retrospective chart review looking at a 30-day timeline to identify patients diagnosed with advanced to late stages of cancer (stage 3 and 4) that had not been referred to palliative care, and had not had recent end-of-life care planning discussions. In addition, a report that demonstrated 220 patients had been admitted to the medical center and expired within 24-hours of admission was discussed with the Chief and the Clinical Nursing Director. It was agreed that some of the patients could have benefited from an end-of-life discussion. The Clinical Nursing Director shared observations related to end-of-life conversations, and the reluctance of providers to have the conversation. Moreover, the director shared that as she discussed this with her staff, providers in the clinic, and patients, she has realized that they have some opportunities for improvement with this component of healthcare.

A broader needs assessment, through the review of demographic data and public reports, revealed that the need exists at a local level as well as in the state of California.

The California Healthcare Foundation released a report in 2013 discussing end-of-life care in the state. *End of Life Care in California: You Don't Always Get What You Want* (2012) addresses the reality in the state that healthcare consumers' preferences at times did not match their care at end-of-life. In addition, the Coalition for Compassionate Care of California published a report of similar findings. To summarize the reports, Californians admitted to wanting less as opposed to more medical intervention at the time of death.

- 67% of Californians say they prefer natural death if terminally ill. Only seven percent say they want everything done;
- 82% say documentation of end-of-life wishes are important, only 23% have done so;
- 80% say they would definitely speak with their doctor about end-of-life wishes, but only seven percent have had a healthcare provider speak with them; and
- 70% said they would rather die at home than in a nursing home or hospital (Coalition for Compassionate Care of California, 2012; California Healthcare Foundation [CHCF], 2013).

Compared to the country as a whole, California had more patients die in the hospital, a higher percentage of Intensive Care Unit (ICU) days, and deaths in the ICU, than any other state in the country (CHCF, 2013). From 2003 to 2010, according to the California Healthcare Foundation, the chances of a California Medicare beneficiary dying in a hospital was 25% more likely as compared to the rest of the United States. The rates of ICU admission hospital deaths varied regionally with Los Angeles being the



highest at 28.7%, followed by San Francisco at 25.8%, and Stockton at 24.6% (CHCF, 2013).

Additionally, the levels of hospice days in the state were below average as compared to the rest of the country. Nationally, the average number of hospice and palliative care days per patient during the last six-months of life increased from 12.4 days to 21.0 days between 2003 and 2010. Unfortunately, the state of California's rate lagged behind the rest of the country with only an increase from 10.2 to 16.8 days in the same time frame. These statistics are not consistent with what California healthcare consumers say they want (CHCF, 2013).

### **Project Sponsor and Key Stakeholders**

The project sponsor is a non-profit, faith-based, community healthcare facility located in Southern California. The medical center consists of a 384 inpatient hospital, and several outpatient clinics, including a cancer center and a transitional medical clinic. The institution offers a wide variety of services from a multitude of medical and surgical specialties. By offering the highest quality care with compassion and respect, the medical center has met the needs of the community for more than 50 years.

Both internal and external key stakeholders were identified as individuals who have a vested interest in the outcome of this project. Individual internal organizational sponsors partnering with the student include the Chief of Oncology Clinic; the Director of Evidence-based Practice and Palliative Care; Executive Leadership of the medical center, including the Chief Executive, Chief Operating, and Chief Nursing Officers; Clinical Nursing Director and healthcare providers of the Oncology Medical Clinic; and the patients. External stakeholders include payers from a reimbursement/cost standpoint,

regulatory agencies concerned with patient quality of care, and interest groups such as Coalition for Compassionate Care of California who advocate for end-of-life care.

The most important stakeholders of this project are the patients at end-of-life who are so desperately in need of quality care. In addition, the families and caretakers have a vested interest in the success of the proposed project, as an increase in provider comfort and subsequent end-of-life discussions will ensure that the invaluable time that they have with their terminally ill loved ones will be spend in accordance with their wishes.

### **Organizational Assessment**

To ensure that the project mission and values align with that of the organization, an organizational assessment was completed. End-of-life care is concerned with patient quality and advocacy of care at time of death. The project focuses on ensuring that patients' wishes are addressed to facilitate a peaceful end-of-life. Being a faith-based organization that values quality care at end-of-life, the medical center is aligned with project values. The organization advocates for systems and structures that are attuned to the needs of the vulnerable and disadvantaged, which is consistent with advocacy at end-of-life.

Organizational needs assessment was also established by reviewing data related to inpatient mortality, specifically patients who were admitted to the organization with end stage terminal illness and died shortly after admission. These patients would have been better suited in palliative or hospice care rather than in an acute care facility.

### **Resources**

An assessment of available resources was conducted early in the project development and planning phase. The cost of implementing this project is quite minimal. There were direct costs in the supply of educational materials. Specific costs include printed materials with informational tools such as SPIKES protocol to use as a reference in initiating end-of-life discussions. This is estimated at no more than \$400.00. Providers participated in the educational program which was conducted at the clinic with the providers during a staff meeting. Although the healthcare providers are salaried personnel, their time was accounted for at an average of \$45.00 per provider per hour, with six providers, is equal to \$270.00 (See Appendix C). Additional costs included time to conduct a baseline assessment using, with permission, Dr. Weismann's, *Self-Assessment of Clinical Competency and Concerns in End-of-Life Care* (See Appendix D). This was completed by the student, and did not entail a financial burden to the institution.

