Incorporating Social Workers and Nurses to Provide Hospice Patient's with an Effective Quality of Life

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Abstract

Ensuring quality of life for hospice patients requires attention to spiritual, financial, and psychosocial needs which is largely the focus of hospice care professionals. Providing quality of life to patients in hospice requires addressing those needs which cannot be accomplished alone but most effectively as part of an interdisciplinary team. This systematic literature review will explore the effectiveness of social workers and nurses who work on an interdisciplinary team in regards to providing quality of life to hospice patients. Through the review of literature this paper will seek to support the hypothesis that interdisciplinary teams between social workers and nurses can increase the quality of life for patients who receive hospice services. The purpose of this study is

to determine what professionals can work together and are most effective as an interdisciplinary team to provide quality of life for hospice patients.

***Keywords:* social workers, nurses, hospice patients, quality of life**

Social workers and nurses are an important part of interdisciplinary teams composed to assist patients who are receiving hospice services. Most interdisciplinary teams consist of nurses, doctors, speech therapists, physical therapists, volunteers, chaplains, and social workers (Neimeyer, Currier, Coleman, Tomer & Samuel, 2011). Each member of the interdisciplinary team has a distinct role to perform which aids in improving the quality of life for patients while they are receiving hospice services. The interdisciplinary teams not only enhance the quality of life for patients who are receiving hospice services but they also ease the burden of family members caring for loved ones who receive hospice services as well (Bronstein & Wright, 2006). While all members of the interdisciplinary teams are important, this paper will focus on the relationship between nurses and social workers on the hospice team.

The social worker has a very distinct and unique role as part of an interdisciplinary team. The social worker helps the family as well as the hospice patient deal with death and their feelings towards the end of life. According to Butzow (2012), "It is the social worker's role to educate, normalize, and remove the stigma that surrounds dying. A better understanding of death and a better response by hospice social workers to the needs of family members could result in improved therapies and outcomes for families experiencing grief and loss" (p. 2).

The nurse ensures that the patient has all medical equipment and medications needed to aid in their comfort during their last days. While both members have very distinct roles, there purpose and goal for the patient overlaps which is to ensure that the patient receives quality care while receiving hospice services. The most successful hospice team should consist of effective communication, cooperation, collaboration, and trust however, these lines can quickly become blurred when the best interest of the patient is not taken into consideration (Otis-Green, Lucas, Spolum, Ferrell, & Grant, 2008). While we would like to believe that the patient's best interest is taken into account at all times, sometimes this is not the case especially when there is miscommunication, no collaboration, and no trust within the interdisciplinary team.

This paper will examine the literature presented on the effectiveness of social workers and nurses working together on an interdisciplinary team. Through the review of literature and research this paper will also strive to gain insight on best practices to providing quality of life through interdisciplinary teams for patients receiving hospice services. It is the goal of this systematic literature review to provide future hospice social workers and nurses with a better understanding of the dynamics of hospice care within interdisciplinary teams.

Literature Review

The quality of life for patients receiving hospice services can be defined in several ways. Often it is defined as making sure patients are comfortable and that there needs are met at the end of life. This can be a daunting task for social workers and nurses if they are not sure what their role is. It can be even more daunting for patients who feel that they are not getting their needs met at the end of life. In an effort to better understand what needs were unmet Arnold, Artin, Griffith, Person, and Graham (2006) conducted a study about the unmet needs of hospice patients from the perspective of social workers. Arnold et al. (2006) wanted to understand (1) the frequency and types of unmet needs; (2) perceptions of the reasons for the unmet needs; (3) barriers to addressing unmet needs; (4) the types of intervention utilized to address these unmet needs; and (5) the outcomes of the intervention.

In this quantitative study, 73 hospice social workers received mail order surveys and answered closed-ended and open-ended questions about the unmet needs of hospice patients. The results of the study indicated that 67.1% perceived the most unmet need for hospice patients was psychosocial in nature and was something that they really did not have any control over. The psychosocial issues were mostly patient and family conflict. 42.5% reported decreased ability to participate in activities that make life enjoyable as an unmet need at time of admission into a hospice facility. 16.0% reported societal and cultural issues regarding illness and death as a barrier to unmet needs. 24.3% reported counseling and support of patient/family as an intervention to address these unmet needs. 67.5% reported positive outcomes for the intervention used to address unmet needs.

In an effort to combat the unmet needs of hospice patients, social workers and nurses must work together to ensure patients have an effective quality of life. The results of this study sheds light on what social workers who are already working with an interdisciplinary team perceive as unmet needs for hospice patients. This information is beneficial as it provides future social workers and nurses with a framework of providing quality care to hospice patients.

According to Kassalainen, Carter, Sangster-Gormley, Ploeg, McAiney, Schindel, Wickson-Griffiths (2013) hospice patients who are in long-term care along with their families can benefit from palliative care from interdisciplinary teams. This study was completed by a qualitative descriptive design using individual interviews in which 143 long-term hospice care member participated. In this research, nurse practitioners were found to be able to provide palliative care in a healthcare setting and also able to focus on relieving and preventing the suffering of patients. The most beneficial method of an interdisciplinary team according to this study was the fact that nurses were available around the clock to provide support for the patient and their families. Nurse practitioners played the most important roles because they managed day-to-day care for the patients, collaborated with other healthcare providers, and also worked within the system to make sure that the patients experienced a good death. Team collaboration played a tremendous role in making sure that services provided to the patient and families were effective. Collaborating with the interdisciplinary teams and providing quality of care helped to eliminate admissions to the hospital. As a hospice patient, one of the criteria's for continued care is that the patient receive all services in-house at the hospice facility. Furthermore, it is the role of the nurse practitioners to provide comfort and care for the patient.

