

■ Article

# The Role of the Acute Care Nurse Practitioner in the Implementation of the Commission on Cancer's Standards on Palliative Care

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As valuable members of the oncology team, acute care nurse practitioners (ACNPs) are in the perfect position to deliver high-quality palliative care. They are instrumental in coordinating the palliative care needs of their patients. Through proper training, ACNPs are able to assess, plan, implement, and evaluate palliative care interventions. Along with oncology-certified nurses, ACNPs help their patients navigate the complexities of the healthcare system. The skills that the American College of Surgeons Commission on Cancer identified in its standard for palliative care are skills possessed by ACNPs, making them the perfect fit to carry out these standards in healthcare institutions around the United States.

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With the increasing complexity of oncology care, the importance of palliative care is growing, particularly in acute care settings. In the author's experience, providing palliative care for patients can increase patient and family satisfaction, improve outcomes, improve staff satisfaction, and reduce healthcare costs. It is a dynamic time to be a nurse practitioner in oncology. A variety of roles exist for nurse practitioners in oncology, including ambulatory care, home and hospice care, specialty practices such as radiation oncology, and acute care settings. With the new accreditation standard for palliative care from the American College of Surgeons (ACOS) Commission on Cancer (CoC), the acute care nurse practitioner (ACNP) has the exciting opportunity to be an instrumental component of palliative care teams in the acute care setting, as do nurse practitioners who work in a variety of other roles, including ambulatory care, primary care, and specialty practices. ACNPs can provide palliative care consultations, educate teams about palliative care, work within their state legislation for palliative care and education reform, and educate other providers, including primary care. In addition, ACNPs can have a vital role in educating the public about the role of nurse practitioners in palliative care and participating on the cancer committee of their facility.

## Defining Palliative Care

Palliative care has many definitions and descriptions from different organizations. Some of the following definitions demonstrate the breadth of palliative care across settings for healthcare delivery and disease categories. The National Consensus Project for Quality Palliative Care (2009) was convened for a second time to further define palliative care as it has evolved in practice and from a growing body of evidence. "Palliative care is both a philosophy of care and an organized, highly structured system for delivering care" (National Consensus Project for Quality Palliative Care, 2009, p. 15). In addition, the project promotes collaborative partnerships to improve the quality and consistency of palliative care across settings and disease categories.

The World Health Organization ([WHO], 2014) views palliative care as an "approach" to relieving suffering and improving quality of life. It further describes palliative care as using a team approach to meet the needs of patients and families, and includes bereavement counseling.

According to the Center to Advance Palliative Care ([CAPC], 2012), palliative care is specialized medical care for people with serious illnesses that focuses on relieving patients' symptoms,

## Case Study

At four o'clock on Friday afternoon after a hectic week, the nurse practitioner answers a page from the intensive care unit (ICU). "Mr. S, the patient in room 10, is asking for you. I don't think the doctors are listening to him." The nurse practitioner walks into the ICU to see the 88-year-old man. Only two days prior, she had assisted the oncologist with the man's bone marrow biopsy for a new diagnosis of acute myeloid leukemia on the medical surgical floor. He looks tired. He is on BiPaP (a form of noninvasive ventilation), and a dialysis catheter is protruding from his neck. The IVs are running; the monitors are beeping.

**Nurse practitioner:** Good afternoon, you look tired. How do you feel?

**Patient:** I am tired and I don't want any more of the dialysis that they did today. I understand what you and the doctor explained to me about this leukemia.

Mr. S expressed his wishes for no intubation, no resuscitation, and no dialysis; he did not want any more procedures. He expressed a complete understanding of what would happen if he was to stop everything. The nurse practitioner reassured the patient that he would be comfortable, that she would help him explain his wishes to his family, and that she would be his advocate for him with other providers.

The nurse practitioner spoke to the nephrologist. He was frustrated that the patient did not want any more dialysis; he felt that he could "buy him a few more days." "But at what cost to the patient's quality of life?" the nurse practitioner asked. He understood and spoke to the patient, telling him they would do no more dialysis. The patient expressed his thanks, and the nephrologist teared up. As the nephrologist quickly left the room, the hospitalist (a physician who coordinates care for patients in the hospital) rushed into the room, saying, "Okay now Mr. S, we are going to give you some blood, and some more medications, and do some more dialysis." Mr. S rolled his eyes to the nurse practitioner, who expressed the wishes of her patient to the hospitalist. The hospitalist informed the patient that he would respect his wishes and offer no more treatment, but did ask that a family meeting take place.

