

EXPLORING AND CLARIFYING THE ROLE OF THE NURSE
ON THE SPECIALTY PALLIATIVE CARE TEAM

by
Brooklyn Taylor Crape

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ABSTRACT

Palliative care interdisciplinary teams seek to relieve the pain, stress, and suffering associated with terminal illness. The medical specialty is relatively new, and rapidly developing to attempt to meet the needs of an estimated 6 million Americans coping with a serious illness. **Problem:** Unfortunately, there is a severe shortage of palliative care professionals, and burnout and dissatisfaction with organizational practices threatens to exacerbate this shortage. Thoughtful use of each interdisciplinary team member's skills is necessary to meet the needs of patients while preserving team satisfaction. Nursing is considered a core role on palliative care interdisciplinary teams, and available evidence suggests nurses positively impact care team satisfaction and the quality of care. However, the palliative care nurse role is under-researched and often misunderstood. The variability of the role across the continuum of care contributes to role misunderstanding. Depending on the setting palliative care nurses may serve as symptom managers, care coordinators, providers of emotional care, team leaders, and/or contributors to quality improvement. This variation requires teams to clarify the role expectations of their palliative care nurses at the microsystem level. **Purpose:** This quality improvement project aims to create microsystem-specific, evidence-based guidelines for the practice of palliative care nurses on a palliative care interdisciplinary team in western Montana with the goal of increasing care team satisfaction and retention. **Methods:** A Plan-Do-Study-Act method will be used to guide the project. A committee lead by a clinical nurse leader will facilitate active, interdisciplinary participation in the improvement process. Prior to intervention the interdisciplinary team will complete a Strengths-Weaknesses-Opportunities and-Threats analysis. The nurses will also record their daily activities for one week and complete a role clarity survey. The outcomes of staff satisfaction and improved retention will be assessed with a yearly survey, self-reports at monthly meetings, and repeated role clarity surveys. **Recommendations:** Since the healthcare environment is ever-changing the quality improvement process should be continuous, and the microsystem specific palliative care nurse guidelines that are created should be considered living documents.

CHAPTER ONE: INTRODUCTION

Palliative care is a medical specialty that relieves pain, stress, and suffering for patients with serious illnesses (Schenker, 2020). In this context a serious illness is defined as any health condition that is associated with a high risk of mortality and has the potential to negatively impact quality of life, daily functioning, or strain on caregivers (CAPC, 2019). Examples of serious illnesses that are appropriate for palliative care include metastatic cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, Alzheimer's Disease, Parkinson's Disease, and Amyotrophic Lateral Sclerosis (ALS) (CAPC, 2021).

Palliative care has also become essential in the care of patients with severe cases of COVID-19 during the global pandemic (CAPC, 2021; Koch & Mantzouris, 2020). Introduction of palliative care specialists is appropriate at any stage of a serious illness, and, unlike hospice care, it can be provided while patients are still seeking curative treatments like chemotherapy or surgery (NIA, 2021). Patients can expect palliative clinicians to provide expert symptom management, take a holistic, patient-centered approach to medical decision-making, and assist in planning for the future (CAPC, 2021). This future planning is called advance care planning, and often includes completing an advance directive or POLST form (NIA, 2018).

While palliative care is a newer medical specialty, its origins trace back to the hospice care movement that began in the United Kingdom (U.K.) in the 1960s (Center for Palliative Care, n.d.). It started as an offshoot of hospice care with the goal of alleviating suffering for patients even earlier in their illnesses (Center for Palliative care, n.d.). It was not until 1990 that the World Health Organization (WHO) designated palliative care as its own medical specialty, distinct from hospice care (UPMC, 2014). The United States (U.S.) was even more delayed in embracing the new specialty. For example, there was no professional certification available for

palliative care registered nurses (RNs) until 2002 (HPCC, n. d.), and The American Board of Medical Specialties (ABMS) did not offer a certification for physicians until 2008 (Loscalzo, 2008).

The availability of specialty palliative care has grown dramatically since the early 2000s. In just over a decade from 2008 to 2019 the percentage of US hospitals with ≥ 50 beds that provide specialty palliative care has increased from 53% to 72% (CAPC, 2019). In addition to hospital-based care, there is also expanding availability of palliative care in other settings, such as nursing homes, outpatient clinics, and home care (NIA, 2021). Even though large strides have been made, there is still a need for continued expansion to meet the needs of the approximate 6 million people in the U.S. who are living with a serious illness (CAPC, 2014).

An interdisciplinary team (IDT) approach is necessary to provide holistic care to this population with complex medical and psychosocial needs (Fernando & Hughes, 2019). In addition to physicians and advance practice registered nurses (APRNs), teams may include nurses, social workers, chaplains, music therapists, art therapists, and bereavement coordinators (CAPC, 2020). Palliative programs can vary significantly in their IDT structure and function as they strive to meet the unique challenges of their patient population and healthcare system (Fernando & Hughes, 2019). While interdisciplinary skill mix varies, nursing is considered a core discipline on the palliative IDT because, while their skills in direct patient care may overlap with the providers on the team, the care coordination that they provide for this complicated population is unique to their skillset (Henderson et al., 2019).

