

Anne M. Wilkinson, Deborah Witt Sherman,  
Tonie Metheny, & Marianne Matzo

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## C H A P T E R

# Palliative Care Nursing

### KEY POINTS

- Palliative care (PC) and hospice nursing reflect a holistic philosophy of care implemented across the life span and in diverse health settings. PC and hospice nurses relieve suffering along the course of illness, through the death of the patient, and into the bereavement period of the family.
- The focus of PC is on the prevention and early identification of serious, progressive, chronic, or life-threatening illness and relief of pain and other physical, psychological, or spiritual problems.
- PC and hospice nursing are provided for patients and their families in a variety of care settings, including, but not limited to acute care hospital units; long-term care facilities; assisted-living facilities; inpatient, home, or residential hospices; PC clinics or ambulatory settings; private practices; and prisons.
- As demonstrated by the nursing process, the standards of practice in PC and hospice nursing describe a competent level of generalist and advanced practice registered nursing care involving assessment, diagnosis, outcome identification, planning, implementation, and evaluation.
- The standards of professional performance require the integration of specific core competencies aimed at ensuring the delivery of safe, quality patient-centered care, including the demonstration of competent professional role behaviors in practice, education, research, and leadership.
- Hospice and palliative nurses' professionalism is enhanced through membership in their professional organizations, certification in their specialty, and professional development through academic and continuing education.
- Family-centered care is the foundation for PC philosophy and PC nursing, meaning the patient and family, rather than the disease, are the primary focus.
- PC nursing embraces cultural, ethnic, and faith differences and preferences, while interweaving the principles of ethics, humanities, and human values into every patient and family-care experience.
- PC nurses collaborate with all members of the interprofessional team to ensure quality and continuity of care in meeting the needs of patients and their families.

## CASE STUDY

In May 2017, Rachael graduated from an accredited master's-level program as a family nurse practitioner and became certified by the American Nurses Credentialing Center (ANCC). After the death of her grandmother from colon cancer, Rachael decided to enroll in a post-master's palliative care (PC) program and became a member of the Hospice and Palliative Nurses Association (HPNA). With 500 clinical hours in PC, Rachael had achieved the required hours of practice in PC; thus, she sought the opportunity to become certified in hospice and PC nursing by the National Board for Certification of Hospice and Palliative Nursing. One patient that Rachael will never forget was J. L., a divorced 45-year-old woman with metastatic colon cancer who had a 12-year-old son and a 14-year-old daughter. J. L. was transitioning out of the hospital to home. Rachael was a member of the Palliative Care Consult team when J. L. was readmitted to the hospital 3 weeks after discharge with nausea, projectile vomiting, and severe abdominal pain. She was diagnosed with a partial bowel obstruction, secondary to recurrence of her cancer, and initially treated with a nasogastric (NG) tube, intravenous octreotide, and opioids for pain. On day four, J. L. requested removal of the NG tube because "the tube hurts worse than my stomach pain did." After much discussion with the interprofessional team, Rachael was able to advocate for J. L.'s desire to have the NG tube removed and receive palliative medication. Rachael told J. L. that the team was concerned that she would begin frequent vomiting again after the tube removal, but J. L. wanted to continue only the medication.

On her next assessment, Rachael asked J. L. what else she needed. J. L. said, "I need to get home as soon as possible." When asked about her sense of urgency, as the vomiting was still not under control, J. L. replied, "I don't have much time left, and want to be home with my children. They need me and I have to make plans so my family knows my wishes. I need to make funeral arrangements and talk to my family about caring for my children. My former husband is in the army and so he won't be able to raise them."

The scope of hospice and palliative care (PC) nursing continues to evolve as the science and art of PC develop in response to changes in society, including the aging of the population, changes in the trajectory of dying, and the rise in advanced chronic illnesses as the major causes of death. In contrast to the acute, disease-focused model of nursing care, in which there is less emphasis on the individuality of the patient and the relationship between the nurse and the patient and family, PC and hospice nursing focuses on the individual (and family) and on the nurse, whose responsibility involves the active, total care of patients and their families to promote and improve their quality of life (QOL; B. R. Ferrell, Coyle, & Paice, 2015; World Health Organization [WHO], 2017). The focus of PC is on the prevention and early identification of serious, progressive, chronic, or life-threatening illness and relief of pain and other physical, psychological, or spiritual problems. PC is not an alternative to other care. It is a complementary and vital part of management that should be integrated in people with advanced illness, alongside appropriate care to reverse illness or prolong life (Faull, 2012). Although hospice nursing and PC are similar in goals and intent, B. R. Ferrell et al. (2015) have indicated that the basic difference between the two is that "hospice can best be described

as a program through which palliative care is intensified as an individual moves closer to death," whereas PC is ideally delivered to "patients living with a chronic, debilitating, and progressive disease and their families ... throughout the course of the patients' disease and its treatment." As patients move closer to death, they should be able to transition seamlessly into a hospice program of care (B. R. Ferrell et al., 2015, p. 4).

PC and hospice nursing reflect a holistic philosophy of care implemented across the life span in diverse health settings. PC and hospice nurses relieve suffering along the course of illness, through the death of the patient, and into the bereavement period of the family (Hospice and Palliative Nurses Association [HPNA], 2017b).

Although PC builds upon the template of hospice care, the latter is now recognized as a type of PC that is offered toward the end of life. PC is the combination of active and compassionate therapies intended to comfort and support individuals who are living with and dying from life-threatening illness. The rise in hospice programs in the United States from 1 program in 1979 to more than 6,100 programs in 2014, including 1,500 hospital-based PC programs, along with a rise in the number of patients and families served from 128,000 in 1985 to approximately 1.65 million in 2014, supports

the projection of future needs for hospice/PC services (B. R. Ferrell et al., 2015; Morrison, Augustin, Souvanna, & Meier, 2011; National Hospice and Palliative Care Organization [NHPCO], 2015).

PC and hospice nursing are provided to patients and their families in a variety of care settings, including, but not limited to acute care hospital units; long-term care facilities; assisted-living facilities; inpatient, home, or residential hospices; PC clinics or ambulatory settings; private practices; and prisons. Practice settings for PC and hospice nursing are changing in response to the dynamic nature of today's healthcare environment. For example, although the majority of hospice care is provided in private residences (nursing homes, homes, and residential facilities), an increasing percentage of care is being provided in hospice inpatient facilities (21.9% in 2010 vs. 26.1% in 2011; NHPCO, 2015). Fulfilling the goals of PC and hospice nursing requires the provision of a wide range of care and services by members of an interprofessional team of experts (Munday & Charlton, 2012).