In a quantitative study by Ellington, Reblin, Clayton, Berry, and Mooney (2012) there were two hospice organizations that participated in research in-which nurses used their ideas to implement a program that assisted hospice patients and their families with receiving the adequate respect while going through the dying process. Open and closed ended questions were asked to make sure that the nurses were providing the care that the families needed. Ellington et al. (2012) wanted to know (1) what are the symptoms the patient experienced? (2) Did the patient sleep ok at night? (3) Would the patient like to meet with the social worker? (4) How important is the patient's and their family's religion. Being able to understand what is important to the patient and their family is the main focus of providing quality of care to the family. The nurses counseled with the patient's and their families which included questions pertaining to the type of medication they were using and what they felt was most effective and the symptoms the medication may have caused if any. The nurses were also able to act as a social worker in the event a social worker was not available at the time. The study also provided clinical examples of how hospice clinicians provided quality care to the patients and their families and also how the nurses were able to meet the needs of the patient and their families with respect.

It is beneficial for hospice patients to have evidenced based practice in bereavement counseling, provided by interdisciplinary professionals. Evidenced base results proven to generate positive outcomes in bereavement counseling will identify interventions for counselors to use with hospice patients and their families (Wilson, 2011). Research show the Assimilated of Problematic Experience Sequence (APES) is a measuring tool that evaluates the ongoing therapeutic change for individual clients and bereavement in hospice care (Wilson, 2011). It primary focus aims to bring together process and outcome in psychotherapy. Assimilation Analysis occurs when client therapy sessions are recorded and the therapist listens to the recording several times, as means of identifying themes or topics of concern that needs to be addressed. The themes are thoroughly discussed during therapy sessions to work through feelings of grief to promote healing (Wilson, 2011). More hospice patients now prefer to die in the comfort of their own homes versus in hospitals (Ewing & Grand, 2012). This preference increases the need for in-home full time careers that will provide for the hospice patient. The Needs Assessment Tool- Caregivers (NAT-C) contains 32 items identifying the needs of careers to effectively care for the hospice patient within their home (Ewing & Grand, 2012). This tool is useful for the primary practitioner, as it identifies components that are necessary for quality of care for hospice patients.

Traditional healthcare settings are often times, limited in the time and access needed to conduct evidence based assessments, interventions, education, and psychosocial follow-ups that are essential to effectively care for hospice patients (Allen, Hazelett, Radwany, Ertle, Fosnight, & Moore, 2012). Therefore, a pilot study called Promoting Effective Advance Care for Elders

(PEACE) was initiated to test the effectiveness of in-home interdisciplinary care management interventions specifically for the geriatric population. This model integrated interdisciplinary treatments to include palliative care, geriatrics, nursing, social work, pastoral care, counseling, and pharmacists (Allen, Hazelett, Radwany, Ertle, Fosnight, & Moore, 2012). Outcome measures are documented at 3, 6, 9, 12, month intervals using five different measurement scales along with the seven domains of Wagner's Chronic Care Model. The PEACE trial was successful in integrating providers across several disciplines throughout institutions whose primary focus was improving coordination of care (Allen, Hazelett, Radwany, Ertle, Fosnight, & Moore, 2012). Palliative care and hospice improves patient outcomes for pain management, depression, patient & family satisfaction. Hospice provides comprehensive, interdisciplinary, team-based palliative care for patients who are dying with an indefinably short prognosis (Meier, 2011).

The primary difference between palliative care and hospice for the dying patient in the US it the determination of eligibility of care. Eligibility of palliative care is determined based upon a need for services and does not have any prognostic restrictions. The eligibility for hospice care is solely based upon the client's prognosis of less than six month to live (Meier, 2011). In other countries both palliative and hospice care are closely similar. There are barriers to receiving palliative and hospice care due to geographic location, inadequate workforce, and limited evidence-based research to guide and measure the quality of care (Meier, 2011). Some clients are not fully aware of the benefits of palliative and hospice care, therefore patient education is necessary for optimal care. Interdisciplinary professions should also receive training to effectively deliver palliative and hospice care to individuals needing end-of-life care (Meier, 2011).

The presence of an interdisciplinary team (IDT) in any clinical setting is to contribute to the clinical performance and to positively affect patient outcomes (Andreatta & Marzano, 2012).

More specifically, in the hospice setting, interdisciplinary teams are formed to address multidimensional pain and improve the quality of life for the dying patients (Dugan, 2012). Interdisciplinary teams can improve these aspects due to the collaboration of expertise from multiple disciplines such as doctors, nurses, chaplains, and social workers. The immense range of skills that is brought into a hospice setting due to an interdisciplinary team is a crucial part of dealing with physical, mental, emotional, and spiritual aspects of hospice patients.

Although each interdisciplinary team member has a role to play, social workers have many roles that may be perceived by other IDT members to overlap or not be crucial to the patient. In the classic 1986 Kulys and Davis study where face-to-face interviews were conducted with various hospice IDT members, social workers were perceived by other IDT members as not meeting the psychosocial needs of patients and families and thus not a crucial member of IDTs in the hospice setting. This underutilization of social workers as a part of a hospice team continued to be found in studies over the years (Csikai, 2002).