The nurse arranged for a family meeting within the hour. The nurse practitioner, hospitalist, and a nurse met with the family and patient, who were well apprised of their loved one's wishes. The hospitalist gave a thorough explanation of the disease process and the nurse practitioner answered all of their questions. The nurse talked to them about the palliative care room in the ICU and the ability of the family to visit. This was a typical day for an acute care nurse practitioner.

pain, and stress. It is focused on "providing patients with relief from the symptoms, pain, and stresses of a serious illness—whatever the diagnosis" (CAPC, 2012, p. 1). It defines the team as medical specialists, including doctors, nurses, pharmacists, and social workers working in partnership with the patient and family to improve quality of life.

The ACOS CoC takes its definition of palliative care from the National Quality Forum (NQF). "Palliative care generally refers to patient- and family-centered care that optimizes quality of life by anticipating, preventing, and alleviating suffering across the continuum of a patient's illness" (NQF, 2011, para. 1). That definition includes an increasing emphasis on patient- and family-centeredness, a hallmark of the Institute of Medicine's (IOM's, 2011) report, *Patient-Centered Cancer Treatment: Improving the Quality of Cancer Care*.

Each definition shares an understanding that palliative care is aimed at the relief of suffering and improvement of quality of life for patients and their families. Despite the linguistic dif-

ferences in each definition, the clear goal of palliative care is to improve the quality of life of patients across the many stages of a wide variety of illnesses through the management of their symptoms, whether medical, emotional, spiritual, or psychosocial. For example, patients with unresolved family issues may need referral to a social worker to help them reconnect with their family in a meaningful way to relieve their emotional distress. Facilitating conversations with the appropriate parties and participating in these conversations is within the realm of the ACNP. However, none of the definitions specifically outline the role of the advanced practice nurse on palliative care teams. The current article seeks to further explore and define the role of the ACNP on palliative care teams in acute care settings.

## Access to Palliative Care

CAPC (2012) reported that more hospitals in the United States are offering palliative care services than ever before, although access to palliative care is variable across the country. According to CAPC (2012), the number of programs in U.S. hospitals with 50 or more beds increased from 658 (25%) to 1,486 (59%) from 2000–2008—a 126% increase. However, Goldsmith, Dietrich, Qingling, and Morrison (2008) reported that although more palliative care services are found in large hospitals (in those with more than 300 beds, 76%), fewer palliative care services are found in small hospitals (in those with fewer than 50 beds, 20%). The study by Goldsmith et al. (2008) also found that uninsured and geographically challenged communities lacked palliative care programs. Specifically, they found that only 41% of public hospitals and less than 30% of sole community provider hospitals had access to hospital-based palliative care (Goldsmith et al., 2008).

## Benefits of Palliative Care Programs

Palliative care benefits not only patients and their families but also physicians, nurses, other staff, and hospitals. Improving the quality of life of patients and relieving suffering are overarching goals of many professionals in health care. Helping patients achieve comfort provides a level of satisfaction for healthcare workers. Hospitals benefit from improved patient satisfaction scores, reduced costs (health care and administrative), and improved employee satisfaction and retention rates when they incorporate palliative care programs. In addition to improving overall patient satisfaction, these programs benefit the institution financially (CAPC, 2012). According to CAPC (2012), the development of palliative care programs in hospitals requires a relatively low investment with immediate impact on outlier cases, overall resource use, and decreased use of intensive care settings. California Health Care Foundation (2010) specified several ways that palliative care programs avoid costs, such as eliminating redundant, unwanted, and unproductive care and reducing the lengths of stay in both the acute and intensive care settings.

Another benefit of palliative care programs is the availability of the specialists in palliative care to see patients. That is particularly important for patients who are transferred from long-term care settings, hospices, and home to emergency rooms and hospitals. The palliative care specialist can see patients in the emergency department or ambulatory care settings, assess their needs and

concerns, and perhaps avoid unnecessary and expensive admissions. Although the main focus of palliative care programs is to improve the quality of life for patients, these programs also can increase patient and staff satisfaction. According to the California Health Care Foundation (2010), palliative care programs provide a competitive edge in the market because of cost savings, high patient satisfaction, improved efficiency, and individualized care. The benefits of palliative care are all encompassing, from patients and employees, to the hospitals themselves.