PC and hospice nurses are licensed, registered nurses who are educationally prepared and qualified for specialty practice at two levels: generalist and advanced. These levels are differentiated by educational preparation, complexity of practice, and performance of certain nursing functions. Palliative and hospice-licensed practical/vocational nurses are also educationally prepared and licensed, but at a different level of complexity in their practice. PC and hospice nursing assistants are educationally prepared through local- and state-mandated processes to meet the requirements of the specific setting in which they function. These requirements differ significantly across the United States, although hours-of-education requirements are specifically defined in the home care, hospice, and long-term care settings on a national basis. There are no licensure requirements for the nursing-assistant level of palliative and hospice caregiver.

According to an article titled "History of the Hospice Nurses Association, 1986–1996" (Amenta, 2001), the founding of the Hospice Nurses Association (HNA) occurred as follows:

[I]n spring 1986 a group of nurses attending the Third Western Hospice Nursing Conference sponsored by the Hospice Organization of Southern California in San Diego, frustrated by the failure of national groups to develop adequate standards and networking structures for hospice nurse, put out the call to start a national hospice nursing organization. (p. 13)

Membership in the organization grew rapidly. In 1998, the word "palliative" was added to the organization's name, now known as the HPNA. By the year 2000, 2,800 nurses had joined this growing organization. With a pattern of continued growth, membership to date has reached more than 11,000 across the 45 national chapters (HPNA, 2017a). In 2014, the HPNA

came together with the Hospice and Palliative Nurses Foundation (HPNF) and the Hospice and Palliative Credentialing Center (HPCC) to form a partnership with a synergized mission. The three distinct organizations form Advancing Expert Care (AEC) and share a joint mission to "advance expert care in serious illness" and a shared vision to "transform the care and culture of serious illness" (Advancing Expert Care [AEC], 2016, p. 1).

## ■ EVOLUTIONARY PERSPECTIVE OF HOSPICE AND PALLIATIVE CARE NURSING

In the early years of the specialty of PC, Billings and Block (1997) identified the following forces that increased national attention regarding PC:

1. A growing interest in death and dying
2. The development of hospice programs
3. Increasing integration of pain and symptom management into conventional care
4. Concern about the high cost of dying
5. Increasing national focus on pain management
6. Greater attention to the role of medicine in caring rather than curing
7. National debates on physician-assisted suicide and euthanasia

These factors combined to create a dramatically increased demand for healthcare providers, including nurses, who are educated at all levels to provide expert, comprehensive palliative and hospice care.

In addition, the landmark "Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment" (SUPPORT; SUPPORT Study Investigators, 1995) highlighted an urgent need for healthcare professionals who were prepared and committed to improving the QOL of seriously ill and dying patients and their families. The findings indicated a lack of communication between patients and their providers, particularly related to end-of-life (EOL) preferences, aggressiveness of medical treatments, and a high level of reported pain by seriously ill and dying patients. The SUPPORT Study Investigators (1995) believed that improving the experience of seriously ill and dying patients requires an individual and collective commitment of healthcare providers, as well as proactive efforts at shaping the caregiving process.

In 1997, the Institute of Medicine (IOM) released a significant report entitled *Approaching Death: Improving Care at the End of Life* (Field & Cassel, 1997). This report identified gaps of knowledge regarding the care of the seriously ill or dying. Based on this report, Field and Cassel reiterated that "the need for consensus and action to improve care for those approaching death is growing more urgent" (p. 17). On average, Americans live longer

than they did in the 19th century, with more than 70% of the population dying after the age of 65 years. According to the National Center for Health Statistics (NCHS), the average life expectancy in the United States in 2016 was 78.6 years, 76.4 years for males and 81.2 years for females (Kochanek, 2017). Over the past 100 years, the leading causes of death have changed from primarily infectious diseases to chronic illnesses experienced by an increasingly aging population. In 2014, the 10 leading causes of death were heart disease, cancer, chronic lower respiratory diseases, unintentional injuries, stroke, Alzheimer's disease, diabetes, influenza and pneumonia, kidney disease, and suicide. These 10 causes of death accounted for 74% of the 2.6 million deaths in 2014 (Xu, Murphy, Dochanek, & Arias, 2016). Although some people will die suddenly and unexpectedly, the dying process for many has been extended, with some individuals, such as those with cancer, facing a steady and fairly predictable decline, whereas others will have long periods of chronic illness punctuated by crises and increasing disability that are often fatal (Gill, Gahbauer, Han, & Allore, 2010; Lage & Crombet, 2011; Lunney, Lynn, Foley, Lipson, & Guralnik, 2003). The result is a national increase in the number of individuals who require PC.

Although hospice and PC have been delivered mainly to patients with cancer, other patients with incurable diseases are also candidates for these services, including the growing number of older adults, those suffering from chronic diseases such as cardiovascular, pulmonary, neurological, and renal disease, as well as patients with AIDS (Boland & Johnson, 2013; Haley, 2013; Mitchell, Noble, Finlay, & Nelson, 2012; NHPCO, 2015; Stiel et al., 2014). In addition, the IOM collaborated with the National Cancer Policy Board and the National Research Council to release a follow-up report called *Improving Palliative Care for Cancer* (Foley & Gelband, 2001), which further supported the need for changes in care of the dying. The report details the undertreatment of distressing symptoms resulting from continued deficiencies in the training of healthcare professionals.

In the report titled *Crossing the Quality Chasm: A New Health System for the 21st Century* (Foley & Gelband, 2001), the IOM argued that professional associations should commit to professional development and competency enhancement by developing curricula, disseminating information, and promoting practice guidelines and standards related to hospice and PC. In April 2004, the standards and guidelines of PC were defined by the National Consensus Project (NCP) Steering Committee in its *Clinical Practice Guidelines for Quality Palliative Care*. This document was the culmination of 2 years of collaboration by 20 representatives from five leading national hospice and PC organizations, specifically the American Academy of Hospice and Palliative Medicine, Center to Advance Palliative Care, HPNA, NHPCO, and the former Last Acts organization. A need for consensus had been defined by practitioners to

provide credible, broad-based guidelines for practice in an effort to standardize and improve the quality of PC in the United States. That need was affirmed when, in the first 2 weeks following publication, 90,000 copies of the guidelines were downloaded from the NCP website ([www.nationalconsensusproject.org](http://www.nationalconsensusproject.org)). More recent, the American Society of Clinical Oncologists (ASCO; Smith et al., 2012) issued a provisional clinical opinion (PCO) calling for the seamless integration of PC into standard oncology practice at the time a person is diagnosed with metastatic or advanced cancer. Although PC is frequently misconstrued as synonymous with EOL care, PC is actually focused on the relief of suffering, in all of its dimensions, throughout the course of a patient's illness. The authors state that "although the use of hospice and other palliative care services at the end of life has increased, many patients are enrolled in hospice less than 3 weeks before their death, which limits the benefit they may gain from these services" (Smith et al., 2012, p. 1094). Strong evidence from a phase III randomized controlled trial (RCT; Temell et al., 2010, 2011) demonstrated that patients with metastatic non-small-cell lung cancer and their families significantly benefited from early PC involvement in their standard cancer care.