Specialty palliative care interventions positively impact quality of care and quality of life, reduce symptom burden, and reduce of the overall cost of care (Kavalieratos et al., 2016). For example, early palliative care consultation during a hospital admission can save an average of

\$3,237 per patient (May et al, 2018). The cost savings for patients with cancer and patients with four or more comorbid conditions is even higher (May et al., 2018). Cost savings come primarily from reduced lengths of stay and lower intensity of medical intervention (May et al., 2018). At the national level, approximately 68% of Medicare spending is related to patients with four or more comorbid conditions (CAPC, 2014). These patients are likely appropriate for palliative care consultation. This means the U.S. hospital system could save an estimated \$6 billion per year if palliative care teams were fully integrated (CAPC, 2014). This is substantial, given that the U.S. spends more on healthcare than any other comparable high-income country, yet continues to fall short with health outcomes (Schneider et al., 2021).

Unfortunately, there is a severe shortage of palliative care physicians, nurses, and other IDT members to meet the needs of this population (Kamal et al., 2017). Over the last decade there has been a rapid acceptance of palliative care as part of the standard of care for patients with serious illnesses, while the workforce has remained stagnant. There are currently 6,600 board-certified physicians practicing in the specialty with a shortage of nearly 18,000 and, unfortunately, this is not expected to improve (Kamal et al., 2017). If there are no changes to the current system the physician workforce will be essentially unchanged over the next 20 years, while the number of patient's eligible for palliative care is expected to increase by 20% (Kamal et al., 2017). This means in 2030 there will be a ratio of one palliative care physician to 26,000 patients in need. While not well studied, it is evident this shortage extends to other IDT members (Kamal et al., 2017). In Montana the disparity is more pronounced, with only 57.1% of hospitals with ≥ 50 beds offering specialty palliative care (CAPC, 2019). In rural Montana this percentage drops to 34.9% (CAPC, 2019).

Burnout and workplace dissatisfaction threaten to exacerbate this staffing crisis in the coming years. In 2017, 62% of the workforce reported experiencing burnout and 19% of the workforce reported at least a 50% chance of leaving the field within 5 years (Kamal et al., 2017). Besides retirement, burnout and dissatisfaction with organizational practice were the most prevalent reasons for considering departure (Kamal et al., 2017). The COVID-19 pandemic has almost certainly exacerbated these issues. It is evident that the palliative care workforce is a very limited and valuable resource. With a staffing shortage that is this dire, it is critical that palliative IDTs work to maximize the impact of each member to meet the needs of patients while also prioritizing staff satisfaction and burnout prevention to retain staff (CAPC, 2020). Since palliative care programs vary significantly in their IDT make-up and function, role protocols must be created at the microsystem level that address the unique demands of each program (CAPC, 2020). Guidelines and protocols that address the role of the nurse on the IDT are particularly important because the role has some overlap with the provider role and tends to be flexible, broad, and misunderstood (Autelitano et al., 2021).

Palliative care nurse (PCN) job titles include descriptors like clinician, triage nurse, navigator, coordinator, or case manager (CAPC, 2020; Fitch & Dietzen, 2019; Venkatasalu, 2015). They work in settings across the continuum of care, from acute to home care. Their function may vary by setting, but there are some common themes in their work. Symptom management, emotional care, coordination of care, and professional engagement are essential in this role (Autelitano et al., 2021; Hokka et al., 2020; Koch & Mantzouris, 2020; Pesut et al., 2017; Rosa et al., 2020; Sekse et al., 2018). There is a lack of research to strongly link PCNs to patient outcomes, however, the available research suggests their contributions improve the quality of care and the satisfaction of the care team (Autelitano et al., 2021; Fitch & Dietzen,

2019; Pesut et al., 2017) While PCNs may increase care team satisfaction, their own satisfaction is challenged by lack of job role clarity and misunderstanding of their role by colleagues (Autelitano et al., 2021). One way to increase job satisfaction is to increase feelings of competence in the role by developing microsystem specific PCN guidelines (Biagioli et al., 2018).

In summary, lack of role clarity can contribute to dissatisfaction at work for PCNs and the rest of the care team. Since dissatisfaction and burnout are serious threats to retaining the palliative care workforce, clarifying roles and addressing team satisfaction is a priority. Palliative IDTs may look to professional guidelines to help define the appropriate role functions for their PCNs, but these guidelines lack the specificity needed to address role confusion within individual microsystems. Since palliative IDTs vary in skill mix and function, teams must develop their own guidelines and protocols (CAPC, 2020). Creating guidelines that clarify the role and priorities of PCNs at the microsystem level has the potential to increase job satisfaction for the entire care team. This is critical to reduce the risk of burnout and turnover amid a severe, nationwide shortage of palliative care clinicians.