### **Team**

Team selection for project completion included the DNP student, the Director of Evidence-based Practice, the Clinical Nursing Director, the Chief of Oncology Medicine for the medical center, an Intensivist board certified in palliative care medicine, and a Nurse Practitioner certified in palliative care. The roles of each team member are as outlined:

- The DNP student role was project management, development, implementation, and evaluation;

- The Director of Evidence-based Practice was a support and mentor to the DNP student who is assisted with networking and facilitation of IRB application as well as co-sponsoring the application at the sponsoring institution, if necessary;
- The Nursing Clinical Director of the Cancer Center was a project facilitator assisting with timelines for project implementation and arranging schedules to allow for education and data collection;
- The Chief of Oncology Medicine was the physician champion for the project and supports provider participation; and
- The Nurse Practitioner and Board Certified Intensivist in palliative care medicine are ad hoc team members assisting with development of the education program.

With permission from the author (See Appendix F), the SPIKES protocol was the communication tool the providers were instructed to use with the intent of increasing their comfort and ability to have end-of-life discussions. Education included video lectures of SPIKES protocol, written materials for reading, and role-playing to expand knowledge and comfort with end-of-life discussions. The time frame for the education was 60-minutes, therefore, educational content was developed to meet that time frame.

### **Cost-benefit Analysis**

End-of-life discussions can impact cost and benefits from both a financial and quality assurance perspective. From a financial perspective, the primary financing vehicle for end-of-life care in the United States is the Federal Medicare program. Approximately 25-30% of Medicare program benefits are spent on end-of-life care (Jennings & Morrissey, 2011). In 2011, according to the Henry J. Kaiser Family Foundation, Medicare spending reached close to \$554 billion, which amounted to 21%

of total spending on U.S. healthcare in that year. Of that \$554 billion, Medicare spent 28%, or approximately \$170 billion, on patients' last six-months of life (Henry J. Kaiser Family Foundation [HJKFF], 2014). With the slowing economic growth in this past decade, and baby-boomer enrollment in the Federal program, it is expected that end-of-life financial burdens that fall on public program financing and families will continue to grow (Jennings & Morrissey, 2011). End-of-life discussions eliciting patient preferences will assist with ensuring that healthcare resources utilized will be consistent with patient wishes rather than allocated for futile treatments that are unwanted, unbeneficial to the patient, and costly to the healthcare system.

There is a growing body of evidence demonstrating that the use of palliative care services is cost effective in various healthcare settings (Taylor, Ostermann, Houtven, Tulsky, & Steinhauser, 2007; Morrison et al., 2008; Conner, 2008). To determine a cost-benefit analysis for the project, a cost avoidance approach was utilized examining intensity of care and cost at end-of-life. At the national level, it is reported that from 1996–2007, 12.5% of Medicare recipients spent at least one week in the Intensive Care Unit during the last six-months of life. By 2007, that percentage had increased to 20.3%. One in three Medicare recipients had surgery their last year of life; one in five had surgery their last month of life; and one in ten had surgery their last week of life. In their last two years of life, patients with chronic illness account for 32% of total Medicare spending. In the state of California, almost one-third of Californians see ten or more physicians in the last six-months of life (Coalition for Compassionate Care of California, 2012).

A number of randomized control trials of palliative care interventions, resulting from end-of-life discussions, have demonstrated a significant savings through cost avoidance (Brumley, Enguidanos, & Jamison, 2007; Gade, Venohr, & Conner, 2008). Two individual health systems recently showed that patients receiving palliative care by interdisciplinary teams had equal or better care with lower overall costs (Brumley et al., 2007; Gade et al., 2008). The first study by Brumley et al. (2007) studied patients in the Kaiser Permanente health maintenance organization, of which 161 were in the palliative care program, and 139 were in the comparison group. Their conclusions were that the patients in the palliative care program had lower emergency department visits and hospital days, and an overall 45% reduction in costs as compared to the usual care patients. In the second study conducted by Gade et al. (2008), 517 patients with life-limiting illnesses were randomized between interdisciplinary palliative care (IPCS) and usual care. The IPCS patients had fewer intensive care admissions, and overall cost per patient was reduced to \$14, 486 from \$21,252 ( $P < 0.001$ ) with use of an interdisciplinary palliative care team.

With implementation of this project, and the assumption that increased end-of-life discussions will occur, leading to a greater volume of palliative/hospice services, the organization can expect to have a substantial cost benefit through avoidance of readmissions to the hospital. The cost will shift from the expensive inpatient setting of hospitals and intensive care units, to the less costly outpatient settings in the form of hospice centers and home visits. The Coalition for Compassionate Care of California conducted a survey in 2011 of 1,669 adult Californians, including 393 who had lost a loved one in the past 12-months. Their report from that survey, *Californians' Attitudes*

*with Death and Dying* (2012), found that patients who had end-of-life discussions, preferred medical treatments that focused on relief of pain and discomfort rather than life-prolonging therapies. In fact, many opt for Do Not Resuscitate (DNR) orders with an advanced directive, enter hospice and end-of-life care, and die at home (Coalition for Compassionate Care of California, 2012).

From a quality and psychosocial perspective, end-of-life discussions and patient self-determination is a component of care in which a monetary value cannot be placed, but is most important in weighing the cost-benefit analysis of this project. The provision of good quality patient-centered care that places emphasis on informed communication and collaboration between the patient and the healthcare team, is an invaluable benefit as it relates to the psychosocial needs of patients and families (Australian Medication Association [AMA], 2007).