Based on the NCP guidelines, the National Quality Forum (NQF, 2012) released *Palliative Care and End-of-Life Care* in recognition of the services increasingly being rendered within the healthcare system. This report endorsed the framework of preferred practices to improve hospice and PC and has been utilized as the first step in developing quality measures (NQF, 2012). Both documents attempt to formalize the concept of PC by providing extended descriptions and definitions differentiating PC from other types of care, and each structures the theory and practice of PC into eight domains: (1) structure and processes of care; (2) physical aspects of care; (3) psychological and psychiatric aspects of care; (4) social aspects of care; (5) spiritual, religious, and existential aspects of care; (6) cultural aspects of care; (7) care of the imminently dying patient; and (8) ethical and legal aspects of care (NCP, 2013). The guidelines are for all settings in which the NQF framework has implications for reimbursement, development of quality measures, and accreditation. These documents are companion pieces serving to complement the process of improving PC quality (NCP, 2013). One of the baseline assumptions of the NCP guidelines is that the qualifications of caregivers are determined by the organizations that grant professional credentials and programmatic accreditation. As a specialty organization, the Hospice and Palliative Care Nurses Association has identified the scope and standards of hospice and PC nursing and the competencies at all levels of nursing practice, specifically nursing assistants, licensed vocational nurses, professional registered nurses, and advanced practice nurses (APNs).

## ■ EDUCATIONAL PREPARATION

It has been recognized that educational preparation for EOL care is inconsistent at best and neglected for the most part, in both undergraduate and graduate medical and nursing curricula (American Association of Colleges of Nursing [AACN], 1997; Chiu et al., 2015; Paice et al., 2006a, 2006b; Shea, Grossman, Wallace, & Lange, 2010). In addition, there is a lack of role models for students in clinical settings as well as a lack of PC content in medical and nursing textbooks (Maani-Fogelman & Bakitas, 2015, p. 30). In accordance with the International Council of Nurses' (ICN) mandate that nurses have a unique and primary responsibility for ensuring the peaceful death of patients, the American Association of Colleges of Nursing (AACN), supported by the Robert Wood Johnson Foundation, convened a roundtable of expert nurses to discuss and initiate educational change related to PC. It was concluded that precepts underlying hospice care are essential principles for all EOL care. Such precepts include the assumptions that persons are living until the moment of death; that coordinated care should be offered by a variety of professionals with attention to the physical, psychological, social, and spiritual needs of patients and their families; and that care should be sensitive to patient and family diversity. It was proposed that these precepts be foundational to the educational preparation of nurses. Based on these precepts, the document entitled *Peaceful Death* was developed, which outlined baccalaureate competencies for palliative and hospice care and content areas where competencies can be taught (AACN, 1997).

Emphasizing the role of nursing in EOL care, the American Nurses Association (ANA) formulated a position statement regarding the promotion of comfort and relief of pain of dying patients, reinforcing nurses' obligation to promote comfort and ensure aggressive efforts to relieve pain and suffering. Specialized PC educational initiatives began in medicine and nursing, such as Education for Physicians on End-of-Life Care (EPEC), and the nursing initiative End-of-Life Nursing Education Consortium (ELNEC). The original goal of ELNEC was to train nurse educators from associate and baccalaureate programs. The ELNEC curriculum has also been modified and specialized for graduate education, geriatrics, pediatrics, oncology, and for use with veterans.

## ■ DEVELOPING THE SCOPE, STANDARDS, AND COMPETENCIES OF PALLIATIVE AND HOSPICE NURSING PRACTICE

By developing and articulating the scope and standards of professional nursing practice, the specialty defines its boundaries, informs society about the parameters of nursing practice, and guides the development of rules and regulations for the specialty. As in all nursing

specialties, PC nurses must accept professional practice accountability and ensure that their practice remains within the scope of their state's nurse practice act, their professional code of ethics, and professional practice standards.

To ensure provision of quality hospice and palliative nursing care, standards have been defined by a credible body of peers who were charged with this responsibility. The standards of hospice care were defined by the NHPCO in 1986. The standards of hospice and palliative nursing practice were first defined by the HNA in 1995, with subsequent revisions to the name of the organization to include PC. Scope and standards of hospice and palliative nursing care define the body of knowledge needed in terms of the standards of practice and performance. Standards of practice refer to the basic level of care that should be provided to all hospice and PC patients and families. Standards of performance for palliative and hospice care nurses describe the standards for activities related to quality of care, performance appraisal, education, collegiality, ethics, collaboration, participation in research, and resource utilization. Documents, such as agency standards, guidelines, policies, procedures, and protocols, may further direct the individual's performance. Standards are defined in broad terms to specify the scope of the specialty of palliative and hospice care nursing.

The standards of palliative and hospice care nursing practice are authoritative statements described by the HPNA for the nursing profession, which identifies the responsibilities for which palliative and hospice care nurses are accountable. Standards reflect the values and priorities of PC nursing and provide a framework for the evaluation of practice. The standards are written in measurable terms and define palliative and hospice care nurses' accountability to the public and the individual and family outcomes for which they are responsible. Standards remain stable over time, as they reflect the philosophical values of the profession; however, the criteria should be revised to incorporate advancements in scientific knowledge, technology, and clinical practice. Criteria must be consistent with current nursing practice and must reflect evidence-based practice.

