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A Pivot to Palliative: An Interdisciplinary Program Development in Preparation for a Coronavirus Patient Surge in the Emergency Department

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Contribution to Emergency Nursing Practice

- The current literature on palliative care in the emergency department indicates the prominent need for emergency nurses and palliative care clinicians to better understand their respective roles and responsibilities to improve palliative care for ED patients.
- This article contributes a program template, process and educational and support resources for emergency nurses focused on improving palliative care in the emergency department during the coronavirus disease pandemic.
- Key implications for emergency nursing practice found in this article are the potential to tailor, replicate, and test our program to improve palliative care in other ED settings.

Key words: Emergency department; Emergency nursing; Palliative care; End-of-life care; COVID; Interdisciplinary collaboration

Introduction

As the coronavirus disease (COVID-19) pandemic continues to unfold in the United States, the health care sector faces harrowing challenges of overloaded systems, unknown viral impact, and considerable mortality. American health care institutions must tailor a swift and strategic response at their local facilities to ensure high quality and compassionate patient care. In the pandemic timeline, Massachusetts was several weeks behind the patient surges that occurred in Seattle and New York City. Witnessing the severe system strain from these cities, Massachusetts hospitals' disaster plans included deploying resources and clinicians in novel ways. One of our hospital's strategies involved an increased focus on the role of palliative care in the ED setting.

While numbers are still emerging, the demographics of patients with COVID-19 in Massachusetts are overrepresented by patients from nursing homes, those older than 70 years, and those with racial and ethnic minority identities.[1] Because elderly patients with multiple comorbidities are at an increased risk of death,[2,3] an extreme demand on

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our local health care system was anticipated with this influx of patients potentially needing end-of-life (EOL) care.

Brigham and Women's Hospital is a 793-bed, Harvard-affiliated, magnet-recognized hospital located in the Longwood medical area of Boston. Its 60-bed, level 1, emergency department sees 63,000 patient visits annually and services patients from metro Boston, throughout the nation, and from 120 countries. As a leader in the Boston health care network and a care provider for a dense, urban setting, measures needed to be taken quickly as the COVID-19 pandemic evolved. In response to a potential patient surge and as part of pandemic disaster planning, we projected that rapid collaboration between palliative care and ED staff was needed to meet the needs of critically ill patients who are COVID-19 positive presenting to the emergency department. We developed a multipronged program designed to provide optimal care for patients who are COVID-19 positive in our large, metropolitan emergency department. The program, program tools, and program development process are provided here to serve as a guide for emergency clinicians, palliative nurses, nurse practitioners (NPs), and nursing leadership looking to establish similar programs within their institutions.

Background

Palliative care is specialized health care for people with serious illnesses. Palliative care focuses on providing symptom relief, communication, and psychosocial/spiritual support with the goal of improving quality of life for patients and their families.[4] Although EOL care is 1 element of this specialty, palliative care and EOL care are not synonymous. Palliative care involvement is appropriate at any stage of serious illness, providing an extra layer of support in conjunction with treatment provided by other medical teams.[5] Palliative care aims to alleviate suffering, a shared goal of ED clinicians. Despite this shared goal, a knowledge gap exists regarding the optimal delivery of palliative care in the emergency department.[6] Models of palliative care delivery differ between institutions depending on department size and volume, and currently, optimal models of department-based palliative care have not been rigorously studied.[6]

The priority focus of emergency nursing has traditionally been geared toward lifesaving and life-sustaining interventions. A fast-paced setting, the emergency department is characterized by rapid throughput processes, which can hinder the necessary nurse-patient empathic bonding that enables effective palliative care.[7] In addition to these obstacles, the perception of palliative care in the emergency department presents a challenge to collaboration among the specialties. Although emergency nurses may recognize the palliative care needs of their patients, they identify lack of time and lack of palliative care education/training as challenges to meeting those needs.[8] ED clinicians have also expressed the cognitive dissonance that palliative care is somehow a means of giving up on a patient or failure to provide appropriate care.[7]