Purpose Statement

The purpose of this quality improvement project is to create microsystem-specific, evidence-based guidelines for the practice of the PCNs on a specialty palliative care IDT in western Montana with the goal of increasing care team satisfaction and retention.

Theoretical Framework

For this project, a theoretical model is needed that addresses interpersonal dynamics within the larger care team and healthcare system. This makes the Nursing Role Effectiveness Model an ideal framework for this project (see Appendix A).

Nursing Role Effectiveness Model (NREM)

The conceptual model was developed in 1998 at a time when there was intensifying focus on quality assurance, patient outcomes, and cost-effectiveness in healthcare (Irvine et al., 1998). The accountability of providers was a major focus at the time, but Irvine et al. (1998) expanded the focus to investigate how nurses contribute to specific patient outcomes. The model guides assessment of the nurse's impact by considering the structure of the care environment and the nurse's key roles (Doran et al., 2002).

Structural components of the model include the nurse, patient, and care environment (Irvine et al., 1998). Nurse factors include education, skill-level, and relevant experience (Lukewich et al., 2019). Patient factors include demographics and type of illness. The care environment refers to variables like staffing, skill mix, job autonomy, and role tension (Doran et al., 2020; Lukewich et al., 2019). These care environment variables are the most relevant to this project.

Process components of the NREM focus on types of nursing interventions, which are grouped into three nursing role categories- independent, dependent, and interdependent (Lukewich et al., 2019). Independent roles refer to activities that nurses perform autonomously without a medical order. These activities include nursing assessment, patient triage, and education (Lukewich et al., 2019). Dependent roles refer to implementation of medical orders.

Interdependent roles refer to activities that the nurse performs with other health care providers, including team communications, coordination of care, and health system improvement (Lukewich et al., 2019).

The NREM recognizes six nursing-sensitive outcomes, including prevention of adverse events, clinical outcomes, patient knowledge of disease, functional health outcomes, patient satisfaction, and cost outcomes (Lukewich et al., 2019). While the model was originally focused on acute care units, it can be adapted to evaluate nursing roles in other care environments. The NREM provides the structure and vocabulary needed to categorize the current-state roles of PCNs on specialty palliative care IDTs and envision an improved future-state. A visualization of the model is represented in Appendix A.

Project

The population for this project is the specialty palliative care IDT for a health system in western Montana. The IDT consists of eight clinicians including two physicians, two APRNs, three PCNs, and one clinical assistant. The Plan, Do, Study, Act (PDSA) model for quality improvement will be used to guide the project (Institute for Healthcare Improvement, 2022). Ongoing PDSA cycles are expected to be necessary due to the ever-changing nature of healthcare. A clinical nurse leader (CNL) will guide a committee of palliative care representatives through this quality improvement project. Prior to intervention each team member will identify opportunities for improvement related to PCN role confusion. The team's PCNs will also complete a short role clarity assessment tool and track daily activities in a journal for one week to reveal current roles and challenges in daily work. The team will then meet to review these assessments in comparison to current job descriptions, guidelines, and protocols, or lack thereof. Interventions that emerge from committee meetings will be documented on a PDSA

template. As cycles continue, guidelines and protocols for the PCNs will be updated appropriately. Ongoing assessments will include review of the original opportunities for improvement identified by the team and repeated role clarity assessment surveys. Satisfaction of the team will be measured with staff satisfaction surveys and qualitative feedback, and retention rates will be continually monitored. These measures will help answer the question at the core of this quality improvement project- on a busy specialty palliative care IDT, can clarifying and prioritizing the role of the PCN improve care team satisfaction and prevent turnover?

CHAPTER TWO: LITERATURE REVIEW

Overview

This chapter synthesizes the literature on appropriate palliative care nurse (PCN) roles on specialty palliative care interdisciplinary teams (IDTs). This review reveals that consistent descriptions of the PCN role exist in the literature, but there is a lack of specificity to make them useful at the microsystem level. Three themes emerged: roles and competencies of PCNs, the impact of PCNs on care teams, and challenges faced by PCNs.

Search Strategy

The literature review was conducted to evaluate roles of PCNs on specialty palliative care IDTs. Databases searched included Google Scholar, CINAHL, PubMed and the Ovid medical research platform. Search terms included palliative nurse, palliative nurse role, specialty palliative nurse, palliative nurse and quality, and palliative nurse and impact. Inclusion criteria included English language, literature from 2015-2021, articles from peer-reviewed medical or nursing journals, and titles that included “palliative nurse.” A total of 36 articles were retrieved. The articles were then reviewed with exclusion criteria for topic relevance. Exclusion criteria included a focus on advance practice registered nurses (APRN), or clinical nurse specialists (CNS) as opposed to RNs, and a focus on primary palliative care skills as opposed to specialty palliative care. The final number of articles totaled 14.