## The Role of the Nurse Practitioner

Advanced practice nurses, specifically nurse practitioners, work in a variety of settings, including acute care. They have the assessment skills and clinical knowledge to incorporate palliative care for all of their patients. In the media, conversations often arise about the high costs of health care, the low number of physicians available to care for patients in the primary care role, and a lack of available specialists, such as oncologists in the acute care setting. Nurse practitioners are educated and well positioned to have a large impact on these issues. According to the American Academy of Nurse Practitioners ([AANP], 2013), nurse practitioners are quickly becoming the health partner of choice for millions of Americans. As clinicians, nurse practitioners combine clinical expertise in diagnosing and treating common conditions with an added emphasis on disease prevention and health promotion. Nurse practitioners in oncology care bring additional clinical expertise in cancer care, including symptom management, which makes them ideal partners on palliative care teams.

## Educational Preparation

The education of nurse practitioners in acute care settings can vary depending on the track of their master's degree program. They may have formal preparation in acute care settings in adult, geriatric, acute, pediatric, or psychiatric tracks. In addition, they all learn about expanding the nursing process into the advanced practice of nurse practitioner. The ACNP curriculum (like curricula for gerontologic, adult, and family nurse practitioner and other master's-level clinical nursing programs) often includes, but is not limited to, clinical decision making, diagnostic reasoning, physical assessment, evidence-based medicine, risk reduction, quality improvement, patient advocacy, palliative care, coordination of care, communication, and teamwork (Rosenthal & Guerrasio, 2010). Certification in palliative care can be achieved through the National Board for Certification of Hospice and Palliative Nurses. The eligibility requirements for certification include passing an examination, holding current licensure in good standing, having completed a nursing program in an accredited school, and holding a master's degree in nursing with specific criteria related to palliative care.

## Scope and Standards of Nurse Practitioner Practice

The scope of practice for the nurse practitioner is defined by the state in which they work, but can vary widely between

states. For example, in New Hampshire, nurse practitioners practice autonomously, may prescribe independently, act as primary care practitioners, and sign government forms such as handicap access and death certificates. However, in Alabama, nurse practitioners do not have autonomous practice. They must have a collaborative agreement with a physician to prescribe medications and cannot sign death certificates, handicap placard requests, or workers compensation requests (AANP, 2012). The role of palliative care nurse practitioners varies, not only state to state, but among practice settings within the state.

The Consensus Model for Advanced Practice Registered Nurse (APRN) Regulation outlines that licensure and scope of practice are based on graduate education within a defined patient population for the APRN role (Kleinpell, Hudspeth, Scordo, & Magdic, 2012). In oncology settings, the Consensus Model can be interpreted to define cancer care services including palliative care services. Services are defined by the patient care needs and not by settings. For nurse practitioners working in acute care, that is particularly significant because patient acuity and care requirements may vary across settings. When implemented, the Consensus Model helps ensure congruence between licensure, accreditation, certification, and education (Kleinpell et al., 2012). Nurse practitioners in cancer care are certified by the Oncology Nursing Certification Corporation (ONCC) as Advanced Oncology Certified Nurse Practitioners (AOCNP®). Nurse practitioners who also practice in hospice and palliative care can choose to be certified as nurses, not advanced practice nurses, in hospice and palliative care (CHPN®) by ONCC.

For nurse practitioners working in palliative care, additional education is needed beyond the formal educational curriculum regulated by the Consensus Model. The variability in the role of the palliative care nurse practitioner could be eliminated by certification through organizations such as the End-of-Life Nursing Education Consortium ([ELNEC], 2013). At the end of 2012, ELNEC rolled out a training course for nurse practitioners to help them achieve palliative care certification as advanced practice nurses through the National Board for Certification of Hospice and Palliative Nurses (visit [www.nbchpn.org](http://www.nbchpn.org) for more information).

