**Introduction of Hospice/ Palliative Care in a Medical Skilled Unit**

**Organizational/ Department Change**

The problem, inefficiency, or issue within some of the medical units in hospitals relate to the lack of palliative care/hospice care.  This problem stems from the issue that most hospital units often discharge patients without any palliative care.  As a result, these patients often go back to their homes without any sufficient guidance or assistance in restoring their usual daily activities.  In the case of orthopedics patients for instance, including those recovering from fractures or a related orthopedic surgery, the lack of palliative care in the orthopedic unit can be a problem.  Palliative care is known to bring about major benefits to patients under long-term care.  For terminal care patients such as breast cancer patients, palliative care related to orthopedic interventions are not sufficiently laid out (Al-Hakim, Jagiello, Mannan, & Briggs, 2006).  Palliative care in this case may involve pathological fractures and other musculoskeletal effects from the cancer. Pain is usually the greatest issue in these terminally ill patients (Al-Hakim, et al., 2006).  Majority of cancer patients usually develop bone metastasis.  They are often referred to orthopedic surgeons for treatment.  The metastasis to their bones can sometimes lead to functional pain and mechanical instability (Al-Hakim, et al., 2006).  These patients may be candidates for surgery depending on the extent of their cancer.  Surgery as a palliative intervention for cancer patients may also be an issue because healing, including bone healing, is often compromised for cancer patients (Al-Hakim, et al., 2006).  Fractures for cancer patients have to be managed using methods which are able to form strong and permanent constructs which can assist in bringing about normal functions (Al-Hakim, et al., 2006).  Gaps in orthopedic and oncologic care is very much apparent in terms of providing the patients with sufficient knowledge and information as well as palliative care in relation to their bone metastasis and other musculoskeletal issues.  The lack of hospice or palliative care is a major issue in the quality of life of cancer patients who may suffer much pain and discomfort from their illness.  Hence, the importance of palliative/hospice care in the orthopedic unit especially to assist cancer patients with bone metastasis.

This change would align with the organization’s mission and vision to provide quality care for patients.  The quality care here, in relation to hospice care, is associated with improving the comfort of patients with chronic or terminal illnesses.  The mission and vision of orthopedic units is to assist patients in gaining mobility and independence in their daily activities, as well as helping them safely carry out their daily activities despite the physical limitations arising from their musculoskeletal issues.

The change model for this case would be related to advanced care planning and palliative care delivery in the orthopedic unit.  The change model is the Educate, Nurture, Advise Before Life Ends (ENABLE) which is a nurse-led intervention seeking to improve palliative care and improve the quality of life of patients with chronic or terminal diseases (Walling, Malin, Hurvitz, Zisser, Coscarelli, Clarke, Harbath, Pietras, Watts, Ferrell, Skootsky, & Wenger, 2017).  This change model can guide the change towards developing an efficient plan which nurses and advanced care practitioners can apply in the orthopedic unit.  This model can push the nursing or healthcare practice towards more specialized care, educating, as well as nurturing care for orthopedic patients requiring palliative care (Walling, et al., 2017).  The ultimate goal is to help these patients in eventually gaining mobility and in decreasing their risks of injury upon discharge (Martin, Sutton, Willars, and Dixon-Woods, 2013).  This change model is in accordance with the need to remodel the orthopedic unit to accommodate palliative/hospice care.  This change model was chosen because it supports the ultimate goal of this paper, especially the goal towards improving the lives of orthopedic patients requiring palliative/hospice care (Martin, et al., 2014).

**Steps to facilitate change**

Two week training for palliative care orthopedic nurse (Walling, et al., 2017).  These two weeks of training will focus on interdisciplinary working among healthcare personnel in the orthopedic unit.  This includes didactic learning and joining specialists in orthopedics, pain management, psychiatry, as well as physical and occupational therapy.  The nurse practitioner will take part in two weeks of advanced care planning for palliative care (Martin, et al., 2014).