Research Gaps

There is a lack of high-quality quantitative data to correlate the PCN’s role directly to care team outcomes. There is also a lack of qualitative data describing the role from the patient or medical provider’s perspective. Overall, more research is needed to clearly define the optimal

role of PCNs on palliative IDTs to maximally utilize their skills and understand their impact on health outcomes (Autelitano et al., 2021; Hickman et al., 2020; Hokka et al., 2020; Ford, 2021).

Roles & Competencies of PCNs

PCNs work in a variety of care settings across the continuum of care, including critical care, acute care units, outpatient clinics, and community-based care. Each setting presents unique demands, but there seems to be broad consensus on the areas of competence that are needed to provide high quality care. Competence as a symptom manager is required in every setting the PCN may practice, and requires clinical expertise in assessment of symptoms, medication review, pharmacologic and non-pharmacologic interventions, appropriate management of symptoms in the context of the patient's goals of care, and patient education (Autelitano et al., 2021; Hokka et al., 2020; Pesut et al., 2017, Rosa et al., 2020). Common symptoms addressed by the PCN include pain, fatigue, psychological distress, nausea, and bowel and bladder problems. Assessing for mobility problems, fall risk, and safety concerns are also a part of this role. Autelitano et al. (2021) estimates that PCNs spend roughly 50% of their time on symptom management which may occur at the bedside, in homes, or over the phone. This time estimate undoubtedly varies based on setting, but is clearly a priority for the PCN role.

PCNs also attend to emotional care, which is a role that includes attending to psychosocial and spiritual distress, listening, being present, and referring to additional resources when appropriate (Autelitano et al., 2021; CAPC, 2021; Hickman et al., 2020; Hokka et al., 2020; Pesut et al., 2017; Sekse et al., 2018). Some typical examples of emotional care might include a PCN helping a patient process some difficult news they received from the medical team or being present with family members of an actively dying patient. The expectation of the PCN in this role is to provide skilled emotional support while assessing for more complicated

problems that require expert attention from other disciplines (Hokka et al., 2020; Sekse et al., 2018).

Care coordination is another core competence for PCNs and is the role most represented in the literature. To coordinate patient-centered care, PCNs participate in goals of care discussions, guide advance care planning, educate patients on their disease processes and care options, and review care plans for appropriateness (Hickman et al., 2020; Koch, & Mantzouris, 2020; Parola et al., 2018; Pesut et al., 2017; Rosa et al. 2020; Sekse et al., 2018). This is an area where PCNs often take the lead on palliative care IDTs (Pestut et al., 20017). Effective care coordination for this population requires a flexible, patient-centered approach, for example, PCNs respect how and when patients want to participate in visits (Pesut et al., 2018). They also ensure coordination when patients are transitioning between levels of care, like when discharging from the hospital to home, a care facility, or hospice care (Venkatasalu et al., 2015). Care coordination might be the primary function of their role, with job titles like navigator or coordinator, or a role they fulfill in addition to other clinical work. Overall, regardless of setting, they serve as conduits for collaboration and communication between all care team members (Fitch & Dietzen, 2019; Ford, 2021; Hokka et al., 2020; Koch & Mantzouris, 2020; Parola et al., 2018; Pesut et al., 2017; Rosa et al., 2020; Sekse et al., 2018; Venkatasalu et al., 2015).

Finally, PCNs are well-positioned for leadership roles (Autelitano et al., 2021; Hokka et al., 2020; Rosa et al., 2020) and quality improvement positions (Lindley et al., 2017). They act as leaders by advocating for the patient's needs at care meetings and during day-to-day care (Autelitano et al., 2021; Rosa et al., 2020). They also demonstrate professional leadership by staying up to date with evidence-based palliative care practice, which puts them in an ideal position to provide education to the larger healthcare team on topics like symptom management,

end of life care, and ethical issues (Autelitano et al., 2021; Hokka et al., 2020). For relevant quality improvement projects, involvement of PCNs is beneficial to the whole team (Lindley et al., 2017). As frontline clinicians, they are aware of the complexities of delivering high quality palliative care and can use this insight when planning, implementing, and championing quality initiatives.

Impact of PCNs on Care Teams

While many sources attempt to explore, define, and clarify the role of PCNs, fewer suggest their direct impact on the care team. The most prominent impact is improvement in the quality of care provided (Autelitano et al., 2021; Fitch & Dietzen, 2019; Hickman et al., 2020; Venkatasalu et al., 2015). For example, Hickman et al. (2020) describe how PCNs prevent inappropriately aggressive medical care in the context of the patient's goals of care. For instance, if a patient's goal is to die at home with a focus on comfort, the PCN will work to prevent hospitalization and invasive procedures for acute issues at the end of life (Pesut et al., 2017; Venkatasalu et al., 2015).