Despite the multiple studies that found that social workers have been an underutilized or unnecessary member of IDTs in hospice settings, some have seen a change in the perceptions of the social worker's role in IDTs. According to Reese (2011), interdisciplinary team members believed that social workers were most qualified for 12 of 24 roles and responsibilities in hospice. This is a tremendous leap since the Kulys and Davis study, demonstrating a change in perceptions of social workers among other interdisciplinary team members. However, social workers are seemingly less sure of their role in IDTs. Although their peers believed they were most qualified for 12 of the determined roles, social workers only felt most qualified for 9.75 of the roles (Reese, 2011).

The discrepancy between social workers perceptions of themselves and their team members' perception and the resulting underutilization of social workers' expertise leads to one question: why? A number of reasons have been proposed including the competition between nurses and social workers, the frustration felt by social workers who believe nurses are assuming many of their roles, and the lack of end-of-life care content in social work education (Parker-Oliver, Bronstein, & Kurzejeski, 2005; Reese, 2011).

Social workers' presence among interdisciplinary teams, especially in the hospice team, has been long-standing. However, many studies and reviews have determined that although they are an integral part of any IDT, they are not fully being utilized and are taking a back seat to nurses. Recent literature has determined that many IDT members feel that social workers are the best qualified to handle many of the roles and responsibilities in the hospice setting, yet their role is still lacking. Social workers have many skills that are of an asset to any team such as their ability to stimulate positive change within their teams, to demonstrate leadership, and to address psychosocial needs; and their skills involving education on professional boundaries and ethics, supervision, intake and discharge planning (Parker-Oliver, Bronstein, & Kurzejeski, 2005; Reese, 2011; Sanders, Bullock, & Broussard, 2012).

Overall, the literature has acknowledged the importance of social workers as a member of interdisciplinary teams in hospice settings. The literature has also acknowledged the need for improvement in collaboration among all interdisciplinary team members as well as the need for increased involvement of social workers in the hospice setting. A reduction in caseloads, education on end-of-life care and pain management, and becoming more proactive in identifying patients needing hospice care and advocating for those in hospice care have been discussed as ways social workers could improve (Dugan Day, 2012; Oliver & Peck, 2006; Stein, 2004). Lastly, to increase the cohesiveness and determine collaboration, Oliver and Peck (2006), suggested that interdisciplinary teams use instruments such as the Index on Interdisciplinary Collaboration (IIC) to determine a baseline on the functionality of their team's organization and to be used for follow-up as needed.

Methods

Data Sources

The Joyner Library at East Carolina University was utilized to obtain articles through the Academic Search Premier database. The articles that pertained to our key words: social worker, nursing, hospice patients and quality of life determined how professionals can work together and are most effective as an interdisciplinary team to provide quality of life for hospice patients. The results from this study will explain how a team of professionals can provide quality of life to hospice patients. When social workers and nurses work together as a team the collaboration of both will provide an effective quality of services to the patient and their family.

Study Eligibility

The findings of this study will provide assistance with the hospice team members to manage pain and ensure quality of life for hospice patients which requires attention to spiritual, financial, psychosocial needs in addition to physical needs which is focused on the hospice care professionals. Being able to provide quality of life will require social workers and nurses to work as a team. Articles that were used in the research were limited to the four key points. Literature reviews published before 2004 were omitted to ensure that up-to-date information was provided in the research.

Results

Training in providing adequate hospice care is needed for healthcare professionals to effectively care for end-of-life patients. Each discipline understands their own responsibility to the patient, however will benefit from cross-training in areas outside of their own (Stein, 2004). Social workers are most effective when they are proactive in caring for patients with life threatening illness (Stein, 2004). Social workers must advocate to local members of legislature and providers, on behalf of their clients to push for access to quality care. Some individuals prefer to die within the comfort of their home, and therefore receive hospice care from family and friends who act as informal caregivers (Wilder, Oliver, Demiris, & Washington, 2008).

Informal caregivers need structural support from social workers and medical professionals, so they are better equipped to help their loved ones and coping with their own feelings of grief and loss. Eighty percent of older adults have one chronic illness with fifty percent having two or more challenges including transportation, costs, communication, service coordination, etc. (Haxton, Boelk, 2010). Research shows that geographic distance and lack of local resources can lead to potential challenges, in which social workers should remain sensitive too (Haxton, Boelk, 2010). Research shows that social workers perform vital roles in hospice settings, however they report feeling the least satisfied within their jobs, as compared to other discipline professionals (Monroe & DeLoach, 2004). According to research, nurses are perceived to be more qualified to provide direct hospice care, and social workers are not used in executing all the interventions they have been trained and educated to do. Social workers are trained and educated to effectively direct hospice care and should be utilized to their full capacity (Reese, 2011).

Social workers tend to take a lead role in collaborating patient care for hospice programs that receive government funding. Research shows that communication during treatment teams occur regularly, however collaboration amongst disciplines will need to improve (Dugan Day, 2012). Challenges that social workers face in hospice interdisciplinary teams include, large caseload, frustration with medical model philosophy, lack of staff flexibility, personality conflicts, and limited psychosocial visits (Oliver & Peck, 2006). However, social workers can overcome challenges by encouraging more collaborative interventions. It is important for all disciplines to identify, establish, and maintain clear professional boundaries when collaborating on how each discipline can help the hospice patient (Sander, Bullock, Broussard, 2012). A common goal for disciplines offering palliative care is to improve the quality of life for patients and their families, through prevention methods and relief of suffering (Elena & Alison, 2013). Nurses have been primarily responsible for conducting a patient’s pain assessment; however, it is important that social workers also be trained to assess pain, as means of effective treatment. Implementation of palliative treatment interventions can increase survival time for the patient and may reduce the amount of aggressive treatments (Lewis, 2013). The primary focus for care planning is maintenance of physical and cognitive function for a patient who has not been identified as dying (Lewis, 2013).