Seeking to standardize palliative care involvement the Center to Advance Palliative Care published a consensus report in 2011. This report called on every hospital to develop a systematic approach for identifying patients in advance who are at a high risk for unmet palliative care needs through a palliative care screening assessment.[9] Many organizations, including the Emergency Nurses Association (ENA), have aligned with this call. The ENA has identified the need for additional palliative and EOL education and mentorship, calling on emergency nurses to be directly involved in quality improvement initiatives around palliative care and EOL care across the care continuum.[10] Similar initiatives also exist in emergency medicine. The American College of Emergency Physicians has developed online resources and tools for their members, seeking to support ED physicians in providing palliative care.[11]

In addition to professional calls to action, formal work has been done in the interest of greater collaboration between emergency care and palliative care. An integrative program has been developed called The Improving Palliative Care in Emergency Medicine (IPAL-EM) project, which guides ED providers to incorporate palliative care into standard practice.[12] Aligning with the IPAL-EM basic and advanced integration categories, we sought out ways through our program to connect emergency and palliative care clinicians with shared a common goal by means of novel processes and protocols.[12] Our work group's overarching goal was to support emergency nurses during a surge in the number of patients with COVID-19 in providing compassionate patient care (both palliative and EOL) through the development and implementation of educational and clinical support tools.

Methods

In anticipation of a surge in the number of patients with COVID-19, ED and palliative care leaders (nurses, NPs, physicians, and social workers) identified the need for swift collaboration between the 2 departments. Our interdisciplinary group worked to understand the workflow of both

the ED and palliative care consult services and to identify and address knowledge and practice gaps. The initial work group included physician leaders from both the emergency department and palliative care, a staff nurse from the emergency department, and a palliative care NP. Our collaborative strategy embraced 2 of the 4 tenets recommended by the IPAL-EM toolkit including (1) launching a palliative care initiative addressing department-specific palliative care needs and deficiencies and (2) recruiting ED palliative care champions to participate in the work.[12]

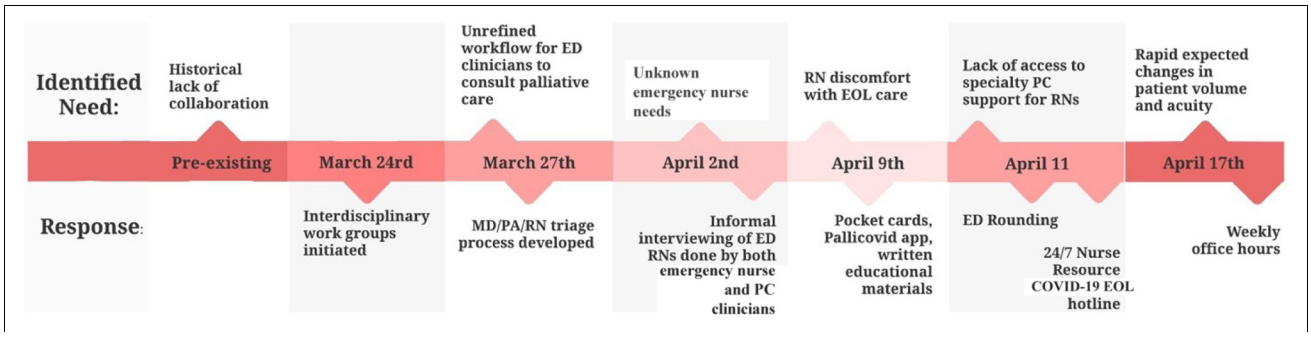
The emergency nurse and the palliative care NP worked together to identify ED-specific nursing concerns. To better understand these concerns, the palliative care NP and the emergency nurse conducted informal interviews at several different time points. Questions were asked regarding emergency nurses' concerns relevant to the commonly accepted domains of palliative care (goals of care, EOL symptom management, patient and family support). Interviews were conducted over a 1-week period and occurred during day and evening shifts. Approximately 40 nurses' input was collected, and discussions lasted from 5 to 10 minutes. The emergency and palliative care nurses compiled a list of questions that the emergency nurses had related to facilitating or executing palliative and/or EOL care. These questions were reviewed collaboratively, and interventions were developed to address what the program planners perceived were the most salient themes. Our iterative process best aligned with the PLAN-DO-STUDY-ACT/ADJUST improvement model used in health care to improve process and carry out change.[13] The Figure depicts our specific cycle with discovered needs and subsequent interventions, which occurred over a 4-week development period from March 24 to April 17, 2020.