PCN interventions have the potential to increase patient and team satisfaction (Pesut et al., 2017; Fitch & Dietzen, 2019). For example, Fitch & Dietzen (2019) found that the introduction of a triage PCN to a hospital-based palliative care IDT increased team wellbeing, while at the same time increasing the number of consults completed per month from 66.5 to 81.6. The providers reported this increase occurred because the coordination provided by the PCN allowed them to spend more time on direct patient care as opposed to organizational tasks, resulting in more patients receiving palliative care consults than would have been possible without the care coordination of the PCN. This means that without adding an additional provider, the team was able to increase the number of hospital consults by 22.7%. As previously stated,

increased palliative care integration in hospitals is known to improve the quality of care and increase cost savings (Kavalieratos et al., 2016), which means PCNs have the potential to increase care team satisfaction while also increasing the quality and cost-effectiveness of care provided in their microsystems.

PCN Role Challenges

PCNs are faced with mortality and the extremes of human emotion in their daily work. In addition, they are tasked with coordinating care in a complex medical system where their job duties often fluctuate. These challenges are compounded by a lack of job role clarity and misunderstanding of their role by healthcare colleagues (Autelitano et al., 2021). This is partly because much of their work tends to be unseen and under-valued due to the nature of care coordination and emotional care (Moran et al., 2021). In addition, the specialty PCN role is still relatively new, and role descriptions in the literature are still broad (Autelitano et al., 2021; Hokka et al., 2020). This may be because it's unclear how a PCN's role should differ based on care setting, so role descriptions include all possible activities they might engage in across the continuum of care, as opposed to specific daily tasks (Hokk et al., 2020). These challenges hold potential for frustration and role confusion within the palliative care IDT.

Another challenge is maintaining feelings of competence in a fast-paced healthcare environment. PCNs that believe they are competent in their role have a positive correlation to job satisfaction and organizational citizenship behavior (Biagioli et al., 2018). This is likely to improve care team satisfaction and patient outcomes. To encourage feelings of competence organizations should provide educational opportunities, foster reflection, provide a supportive work environment, and empower PCNs to be active in developing their own professional guidelines that are specific to their IDT and microsystem (Biagioli et al., 2018).

Summary

The PCN role requires competence in symptom management, emotional care, care coordination, and leadership activities. Their presence on palliative care IDTs can increase care team satisfaction and enhance the quality of care provided. The role is challenging for several reasons, including the lack of job role clarity, and misunderstanding of the role by the larger healthcare team. Opportunities exist in individual microsystems to clarify the expectations of PCNs on specialty palliative care IDTs, with the potential to improve team satisfaction, and secondarily the quality, efficiency, and cost-effectiveness of care provided.

CHAPTER THREE: METHODS

Introduction

This chapter describes the proposed methods for implementing a quality improvement project focused on microsystem-specific, evidence-based guidelines for the practice of the palliative care nurses (PCNs) on a palliative care interdisciplinary team (IDT) in western Montana. PCNs have the potential to positively impact the satisfaction of care teams and the quality of care provided by the IDT (Autelitano et al., 2021). However, their job is challenging due to lack of job role clarity, which has the potential to cause frustrating role confusion on the palliative IDT. With an ongoing shortage of palliative care professionals, it's important to attend to the satisfaction and preservation of the current workforce by improving team processes. The following methods provide the opportunity to explore role confusion challenges faced by the IDT, address the lack of microsystem specific PCN guidelines, and clarify misunderstandings of the PCN role by the larger healthcare team. The ultimate purpose of the project is to clearly define and prioritize the most appropriate roles for the PCNs on the team with the goal of increasing care team satisfaction and retention.

Design

The Institute for Healthcare Improvement (IHI) (n.d.) Model for Improvement will guide the project design (see Appendix B). The action-oriented model is designed to bring the scientific method of improvement to real-world work settings, while rapid Plan-Do-Study-Act (PDSA) cycles facilitate continuous improvement (IHI, n.d.). Components of the model can easily be integrated into existing organizational quality improvement practices without replacing

established systems. For these reasons, it is an ideal method to address role confusion and process improvements within palliative care IDTs.

Setting

The setting of the project will be a health system in Western Montana that provides emergency, psychiatric, obstetric, pediatric, oncology, cardiac, medical-surgical, and critical care services in a 200-bed hospital, as well as providing expansive ambulatory services in the region. In 2020 the system provided 9,362 inpatient admissions and 305,968 outpatient visits (American Hospital Association, 2022). The population for this project is the palliative care IDT for the health system that provides acute care throughout the hospital, as well as ambulatory and telehealth services for the region. Ambulatory care is provided in the team's stand-alone office, as well as offsite in the system's cancer center and local skilled nursing facilities. The team includes three PCNs, two physicians, two APRNs, a nurse manager, and a clinical assistant. Most of the team works full-time, with the exception of one part-time physician and one per diem PCN. Services are provided Monday through Friday from 8 AM to 5 PM. In 2021 the team performed an average of 183 inpatient visits and 51 ambulatory visits per month. In the hospital setting an average of 8.8% of all admitted patients are consulted by the palliative care team.