Research indicates several assessment tools that may be beneficial to expediting quality for end-of-life patients and their families. The Assimilated of Problematic Experiences Sequence (APES) is a measuring too used to evaluate ongoing therapeutic change for individual clients and bereavement in hospice care (Wilson, 2011). The Needs Assessment Tool-Caregivers (NAT-C) is a tool indicated for general practitioner consultations and identifies the needs of caregivers (Ewing & Grande, 2012). The primary supports needed by caregivers are respite support, physical health concerns, financial and work issues, practical, and emotional support (Ewing & Grande, 2012). Family conferences amongst nurses, doctors, social workers, clergy, pharmacists, etc., proved beneficial in maintaining effective quality of care for hospice patient (Altilio, Otis-Green, Dahlin, 2008). The Translating Research into Practice approach is designed to determine evidenced based interventions for managing pain in patients with end stages of cancer (Herr, Titler, Fine, Sanders, Cavanaugh, Pharm, Tang, Forucci, 2012).

Discussion

The wide range of hospice patient needs requires many hospice settings to employ an interdisciplinary team. These interdisciplinary teams include professionals such as nurses, social workers, doctors, and chaplains. However, interdisciplinary teams are not limited to these professionals and may include any professional that can help the patient's needs be met ensuring a good quality of life. Gathering professionals with medical, spiritual, financial, psychosocial and other expertise allows patients to receive such care.

Social workers are one of many individuals that may make up an interdisciplinary team. In hospice, social workers have a large role with some responsibilities changing over time. One of the roles that social workers take on involves helping the hospice patient come to terms with dying and their feels about their impending death (Butzow, 2012). Social workers also provide support for patients' family members who are trying to cope with their loved ones' death.

Nurses have a very different, but equally as important, role than social workers. Nurses are responsible for providing assistance to the patient's, physician, and typically take care of dispensing medication, checking up on the patient making sure to note any changes, and making sure that they can help ease any discomfort. Although nurses are responsible for mostly physical needs, due to the amount of time they spend around the patients, the lines may become blurred when determining who is responsible for meeting psychosocial needs (Otis-Green, Lucas, Spolum, Ferrell, & Grant, 2008). Many patients turn to their nurses for emotional support due to the relationship that has evolved over time. Unfortunately, this has led many nurses to feel that social workers do not play an important role in the hospice setting and may be partially responsible for the underutilization of social workers in the hospice setting (Csikai, 2002; Parker-Oliver, Bronstein, & Kurzejeski, 2005).

Although the classic Kulys and Davis study in 1986 found that social workers were viewed as not meeting hospice patients' needs, new studies such as the one by Reese, 2011, illustrate that interdisciplinary team members are beginning to put more responsibility on social workers. Social workers were thought to be most qualified for half of the major duties in the hospice setting (Reese, 2011). Despite their team member's confidence and growing positivity, social workers were viewed themselves as only most qualified to handle a little more than a third of the major duties in the hospice setting (Reese, 2011).

The use of interdisciplinary teams in the hospice setting allows for patients to have more than just their physical needs met as previously discussed. This helps to ensure that these patients are not having important aspects such as mental health being overlooked. Furthermore, having a large team helps serve as a checks and balances system to ensure that ethical and professional conduct is being exhibited by each team member. Unfortunately, interdisciplinary team members are suffering with social workers reporting the lowest job satisfaction (Monroe & DeLoach, 2004). Excessive number of caseloads, lack of end-of-life care training and education, and ineffective collaboration and communication are some of the stresses that interdisciplinary team members face (Dugan Day, 2012; Oliver & Peck, 2006; Stein, 2004).

In conclusion, these findings suggest that although interdisciplinary teams are effective, there can still be major strides made in the effectiveness of interdisciplinary team members in the hospice setting. All potential interdisciplinary team members could benefit from the information on teamwork and effective communication and collaborative skills. This could be accomplished by including such coursework in degree seeking programs in the helping professions or by requiring such training for interdisciplinary team member employees. It would also benefit interdisciplinary teams to incorporate instruments to measure the collaboration among the team, such as the Index on Interdisciplinary Collaboration (Oliver & Peck, 2006). Furthermore, cross-training interdisciplinary team members may help build each individual's skillset in the team while helping increase awareness of what each member does in the team (Stein, 2004). Although cross training would not make a social worker able to call themselves a nurse or vice versa, having the opportunity to see exactly what their team member does could help with the cohesiveness of the group. Ultimately, social workers and other interdisciplinary team members help ensure quality of life for hospice patients but should be studied further to determine the best procedures to increase their effectiveness.

Appendix

Literature Review Matrix

Interdisciplinary Teams between Nurses and Social Workers Increasing Quality of Life