## Standards of Practice

Standards of practice (ANA and HPNA, 2014) describe a competent level of generalist and advanced practice registered nursing care as demonstrated by the nursing process, involving assessment, diagnosis, outcome identification, planning, implementation, and evaluation. The development and maintenance of a therapeutic nurse-patient and family relationship is essential throughout the nursing process, which forms the foundation of clinical decision making and encompasses all significant actions taken by hospice and PC nurses in providing

care to individuals and families. The precepts of nursing practice include the following:

1. Providing age-appropriate and culturally, ethnically, and spiritually sensitive care and support
2. Maintaining a safe environment
3. Educating patients and families to identify appropriate settings and treatment options
4. Ensuring continuity of care and transitioning to the next appropriate setting
5. Coordinating care across settings and among caregivers
6. Managing information and protecting confidentiality
7. Communicating promptly and effectively

A fundamental practice focus for hospice and PC is the *plan of care*, which is developed with the patient and family as the unit of care and members of the interprofessional team. At the very minimum, the interprofessional team includes the physician, nurse, social worker, and clergy. Care responsibilities extend beyond the death of the patient and offer bereavement care to families for a minimum of 1 year. Relief of suffering and QOL for individuals and families are enhanced by:

- Providing effective pain and symptom management
- Addressing psychosocial and spiritual needs of patient and family
- Incorporating cultural values and attitudes in developing a plan of care
- Creating a healing environment to promote a peaceful death
- Supporting those who are experiencing loss, grief, and bereavement
- Promoting ethical and legal decision making
- Advocating for personal wishes and preferences
- Utilizing therapeutic communication skills in all interactions
- Facilitating collaborative practice
- Ensuring access to care and community resources through influencing and developing health and social policy
- Contributing to improved quality and cost-effective services
- Creating opportunities and implementing initiatives for PC education for patients, families, colleagues, and community
- Participating in the generation, testing, and evaluation of PC knowledge and practice

Registered nurses at the generalist level have completed a nursing program and passed the state licensure examination for registered nurses. Registered nurses who practice in PC settings may provide direct patient and family care, and may function as educators, case managers, and administrators as well as in other nursing roles. Advanced practice registered nurses (APRNs), those with postgraduate education in nursing, including

advanced didactic and clinical education, knowledge, skills, and scope of practice in a nursing specialty, are in a unique position to substantially contribute to the improvement of care provided to dying patients and patients with advanced chronic illness (Shea et al., 2010). APRNs develop and implement advanced plans of care based on the synthesis of complex health-assessment data. APRNs are expert clinicians, leaders, educators, consultants, and researchers. The standards apply to both generalists and APRNs. There is specific notation of standards that apply only to the APN.

**Standard 1: Assessment.** The hospice and palliative registered nurse collects comprehensive data pertinent to the patient's health or the situation.

**Standard 2: Diagnosis.** The hospice and palliative registered nurse analyzes the assessment data to determine nursing diagnoses or issues.

**Standard 3: Outcome identification.** The hospice and palliative registered nurse, in partnership with the interprofessional healthcare team, identifies the expected outcome for a plan of care individualized to the patient or the situation.

**Standard 4: Planning.** The hospice and palliative registered nurse develops a plan of care that describes strategies and alternatives to attain expected outcomes.

**Standard 5: Implementation.** The hospice and palliative registered nurse implements the identified plan of care.

**Standard 5A: Coordination of care.** The hospice and palliative registered nurse coordinates care delivery.

**Standard 5B: Health teaching and health promotion.** The hospice and palliative registered nurse employs strategies to promote health and a safe environment.

**Standard 5C: Consultation.** The hospice and palliative registered nurse and the nursing-role specialist provide consultation to influence the identified plan, enhance the abilities of others, and effect change.

**Standard 5D: Prescriptive authority and treatment.** The advanced practice hospice and palliative registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.

**Standard 6: Evaluation.** The hospice and palliative registered nurse evaluates progress toward attainment of outcomes.

## Standards of Professional Performance

Standards of professional performance (ANA and HPNA, 2014) and the associated measurement criteria describe professional role behaviors, including those related to ethics, education, evidence-based practice and research, quality of practice, communication, leadership, collaboration, professional practice evaluation, resource utilization, and environmental health. Hospice and palliative nurses must be self-directed and purposeful

in seeking necessary knowledge and skills to develop and maintain their competency. Hospice and palliative nurses' professionalism is enhanced through membership in their professional organizations, certification in their specialty, and professional development through academic and continuing education.

**Standard 7: Ethics.** The hospice and palliative registered nurse integrates ethical provisions in all areas of practice.

**Standard 8: Education.** The hospice and palliative registered nurse attains knowledge and competency that reflects current hospice and palliative nursing practice.

**Standard 9: Evidence-based practice and research.** The hospice and palliative registered nurse integrates research findings into practice and generates new knowledge related to the specialty.

**Standard 10: Quality of practice.** The hospice and palliative registered nurse systematically enhances the quality and effectiveness of nursing practice.

**Standard 11: Communication.** The hospice and palliative registered nurse communicates effectively with members of the interprofessional team and contributes to the professional development of peers and colleagues.

**Standard 12: Leadership.** The hospice and palliative registered nurse provides leadership in the professional practice setting and the profession.

**Standard 13: Collaboration.** The hospice and palliative registered nurse collaborates with the patient, the family, the interprofessional team, and others in the conduct of nursing practice.

**Standard 14: Professional practice evaluation.** The hospice and palliative registered nurse evaluates one's own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations.

**Standard 15: Resource utilization.** The hospice and palliative registered nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.

**Standard 16: Environmental health.** The hospice and palliative nurse promotes a healthy environment.

Standards of practice and standards of professional performance are also written for palliative- and hospice-licensed practical/vocational nurses and for palliative and hospice nursing assistants. Variations to each standard are made to adapt to scopes of practice and statutory regulations.

## Competencies

Practice in the current healthcare system presents nurses with increasingly complex issues and situations arising from a multitude of factors, including advances in medical technology, greater acuity of patients in hospital and

community settings, aging populations and complex disease processes, as well as ethical and multicultural issues. Nursing competencies must reflect and address these new challenges. According to ANA and HPNA (2014), competencies represent the “quantifiable knowledge, attitudes, and skills that practitioners demonstrate in the performance of safe, consistent, compassionate, state-of-the-art, evidence-based EOL care, which conforms to the patients’ and their families’ wishes” (p. 1). This definition applies to all levels of nursing practice, although the specific clinical judgments and core competencies vary with each level. The competencies for the palliative and hospice generalist and APN were initiated in 2001. Subsequently, competencies for the palliative- and hospice-licensed practical/vocational nurse and nursing assistant were also written.

The basic competencies of PC nursing represent the knowledge, skills, and attitudes demonstrated when providing evidence-based physical, emotional, psychosocial, and spiritual care. The care is provided in a collaborative, interprofessional manner across the life span in diverse settings to individuals and families experiencing progressive illness. The generalist-level competencies and the related general statements are written to the text that follows with special notation only for APNs when applicable.