Preparation

Choosing a skilled leader to guide this project will be essential to its success. A clinical nurse leader (CNL) has training specific to quality and process improvement in the clinical setting, which is an ideal fit for this project. Essential CNL skills include facilitating collaborative interprofessional approaches of care delivery, creating an understanding and appreciation amongst healthcare teams of the similarities and differences in their roles, and

collaborating across the continuum of care to plan, implement, and evaluate improvements in practice (AACN, 2013). Expertise in these areas will be particularly useful for this project that is focused on team roles, dynamics, and processes.

The only inclusion criteria for participation in the project is being on the palliative care IDT. The entire nine-person palliative care team will be involved in the quality improvement process, while the PCNs, one provider representative, nurse manager, and the CNL will form a committee and be more actively involved. Staff members outside of the palliative care IDT will be excluded from participating since the project is concerned with internal team roles and processes.

No marketing or business plan will be needed for this project, but a needs assessment will be necessary. To understand the needs of the team regarding role confusion, the committee will meet to perform a SWOT analysis (see Appendix C). SWOT stands for strengths, weaknesses, opportunities, and threats, and is an effective needs assessment tool that enables health professionals to contribute to healthcare development (Benzaghta et al., 2021). Expected threats may include limited time, high workload, and inability of nurses to bill for services. Identification of threats and challenges prior to process improvement will help the team anticipate and overcome these issues.

Ethical Approaches

Since this quality improvement project does not involve research or human subjects, IRB approval will not be needed (Bass & Malloy, 2020). However, if the project was ever expanded to include the study of patient outcomes, this should be reconsidered.

Implementation

Prior to implementing process changes, the PCNs will track their daily activities and time spent on each activity in a journal for one week. Brevity should be encouraged, as this is not meant to be a detailed report, but a way to shed light on the work currently performed by the PCNs. Protected health information should not be recorded in the journal since it is irrelevant to the purpose of the activity tracking. The CNL will review these journals to identify themes and compare the PCNs daily work to any current meso- and microsystem guidelines used by the health system. The PCNs will also anonymously complete a short role clarity assessment tool to identify common role confusion issues on palliative care IDTs prior to the start of the project. This assessment tool will be discussed later in more detail. A synopsis of these baseline assessments, including SWOT analysis, journal themes, and survey results, will be discussed with the IDT at a department meeting prior to the first PDSA cycle. The team will have the opportunity to add to the SWOT analysis, comment on journal themes, and brainstorm priorities for the first PDSA cycle. Minutes should be recorded as usual for department meetings.

The first committee meeting will occur within one week of the department meeting and will continue on a monthly schedule. The first step will be to establish the goal of the project and the outcomes of interest. The goal will be to create a microsystem-specific guideline for the role of the PCNs on the palliative care IDT. This guideline should be a living document that is revisited at regular intervals as the healthcare environment, patient population, and team composition evolve over time. The outcomes of interest will be care team satisfaction and staff retention. Both outcomes will be assessed with the organization's yearly staff satisfaction survey that is already in place. In addition, care team satisfaction will be qualitatively assessed through

self-reporting at department meetings. Retention rates will continue to be monitored and exit interviews will be performed in the case of any departures during this time.

Once goals and outcomes are established, the committee will propose plans for the first PDSA cycle. The CNL will lead committee meetings by facilitating constructive discussion and feedback from the group. She will also provide the organization's preferred PDSA template and be tasked with updating the template with each cycle. An example PDSA worksheet is provided for reference (see Appendix D). The nurse manager will be responsible for updating or creating microsystem guidelines over the course of multiple PDSA cycles. She will also share progress with the IDT and facilitate feedback on the process at department meetings. The PCNs and the provider representative on the committee will be responsible for implementing any changes in practice with each PDSA cycle and providing feedback on the outcome of interventions.

Validity & Reliability

The CNL's expertise in evidence-based quality improvement will ensure rigor in the PDSA process. In this setting the CNL will also serve as a valuable outside perspective for the palliative care team. In addition, all nine members of the palliative care team will be responsible for member checking the ongoing results of PDSA cycles to confirm the results match their real-world experience and ensure the credibility of the guidelines produced by the project.

Timeline

PDSA cycles and the associated committee and department meetings will take place monthly. A more thorough review of progress will occur at six months and again at one year. This will include reflection from the entire IDT at a department meeting on original goals, outcomes, and progress to provide the opportunity to re-focus efforts as needed. The living

PDSA document will be reviewed as a team to facilitate this reflection. Any guidelines or other tools created by the committee so far will also be presented to the team for feedback.