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1. Stein, G. L. (2004). Improving our care at life's end: Making a difference. *Journal of Health & Social work, 38,* 77-79.	Acknowledges and discusses barriers that prevent many individuals from seeking end-of-life care as well as increasing the quality of care.	N/A	Court cases where individuals sued their physicians due to lack of adequate care
2. Wilder, H. M., Oliver, D., Demiris, G., & Washington, K. (2008). Informal hospice caregiving: The toll on quality of life. *Journal of Social Work In End-Of-Life & Palliative Care, 4*(4), 312-332.	Caregivers overall were found to have a medium-high perceived quality of life in all domains. However, caregiver quality of life was found to decrease over time.	Caregivers *n = 76* Range *n = 22-87* Average *n = 59*	Caregiver Quality of Life Index-Revised (CQLI-R)
3. Haxton. J. E., & Boelk, A. Z. (2010). Serving families on the frontline: Challenges and creative solutions in rural hospice social work. *Social Work In Health Care, 49*(6), 526-550.	A number of challenges were identified including distance, multiple roles, accessing community-based services, lack of anonymity as a professional, and the importance of privacy to many rural patients.	Social Workers *n = 339* Women *n = 90.9%* White *n = 94.7%*	Web-based survey containing 107 items, multiple choice and open-ended questions, taking approximately 15 minutes
4. Monroe, J. & DeLoach, R. J. (2004). Job satisfaction: How do social workers fare with other interdisciplinary team members in hospice settings? *Omega: Journal of Death & Dying, 49*(4), 327-346.	A high degree of job satisfaction was reported with social workers and nurses ranking first and second, respectively, in job satisfaction among the professionals who participated.	IDT members *n = 65* Range *n = 26-64*	Six-item index adapted by Price and Mueller from Brayfield and Rothe's (1951) 18-item index.

5. Cagle, J., & Bolte, S. (2009). Sexuality and life-threatening illness: implications for social work and palliative care. *Health & Social Work*, *34*(3), 223-233.	A review of the literature suggests that a tactful and comprehensive assessment of sexuality is an important component of quality end-of-life care.	Literature Review *n = 83*	N/A
6. Reese, D. J. (2011). Interdisciplinary perceptions of the social work role in hospice: Building upon the classic kulys and davis study. *Journal of Social Work In End-Of-Life & Palliative Care*, *7*(4), 383-406. doi:10.1080/15524256.2011.623474.	Directors found social workers best suited to address 12 od 24 areas. However, the perception that responsibility for financial counseling and making referrals hasn't change in the last two decades.	Hospice Directors *n = 43*	Perceived Roles of Team Members in Hospice questionnaire
7. Dugan Day, M. (2012). Interdisciplinary hospice team processes and multidimensional pain: A qualitative study. *Journal Of Social Work In End-Of-Life & Palliative Care*, *8*(1), 53-76. doi:10.1080/15524256.2011.650673	The study revealed that the IDT members were committed to quality care for multidimensional pain. Social work leadership could possibly increase leadership and the structure of IDTS can be improved with protected work time and training.	Team Participants *n = 15* White *n = 14* African American *n = 1* Women *n = 13* Men *n = 2*	Team members were interviewed individually and the author took systematic notes of team treatment planning meetings over a period of a year.
8. Oliver, D., & Peck, M. (2006). Inside the interdisciplinary team experiences of hospice social workers. *Journal Of Social Work In End-Of-Life & Palliative Care*, *2*(3), 7-21. doi:10.1300/J457v02n03-0	Social workers report strong communication and trust among IDT. Positive and problematic interdisciplinary collaboration was reported. Need for an increase in IDT collaboration.	Hospice Social Workers *n = 23* Hospice Programs *n = 20*	Qualitative follow-up to a previously conducted quantitative study; utilized Index on Interdisciplinary Collaboration (IIC).
9. Sanders, S., Bullock, K., & Broussard, C. (2012). Exploring professional boundaries in end-of-life care: Considerations for hospice social workers and other members of the	Development of specific policies and procedures regarding the conduct of staff with patients and families. The use of peer supervision,	Case Studies identifying challenges that hospice social workers and members of IDTS *n = 4*	Case Studies

team. *Journal Of Social Work In End-Of-Life & Palliative Care*, *8*(1), 10-28. doi:10.1080/15524256.2012.650671	specific training, and education about professional boundaries within a hospice setting would benefit members of an IDT.		
10. Parker-Oliver, D., Bronstein, L. R., & Kurzejeski, L. (2005). Examining variables related to successful collaboration on the hospice team. *Health & Social Work*, *30*(4), 279-286.	The extent of interdisciplinary collaboration was perceived high by a majority of social workers who participated. More research should be conducted to determine the variance.	Social Workers *n = 77*	Introduction and explanation letter, demographic questions and the IIC
11. Wilson, J. (2011). The assimilation of problematic experiences sequence: An approach to evidence-based practice in bereavement counseling. *Journal of Social Work in End-of-Life & Palliative Care*, *7*(4), 350-362. doi:10.1080/15524256.2011.623468	Bereavement counselors who use the APES assimilation model will be more equipped to help their client's transition through the stages of grief and loss.	Lit Review- It is proposed that this model can be used for individuals who are actively experiencing grief and loss.	Assimilation of Problematic Experiences Scale qualitatively analyzes eight developmental stages from 0-7.
12. Ewing, G., and Grande, G. (2012). Development of a career support needs assessment tool (CSNAT) for end-of-life care practice at home: A qualitative study. *Palliative Medicine*, 27(3), 244-256. doi: 10.1177/0269216312440607	This study found two primary groups of support that carers needed including, 1. Support to enable them to care for their family and 2. Personal support for themselves.	Qualitative study, 60% women, age range 35-82. Median age is 66 years. *n* = 75	Carer Suppport Needs Assessment Tool (CSNAT)- evidenced based comprehensive measure of carer's support needs in 14 domains.
13. Altilio, T., Otis-Green, S., & Dahlin, C. M. (2008). Applying the national quality forum preferred practices for palliative and hospice care: A social work perspective. *Journal of Social Work in End-of-Life & Palliative Care*, *4*(1), 3-16. doi:10.1080/15524250802071999	"Family conferencing are helpful in guiding the social work focus for the hospice client and their families, with emphasis to social networking, culture, finances, intimacy, communication, and access to services."	Lit Review- Research suggests the family care planning process to include primary doctors or consulting health care professionals, nurses, social workers, chaplains, psychologists, rehabilitation professional, along with the client and family.	Clinical Practice Guidelines for Quality Palliative Care, (NCP). National Quality Forum (NQF), was used to form the National Framework and Preferred Practices for Palliative and Hospice Care Quality Measurement and Reporting.