Part of the patient-centered approach model of care is causing a greater shift toward focus in quality of life (Bergman, Brook, & Litwin, 2013). With this approach, healthcare providers respond to the issues of greatest importance to the patient, and deliver care that is value-congruent. Research has shown that patients and families tend to value clear communication regarding patient condition, effective symptom management, the preservation of autonomy, and avoidance of prolonged death (Bergman et al., 2013). Utilizing end-of-life discussions to elicit this vital information from the patient will lead to treatments that facilitate quality and patient satisfaction. This results in a cost benefit for the healthcare organization as measured by patient satisfaction scores in both the inpatient and outpatient settings. With recent government reimbursement incentives linked to patient quality and satisfaction, successful

performance can lead to higher revenue for the organization in the form of higher percentages of reimbursements.

To conclude this analysis, beneficence, one of the ethical principles, states, “we should act in ways that promote the welfare of other people” (Paulus, 2014).

Beneficence is implicit to the role of all healthcare professionals as part of the “helping profession.” Healthcare providers, as part of their ethical obligation, daily accept the duty to seek benefit for their patients. End-of-life discussions provide an opportunity for patients to advocate for their care, and for healthcare providers to facilitate care that is most beneficial and in accordance with patient desires. By engaging patients in end-of-life discussions and being honest about the benefit of their care choices, healthcare providers can guide patients in their decision-making to promote a peaceful patient-centered end-of-life.

### **Scope**

The scope of this project focuses on healthcare providers’ ability to communicate with patients at end-of-life regarding their prognosis and choices for care. Specifically, the project addressed the issue of initiating end-of-life conversations. A baseline assessment need was completed, and an evidenced-based educational intervention was implemented offering providers guidelines and tools to conduct successful end-of-life conversations in appropriately identified patient populations. The project compared pre- and post- educational intervention data specific to the completion of end-of-life discussions as evidenced by health record coding, documentation in provider progress notes, and completion of end-of-life healthcare directives.

### **Project Mission, Goals, and Objective Statements**



## **Project Mission**

The mission of this project was to improve the quality of end-of-life care for patients with life-limiting illnesses by increasing providers' comfort with end-of-life conversations through utilization of advanced directives for healthcare. Talking about death is never easy. At times, it is difficult for healthcare providers to approach the topic with patients who are aging and living with serious life-limiting illness. Reports in the end-of-life literature reveal that healthcare professionals avoid discussions about preparations for care. Discussion barriers include professionals not feeling prepared, and a lack of framework for such discussions (Rizzo et al., 2010).

## **Project Goal**

By providing structured education, guidance, and practical tools, the goal of this project was to increase clinicians' comfort in engaging in meaningful end-of-life communication with patients, leading to improved quality of care at end-of-life. Many health care organizations do not have a process in place to prompt discussions with patients and families about health care directives or their end-of-life wishes.

## **Project Objective Statements**

**Objective 1.** Assess the needs of education in end-of-life communication at the Oncology Medical Clinic with a self-assessment questionnaire.

**Objective 2.** Successfully implement an end-of-life discussion education program for healthcare providers in an Oncology Medical Clinic.

**Objective 3.** Evaluation of the educational program.

An expected outcome of the project was an increase in providers' initiation of end-of-life discussions of 15% from baseline to post-education implementation, as

evidenced by documentation in progress notes, and/or completion of advanced directive/physician order for life-sustaining treatment. In addition, it was expected that healthcare providers' comfort with end-of-life conversations would improve due to the implementation of specific tools as evidenced by the post self-assessment questionnaire.

## **Chapter III**

### **Theoretical Underpinnings of the Project**

#### **Change Theory**

Organizational change is never easy. Change is made easier by utility of a change theory to support the change process, and building a model of the planned change (Zaccagnini & White, 2011). The theory chosen for this project is Kotter's Eight Step Change Model. The change theory was developed by Dr. John Kotter, a professor at the Harvard School of Business. The theory is based on 40-years of research related to organizational change and focuses on planning for change. The foundation of the project is changing current practice in end-of-life care. Dr. Kotter's theory will provide an eight-step structured framework to assist with organizational change as follows:

- Establishing a sense of urgency—help others to see the need for change;
- Creating a guiding coalition—assembling a group with the power to lead change;
- Development of a change vision—shape a vision to steer the change effort;
- Communicating that vision for buy-in;
- Empowering broad base action by removing obstacles of the vision;
- Generating short term wins—track and evaluate accomplishments;
- Never letting up—building upon change; and
- Incorporation of change into culture (Kotter International, 2012)

#### **Nursing Theory**

The nursing theoretical framework chosen for this project is Peaceful End-of-life developed by Cornelia Ruland and Shirley Moore. This middle-range nursing theory is based on standards of care. Standards of care offer a promising approach because of

their empirical base in clinical practice, their focus on linkages between interventions and outcomes (Ruland & Moore, 1998). Ruland and Moore (1998) explain that the standard of the theory is a peaceful end-of-life for terminally ill patients. At the time of theory development, clinical guidelines to guide the care of the terminally ill patients did not exist, impeding the provision of quality nursing care for the dying patients. The main focus for standard development was not on the dying itself, but on peaceful and meaningful living during the final days that remained for the patients, significant others, and family members.

According to Hodo and Buller (2012), the goal at end-of-life is not to use the most cutting-edge, advanced treatment that typically leads to over-treatment. Rather, the end-of-life goal is to mitigate distressing symptoms through the judicious use of comfort measures to enhance quality of life and achieve peaceful death (Hodo & Buller, 2012). The theory reflects on the complexity that is involved with taking care of the terminally ill, and the interventions involved achieving the desired outcome of peaceful death (Ruland & Moore, 1998). The major concepts that this theory is based on are: (1) being free of pain, (2) experiencing comfort, (3) experiencing dignity and respect, (4) being at peace, and (5) being close to your significant others (Ruland & Moore, 1998). The theory is useful in its review of care of patients at the end-of-life stage, and in the suggestion of interventions that can be utilized to achieve patient desired outcomes.