The standards of practice for ACNPs from the American Association of Critical-Care Nurses (2006) are based on the nursing process. The ACNP participates in the assessment and data collection for acute, critical, and complex patients who are chronically ill. The ACNP works with the interdisciplinary team to develop appropriate interventions for the desired outcomes. That team may consist of nurses, physicians, therapists, dietitians, specialists, social workers, case managers, chaplaincy, the patient, and/or the family. The ACNP has the accountability to ensure that these interventions are implemented and to evaluate the outcomes of these interventions. For example, in the hospital setting, symptoms are assessed, managed, and re-evaluated, and patient-specific goals of care are set for each patient seen in palliative care consultations. The palliative nurse practitioner working in other settings also would work within these standards. Outpatient consultative services would assess patient needs and analyze those needs to develop a palliative care plan that included interventions and outcome measurements.

In one community hospital in southern New Hampshire, patients who are uninsured or minimally insured do not have access to health care until they are suffering from multiple complications of several comorbidities at the same time, which puts them at risk for early mortality. It takes a collaborative effort of the healthcare team to care for these patients. The healthcare team includes financial counselors to help the patients access Medicaid or other specialized low-cost healthcare insurance programs, social workers to investigate other funding sources and provide support for social issues, case managers to assist with discharge planning and finding primary care physicians willing to care for an uninsured patient with complex medical problems, nurses, nutrition specialists, and spiritual counselors. The ACNP can act as the team leader to coordinate input from specialists and provide the patient with a plan that is both agreeable and feasible.

ACNPs are trained to identify patients in need of palliative care services but often are challenged to find creative ways to reach populations who have difficulty accessing healthcare services. Culturally, some populations believe in the family taking care of the elders and those who are sick within the family. That provides a unique challenge to the ACNP, who must understand the cultural differences of patients, respect their choices, and provide support in whatever way possible. For example, one ACNP worked with a Japanese man who had a devoted son. The man had several healthcare challenges, including metastatic prostate cancer and a history of cerebral vascular accidents. After several hospital stays and a stay at rehabilitation, the son took the patient home. After several weeks at home, the son, who had previously refused visiting nursing services, was overwhelmed with caring for his father and felt that the father was not doing well. The ACNP made home visits to discuss palliative care, hospice, and supportive services available to the son and his father. After the second visit, the son agreed to have hospice come into the home. Through hospice provider interventions, the father was more comfortable and the son had some peace knowing he was doing the best for his father. After several weeks, the patient died in his home. His death, although upsetting for the family, was tempered by the fact that his wishes, including dying at home, were respected by the family.

## Commission on Cancer Standard

The new CoC accreditation standard for palliative care services requires that cancer centers provide patients with palliative care services. These services may be available on-site using an interdisciplinary approach or through consultation. Each facility will define its own palliative care services or referrals for these services. The suggestion from the CoC (2012) is that the institution have “at least one physician and one non-physician member and may include a nurse with specialized training or certification in hospice and palliative nursing” (p. 23).

Although the standard does not specifically address advanced practice nurse practitioners, it does address skills the nurse practitioner is qualified to perform. The services the CoC standard lists as part of the palliative care services include but are not limited to

- Team-based care planning
- Pain and symptom management
- Communication among patients, families, and providers

- Continuity of care across a range of clinical settings
- Attention to spiritual comfort
- Psychosocial support for patients and families
- Bereavement support for families and team members
- Hospice care (CoC, 2012).

Nurse practitioners have many skills that can improve palliative care in acute care settings (see Figure 1).

## Acute Care Nurse Practitioner as Navigator

ACNPs include the role of navigator as part of their practice, like others in health care. The CoC is phasing in a new accreditation standard for patient navigation. By 2015, cancer centers seeking accreditation must integrate a role for patient navigators to help “patients, families, and caregivers to overcome healthcare system barriers and facilitate timely access to quality medical care” (CoC, 2012). Oncology nurses are uniquely qualified to act as a navigators; in addition, ACNPs have skills that are advantageous during the navigation process. Hospitalization usually is a stressful time for patients and families, and ACNPs can use their skills as navigators to reduce stress and improve quality of life. They can assess patient needs while they are in the hospital and facilitate adequate referral for services required after discharge. Overlap exists between the skills needed for navigation and palliative care. A useful metaphor is one of the patients and their health as a ship. The captain is the oncologist or other primary physician. The nurse practitioner acts as a first mate and navigator. The patient, nurses, and other healthcare workers are all members of the crew. Without each person on the ship doing their job, disaster may occur. The captain guides the ship into many ports. The ship navigates the muddy waters of cancer care with greater ease because of the captain and crew. Although the ship travels between many ports, the navigator facilitates these transitions, thereby decreasing patient distress and improving quality of life. Both the navigator and nurse practitioner use advanced communication skills and clinical expertise to deliver compassionate care across transitions.