■ **Clinical Judgment.** Critical thinking is a multidimensional skill involving a cognitive or mental set of processes or procedures involving reasoning and thoughtful, systematic, reflective, rational, outcome-directed thinking based on a body of knowledge, as well as examination and analysis of all available information and ideas (M. Ferrell, 2017). At the generalist level, the palliative and hospice nurse demonstrates critical thinking, analysis, and clinical judgment in all aspects of palliative and hospice care of patients and families experiencing life-limiting illness through the use of the nursing process to address the physical, psychosocial, and spiritual/existential needs of patients and families. At the advanced practice level, the palliative and hospice nurse must be able to respond to all disease processes with advanced clinical skills.

■ **Advocacy and Ethics.** The use of sophisticated medical technology, precision medicine, and genetics/genomics has created new challenges for nurses in all settings, but with implications for the appropriateness of advanced technological care with advanced illness or those at the end of life. Understanding the role of the professional nurse in ethical decision making helps the nurse articulate her or his own ethical positions and also develops the skills needed to make ethical decisions in the development of care plans (M. Ferrell, 2017). The palliative and hospice nurse incorporates ethical principles and professional standards in the care of patients and families who are experiencing life-limiting illnesses or progressive illness, as well as identifying and advocating for their wishes and preferences. Promoting ethical and

legal decision making, advocating for personal wishes and preferences, and ensuring access to care and community resources through influencing or developing health and social policy are ways for the nurse to incorporate ethical principles and professional standards in the care of patients and their families.

■ **Professionalism.** *Professional conduct in nursing* refers to the manner in which a person behaves while acting in a professional capacity. It is generally accepted that when performing their duties and conducting their affairs, nursing professionals will uphold exemplary standards of conduct, commonly taken to mean standards not generally expected of laypeople or the “ordinary person in the street.” The palliative and hospice nurse demonstrates knowledge, attitude, behavior, and skills that are consistent with the professional standards, code of ethics, and scope of practice for palliative and hospice nursing.

■ **Collaboration.** Interprofessional collaborative practice involves employing multiple health professionals to work together with patients, family, and communities to deliver best practices and to ensure the best patient outcomes (M. Ferrell, 2017). The palliative and hospice nurse actively promotes dialogue with patients and families, the healthcare team, and the community to address and plan for issues related to living with and dying from chronic, life-limiting progressive illness.

■ **Systems Thinking.** A systems approach applied to health is one that employs scientific insights to understand the elements that influence health outcomes; models the relationships between those elements; and alters the design, processes, or policies based on the resultant knowledge to produce better health at a lower cost. By understanding how these elements operate independently, as well as how they depend on one another, a systems approach can help with the design and integration of people, processes, policies, and organizations and can be useful at all levels of the health system—patient-clinician interaction, healthcare unit, organization, and community (Kaplan et al., 2013). The palliative and hospice nurse utilizes resources necessary to enhance QOL for patients and families experiencing life-limiting progressive illness through knowledge and negotiation within the healthcare system.

■ **Cultural Competence.** *Culture* is defined as the learned patterns of behavior, beliefs, and values that can be attributed to a particular group of people, including such elements as manner of dress, language spoken, rules and norms of behavior, dietary practices, and even health beliefs, all of which guide a person’s thinking, decisions, and actions (M. Ferrell, 2017). Most countries today are extremely culturally diverse, and as such, nurses need the knowledge and skills to interact

with a variety of individuals and groups of similar and dissimilar cultural backgrounds. The palliative and hospice nurse demonstrates cultural competence by respecting and honoring the unique diversity and characteristics of patients, families, and colleagues in palliative and hospice care.

■ **Facilitation of Learning.** The palliative and hospice nurse facilitates learning of patient, family, self, members of the healthcare team, and the community through the development, implementation, and evaluation of formal and informal education related to living with and dying from life-limiting progressive illnesses.

■ **Communication.** Many nursing professionals feel unprepared or uncomfortable in communicating with patients and families facing a life-limiting illness, particularly when delivering bad news. However, it is important that nurses become skilled in PC communication. Reflection, obtaining education, reading, and talking with PC professionals and colleagues can assist the individual in considering his or her own attitudes and values pertaining to the end of life, but also improve his or her skills in communicating with others, including members of interprofessional teams. The palliative and hospice nurse demonstrates the use of effective verbal, nonverbal, and written communication with patients and families, members of the healthcare team, and the community to address therapeutically and convey accurately the palliative and hospice care needs of patients and families.

Advanced practice hospice and palliative nurses are held to the same competencies, but at an advanced level, because they exercise a high degree of critical thinking, analysis, and independent judgment, within the framework of autonomous and collaborative interprofessional practice. APNs are distinguished by their ability to synthesize complex data, implement advanced plans of care, and provide leadership in palliative and hospice care. The roles of the advanced practice hospice and palliative nurse include, but are not limited to expert clinician, leader, or facilitator of interprofessional teams; educator; researcher; consultant; collaborator; advocate; and administrator. Advanced practice palliative and hospice nurses who have fulfilled the requirements established by their state’s nurse practice act may be authorized to assume autonomous responsibility for clinical role functions, which may include prescription of controlled substances, medications, or therapies. To practice as an advanced practice palliative and hospice nurse, national certification in advanced practice palliative and hospice nursing is recommended, although it is recognized that the advanced practice palliative and hospice nurse may have concurrent advanced practice certification in another specialty.

Competencies for the licensed practical nurse focus on decision making instead of clinical judgment. For the



nursing assistant, clinical judgment is rooted in observation and reporting. Although the core competencies are very similar in all four levels of nursing, the criteria are specific to the various scopes of practice.

### ■ CERTIFICATION IN HOSPICE AND PALLIATIVE CARE NURSING

Incorporated in 1987, the HNA became the first professional nursing organization dedicated to promoting excellence in the practice of hospice nursing. In March 1994, the National Board for the Certification of Hospice Nurses (NBCHN) offered the first certification examination and the credential of Certified Registered Nurse Hospice (CRNH). In 1999, the NBCHN became the National Board for Certification of Hospice and Palliative Nurses (NBCHPN), offering a new designation to recognize base competence in hospice and palliative nursing: the certified hospice and palliative nurse (CHPN). The NBCHPN is now known as the *HPCC*. For the licensed generalist, a minimum of 2 years of clinical experience in palliative and hospice care is recommended. By 2015, nearly 11,000 registered nurses were certified as CHPNs.