To meet the needs of emergency nurses, we curated a portfolio of easily accessible educational and support tools in both tangible and digital formats. The aims of these tools were to provide in-the-moment clinical decision-making support as well as access to direct support from palliative care clinicians. The broadcasting of these tools was through word of mouth, e-mail distribution from the emergency department's Professional Development Manager software and printed fliers.

As each tool was developed and deployed, we sought real-time verbal feedback from users regarding the accessibility, helpfulness, and clarity of content. Most feedback was received informally during ED rounding and through the emergency nurse collaborator. The emergency and palliative care nursing team recognized that a cycle of rapid assessment and implementation was needed to continuously evaluate evolving emergency nursing needs in a rapidly changing care landscape.

Results

To date there has been no surge of EOL-specific care in our emergency department as had been anticipated during the disaster planning. The specific deliverables from our process included a template for improving palliative care access in the emergency department and the educational/clinical support tools. Table 1 highlights each educational and support tool, its description, and access method. Our digital resources can be accessed online at www.pallicovid.app. The Supplementary Appendix provides an example of one of our clinical support tools to assist emergency nurses with EOL symptom management. Table 2 provides a logic model for the reader to guide in the replication of our program. Our program has included the development and implementation of tools and support mechanisms as indicated but has yet to execute evaluation metrics at this time.



FIGURE

Rapid needs identification and implemented response of emergency department/palliative care RN collaborative. RN, registered nurse; EOL, end-of-life; PC, pallitative care; MD, medical doctor; PA, phyician assistant; COVID-19, coronavirus disease.

TABLE 1
Palliative care toolkit for emergency nurses

Tool	Description	Access
Pocket cards	Guidelines designed for nurses and providers regarding symptom management in the imminently dying patient; communication tools and links to institution-specific resources	Hand distributed Online at pallicovid.app
ED rounding	In-person, informal rounds 2–4 times weekly by palliative care clinicians, including NP, in the emergency department Provided opportunity for rapport building, gathering feedback on resource use, and distributing pocket cards	In-person
COVID-19 nurse resource line	Pager covered 24-7 by palliative care NPs for nursing advice on planning care, communication, and symptom management for patients with COVID-19 and families	Hospital pager system
Palliative care office hours	Weekly 1-hr office hours held by 2 palliative care NPs intended to provide a drop-in style forum for emergency nurses to ask palliative care specific questions	Zoom line, e-mail notifications
BWH nursing resources and FAQs	Used themes identified by emergency nurses to collate resources for nurses in the form of "Frequently Asked Questions." These included original resources made by emergency nurse palliative care champion, links to institution-specific resources for symptom management and other consulting services, as well as links to external palliative care resources such as Fast Facts and Vital Talk	Online at pallicovid.app

COVID-19, coronavirus disease; NP, nurse practitioner; BWH, Brigham and Women's Hospital; FAQ, frequently asked question.

Discussion

Our program presents an opportunity to connect emergency care and palliative care. As this was new territory in our institution, clinicians needed to effectively communicate and develop a mutual understanding of roles and a unified patient-centered focus. This close collaboration resulted in a suite of resources and support mechanisms for emergency nurses through interdisciplinary contribution.