This theoretical framework, although limited in its use in research thus far, was chosen due to its consistency with the end goal of the project, which is to improve end-of-life quality of care for patients approaching death. This model provides a framework that reminds healthcare providers of the important aspects of care during the end-of-life

phase. It reminds the provider not only treat the patient, but also the significant others. This theory can be applied to any care setting, even within a patient's home. No matter where the patient resides, the focus on care is not to be on cure, but instead on treating the patient toward the goals of the five concepts: no pain, comfort, dignity and respect, peace, and closeness with significant others (Ruland & Moore, 1998). If these goals are achieved, the patient will experience an end-of-life that is peaceful and aligned with their wishes, which is the overarching goal of this doctoral nursing capstone project.

## **Chapter IV**

### **Project Plan**

#### **Setting**

The setting for this project was an oncology medical clinic affiliated with an acute care facility in a California city. The clinic is part of an integrated Cancer Center, which provides services to an average of 300 patients per day. The center includes a radiation oncology clinic, an infusion clinic, a research department, and a data analysis department. The nursing clinical director, in collaboration with four managers, has oversight of the providers in the clinic—a total of approximately fifty staff, including medical oncologists, ten RN infusionists, two licensed social workers, and four registered nurse navigators.

#### **Population of Interest**

The population of interest was the healthcare providers at the oncology medical clinic that were caring for patients with life-limiting illnesses at advanced to end stages of their illness trajectory. This project focused on the RN Nurse Navigators and the Licensed Social Workers. The Nurse Navigator role is filled by a registered nurse specializing in the oncology patient population. Their role includes:

- Assisting patients and families with understanding diagnosis and treatment options;
- Ensuring that patients have the information necessary to participate in their care and make informed decisions;
- Coordinate care with the medical team;
- Enhance communication with care providers;

- Advocate for patients throughout their illness trajectory.

The licensed Social Workers role in the care of the oncology patient population includes:

- Supporting staff in the delivery of service and coordination of interventions to meet the psychosocial needs of the oncology patients;
- Assisting in the identification of the learning needs of the oncology patient;
- Participate in interdisciplinary rounds to resolve complex problems.

A needs assessment, as outlined earlier, has identified a need to increase their comfort level in conducting end-of-life discussions with the appropriate patients at the clinic. A baseline assessment of each provider's current conversation participation was gathered. The plan was to implement an educational program to provide framework and strategies on how to have these discussions with their patients. The population was resurveyed at the end of the project to determine changes in their level of comfort and participation in end-of-life discussions.

### **Measures, Instruments, Activities**

Healthcare providers' comfort with end-of-life discussions was assessed using a modified version of Dr. David E. Weissman's *Self-Assessment of Clinical Competency and Concerns in End of Life Care* (See Appendix D). Healthcare providers were requested to answer Part One of the Survey including questions 1-6 and question 16 pre-intervention. There was a specified time frame to monitor provider activities as related to end-of-life discussions. Once the implementation of the project was completed, the same self-assessment tool was completed again by providers to assess changes in their level of confidence and comfort with end-of-life discussions.

Educational activities were presented by the project leader to the healthcare providers at the oncology clinic using educational materials developed by Dr. Robert Buckman (deceased) and Dr. Walter Baile to teach communication skills for end-of-life discussions. Education was approximately one-hour in duration, and focused on teaching healthcare providers to use the SPIKES communication tool to initiate end-of-life conversations.

### **Timeline and Project Tasks**

The timeline for this project began in February 2014 with development and proposal of the project to the sponsoring facility. The anticipated duration of the project from beginning to end was approximately eight-months (See Appendix A & B). A summary of tasks included the application for Institutional Review Board (IRB) approval from the healthcare facility, then the University of Nevada, Las Vegas; baseline assessments of providers and chart audits (See Appendix D & E). The goal of the audit was to identify patients with specific triggers such as age, diagnosis, appropriateness for end-of-life discussions as evidenced by the “surprise question,” whether or not the discussion occurred, and the disposition. The next task was to implement use of the education and tools by the providers to initiate end-of-life discussions with concurrent monitoring by the project leader and support team (See Appendix F). After the activity monitoring period, the task of post data collection began. This included a repeat of the questionnaire to providers to determine changes in their comfort level with end-of-life discussions, and a retrospective chart audit during the implementation phase to determine volume and specific provider participation in end-of-



life discussions. Final tasks included evaluation and analysis of data, and a final defense presentation at the University of Nevada, Las Vegas.

### **Resources and Supports to Project**

Project team members were the resources and supports to the project. The Chief of Oncology Medicine, who oversees the Cancer Center, was very enthusiastic about the project. He has been a physician champion in the promotion of end-of-life discussions for quite some time, and has verbalized his hope for the project's success and change in practice that will benefit patients at their end-of-life stage. The Nursing Director was in support as well. The Director of Evidence-based Practice and Nurse Director for the Cancer Center were both a resource and support as they assisted with monitoring adherence to the project timeline and implementation to ensure that results were accurate.

### **Risks and Threats**

Potential risks and threats to the project include lack of engagement by the participants, employee turnover, time frame barriers, and technological issues. These threats were identified and discussed amongst team members, and strategies were put into place to try to avoid them. In addition, one must consider unforeseen risks and threats that are out of the control of the project team leader including a change in institutional leadership, new regulations or policies, and economical or business challenges that have the potential to impact the ability to implement the project.

Another threat to this project is the organization incentivized initiative to ensure that patients complete an Advanced Directive for Healthcare. Due to this clinical strategic goal, it is expected that many of the patients will have an Advanced Directive

on file. What is crucial to this project is that the end-of-life conversation was individualized and recent, as a patient with advanced to end stages of cancer must have a conversation that is reflective of their current situation so informed choices can be made, such as participation in palliative care and hospice.

