

Impact of a Nurse-Led Palliative Care Screening Tool on Medical Oncology Units

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There is a lack of early integration of palliative care in patients with advanced cancer, which has been shown to result in suboptimal quality of life across their disease continuum. Standardized palliative care screening tools are valuable for identifying patients with early palliative care needs but have yet to be adapted into standard practice in the oncology community. This project aimed to determine whether a nurse-led palliative care screening tool increased palliative care consultations, decreased the average length of stay, reduced readmission rates among adult patients with solid tumor malignancies, and improved knowledge and confidence among nurses regarding palliative care.

AT A GLANCE

- A lack of early integration of palliative care for patients receiving oncology care has been linked to poor quality-of-life outcomes.
- The use of validated screening tools can help eliminate the ambiguity surrounding when to schedule a palliative care consultation, improving patient outcomes.
- The autonomy granted by nurse-led tools facilitates nurses having a more principal role in patient discussions within an interprofessional team.

KEYWORDS

palliative medicine; oncology; palliative care criteria; screening tools

DIGITAL OBJECT IDENTIFIER

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The American Cancer Society (2023) estimated that in the year 2023, 18 million Americans would live with cancer or have a history of cancer and 1.9 million new cases would be diagnosed. One-third of patients diagnosed with cancer will die of the disease within five years (American Cancer Society Medical and Health Content Team, 2020). The lack of early palliative care (PC) integration has been linked to increased symptom burden, greater distress, and suboptimal quality of life throughout a patient's disease continuum (Halperin, 2017).

A study of 8,000 patients receiving oncology care showed that 38% were referred to PC within 30 days of the end of life (EOL), 17% within one week, and 2% within 24 hours (Heung et al., 2021). *Palliative care* and *hospice* are two terms that are often, but incorrectly, used synonymously. This misconception leads to barriers in providers' and patients' attitudes toward these services. If not corrected early, this can lead to continued hesitancy to use PC or refer patients to PC (Agne et al., 2021). Recognizing this potential barrier, the American Society of Clinical Oncology updated its clinical practice guidelines to state that all patients with advanced cancer should receive PC concurrent with active treatment and, most importantly, early in their disease continuum (Ferrell et al., 2017). Late referrals to PC, as well as associated poor quality of life and EOL outcomes in patients, increase provider distress and decrease job satisfaction (Heung et al., 2021).

Patients who receive late referrals to PC cannot benefit from the full range of palliative services and are more likely to die in the hospital (Adelson et al., 2017; Hui & Bruera, 2015). When nurses appropriately identify and convey PC needs, patients are more likely to be discharged to home with homecare service before death, which decreases the rate of readmissions and the use of acute care services such as the intensive care unit or emergency department (Adelson et al., 2017; Gemmell et al., 2020; Hanson et al., 2017; Hudson Lucas & Dimmer, 2021; Hui et al., 2014, 2018).

The American Society of Clinical Oncology and the Lancet Commission on PC and Pain Relief encourage validated screening and referral tools to increase early use of PC. The Lancet Commission additionally states that using standardized care pathways starting at diagnosis shows promise in improving quality of life (Adelson et al., 2017; Ferrell et al., 2017; Hudson Lucas & Dimmer, 2021; Hui et al., 2014, 2018). When screening tools have been applied retrospectively, many patients with cancer would have met the requirements for PC, regardless of whether they were early in diagnosis or nearing EOL.