Through our development and implementation process, we rapidly created a program to support emergency nurses in providing palliative and EOL care in anticipation of a surge in the number of patients with COVID-19. This process was noted by the program developers to be most productive as an interdisciplinary, interprofessional effort requiring the understanding of roles and responsibilities of emergency and palliative clinicians to produce a patient-centered and clinically supportive program. Our

TABLE 2
Logic model: A guide to program design

Inputs	Activities	Measures/Outputs	Outcomes	Impacts
Palliative care physician and nurse practitioner	Site toolkit development	No. patient health care proxies identified and contacted	Increased knowledge, skill, and attitudes about palliative care in the emergency department by emergency nurses	Optimal care for patients with previously established goals of care
ED physician and nurse	1. Palliative care rounding in the emergency department	No. incomplete or missing MOLST forms	Improved EOL care in the emergency department	Service delivery with full integration of palliative care in the emergency department
ED professional development manager	2. Pocket card resources	No. new palliative care consults	Decreased time to palliative care referrals from the emergency department	Prevention of unwanted use of life-prolonging care or resuscitation procedures in patients with MOLST forms, or other predetermined goals
Fast facts[14]	3. Initiate 24-7 palliative care nurse resource pager	No. palliative care rounds completed	Collaborative workflow processes for palliative care in the emergency department established	
Vital talk[15]	4. Initiate palliative care office hours	No. pocket card resources downloaded/used by emergency nurses	Improved symptom management for patients requiring palliative and/or EOL care	
Center to advance palliative care consensus report	Tailored professional development education for emergency nurses	No. palliative care nurse office hour visits	Increased engagement of emergency nurses in identifying health care proxies and MOLST forms	
ACEP palliative care toolkit	Facilitate conversations regarding patient goals of care	No. patients assessed for palliative care goals		
ENA position statement	Interdisciplinary collaborative team building	Time to palliative care referral		

continued

TABLE 2
Continued

Inputs	Activities	Measures/Outputs	Outcomes	Impacts
Hospital information technology platforms to share information and professional development educational materials		No. interdisciplinary work group meetings		

MOLST, medical orders for life-sustaining treatments; ENA, Emergency Nurses Association; ACEP, American College of Emergency Physicians; EOL, end-of-life.

collaborative work group experience aligns with current evidence showing that new health care initiatives can be clinically effective and rewarding when they are interprofessional and strategically focused.[16] Our work process further aligns with professional calls from the ENA and the Center to Advance Palliative Care.[9,10] The recruitment of our ED palliative care champions for the project proved extremely productive supporting the IPAL-EM toolkit recommendations.[12] The nursing staff contribution to the integration of palliative care into ED patient care, as accomplished in our program, is also supported in the literature.[17]

The strengths of our program included our rapid cycle learning and adaption process, the comprehensive support provided through our 24-7 palliative nurse coverage, and the development of educational and clinical support tools available to nurses in hard copy or digital format. A rapid cycle learning process, accomplished in our program through our in-person clinician rounding and biweekly team meetings, is identified in the literature as the process that may be best suited for quickly developing new interventions in uncertain and changing times.[18,19] The 24-7 palliative support model was also used in New York with positive outcomes as our program also experienced.[20] Educational and clinical support tools to address symptom management are a shared focus of other institutions working to support emergency nurses.[21]

Challenges and barriers to collaboration and implementation of this program included factors that are commonplace, for example, clinician time and availability to contribute to the program. The challenge of launching a program in the emergency department was threatened by a lack of initial emergency nursing leadership focus owing to competing concerns in the department related to COVID-19. Leadership buy-in is recognized as a critical component of success[19] and was ultimately provided to our program throughout our process. In addition to time and attention, space and physical access to the emergency department presented a problem as work-group meetings were hindered by physical distancing, and concerns around infection control and personal protective equipment use. Space and distancing practices have been a challenge for many in the health care and technology has been used to address these concerns.[22] A virtual meeting platform was easily used for our ED/palliative care work-group sessions.

Evaluation metrics for our program have not been formally executed at this time owing to limitations related to COVID-19. We found that evaluation of rapidly implemented initiatives and interventions is a shortcoming for many during COVID-19 times and is an area of increased study.[18,19,23,24] Our shared logic model presents a list of recommended metrics that could be used to evaluate this program. These are currently under consideration by our team for future evaluation of our program. A literature review executed by Thiel et al[25] identified the lack of evaluation tools to assess changes in clinicians' knowledge, skills, and attitudes related to palliative care after participating in interdisciplinary learning experiences. An evaluation of the frequency of use of our education and clinical support tools by our emergency staff is proposed as a starting point. Our team noted that education and clinical support for emergency nurses related specifically to EOL care was not as necessary as other palliative care support owing to the limited EOL care provided in our emergency department as the surge progressed.