At the six month and one year time points the PCNs will also complete another short role clarity assessment for comparison to their baseline assessment of role confusion on the IDT. After one year the committee will vote on the frequency of future meetings. With the ever-changing nature of healthcare, it will be beneficial to continue committee meetings indefinitely, but they will not likely be needed at the same frequency.

Simple Role Clarity Assessment Team Exercise

As mentioned, a role clarity assessment tool will be used as one way to measure progress toward improving role confusion issues for the PCNs. The Center for Advancing Palliative Care (CAPC) provides an appropriate instrument called the Simple Role Clarity Assessment Team Exercise (see Appendix E). This instrument is a practical tool created by interdisciplinary palliative care experts to address the common issue of overlapping roles and resulting role confusion on palliative care IDTs (CAPC, n.d.). The 11-item assessment asks team members to rate statements from one to five based on how often they are true, with one being rarely true and five being always true. Statements relate to scope of practice, team dynamics, effective use of skills, and clear team roles.

The resulting total score and individual item scores of the assessment are meant to identify opportunities for improvement and topics for further team discussion. Descriptive statistics will be calculated to identify trends, but with only three PCNs completing the assessment, results should be considered in the context of the larger project. To encourage honesty, the assessment will be completed anonymously. This tool has not been tested to

determine validity or reliability, but due to its specificity to the goals of this project and its low risk to directly impact patient care, it is an appropriate tool for quality improvement at this level.

Limitations

While replicable, this quality improvement project will produce PCN guidelines specific to the microsystem where it is performed. Palliative care IDTs will need to go through their own quality improvement processes to produce the most useful, specific guidelines for their PCNs. This project is also limited to process improvements within the team with the goal of staff satisfaction and retention. The project is not focused on efficiency or patient outcomes, although it could reasonably expand to include these outcomes over time. Additional resources, ethical considerations, and appropriate instruments would need reconsideration if the project expanded.

Budget

No increase in department budget will be necessary for this project. Team members will participate in the project during work hours and no additional supplies or technology will be necessary. If PDSA cycles reveal that additional supplies or tools are needed for PCNs to fulfill their role effectively, the investment should be evaluated case by case.

Summary

A PDSA-based quality improvement method is a good fit to address the lack of role clarity for PCNs on the palliative care IDT. Along with the PDSA model, a CNL lead committee-based approach will encourage active, interdisciplinary participation in the improvement process. The goal of the project is to increase care team satisfaction and improve retention. These outcomes will be assessed with the regular yearly staff satisfaction survey, self-

reports at department and committee meetings, and repeated role clarity assessments. Since the healthcare environment is ever-changing and the PCN role is especially vulnerable to role confusion, the quality improvement process should be continuous, and the microsystem-specific guidelines that emerge should be considered living documents.

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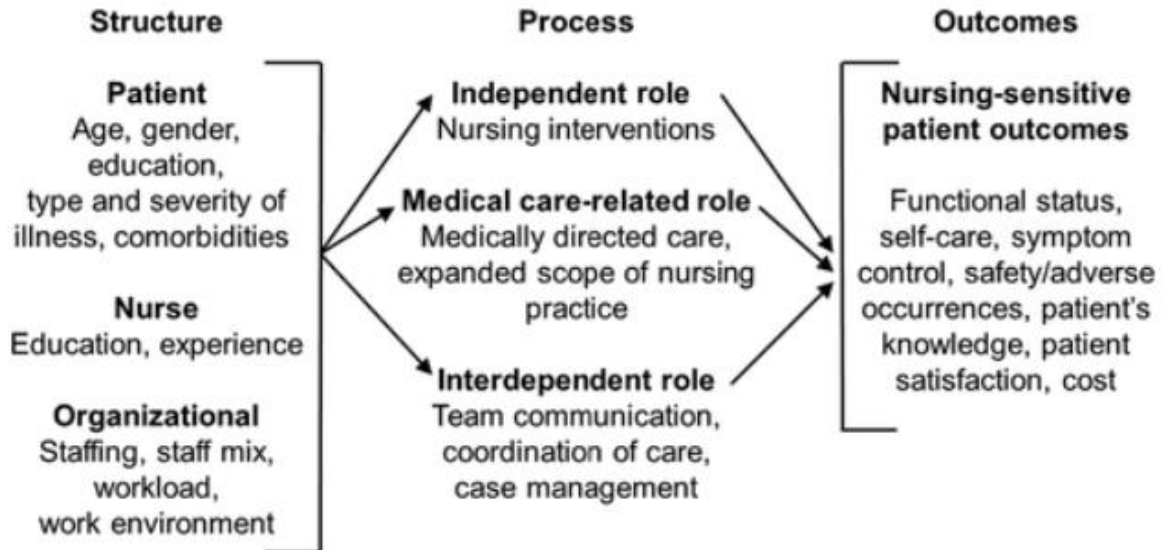
APPENDICES

APPENDIX A

ILLUSTRATION OF THE NURSING ROLE EFFECTIVENESS MODEL

Appendix A

An illustration of the Nursing Role Effectiveness Model.