14. Noyes, J., Edwards, R. T., Hastings, R. P., Hain, R., Totsika, V., Bennett, V. …Lewis, M. (2013). Evidence-based planning and costing palliative care services for children: novel multi-method epidemiological and economic exemplar. *BMC Palliative Care*, 12(18), 2-17.	Many of the life-limiting deaths that were reported on the death certificates did not have referrals for palliative care services, concluding potential for palliative referral were not recognized by health professionals.	Children and young people, ages 0-19, with complex health and palliative care needs, parents, and multi-agency palliative care professionals. Of 1052 Welsh resident deaths between 2002-2007, only *n* = 569 were result of life-limiting conditions. Of 887 Wales death certificates of children, only *n* = 196 were considered life-limiting	Together for Short Lives/Royal College of Pediatrics and Child Health (RCPCH) categories
15. Herr, K., Titler, M., Fine, P. G., Sanders, S., Cavanaugh, J. E., Swegle, J., . . . Forcucci, C. (2012). The effect of a translating research into practice (TRIP)--cancer intervention on cancer pain management in older adults in hospice. *Pain Medicine (Malden, Mass.), 13*(8), 1004-1017. doi:10.1111/j.1526-4637.2012.01405.x	Decreases in pain severity from baseline to post-intervention during the second week of hospice. There were relatively small decrease changes in pain severity however, unlikely to be clinically significant.	*n* = 738 Older adults. Mean 77.6 years and at 78 years.	(CPPI)-Cancer Pain Practices Index was used to measure the cancer pain practices. (NRS)- Reports of pain severity recorded in the medical record. (TRIP-CA)- Translating Research into Practice for pain management in older adults with Cancer.
16. Allen, K. R., Hazelett, S. E., Radwany, S., Ertle, D., Fosnight, S. M., & Moore, P. S. (2012). The promoting effective advance care for elders (PEACE) randomized pilot study: Theoretical framework and study design. *Population Health Management, 15*(2), 71-77. doi:10.1089/pop.2011.0004	PEACE Intervention offers organizational structure, leadership, incentives, and resources. Establishes community linkages. Provide effective self-management support. Redesign in the delivery of the system. Encourages evidence based support. Improve information systems.	Age > 60 years old. Life limiting illnesses, be nursing home eligible, must have Medicaid, have 2 deficits of Activity of Daily Living	Symptom Management (measured using the Memorial Symptom Assessment Scale). Quality of life/death (measured using QUAL-E). Relationships (measured using the Meaning in Life Scale). Decision making, care planning, continuity, communication

				(measured using the Hospital Anxiety and Depression Scale).
17.	Daveson, B. A., Simon, S. T., Benalia, H., Downing, J., Higginson, I. J., Harding, R.,. PRISMA. (2012). Are we heading in the same direction? European and African doctors' and nurses' views and experiences regarding outcome measurement in palliative care. *Palliative Medicine*, *26*(3), 242	Doctors and nurses both are using outcome measures with emphasis in training, information & guidance. Education and training is needed for competency based training. Doctors and nurses need free access to effective tools for multidisciplinary cross-training and cohesive research.	Doctors n = 196, with a mean age of 46.9. Nurses n = 104, with a mean age of 45.1. Majority of doctors were male, n = 100. Majority of nurses were female n = 87.	Qualitative interviews using Palliative care Outcome Scale (POS). Checklist for Reporting Results of Internet E- Surveys (CHERRIES).
18.	Oliver, D. P., Wittenberg-Lyles, E., Washington, K. T., and Sehrawat, S. (2009). Social work role in hospice pain management: A national survey. *Journal of Social Work in End-of-Life & Palliative Care*, 5, 61-74. doi: 10.1080/15524250903171900	Average caseload for social worker is twice as high than for the hospice nurse at 23.4 patients. Social workers can aid in the pain management for the client.	Lit Review	National Survey was used to answer three primary questions, 1.How Hospice social workers assess pain, 2. How hospice social workers utilize caregivers in the pain assessment, 3. How hospice social workers work with multidisciplinary teams to the psychosocial components of pain.
19.	Hudson, P., Thomas, T., Quinn, K., & Aranda, S. (2009). Family meetings in palliative care: Are they effective? *Palliative Medicine*, *23*(2), 150.	Family meetings can be effective when done according to clinical practice guidelines.	Nurses with at least 3-year experience in palliative care and a postgraduate. Healthcare professionals including doctors and social workers. Patients and family carers that met the inclusion criteria.	Family Inventory of Needs (FIN), measure the needs of the family. 5-Point Linkert Type Scale. Pre/Post Meeting questionnaires, Family meeting evaluation forms, Focus Groups.
20.	Meier, D. E. (2011). (2011). Increased access to palliative care and hospice services: Opportunities to improve value in health care. *The Milbank Quarterly*, *89*(3), 343-380.	Palliative care outside hospice is growing and is evidenced by hospital care services, education, and training for professionals.	Lit Review	Family Evaluation of Hospice Care (FEHC).Quality Assessment and Performance Improvement (QAPI) program required for