Communication training.  This training includes the ask-tell-ask and response to emotion (Walling, et al., 2017).  The training for this includes a role-play for the nurse practitioners with the practitioners also taking part in learning exercises (Walling, et al., 2017).  Nurse practitioners have to be supervised by palliative care physicians who are experts in assessing symptoms and in the management of serious illnesses (Hastings, Suter, Bloom, & Sharma, 2016).  The nurse practitioners would also take part in regular team meetings in order to sustain the education gained from the intervention plan (Hastings, et al., 2016).

Referral process and identifying patients. Nurse practitioners who will be working with hospice patients in the orthopedic unit have to be instructed by the oncologists about hospice code status (Walling, et al., 2017).  The oncologists have to inform the nurse practitioners about the importance of providing psychosocial support for patients, as well providing support in coping with their symptoms (Hastings, et al., 2016).  This will help ensure prognostic awareness in order to guarantee that timely decisions in treatment are undertaken by the nurse practitioners (Walling, et al., 2017).  The referral form seeks to communicate treatment options to nurse practitioners in order to promote the use of advanced care planning which is consistent with shared goals as developed by the orthopedic, oncology, and palliative care team (Hastings, et al., 2016).

These steps align with the change model which seeks to educate and nurture, as well as advise the patient who is under palliative care (Sheard, 2014).  The change model seeks to improve the quality of life of palliative care patients, and the above steps also seek to improve the knowledge and skills of nurse practitioners in the orthopedic unit managing palliative care patients (Hastings, et al., 2016).  These steps match the model which seeks to introduce a significant change in the orthopedic unit in terms of training nurse practitioners to be informed and educated about orthopedic patients under hospice care (Sheard, 2014).

Those involved in managing this change would be the medical and nursing managers of the orthopedic unit and the managers of hospice and palliative care (Hastings, et al., 2016).  The nurses and medical professionals in charge of palliative care have to work with the managers of the orthopedic unit in order to initiate and manage the change (Sheard, 2014).  These nurses and medical professionals have to work with each other in order to consciously include palliative care in their plans related to orthopedic patients (Martin, et al., 2014).  In terms of skills, the physicians and nurses have to possess good communication skills (Martin, et al., 2014).  Communication can help ensure that they would listen and coordinate with each other while also listening and coordinating with their patients (Hastings, et al., 2016).  Good delegation skills are also needed especially on the part of physicians who would have to assign and delegate hospice and palliative care tasks to nurses in the orthopedic unit (Nelson-Brantley, Ford, Miller, & Bott, 2018).  Their delegation skills have to be good enough to ensure that they would be able to delegate the proper tasks to the proper nurses and healthcare professionals, along with the appropriate and complete instructions (Nelson-Brantley, et al., 2018).  Leadership skills are also needed in order to implement the change.  Without the will of a strong leader, the change is unlikely to be implemented in the unit (Nelson-Brantley, et al., 2018).

**References**

Al-Hakim, W. I., Jagiello, J. M., Mannan, K., & Briggs, T. W. (2006). The palliative role of orthopaedics: Orthopaedic procedures can help terminally ill patients and are underused. *BMJ: British Medical Journal*, *332*(7552), 1227.

Hastings, S. E., Suter, E., Bloom, J., & Sharma, K. (2016). Introduction of a team-based care model in a general medical unit. *BMC health services research*, *16*(1), 245.

Martin, G. P., Sutton, E., Willars, J., & Dixon-Woods, M. (2013). Frameworks for change in healthcare organisations: A formative evaluation of the NHS Change Model. *Health services management research*, *26*(2-3), 65-75.

Nelson-Brantley, H. V., Ford, D. J., Miller, K. L., & Bott, M. J. (2018). Nurse Executives Leading Change to Improve Critical Access Hospital Outcomes: A Literature Review with Research-Informed Recommendations. *Online Journal of Rural Nursing and Health Care*, *18*(1), 148-179.

Sheard, D. (2014). Achieving culture change: a whole organisation approach. *Nursing and*

*Residential Care*, *16*(6), 329-332.

Walling, A. M., D’Ambruoso, S. F., Malin, J. L., Hurvitz, S., Zisser, A., Coscarelli, A., ... &

Ferrell, B. (2017). Effect and efficiency of an embedded palliative care nurse practitioner in an oncology clinic. *Journal of oncology practice*, *13*(9), e792-e799.