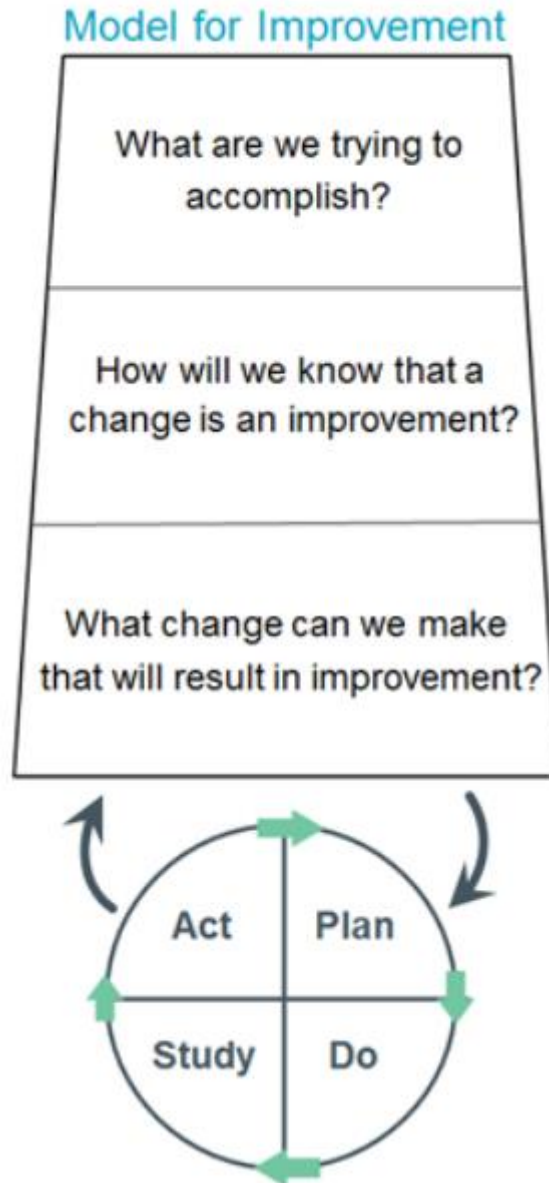


APPENDIX B

ILLUSTRATION OF THE MODEL FOR IMPROVEMENT

Appendix B

An illustration of the Model for Improvement.



APPENDIX C

ILLUSTRATION OF THE SWOT ANALYSIS MATRIX

Appendix C

An illustration of the SWOT Analysis Matrix.

Figure 1. The SWOT Matrix

Opportunities/ Threats	Strengths	Weakness	External Factors
	SO	WO	
	ST	WT	
Internal Factors			

APPENDIX D

ILLUSTRATION OF THE INSITUTE FOR HEALTHCARE IMPROVEMENT

PDSA WORKSHEET TEMPLATE

Appendix D

A PDSA Worksheet Template from the Institute for Healthcare Improvement.

Template: PDSA Worksheet

Objective:



1. Plan: Plan the test, including a plan for collecting data.

Questions and predictions:

-
-

Who, what, where, when:

Plan for collecting data:



2. Do: Run the test on a small scale.

Describe what happened. What data did you collect? What observations did you make?



3. Study: Analyze the results and compare them to your predictions.

Summarize and reflect on what you learned:



4. Act: Based on what you learned from the test, make a plan for your next step.

Determine what modifications you should make — adapt, adopt, or abandon:

APPENDIX E

ILLUSTRATION OF THE SIMPLE ROLE CLARITY ASSESSMENT TEAM EXERCISE

Appendix E

An illustration of the Simple Role Clarity Assessment Team Exercise.

Simple Role Clarity Assessment Team Exercise	
<i>Instructions: Using a scale of 1 to 5, with 1 being rarely and 5 being always, how often are the following statements true? Tally responses, discuss as a team, and prioritize ideas for improvement.</i>	
_____ I am clear about my role on the team _____ My job description accurately defines my role _____ I know which patients are assigned to me or that I need to see each day _____ I am comfortable expressing my opinion or offering my perspective _____ I am practicing at the top of my license _____ Others on my team understand my role	_____ I am aware of the unique skills or areas of expertise of my teammates _____ As a team we effectively use the skills and expertise of all disciplines _____ As a team we take time to clarify roles _____ We all take turns leading team meetings or case reviews _____ Overall, I feel I am a strong fit for this team and consistently contribute to its effectiveness