### **Evaluation Plan**

Project evaluation was conducted through the collection of post intervention data. Success of the project was determined by evaluation of data in the form of the health provider post intervention questionnaire demonstrating an increased comfort level with end-of-life discussions. In addition, project success will be determined by quantitative data in the form of increased volumes of end-of-life discussions by providers as demonstrated through documentation of progress notes of a referral to palliative care or hospice, and/or the completion of an Advanced Directives and/or Physician Order for Life Sustaining Treatment (POLST). When providers engage patients in end-of-life discussions, this is documented in the patient progress notes. This is one method to quantify specific healthcare providers' change in practice. Additionally, an increase in the volume of referrals to palliative care, hospice, or the completion of an Advanced Directives or POLST that specific providers assisted patients with, will demonstrate an increase in healthcare providers' comfort with end-of-life discussions.

## **Chapter V**

### **Project Implementation and Summary**

#### **Initiation of the Project**

Institutional Review Board (IRB) approval from both the institution planned for the project setting and the University of Nevada Las Vegas was obtained. The first step in project initiation entailed an educational in-service to explain the project to the participants. The project lead attended a staff meeting in which a one-hour timeframe was slotted for project discussion and education. The education included a PowerPoint presentation, examples of discussions, and videos explaining the SPIKES protocol. Participants were also given a laminated badge card with the SPIKES protocol outlined to use as a quick reference guide in the planning for these discussions. The project lead explained the use of the surprise question to identify appropriate patients to have discussions with, as well as the tools that would be used in the chart auditing.

#### **Threats and Barriers**

Specific threats and barriers were identified as the project was initiated, and included participant engagement and project monitoring. Historically, end-of-life discussions were not a part of the participants' role. In addition, there was discussion related to the role of the primary care provider in end-of-life discussions, rather than the specialists. There were concerns related to the ability to initiate end-of-life conversations and level of engagement. Barriers to this project include the challenge of continuous monitoring for the project leader, as the project setting is at a clinic with operating hours that conflict with the work schedule of the project leader. Strategies to overcome this obstacle were implemented such as weekly communication and data collection from

participants. The project lead also was available via phone or email communication to participants at any time during the implementation phase should questions or concerns arise.

### **Project Monitoring**

Project monitoring included weekly communications as well as visits to the clinic by the project lead to follow-up with participants. The participants submitted documentation to the project lead on a weekly basis identifying patients where the SPIKES protocol was utilized to facilitate end-of-life discussions. In addition, a list of all patients encountered during the implementation phase was submitted to the project lead to later assist with the analysis of project outcomes.

### **Data Collection**

Data collection included a baseline retrospective chart audit of the documented interactions between each participant and their encounters with their patients for 30-days prior to project implementation. A total of 168 charts were reviewed in the pre-implementation phase. This was conducted to identify the number of appropriate patients to have an end-of-life conversation with, and those that actually occurred. Pre-implementation data collection included completed self-assessment surveys obtained from participants.

Post-education, after utilization of the SPIKES tool and surprise question for 60 days, data was again collected. Data included a retrospective chart audit of the documented interactions between participants and their patients. A total of 297 charts were reviewed for patient appropriateness to have conversations, and for conversations that actually occurred. As part of the data collection process, post-education and

utilization of communication tools, the participants repeated the self-assessment surveys scoring their comfort levels with discussions.

### **Data Analysis**

An analysis of the data was conducted to demonstrate project outcomes. The first part of data analysis was to review the self-assessment survey completed by the participants. Each participant's comfort score was calculated by adding the total score of the seven questions asked on the self-assessment tool (See Appendix D). A total score of between 7 and 28 was possible, with a completely independent comfort level score being 28. Scores were between 21 and 26, which indicated providers' limited comfort with end-of-life discussions, with some opportunity for improvement. Participants were also asked to disclose their age, gender, ethnicity, and years of practice to allow for correlation or trends. There were no trends in comfort level associated with age, gender, ethnicity, or years of practice (See Table G1).

Post-intervention, after utilizing the SPIKES framework tool for a total of 60 days, the providers repeated the same self-assessment tool to identify changes in comfort level (See Table G2). Each participant reported an increase in comfort levels, with the most significant increase score being seven points. Trends in question responses identified each participant scoring themselves a four, or comfortable enough to perform independently, on questions related to discussion of Do Not Resuscitate (DNR) orders, hospice referrals, and a shift in treatment from curative to comfort care post-intervention.

Quantitative data was also represented in the volume of end-of-life discussions pre- and post-intervention. Retrospective audit charts were conducted reviewing the total

number of patient encounters, the number of those encounters that were appropriate for an end-of-life discussion, and the number of recent discussions that occurred to demonstrate a percentage of conversations. Pre-intervention data reveals each provider having between 44 and 62 patient encounters for the baseline month. Of those encounters, patients identified as appropriate for end-of-life discussions varied between 24 and 31 patients. Of the four participants, three had a baseline of zero percent, and one had a baseline of ten percent (See Figure 1 G).

Post-intervention a retrospective audit of charts was completed for 60 days. The total number of patient encounters, appropriate patients for conversations, and actual conversations were calculated to determine if a percentage increase occurred (See Figure 2 H). Participant volumes of conversations increased between zero and one-hundred percent from participant baseline. The participants conducted a total of 42 conversations combined. Of those 42 conversations, four patients were referred to hospice care, thirteen patients were referred to palliative care services, and twenty completed an Advanced Directive or POLST.