Recognizing the need to offer an examination for advanced practice hospice and palliative nurses, in 2000 the NBCHPN began discussions with New York University and the ANCC to collaborate for this purpose. In an effort to expand the portfolio of examinations, NBCHPN successfully negotiated a buy out of the partnership with ANCC effective December 2004 and has been successfully certifying nurses as advanced certified hospice and palliative nurses (ACHPNs). Eligibility for this level includes having a current unrestricted registered nurse license, graduating from an accredited institution granting graduate-level academic credit for a master's or higher degree in nursing, and having a minimum of 500 hours of supervised advanced practice in PC as a clinical nurse specialist or nurse practitioner. As of 2015, nearly 1,200 individuals were certified ACHPNs (HPNA, 2017a).

Through a commitment to a strategic plan to provide certification for all levels of caregivers, NBCHPN began certifying nursing assistants in hospice and PC in 2001 as certified hospice and palliative nursing assistants (CHPNAs). To be eligible for the examination, the nursing assistant must have a minimum of 2,000 hours in palliative and hospice care as validated by the nursing supervisor. By 2013, nearly 4,000 nursing assistants were certified as CHPNAs. Continuing with the strategy of providing certification for all levels of caregivers, in 2002 NBCHPN began the process of developing the scope, standards, and competencies for the licensed practical/vocational hospice and palliative nurse. To be eligible for the examination, the certified hospice and palliative

licensed practical/vocational nurse (CHPLN) must be licensed and recommended to have logged 2,000 clinical hours in the prior 2 years. In 2017 (HPNA, 2017a), more than 811 CHPLNs had successfully completed the certification requirements.

*Certification*, as defined by the American Board of Nursing Specialties (ABNS, 2017), is “the formal recognition of the specialized knowledge, skills, and experience demonstrated by the achievement of standards identified by a nursing specialty to promote optimal patient care.” Certification is valued for the following reasons:

- Certificates achieve a tested and proven competency across the spectrum of hospice and PC.
- Certificates increase nurses' knowledge of hospice and PC by seeking and maintaining certification.
- Certificates demonstrate a commitment to one's specialty practice through pursuit of certification.
- Certificates demonstrate dedication to professional development by attaining the credential.
- Certificates are assets in themselves because the commitment to certification improves patient outcomes, provides compensation incentives, and gains industry-wide recognition for nurses.
- Certified nurses are assets to their employers because, in an atmosphere of increasing awareness regarding quality in healthcare and appropriate utilization of services, certification is a recognized marker of quality by patients, physicians, providers, quality-improvement organizations, insurers, credentialers, and the federal government.

### ■ PRINCIPLES OF PALLIATIVE CARE AND RELEVANT CONCEPTUAL FRAMEWORKS

A core principle of PC across the entire disease spectrum and in all settings is the concept that the patient and family constitute the unit of care. The patient and family, rather than the disease, are the primary focus of care. The constructs of family-centered care form the foundation of the PC philosophy. PC addresses the meaning of disease, suffering, life, and death within the context of each family unit (NCP, 2013). PC recognizes that each family member will experience the disease process and all of its implications within the context of his or her particular worldview, and individual care plans are developed to reflect these worldviews. Another core PC principle is the commitment to collaborate through an interprofessional team process (Cairns & Yates, 2003; Leslie, Adams, & Kutner, 2002; Meier & Beresford, 2008; NCP, 2013; Oliviere & Hargreaves, 2017). So as to assist a family in crisis to establish and then achieve mutually agreed-upon goals, the PC team integrates and coordinates the assessment and interventions of each team member and creates a comprehensive plan of care.

Good PC is significant in the manner in which it embraces cultural, ethnic, and faith differences and preferences while interweaving the principles of ethics, humanities, and human values into every patient- and family-care experience (Dy, Lupu, & Seow, 2012; Morrison & Meier, 2004; Oliviere & Hargreaves, 2017). Furthermore, clinical ethics is an essential footprint for the provision of palliative and EOL care. Although clinicians often learn the theoretical principles behind ethics (Beauchamp, 2003; Dy et al., 2012; Morrison & Meier, 2004), PC necessitates that these principles be incorporated into the practice or “put into motion” 24 hours a day, 7 days a week (Block, 2007; Bruera & Hui, 2012). PC embodies this concept of ethics in motion, as each interprofessional team member, including patient and families, contemplates the ethical questions in advanced disease and in EOL decision making. Ethical challenges present themselves to the PC interprofessional team on an hourly basis.

Several conceptual frameworks or middle-range theories in nursing or related health disciplines provide a lens in both the assessment and treatments of PC patients

and their families. The founder of St. Christopher’s Hospice in London, Dame Cicely Saunders, put forth a conceptual model of “whole-person” suffering. Saunders espoused that whole-person suffering has four dimensions: physical, psychological, spiritual, and social (De Lima & Pastrana, 2016; Mount, Hanks, & McGoldrick, 2006; Oliviere & Hargreaves, 2017; WHO, 2007). Under this concept, suffering affects each domain of the biopsychosocial–spiritual aspects of care. This conceptual model forms the basis for the description of PC nursing practice. Also relevant is the Calkin model of advanced nursing practice (Bryant-Lukosius, Dicenso, Browne, & Pinelli, 2004), which serves as an excellent model on which to base PC advanced practice nursing. Calkin defines the clinical judgment abilities of three nursing practice levels as novice, expert by experience, and the master’s-prepared nurse. The following case study illustrates Saunders’s four dimensions of human suffering within the context of Calkin’s model. The case study also demonstrates the APN subroles of expert clinician, educator, consultant, researcher, and collaborator (Callaway, 2012; Chulk, 2008).

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### **CASE STUDY Conclusion**

Once a decision was reached that J. L. would pursue palliative treatment, Rachael insured that the interdisciplinary team met with J. L. and her family members to include them in planning and to discuss home care. J. L. was able to verbalize her desire that she spend her remaining time at home, even if she was vomiting. The coordination of care between the PC nurse practitioner and the home care team was extremely important. J. L.’s sister assumed responsibility for her home care and J. L. agreed to enroll in hospice. All family members agreed that this was the best course of action as it adhered to their cultural and religious beliefs. J. L. felt secure given the expertise of the PC nurse practitioner and valued the person- and family-centered approach to care that would also be offered by interprofessional members of the hospice team. J. L. stated, “I’m so grateful that I can spend it at home surrounded by my family and friends and I know the nurses will care not only for me but my family. The nurses have helped to relieve not only my pain and other symptoms, but have helped me find strength to make peace with my life.”

