Problem:
More than one million people die each year without these services being offered to them. 25% of Medicare expenditures take place during the last year of the patient’s life, and these expenditures grow in significance as the population of the United States continues to age. By 2030, 20% of the U.S. population will be over the age of 65.1,2 Issues of pain control, symptom management and psychological distress plague many with chronic illnesses having limited or nonexistent treatment options.1

Evidence:
Palliative Care has demonstrated success in the pain and symptom management and improving the quality of life of patients with serious medical conditions for whom curative treatment options may be decreasing or unavailable.1,2,3,4 In addition to the benefits of assisting these patients with goal setting and improving their symptoms, Palliative Care programs have been shown to decrease healthcare expenses by as much as $4900 per admission for these patients through the avoidance of unnecessary and painful procedures and diagnostics tests.1

Strategy:
A 225 bed hospital affiliated with an academic center is developing and expanding a Palliative Care program to meet the needs of a diverse patient group, including oncology patients and senior citizens with a variety of chronic healthcare conditions. This hospital is using a variety of methods to increase the number of patients who utilize the available Palliative Care services and provide them with evidence-based Palliative Care treatment, as advocated by the Textbook of Palliative Nursing, the End-of-Life Nursing Education Consortium, the American Academy of Hospice and Palliative Medicine, the Hospice and Palliative Nurses Association and other literature as listed within the Bibliography.

Among the strategies for increasing knowledge and census within the hospital staff:

a. Attending staff meetings for nurses and other healthcare workers to update them on the principles of Palliative Care.

b. A Clinical Nurse Specialist (CNS) to assist with obtaining referrals and screening patients.

c. Assistance by the CNS to help nurses determine the best way to approach physicians on appropriate patients to suggest referrals.

d. Visible daily rounding by the Palliative Care team.

e. Rotations by Fellows with the Palliative Care team, to increase understanding of the program and recognition of appropriate patients by multiple disciplines.

f. Data collection and tracking to assess the effectiveness of the program, both in financial terms and in terms of improving quality of life.


**Practice:**
Prior to the initiation of the above strategy, Palliative Care consults were primarily handled by physician teams who also had other responsibilities. A widespread misunderstanding among both nurses and physician was present in the hospital setting, including the belief that palliative care should only be consulted at the end of life, and confusion between palliative care and Hospice.

**Evaluation:**
In addition to tracking the success of the program via increased number of consults, the palliative care program is currently in the process of tracking both changes in patient resuscitation status and the success in relieving patient symptoms. Symptoms tracked daily to assess include pain, fatigue, anxiety/nervousness, emotional distress, level of consciousness, dyspnea, stool patterns, nausea/vomiting, and other symptoms described by the patient (such as hiccups or loss of appetite).

**Results:**
Over the last four months, the program has seen a two to three-fold increase in the number of patient referrals with the utilization of these strategies. Evaluation of symptom management and appropriate change in resuscitation status is still ongoing.

**Lessons Learned:**
Future efforts will include an all-day educational program on Palliative Care with contact hours offered to nurses and a Palliative Care Referral Request Form to increase the ease with which staff on all shifts can suggest referrals. Nurse and physician education on the scope and benefits of palliative care remains a strong priority. Assessing the appropriateness of some palliative care referrals also remains an ongoing challenge. The role of the CNS in the Palliative Care Service remains in evolution.

**Bibliography:**
2. Palliative and End of Life Care, (accessed at the National Priorities Partnership website on 12/16/08 http://www.nationalprioritiespartnership.org/PriorityDetails.aspx?id=608)
3. End of Life Nursing Care Consortium-Critical Care Training Program; Administered by the City of Hope and American Association of Colleges of Nursing, Updated in 2008.