A paired sample t- test was conducted to compare comfort level scores pre- and post-intervention. There was no significant difference in the scores pre-intervention ( $M=23.50$   $SD=2.380$ ) and post-intervention ( $M=27.25$   $SD=.957$ );  $t(3) = -2.343$ ,  $p = .101$ . (See Table 3 & 4 H). The paired sample statistics demonstrated a mean comfort score of 23.50 pre-intervention and 27.25 post-intervention. The standard deviation for pre-intervention is 2.380 and .957 post-intervention demonstrating a larger variation in scores pre-intervention than post. The Sig (2-tailed) value is .101 concluding that there is no statistical difference between pre-and post-intervention scores.

## **Dissemination**

Dissemination of the project is planned to report results to the stakeholders, academic community, and other professionals in similar settings. End-of-life care continues to be a challenge for our healthcare system. The results of this project will heighten awareness for this vulnerable patient population, and may influence a change in practice to optimize care. The project lead will share the project findings with the stakeholders through a presentation at the project site. The audience will include project participants and institutional leaders. The presentation will include a summary of the project, and its results with recommendations on sustainability. In addition, the project will be a resource to the academic community through publication in the university's electronic database. Lastly, to disseminate project results on a larger scale, the manuscript will be presented to appropriate peer-reviewed journals for potential publication.

## Appendix A ~ Timeline

<b>February 2014</b>	<b>Proposal to sponsoring institution, Needs Assessment</b>
<b>March 2014</b>	<b>Ongoing Project Development</b>
<b>April 2014</b>	<b>Project Proposal to University of Nevada, Las Vegas</b>
<b>May 2014</b>	<b>Application to IRB at both institutions</b>
<b>June 2014</b>	<b>Pending IRB approval</b>
<b>July 2014</b>	<b>Ongoing Project Development</b>
<b>August 2014</b>	<b>Collection of baseline data</b>
<b>September 2014</b>	<b>Educational Intervention</b>
<b>October 2014</b>	<b>Monitoring</b>
<b>November 2014</b>	<b>Monitoring</b>
<b>December 2014</b>	<b>Post Data Collection</b>
<b>January 2015</b>	<b>Evaluation of Project</b>
<b>February – April 2015</b>	<b>Defense</b>



## Appendix B~ Project Tasks

TASK	Week 1	Week 2	Week 3	Week 4	Week 12	Week 13
Needs Assessment						
Project Proposal						
IRB						
Baseline Data						
Education						
Implementation						
Monitoring						

TASK	Week 14	Week 15	Week 16	Week 17	Week 20	Week 26
Monitoring						
Monitoring						
Post Data						
Evaluation						
Defense						

## Appendix C~ Budget

Budget for Implementation of Easing Comfort with End-of-Life Discussions				
Estimated Costs				
Category	Item	Qty	Price	Total
Staffing	DNP student	160 hours		
Education Materials	Education pack	3	\$400.00	\$400.00
Training	Staff Training	6	\$45.00/hr	\$270.00
	Monitoring	6-8 weeks	0	0
Total Costs				<b>\$670.00</b>

## Appendix D

### Tools and Measurements-Survey

#### SELF-ASSESSMENT OF CLINICAL COMPETENCY AND CONCERNS IN END-OF-LIFECARE

DAVID E. WEISSMAN, MD

1. Adapted from: Weissman DE, Norton A, et al. A survey of competencies and concerns in end-of-life care for physician trainees. J Pain Symptom Manage 1998; 15:82-90

**I. Please rank your degree of comfort with the following patient / family interactions and patient management topics, using the following scale:**

- 4 = Comfortable to perform independently**
- 3 = Comfortable to perform with minimal supervision**
- 2 = Comfortable to perform with close supervision / coaching**
- 1 = Need further basic instruction**

- 1. \_\_\_\_ conducting a family conference to discuss important end-of-life decisions.
- 2. \_\_\_\_ giving bad news to a patient or family member.
- 3. \_\_\_\_ discussing DNR orders.
- 4. \_\_\_\_ discussing home hospice referral.
- 5. \_\_\_\_ discussing a shift in treatment approach from curative to comfort care.
- 6. \_\_\_\_ discussing treatment withdrawal (e.g. antibiotics, hydration)
- 7. \_\_\_\_ discussing advance directives with patients

**THE END**

\*this tool has been modified therefore validity may be impacted

## Appendix E

### Tools and Measurements

#### Retrospective Electronic Chart Audit Tool

Provider	Patient Initials	Gender	Age	Ethnicity	Diagnosis	EOL Discussion Appropriate *(Surprise?)	EOL Discussion Occurred Using ****SPIKES Y or N Length of EOL	Disposition: **Advanced Directive or ***POLST Referral to Palliative/Hospice

\* Surprise Question - The "surprise" question--"Would I be surprised if this patient died in the next year?"--improves end-of-life care by identifying patients with a poor prognosis.

\*\*Advanced Directive-a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.

\*\*POLST –Physician Order for Life Sustaining Treatment- is an approach to improving end-of-life care encouraging doctors to speak with patients and create specific medical orders to be honored by health care workers during a medical crisis. It is a form that gives seriously-ill patients more control over their end-of-life care, including medical treatment, extraordinary measures.

## Appendix F

### Copyright Permission Footnote

1 - From “SPIKES a six step protocol for delivering bad news: application to the patient with cancer” by Walter F Baile, Robert Buckman, et al. (2000). *The Oncologist*, 5, 302-311. Copyrighted 2000 by W.F. Baile and R. Buckman. Reprinted with permission.