	doi:10.1111/j.1468-0009.2011.00632.x			Medicare. Community Assessment Record & Evaluation (Care).
21.	Neimeyer, R. A., Currier, J. M., Coleman, R., Tomer, A., & Samuel, E. (2011). Confronting Suffering and Death at the End of Life: The Impact of Religiosity, Psychosocial Factors, and Life Regret Among Hospice Patients. Death Studies, 35(9), 777-800.	This quantitative study examines the impact of demographic characteristics, religious and psychosocial factors, and life regret on death attitudes and psychological well-being for hospice patients.	Hospice Patients n=153 African American n=35%, Caucasian n=65%, Men, n=46%, Women, n=54%	The Death Attitude Profile-Revised (DAP-R), World Health Organizations Quality of Life Scale (WHOQOL), Multidimensional Fear of Death Scale (MFODS), The Regret Scale (RS), Rosenberg's Self Esteem Scale (RSE), Religious Orientation Scale
22.	Arnold, E., Artin, K., Griffith, D., Person, J., & Graham, K. G. (2006). Unmet Needs at the End of Life: Perceptions of Hospice Social Workers. Journal Of Social Work In End-Of-Life & Palliative Care, 2(4), 61-83.	The purpose of this quantitative study was to examine the experiences of hospice social workers in working with hospice patients who had unmet needs at the end of life.	Hospice Social Workers n=73	Survey packets which included questions about the background, education, and training of participants. Survey included closed-ended and open-ended questions about participants experience with hospice patients
23.	Linder, J. F., & Meyers, F. J. (2009). Palliative and End-of-Life Care in Correctional Settings. Journal of Social Work In End-Of-Life & Palliative Care, 5(1/2), 7-33.	Article focusing on end of life and palliative care for inmates within a prison system.	N/A	N/A
24.	Murty, S. A., Gilmore, K., Richards, K. A., & Altilio, T. (2012). Using a LISTSERV™ to Develop a Community of Practice in End-of-Life, Hospice, and Palliative Care Social Work. Journal Of Social Work In End-Of-Life & Palliative Care, 8(1), 77-101. .	This article discusses the concept of technology supported community practice. Empirical data shows how electronic discussion groups has contributed to the growth of community of practice dedicated to improving palliative and end-of-life care among social workers	N/A	Email discussion group (SW-PALL-EOL), List serve

25.	Jennings, B., & Morrissey, M. (2011). Health Care Costs in End-of-Life and Palliative Care: The Quest for Ethical Reform. Journal Of Social Work In End-Of-Life & Palliative Care, 7(4), 300-317.	This article focuses on an ethical perspective on health care cost control in the contest of end-of-life and palliative care, an area considered by many to be a principle candidate for cost containment.	N/A	N/A
26.	Otis-Green, S., Lucas, S., Spolum, M., Ferrell, B., & Grant, M. (2008). Promoting Excellence in Pain Management and Palliative Care for Social Workers. Journal Of Social Work In End-Of-Life & Palliative Care, 4(2), 120-134.	The purpose of this article was to describe the development of a national educational program designed to promote excellence in pain management and palliative care for social work professionals.	Evaluation data N=276	Social workers were recruited by distributing news of the training through organizational web-postings, professional listservs, mailed announcements
27.	Empeño, J., Raming, N. J., Irwin, S. A., Nelesen, R. A., & Lloyd, L. S. (2013). The Impact of Additional Support Services on Caregivers of Hospice Patients and Hospice Social Workers. Journal Of Death & Dying, 67(1/2), 53-61.	The hospice caregiver support project provided support services to caregivers identified by the hospice social worker as needing this support and/or assistance.	Caregivers N=123	Referrals from hospice social workers
28.	Bronstein, L. R., & Wright, K. (2006). The Impact of Prison Hospice: Collaboration Among Social Workers and Other Professionals in a Criminal Justice Setting that Promotes Care for the Dying. Journal Of Social Work In End-Of-Life & Palliative Care, 2(4), 85-102. doi:10.1300/J457v02n04-05.	This is a qualitative study to learn about the interdisciplinary collaboration between social work and criminal justice using prison hospice as an example of this collaboration.	Prison hospice Coordinators N=14	Telephone surveys and interviews
29.	Roff, S., (2001). Analyzing End-of-Life Care Legislation. Social Work in Health Care, 33(1), 51-68. doi: 10.1300/J010v33n01_05.	This article discusses recent proposed policy responses to various political and social controversies surrounding end-of-life care. This article suggests criteria for evaluating end-of-life policy in general and offer a framework for evaluating proposed legislation	N/A	N/A

30.	Gwyther, L. P., Altilio, T., Blacker, S., Christ, G., Csikai, E. L., Hooyman, N., & Howe, J. (2005). Social Work Competencies in Palliative and End-of-Life Care. Journal Of Social Work In End-Of-Life & Palliative Care, 1(1), 87-120. doi:10.	This article focuses on the national social work leadership summit which met in 2002. The summit placed high priority on the development and dissemination of a summary document of the state-of-the-art practice of social work in palliative and end-of-life care.	N/A	N/A
31.	Ellington, L., Reblin, M., Clayton, M. F., Berry, P., & Mooney, K. (2012). Hospice nurse communication with patients with cancer and their family caregivers. Journal of Palliative Medicine, 15(3), 262-268. doi:10.1089/jpm.2011.0287	Nursing visits that were recorded during the nursing home visits were found feasible. RIAS was suitable to capture the content of the research.	Hospice Organizations n=2	Roter Interaction Analysis System (RIAS)
32.	Hindmarch, J. (2012). Nurse leaders have the vision and expertise to widen access to palliative and end-of-life care. International Journal of Palliative Nursing, 18(11), 531.	Hospice nurses have demonstrated how the vision and expertise meet the needs of the families and the patient.	Nurse Leaders n=43 Non-White n=5% NCPC n=8%	N/A
33.	Hughes, L. D. (2012). Assessment and management of pain in older patients receiving palliative care. Nursing Older People, 24(6), 23	Older patient's received palliative care which can be nursed in different settings.	N/A	SOCRATES Pain Questionnaire
34.	Kaasalainen, S., Carter, N., Sangster-Gormley, E., Ploeg, J., McAiney, C., Schindel Martin, L., Wickson-Griffiths, A. (2013). Role of the nurse practitioner in providing palliative care in long-term care homes. International Journal of Palliative Nursing, 19(10), 477.	Nurse practitioner provided quality of care for the patient's and their families.	Physicians n=9 LPN n=20 Support Worker n=15 Managers n=19 RN n=10 Care Provider n=31 Residents n=14 Family members=21	Software program N-Vivo 9.0 Qualitative descriptive design

