Palliative care (PC) evolved from hospice care, which debuted in England at the end of the 19th century. The first hospice program in the United States opened in 1971 (Martinez, 2011). PC needs to be better understood and differentiated from hospice care. PC is a broader version of hospice care; it starts at diagnosis andkeeping the patient as the focus. Moving from curing disease and preventing death to preparing for death was an enormous change in philosophy and practice in medicine. Death had been viewed as “medical failure” (White, 2012, p.133). At North Shore-LIJ Huntington Hospital, the need to initiate PC became evident more than a decade ago. It took the determination of a few individuals and the support of the administration to get where we are today. A robust team is led by a PC fellowship-trained physician and includes a nurse practitioner, a dedicated social worker, and a recently hired second physician. They provide PC to patients throughout the hospital, including in Critical Care. The success of the initiative was proven by the number of consults within the first year of inception of the program: 679. This number translates into a percentage above the benchmark established by the Center to Advance Palliative Care. A reduction in the length of stay and the number of Ethics Committee consults also reflected success. Several testimonials written by staff members were submitted with our Magnet® documents. Also, new policies have been implemented to improve decision making (e.g., obtaining a PC consult prior to percutaneous endoscopic gastrostomy tube placement in a patient with dementia). The strength of the program is evidenced by the serious commitment and full dedication of a robust, enthusiastic committee. The committee meets monthly and follows an agenda that includes an educational portion, data reporting, and discussion about upcoming needs and projects. This committee has several established goals, the first of which is to achieve Joint Commission certification. Other goals are to increase clinical coverage and establish dedicated PC beds or an entire unit. The committee has expanded beyond the hospital to the community, reaching residential health care facilities to promote education regarding advance directives and end-of-life decision making.

While patients are in the hospital, they could be in crisis. Because of is-
sues related to level of sedation, inability to swallow, or nausea and vomiting, it might be most suitable to administer medication intravenously (IV). The need for this mode of drug administration was the driving force for getting the nursing staff on board. They needed education and competency to IV push medications specifically used in PC, such as Haldol® and Robinul®.

A policy was drafted and the existing physician order form was revised to include parameters, guidelines, and limitations with all IV push medication orders. The policy mandated that only specified prescribers could write those orders, and only educated and competent registered nurses (RNs) on one unit—the Oncology Unit—could complete the task. We hope to eventually expand the initiative to include all other units within the hospital.

Implementation of the policy meant that a formal educational program was needed. A multidisciplinary team designed and presented a 90-minute program to all RNs on the Oncology Unit. Medicine gave an overview of what PC and hospice care mean to and offer this patient population. Pharmacy prepared and presented a comprehensive review of all drugs introduced in the therapy. A doctorally prepared pharmacist created a detailed grid including all drugs, as well as dose, required monitoring, dilution, speed of administration, and units in which allowed. This can be easily accessed by all nurses online and is continually updated. This initiative makes a major contribution to decreasing adverse drug events caused by inaccurate, outdated information. Nursing reviewed its policy and procedure requirements and implementation. This didactic presentation was followed by a hands-on session to discuss and practice all details related to dilution, administration, and safety (e.g., the importance of syringe labeling). At the end of the educational session, attendees were given a multiple-choice test. The minimum of 80% to pass was met by all participants. Questions and correct answers were discussed as a group. This program was repeated four times to accommodate both day and night shifts. Nursing staff were required to attend.

For the purposes of this article, a brief survey was conducted via e-mail, asking about the effects of attending the session. The respondents unanimously reported that the program improved their confidence and comfort and empowered them to treat patients effectively and efficiently. The director of the cancer services reported a vast improvement in pain management since implementation of this modality.

This initiative in PC is currently limited to one unit, which means patients are occasionally transferred to the Oncology Unit for this type of care. Program expansion is being explored. An unexpected outcome not related to the initiative was collaboration between Nursing and Pharmacy to prepare a lengthy, detailed information module on all aspects of IV push administration that is available online and regularly updated.

Because the PC team is working toward obtaining Joint Commission certification, it is crucial that a higher percentage of nurses be certified in palliative and hospice nursing. The PC team, in collaboration with Nursing Education, prepared and presented a three-part series open to all interested staff nurses. Staff were encouraged to attend on their own time. The classes were free to all North Shore–LIJ Huntington Hospital employees. Two continuing education contact hours were offered per session (a total of six if all sessions were attended). The sessions, scheduled for three consecutive Wednesdays, were advertised in advance. An average of 41 nurses, from different areas of the hospital, attended each session. This course was taught by several experts, contributing to its success. It followed and covered the syllabus of the Core Curriculum for the Generalist Hospice and Palliative Nurse (Hospice and Palliative Nurses Association, 2010). Many positive comments were included on the evaluations.

The total number of certified nurses has not increased significantly. According to Schmal (2012), “Specialty certification is one method that has been identified to assure the public that a nurse has the knowledge and skills to provide safe, high-quality care” (p. 177). The PC team, Nursing Education, and the nursing administration recently discussed ways to increase this number. Suggestions included planning or organizing study groups, having short review sessions focused on sample questions, and creating a library of review books and articles. Benefits and incentives were discussed, such as encouraging those with certification to participate in public education regarding end-of-life issues and creating a wall of fame for those who have passed the examination. A financial incentive already exists through the hospital.

The beliefs and perceptions of nurses caring for patients who are suffering from or dying of life-threatening illnesses must be strengthened so that they provide the most effective and efficient patient- and family-centered care.

REFERENCES