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### **The Advance Practice Nurse’s Role in Palliative Care**

The following case example is that of an APN bringing a specific and well-defined set of qualities, knowledge, and judgments to caring for individuals and families facing serious, progressive, or life-threatening illness. This includes advanced scientific and biophysical knowledge, analytical skills, and mastery of a broad repertoire of communication and interpersonal skills. Specialized knowledge and proficiency in the ability to incorporate

ethics; humanities; cultural diversity; family, spiritual, and psychological issues into care are also demanded (Bruera & Hui, 2012; Coyne, 2003; Kuebler, 2003; Meier & Beresford, 2006). The Calkin model of advanced nursing practice (Bryant-Lukosius et al., 2004) serves as an excellent model on which to base PC advanced practice nursing. The following case study illustrates Dame Cicely Saunders’s four dimensions of human suffering within the context of Calkin’s model, while demonstrating the APN subroles of expert clinician, educator, consultant, researcher, and collaborator (Callaway, 2012).

## **CASE STUDY *An Exemplar Relevant to Advanced Practice Nursing***

Mrs. S. is a 52-year-old woman who has been suffering from the sequelae of stage 4 metastatic breast cancer for the past 3 years. All curative interventions, including surgical resection, chemotherapy, radiotherapy, hormone therapy, and experimental therapy, have failed to halt the progression of her disease, which now affects her lungs, liver, and bones, most notably her spine. Mrs. S.'s major distressing physical symptom is severe neuropathic pain, which radiates around her back to her abdomen. This pain has limited her ability to bathe, cook, eat, get dressed, and walk. Essentially all activities of daily living have been stripped from her, and she is now confined to bed under the care of her husband. Prior to her cancer, she prided herself on being extremely independent. Currently, her neuropathic pain is being managed by steroids, tricyclic antidepressants, neuroleptics, and methadone. Mrs. S. has two teenage children and has been on disability from her job as a television personality for the past several months. She is Baptist and is an active member of her church.

### **ASSESSMENT OF THE PATIENT AND FAMILY**

Through daily interactions with Mrs. S. and her family, the APN on the PC unit built a therapeutic relationship that focused on all dimensions of human suffering: physical, psychological, spiritual, and psychosocial. Despite the aggressive titration of pharmacotherapy being used to treat Mrs. S.'s pain, she continued to suffer from intense neuropathic discomfort. Her pain rating consistently was eight or above out of 10 on a visual analog scale, and over time, her sense of despair about dying in such agony was increasing. In consultation with other interprofessional team members, the APN was analyzing current research and consulting with other pain experts for novel approaches in treating neuropathic pain. The use of intravenous lidocaine has been successful in similar scenarios, and after critical analysis by the APN, the interprofessional team decided to try this therapy. The APN presented all the literature regarding the use of intravenous lidocaine in refractory neuropathic pain to the hospital's quality committee. The committee granted permission for immediate use and requested that the APN develop an evidence-based guideline to be used in future for patients with neuropathic pain. The APN quickly developed an evidence-based guideline as the neuropathic pain was escalating daily. The next step was to educate all team members, specifically, the nursing and pharmacy staff, as well as the patient and family, about the etiology, sequelae, and rationale for choosing this intervention. Mrs. S. received a test dose of the lidocaine and her pain decreased about 10% within 1 hour. Thus, the intravenous lidocaine was deemed appropriate to continue. Over the next days, her pain level decreased to two out of 10. Respecting the value of nonpharmacological measures in relieving pain, the APN assisted in having Mrs. S. offered massage and music therapy. She declined guided imagery.

While Mrs. S. was experiencing her pain crisis, the APN spent a lot of time with her, thus allowing an opportunity for Mrs. S. to express her feelings and fears. She revealed that she felt close to death and was struggling with guilt about one of her desires upon dying—that of spending her last minutes alone, if possible. She was fearful that this request would offend her very protective and involved family. But she had lived a very independent life and wanted to die that way. The APN listened, reflected, and assessed the situation and reported her findings to the interprofessional team. Based on the APN's observations and recommendations, the interprofessional team members set forth a plan to help Mrs. S. and her family deal with these very important issues. Social work and chaplaincy intensified their involvement.

Through interventions by the interprofessional team, Mrs. S.'s family was learning to become more comfortable with respecting her request and were working through their feelings of "abandoning" their wife and mother in time of need. This would continue to be a process.

With in-depth knowledge of family systems theory, the APN identified the need for the interprofessional team to address the already actualized loss of Mrs. S.'s role within the family, including that of mother and wife. The APN consulted the bereavement counselor as an early intervention for high-risk grief status, as Mrs. S.'s family was still dealing with their loved one's request of dying alone.

Progressively, Mrs. S. showed signs and symptoms of nearing death. As her pain increased, the APN adjusted Mrs. S.'s pain regimen so that she would remain comfortable. The APN

and the interprofessional team increased support to Mrs. S.'s family to help them honor her wish for privacy at the time of death.

By maintaining a consistent presence with the patient and family and among the interprofessional team members, the APN helped to minimize decision-making conflicts. With advanced knowledge in the humanities, the APN, through language and image, gave expression to the experience of illness, death, grief, and human suffering.

## DISCUSSION OF THE ADVANCED PRACTICE NURSE'S ROLE

**Clinician.** The APN utilized sophisticated and appropriate assessment strategies to evaluate pain and symptoms. The APN interfaced with other interprofessional team members to develop and implement a comprehensive plan of care. The APN identified novel approaches to the treatment of neuropathic pain and developed hospital-based standards of practice to reflect and support this treatment strategy and then executed the interventions. Advanced clinical knowledge of complex pain syndromes and comfort measures used to address symptoms was demonstrated through utilization of innovative, ethically sound, and scientifically based practice.

**Educator.** The APN facilitated complex philosophical, ethical, and clinical management discussions that assisted the patient, family, and all interprofessional team members in achieving a positive outcome. The APN assessed the learning needs of Mrs. S. and her family and the entire staff. The APN presented scientifically based education on the following issues: (a) the management of neuropathic pain, (b) the potential for role conflict, (c) the actual loss/anticipatory grief, and (d) the potential for high-risk bereavement. The APN also educated other disciplines; for example, she influenced the quality committee and pharmacy staff through in-service activities and guidelines on the philosophy of PC and developed individualized treatment strategies, most notable, the use of intravenous lidocaine for intractable neuropathic pain.