## The Role in Action

The role of the oncology nurse practitioner liaison was developed in a community hospital already accredited by the CoC. The role was developed to improve palliative care and interprofessional communication between the oncologist and hospitalist teams, facilitate physician use of clinic time, and work with the team on the inpatient oncology floor to promote palliative care for patients with cancer. In this setting, the nurse practitioner practiced in multiple settings and roles.

One role was a navigator for existing and newly diagnosed patients with cancer in the acute care setting. In the navigation role, the ACNP coordinates care with the hospitalist team, oncologists, and other specialists. As a member of the inpatient oncology team, the ACNP participates in team meetings for all patients on the units and offers clinical expertise for all patients.

In another role, the ACNP provides palliative care consultations for patients in the acute care setting. During consultations, the ACNP provides advice on symptom management for all inpatients with new or existing cancer diagnoses in collaboration

with a physician, the palliative medicine specialist. The ACNP brings expertise in symptom management for pain, symptoms related to chemotherapy, distress, fatigue, dyspnea, and other symptoms that impact patient quality of life.

In this new role, the ACNP functions as a bridge between the inpatient and outpatient settings. The ACNP meets with the patient at time of follow-up appointment with the primary oncologist to assess goal management and achievement since hospital discharge. In addition, he or she conducts check-in visits when patients are in the outpatient oncology clinic receiving chemotherapy. The ACNP also consults with the ambulatory cancer center regarding treatment and follow-up of more complex patients.

Another role is that of a palliative care consultant for the hospitalist and other nurse practitioners. Across the roles, he or she provides patient education about diagnosis, treatments, plans of care, and prognosis, as well as facilitates appointments. The ACNP in oncology also provides staff education and develops systems that will benefit patient care in all settings. Finally, the ACNP works to increase access to palliative care across all diagnoses, not just cancer.

During the implementation of this new role, challenges developed requiring new strategies. In particular, the providers (including hospitalists and ancillary personnel) were unclear about the role of the ACNP. The collaboration between the hospitalists and the ACNPs initially was demonstrated by the question, "What do you do?" Over time, they began to solicit the clinical expertise of the ACNP before they forged ahead with treatment plans. They expressed their appreciation for the ACNP knowing that these patients and the families understood the cancer treatment plan and strategies for symptom management. The oncologists initially had some difficulty allowing the nurse practitioner to take care of some of their patients. The collaboration that was built among the oncologists, patients, family members, and nurse practitioner allowed the oncologists to deliver high-quality patient care that reached beyond curative treatments and now includes palliative care to improve quality of life.

During the first year of implementation of this new role, the ACNP moved from the acute care setting to triage in outpatient settings and the emergency department. The ACNP now also provides home visits to follow-up with patients after hospital discharge. Some challenges include the numerous roles and settings for the ACNP. In addition, accessing patient information through several different computer systems and electronic and paper medical records can be difficult. Another obstacle is the so-called "red tape" of working for a hospital system, as well as defining the role of advanced practice nurses within the hospital and community settings. Areas for improvement include developing a more tailored job description. Currently, the job description is generic to all nurse practitioners who work with in the system. Quality metrics also need to be developed to quantitatively demonstrate the benefits of the position.