As the COVID-19 pandemic persists, we believe our program serves as a template for others to guide them in developing programs to support their emergency nurses in providing comprehensive and effective palliative and EOL care in rapidly changing times. We recommend that programs are interdisciplinary and interprofessional and use a rapid learning cycle to develop tailored education and clinical support tools specific to their clinical demands.

Future Collaboration

Although this program was propelled by necessity in a challenging and unpredictable time, its development marks a new chapter in our emergency department and palliative care's working relationship. Our future collaborations will likely focus on options to evaluate our program's impact. As we better understand how our program influences nursing practice and patient care, we can strategize how to carry such a program beyond disaster planning and into standard practice. Educating and supporting staff with an accessible and digital presence has the potential to leave a lasting impression on emergency nurses and how they can proactively facilitate and execute palliative care for their patients.

Considerations for future collaboration also include the development of interventions to support ED clinicians in recognizing their patients' palliative care needs and responding to those needs. For example, it has been established that many patients arrive to the emergency department with paperwork that is outdated, incomplete, or missing medical orders for life-sustaining treatments, leading to potentially invasive and unnecessary interventions.[26] This issue is made worse during COVID-19 times as patients and their loved ones/advocates are often physically separated because of visitation restrictions. Training can be developed for emergency nurses to identify patients without these forms to facilitate connection to palliative care clinicians. Together the emergency department and palliative care can work toward facilitating goals-of-care conversations before critical patient events occur.

Implications for Emergency Clinical Practice

Our program demonstrates that interprofessional (registered nurse, physician, social worker, NP), interdisciplinary (emergency department, palliative care) planning and implementation can bring about a novel program for a need that had been recognized previously, but not fully addressed. The need for collaborative efforts was especially true as the landscape of emergency care was changing rapidly and potentially significantly as a result of COVID-19. Our program highlights several implications for emergency nurses. These include (1) the clarification of palliative care's contribution to ED patient care, (2) the identification of the efficacy of a truly collaborative emergency palliative care process, (3) the potential to make evaluating a patient's palliative care needs part of emergency nurses' standard assessments, and (4) providing a template for others to evaluate our program in their own institutions.

Our program provides an opportunity to become better acquainted with the role of palliative care in emergency care. Better understanding opens the door to facilitating greater palliative care involvement. Emergency nurses can experience the focus of palliative care on aligning interventions with a patient's care preferences and goals. A deeper understanding of palliative care is made possible through the contribution of palliative care earlier in a patient's journeys. We look forward to and encourage others to use our shared program and welcome their evaluation in their own clinical settings.

Conclusion

During a time of unprecedented insecurity brought about by the COVID-19 pandemic, ED clinicians were called on to identify patients' goals and care preferences with a lack of patient family/support presence and with limited training regarding palliative care principles. As the role of palliative care in the emergency department has been explored, yet not well defined, palliative care clinicians were also challenged to learn the workflow and practices of the emergency department to best serve this patient population. In this publication, we have provided a template of our process aimed to improve palliative care delivery in the emergency department through educational and support resources. Rapid learning processes and communication between nurse representatives from the 2 specialties allowed for the development of both in-the-moment support and educational tools. The implementation of this program demonstrates that an interdisciplinary and collaborative approach to addressing these challenges can yield a supportive program during a surge in the number of patients testing positive for COVID-19, while developing a working relationship between emergency nursing and palliative care. By working together in a crisis, nurses within these 2 specialties found a path to supporting patient care that will last beyond the pandemic itself.

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Author Disclosures

Conflicts of interest: none to report.

Supplementary Data

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Supplementary Appendix

End-of-life care clinical reference tool to guide emergency nurses in symptom management