2- From “A survey of competencies and concerns in end-of-life care for physician trainees” by David E Weissman, A. Norton, et al. (1998). *Journal of Pain Symptom Management*, 15:82-90. Copyright 1998 by D.E. Weissman. Reprinted and Adapted with permission.

## Appendix G

### Tables and Figures

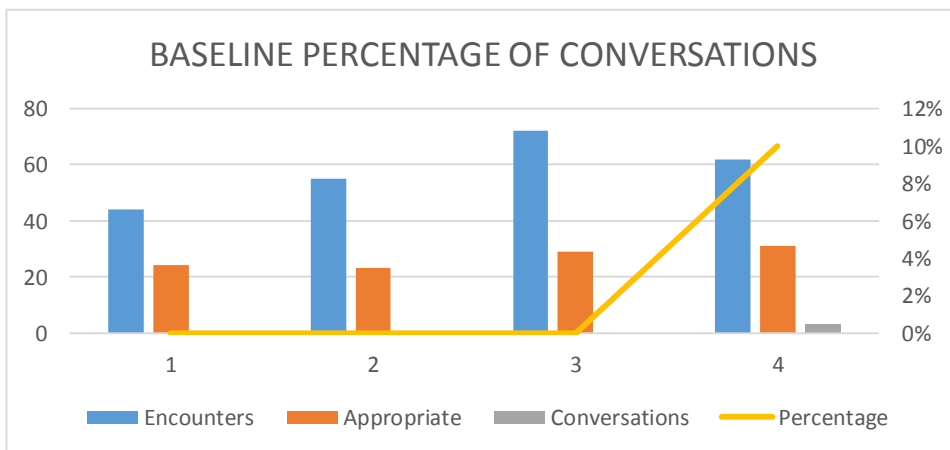
Table 1. *Pre-Intervention Comfort Scores*

Participant	Age	Gender	Role	Ethnicity	Years Practice	Score
1	55-60	F	LSW	Asian	11	21
2	55-60	F	LSW	Hispanic	25	22
3	35-40	F	RN	Caucasian	14.5	26
4	25-30	F	RN	Caucasian	5	25

Table 2. *Post-Intervention Comfort Scores*

Participant	Age	Gender	Role	Ethnicity	Years Practice	Score
1	55-60	F	LSW	Asian	11	28
2	55-60	F	LSW	Hispanic	25	28
3	35-40	F	RN	Caucasian	14.5	27
4	25-30	F	RN	Caucasian	5	26

Figure 1. *Baseline Percentage of Conversations*



## Appendix H

### Tables and Figures

Figure 2. *Post-Intervention Percentage of Conversations*

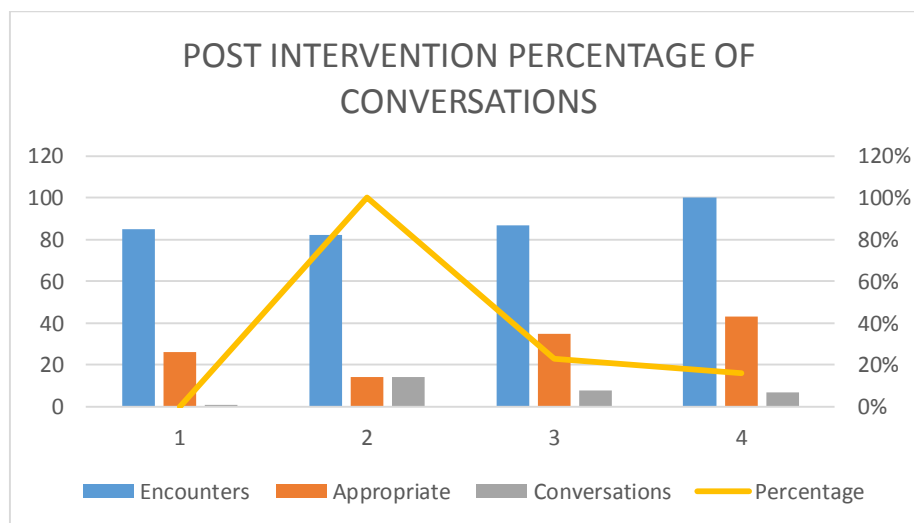


Table 3. *Paired Sample Statistics*

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pre Intervention	23.50	4	2.380	1.190
	Post Intervention	27.25	4	.957	.479

Table 4. *Paired Sample t-Test*

Paired Samples Test									
		Paired Differences					t	df	Sig. (2-tailed)
			Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Pre Intervention - Post Intervention	-3.750	3.202	1.601	-8.844	1.344	-2.343	3	.101

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## **CIRRICULUM VITAE**

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### **PROFESSIONAL SUMMARY**

Compassionate and dedicated Registered Nurse with 25 years of nursing experience. Diversified experience including medical surgical, SDU, ICU, Staff Education, and Nursing Administration. Well regarded skills and reputation for providing quality, patient-centered care in an acute care setting. Excellent verbal and written communication skills.