Many successes in implementing this role have been observed. Excellent communication skills with other providers and ancillary staff were essential in bridging care settings and healthcare providers. Those skills include face-to-face meetings, participation during rounds, and defining of preferred methods of communication (e.g., email, phone). The ACNP uses other communication strategies with the patients and families, in-

- ▶ **Educating patients and families:** Promote disease and prognosis understanding, provide treatment education, and define and re-evaluate treatment goals.
  - ▶ **Getting involved in legislation to promote NP practice:** ACNPs can develop and support state legislation to include palliative care education and training.
  - ▶ **Having the difficult conversations:** "The ACNP often has the time and the one-on-one interaction opportunity that encourages growth of the therapeutic relationship required to initiate a difficult conversation with a patient" (Svarovsky, 2013, p. 48).
  - ▶ **Identifying barriers to palliative care in acute settings:** Limited knowledge of the definition of palliative care, fear that initiating palliative care is signing a death sentence for patients, an inability to access palliative care, and fear of having difficult conversations all are common barriers.
  - ▶ **Identifying practice barriers for ACNPs:** ACNPs can provide education to hospital administrators and physicians about the scope and standards of practice of NPs. They also can provide education about the laws regarding state practice and the national standards and scope of practice for NPs. These initiatives will contribute to more clear definitions about the ACNP role in the hospital system.
  - ▶ **Managing the transitions:** Patients in the current U.S. healthcare system experience many transitions in care, from doctor to doctor, floor to floor within the hospital, as well as discharge transitions (rehabilitation, acute, short-term, skilled care, or discharges to a higher or lower level of hospital care).
  - ▶ **Overcoming barriers to palliative care:** ACNPs can educate hospitalists, intensivists, and nurses about what palliative care is, how to access it, and how to communicate with patients who have complex medical problems.
  - ▶ **Using health care efficiently:** Through the use of a palliative approach to care, expensive and unwanted tests and procedures can be eliminated. As a member of an interdisciplinary team, the ACNP can shorten the length of hospital stay while meeting the patients' goals.
- ACNP—acute care nurse practitioner; NP—nurse practitioner

### FIGURE 1. NP Skills Improving Palliative Care Practice

cluding asking the hard questions to identify the areas of most importance to the patient. By understanding patient values and priorities, the ACNP can improve patient quality of life, provide follow-up on issues, use clinical expertise, and develop rapport with patients and families. In addition, the ACNP can provide staff education on areas of clinical interest based on case studies and evidence from the literature. Finally, the ACNP can network with ancillary departments in the hospital and in the surrounding community, including other providers, hospitals, clinics, community organizations, and the people in the area.

Moving forward, room for growth exists in the role of the nurse practitioner in the acute care setting. Certification in palliative care for nurse practitioners is an important first step in ensuring consistent training and levels of competence. Nurse practitioners can develop the role of palliative care consultant for all patients newly diagnosed with cancer. They also could provide telephonic monitoring of more complex patients and triage incoming phone calls to the practice. In addition, providing more education to the inpatient oncology unit staff, as well as others interested in cancer care, palliative care, and symptom management is an important task for nurse practitioners.

## Implications for Practice

- ▶ Improve symptom management through earlier and more thorough detection by using palliative care assessment skills.
- ▶ Enhance the patient experience through palliative care coordinated across settings.
- ▶ Enrich professional practice for acute care nurse practitioners, leading to improved retention and job satisfaction.

Finally, nurse practitioners in oncology can be involved in the development and rewriting of hospital policies to reflect the roles of the advanced practice nurse and the integration of evidence-based palliative care.

## Conclusion

ACNPs are valuable members of the oncology healthcare team and instrumental in coordinating palliative care across settings. With their level of clinical expertise, nurse practitioners can provide comprehensive assessments and incorporate palliative care for all patients with advanced illnesses. The ability of the ACNP to facilitate coordination of inpatient and outpatient care in a complex medical system will reduce the stress of advanced disease for patients and improve their quality of life. By virtue of education and experience, nurse practitioners can improve quality of life by assessing patient holistic needs and addressing each area of distress.

Cancer services in the community hospitals can implement the new CoC accreditation standards either by developing or expanding existing palliative care programs or by starting new palliative care programs for their centers. Advanced practice nurses should be involved in the development or creation of these palliative care programs.

Future growth of palliative care includes nurse practitioners leading programs in palliative care, certification for nurse practitioners and RNs, and developing a team of experts. Palliative care should be accessible to all patients, not just those at the end of life. Palliative care consultations and services need to be reimbursable by insurers. Palliative care needs to use navigators to smooth transitions between settings and into hospice care. Nurse practitioners should be integrated into palliative care programs to enhance the continuity of care, provide individualized symptom management, and improve quality of life for all patients.

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