**Researcher.** The APN generated new knowledge through research and the translation of evidence into practice. The APN investigated and integrated PC research strategies, for example, the use of intravenous lidocaine, to formulate an individualized plan of care for Mrs. S.

**Collaborator.** The APN mentored staff in biopsychosocial and spiritual assessments and interventions. The APN built and preserved collaborative relationships and identified resources and opportunities to work with PC colleagues. The APN facilitated the development and implementation of staff forums, in-service training, physician–nurse collaboration, and quality committee consultation. The APN demonstrated the value of collaboration with the patient and family, the interprofessional team, and other healthcare professionals to facilitate the best possible outcome.

**Consultant.** The APN consulted with the PC physician, PC colleagues, and quality-committee representatives to determine the appropriate treatment strategies for meeting the needs of the patient and family. Also, the bereavement counselor was consulted after the APN identified the actualized loss experienced by Mrs. S.'s family. As a consultant, the APN was consistently available to the patient and family, interprofessional team members, and other healthcare professionals to discuss and explain issues surrounding the PC philosophy.

## ■ CONCLUSIONS

Generalist nurses and APNs in PC and hospice care bring a specific and well-defined set of qualities, knowledge, and judgments to caring for individuals and families facing serious, progressive, or life-threatening illness. This includes advanced scientific and biopsychosocial–cultural–spiritual knowledge, analytical skills, and mastery of a broad repertoire of communication and interpersonal skills.

Evidence suggests that early interventions of PC improve QOL, cost of care, and even survival in patients with metastatic cancer. Until recently, data from RCTs

demonstrating the benefits of PC in patients with metastatic cancer who are also receiving standard oncology care have not been available (Smith et al., 2012). PC is an emerging specialty within healthcare and nursing. The philosophy and delivery of PC transcends all areas of nursing where suffering accompanies illness. The PC nurse is a true leader within the interprofessional team and hence is in an ideal position to establish standards for consistent practice, foster education, and promote research. It is a professional privilege to be in the field of PC nursing as it brings hopefulness to areas of EOL care that traditionally have been avoided—for example, ethics, pain, and human suffering. Equally applicable to

the art of PC nursing practice is Thoreau's (1854) statement: "It is something to be able to paint a picture, or to carve a statue, and to make a few objects beautiful. But it is far more glorious to carve and paint the atmosphere in which we work, to affect the quality of the day—this is the highest of the arts" (p. 90).

## CASE STUDY

### AN INTERPROFESSIONAL PERSPECTIVE

Mackenzie Frederick, BS in Nutrition Sciences, Dietetic Technician, Registered (DTR)

Although Mrs. S. is suffering from severe pain, her other major distressing physical problem was malnutrition. The role of the dietician in the PC interdisciplinary team is to assess patients for adequate dietary and fluid intake, recommend interventions that will increase QOL, and evaluate the patient's nutritional status. Most cancer patients who are receiving PC pass away from malnutrition, so measures to maintain an adequate dietary intake preserve life and increase QOL. As such, nutrition goals are directed at these measures rather than increasing weight.

The dietician should remove all dietary restrictions placed on the patient and should not impose calorie or protein goals. Any dietary intake is encouraged. The dietician will assess the patient for intake by performing a 24-hour recall, and help the patient to determine what types of foods he or she would enjoy eating or previously have enjoyed. The patient's activity tolerance would be evaluated to identify tasks that can be performed in the kitchen, such as peeling vegetables while sitting at a kitchen table. The family will be coached to involve the patient in any way so as to increase QOL by participating in tasks that are enjoyable.

A particular area of focus for the dietician who is on the interprofessional PC team is assessment of bowel patterns, gastrointestinal (GI) disturbances, and fluid intake. Patients with cancer experience a range of GI problems secondary to chemotherapy and pain medications. These problems include early satiety, loss of appetite, loss of or altered taste, nausea, vomiting, constipation, and dehydration. A patient like Mrs. S. is at a high risk for dehydration, which is the number one reason for hospitalization in patients receiving PC. If the risk is identified early, the patient can be coached on strategies that encourage fluid intake or the patient can receive IV fluids several times a week in a clinic or treatment facility to avoid hospitalization.

The dietician who recognizes opioid-induced constipation will recommend stool softeners or laxatives to be added to the medication regimen.

Patients can experience loss of appetite secondary to depression, and in the event that depression is disclosed to the dietician, a referral to counseling or social services would be made. Patients who may also express interest in regaining strength lost from muscle atrophy secondary to malnutrition are referred to physical therapy.

## Evidence-Based Practice

McCorkle, R., Jeon, S., Ercolano, E., Lazenby, M., Reid, A., Davies, M., ... Gettinger, S. (2015). An advanced practice nurse coordinated multidisciplinary interventions for patients with late-stage cancer: A cluster randomized trial. *Journal of Palliative Medicine*, 18(11), 962–969. doi:10.1089/jpm.2015.0113

### ABSTRACT

#### Background

It has been demonstrated that patient health outcomes improve when the PC team is consulted. There are few studies that document patient's self-reported clinical outcomes when PC is integrated within comprehensive cancer care.

**Objective**

To evaluate the effects of a multidisciplinary coordinated intervention by APNs at the oncology clinic level, as compared with patients newly diagnosed with advanced cancer seen by the usual multidisciplinary oncology care team.

**Methods**

Clustered RCT of 146 patients who were enrolled with late-stage cancer from four disease-specific multidisciplinary oncology clinics (gynecology, lung, head and neck, and gastrointestinal) and randomized to a 10-week standardized intervention or usual oncology care. The intervention was delivered by different members of the multidisciplinary oncology team, but was coordinated by an APN. The intervention included monitoring patient's status, providing symptom relief, teaching patients and their family caregivers, coordinating care, responding to questions, and executing complex care procedures. The usual oncology care group also involved multidisciplinary care but was not coordinated by an APN. Patient's self-reported health, health distress, symptoms, depression, anxiety, uncertainty, self-efficacy, functional status, and QOL were recorded at baseline and at 1 and 3 months.

**Results**

There was no statistically significant difference between the intervention group directed by an APN and the usual disease-specific multidisciplinary oncology care groups at 1 and 3 months postbaseline. However, physical and emotional symptoms remained stable or significantly improved for both groups.

**Conclusions**

For patients with advanced cancer, their self-reported clinical outcomes remained stable or improved in both the intervention and the usual care groups over time. A multidisciplinary approach to cancer care with the integration of PC into disease-specific comprehensive oncology care results in stable or improved patient outcomes.

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