### **EDUCATION, TRAINING, & PROFESSIONAL AFFILIATIONS**

- Associates Degree in Nursing, University of New York  
12/1995
- Bachelor of Science, Nursing - California State University Dominguez Hills  
12/2010
- Master of Science, Nursing- California State University Dominguez Hills  
12/2012
- Doctorate Nursing Practice – University Las Vegas Nevada  
05/2015
- Member, American Association of Critical Care Nursing  
2009-Current
- Member, Sigma Theta Tau International, Xi Theta Chapter  
2010-Current
- Member, Phi Kappa Phi Honor Society  
2010-Current
- Member, Association California Nurse Leaders  
2013-Current
- Facilitative Leadership Training  
2011
- Clinical 3 Advancement  
2011
- Quality Management Lean Process Certification  
2011
- Critical Care RN Certification (CCRN)  
2012
- Certified Nurse Manager and Leader (CNML)  
2014



## NURSING CAREER PROGRESSION

### KAISER PERMANENTE

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#### ASSISTANT CLINICAL DIRECTOR CRITICAL CARE SERVICES 02/2014-present

- Oversight of 30 bed Critical Care and 22 bed Definitive Observation Unit
- Directly manages 98 staff members
- Supervises daily activities of staff. Coordinates scheduling and work assignments, utilizing knowledge of patient acuity, working within established unit targets and budgetary guidelines.
- Assist Clinical Director in the planning, development, implementation, delivery and evaluation of quality patient care
- Ensure patient care and quality standard meet federal and state regulatory requirements
- Development of Medical Center Wide and Department Specific policy and procedures
- Develop and implement action plans to achieve improved staff development and delivery of patient care
- Investigate and resolves patient, family/ member, and staff concerns

#### ASSISTANT CLINICAL DIRECTOR EDUCATOR CRITICAL CARE SERVICES LEAD EDUCATOR 04/2012-02/2014

- Collaborates with Managers, Department Administrator and Physicians to develop, design, deliver and evaluate/improve education strategies and special projects/programs based on clients' departmental goals and needs, as well as organizational goals/objectives.
- Implements education programs and strategies to meet regulatory requirements and organizational needs.
- Participates in competency assessments and evaluations of new and existing staff
- Member of KP SCAL Regional Director of Education Peer Group
- Chair of Medical Center Wide Education Committee
- Oversight and responsibility for all Medical Center Wide Education Initiatives

### ST. JUDE MEDICAL CENTER

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#### CLINICAL COORDINATOR SDU/CARDIAC TELEMETRY 11/2011- 03/2012

- Oversight of 28 Cardiac Telemetry/12 bed SDU as a fulltime coordinator
- Maintains awareness of staff skill level and assigns patient care according to competencies and job description

- Supervises daily activities of staff. Coordinates scheduling and work assignments, utilizing knowledge of patient acuity, working within established unit targets and budgetary guidelines.
- Maintains a comprehensive awareness of unit resources and needs. Effectively communicates and initiates appropriate action and resolution
- Assist department manager with unit incident reporting review and resolution
- Input employee payroll
- Collaborate with management team in interview and hiring process

#### RAPID RESPONSE TEAM

03/2010-11/2011

- Respond to all medical emergencies including code blue, white, stemi, and stroke throughout the facility
- Proactive rounding on inpatient population to identify high risk and effectively prioritize patient needs
- Remain calm and professional throughout critical incidents.
- Assess patient status and notify physicians of clinical changes
- Interact with departments regarding patient care
- Strong analytical skills, capable of assessing conditions and implementing appropriate intervention.
- Educate and mentor staff members

#### ADMINISTRATIVE RESOURCE NURSE (HOUSE SUPERVISOR) 03/2007-03/2012

- Oversight of 384 bed acute care facility
- Under general direction responsible for ensuring the active, on-going coordination of nursing services throughout the hospital
- Responsible for staffing of nursing personnel in direct patient care areas
- Placement of patients in appropriate units dependent on diagnosis and acuity
- Act as a liaison between staff and administration
- Extensive experience in dealing with challenging patients and families

#### CRITICAL CARE NURSE/COORDINATOR

04/2001-11/2011

- Oversight of 32 bed/20 bed critical care unit as a relief coordinator
- Maintains awareness of staff skill level and assigns patient care according to competencies and job description
- Supervises daily activities of staff. Coordinates scheduling and work assignments, utilizing knowledge of patient acuity, working within established unit targets and budgetary guidelines.
- Maintains a comprehensive awareness of unit resources and needs. Effectively communicates and initiates appropriate action and resolution
- Demonstrates ability and motivates coworkers to coordinate work activities within scheduled shift, to promote optimal patient care and self-wellness
- Performed the duties of a CCU nurse and cared for critically ill patients

## MEDICAL SURGICAL NURSE/RESOURCE

11/1996-4/2001

- Resource/Charge nurse of 40 bed medical surgical unit
- Supervise staff in direct patient care including making daily work assignments
- Maintain awareness of unit resources and needs
- Communicated with members of the health care team about patients' care
- Created plans of patients care
- Carried out nursing care of assigned patients on daily basis

## THC OF ORANGE COUNTY

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### CRITICAL CARE

01/1995-11/1996

- Participated in the opening of the facility including initiation of policy and procedures according to state guidelines and regulations
- Performed the duties of a CCU nurse and cared for critically ill patients
- Communicated with patient, significant others and health team members in the coordination of care

### **SELECTED PROFESSIONAL ACCOMPLISHMENTS**

- 2014 Led efforts in the redesign of Healthcare Worker Orientation KFH
- 2013 Co Led development of organizational Interprofessional Evidenced Based Council
- 2013 Led inpatient efforts in obtaining Center of Excellence Minimally Invasive Gynecological surgeries (COEMIG)
- 2013 Development of Medical Center Wide Education Plan Kaiser Permanente Downey Medical Center
- 2012 Developed policy and procedure and implementation of Therapeutic Hypothermia Program in the adult patient population
- 2012 Led revision of Downey Medical Center Kaiser Permanente New Employee Healthcare Worker Orientation to a collaborative program between inpatient and ambulatory practice
- 2012 Complete redesign of Critical Care Education program
- 2012 Redesign and streamline process for on-boarding new KP employees and travelers
- 2011 Co led organizational Sepsis Initiative including medical center wide education and implementation of Code Sepsis protocol
- 2010 Assisted in development of organizational Rapid Response Team