35. Lewis, K. (2013). How nurses can help ease patient transitions to end of life care. Nursing Older People, 25(8), 22.	Dying patients are included in discussions concerning their quality of life. Nurses enable conversations about how the quality of life takes place and what to expect.	N/A	N/A
36. Lundberg, T. Olsson, M., Furst, C. (2013). The perspectives of bereaved family members on their experiences of support in palliative care. International Journal Of Palliative Nursing, 19(6), 282-288.	Being closed to someone who is dying is a major challenge. Receiving palliative care put the patient and the family in control of their care which educates them on the structure of hospice care.	Categories n=5 Interviews n=8 months Patients n=60 Female n=12 Male n=13	Exploratory qualitative study and Qualitative individual interviews.
37. Richardson K., MacLeod R., Kent B., (2011). A Steinian approach to an empathic understanding of hope among patients and clinicians in the culture of palliative care. Blackwell Publishing Ltd	All health professionals should be appreciative of the different experiences patients experience and to be respectful of the direction they chose to follow.	Personal experiences Authors n=3	Doctoral dissertations(Edith Stein)The Literary of Investigative Practices
38. Shigeko I., Hiroko N., Chihoko S., Emiko I., (2012). Defining end-of-life care from perspectives of nursing ethics. *Nursing Ethics* 19(5) 608–618.	Palliative care is a special care that is provided to dying patients. According to the code of ethics for nurses they are required to promote health, prevent illness, and alleviate suffering.	N/A	Nursing Association (JNA) National Institute of Health (NIH)
39. Thompson, A. (2013). How schwartz rounds can be used to combat compassion fatigue. *Nursing Management* (Harrow, London, England: 1994), 20(4), 16.	The focus of Schwartz rounds is to allow the interdisciplinary team to work in and environment that is safe provide confidentiality to patients.	N/A	Schwartz Rounds
40. Elena I., Alison W., (2013).Understanding the palliative care needs of heart failure patients *British Journal of Community Nursing* vol 18, No 9	The role of a nurse understands that all hospice patient benefit from receiving palliative care.	Sample n=208	3 databases Medline, CINAHL, and Web of Science

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Table 1

Research question, purpose, and problem

Research Question, Purpose, and Problem	**RQ:** Do social workers and nurses as a team provide quality of life for hospice patients?
	Purpose: Determine what professionals can work together and are most effective as an interdisciplinary team to provide quality of life for hospice patients
	Problem: Managing pain and ensuring quality of life for hospice patients requires attention to spiritual, financial, psychosocial needs in addition to physical needs which is largely the focus of the hospice care professionals. Providing quality of life requires addressing all of the needs listed above, none of which can be accomplished by one discipline or professional.

Table 2

Cochrane Systematic Review

Steps 1, 2& 3	•Defining the review question and developing criteria for including studies •Searching for Studies •Selecting studies and collecting data
Steps 4 & 5	•Assessing risk of bias in included studies •Analysing data
Ste[s 6, 7, & 8	•Adressing reporting biases •Presenting results and "summary of findings" tables •Interpreting results and drawing conclusions

Table 3

Synthesis of Keywords

Years	**Keywords**	**Number of Articles**
1894-2014	Social Workers	N = 192,800
2003-2013	Social Workers + Hospice Patients	N = 624
2003-2013	Social Workers + Hospice Patients + Interdisciplinary Teams	N = 50
2003-2013	Social Workers + Hospice Patients + Nurses	N = 236
2003-2013	Social Workers + Hospice Patients + Quality of Life	N = 135
2003-2013	Social Workers + Hospice Patients + Quality of Life + Interdisciplinary Teams	N = 12
2003-2013	Social Workers + Hospice Care + Interdisciplinary Teams	N = 112

Note. Academic Search Complete, ERIC, Health Source: Nursing/Academic Edition, PsycARTICLES, PsycINFO, SocIndex with Full Text

Table 4

Synthesis of Journal Articles for Keywords Social Workers + Hospice Patients + Quality of Life (N=135)

Total Articles for Keywords Social Workers + Hospice Patients + Quality of Life		N = 135
Omit Dissertations	2	N = 133
Omit Books and Magazines	9	N = 124
Limit To Scholarly (Peer Reviewed Journals)	0	N = 124
Limit To Full Text	82	N = 42
Omit Articles That Do Not Match Keywords	35	N = 7
Total Number of Articles From Searching Databases for Keywords Social Workers + Hospice Patients + Quality of Life		N = 7

Note. Academic Search Complete, ERIC, Health Source: Nursing/Academic Edition, PsycARTICLES, PsycINFO, SocIndex with Full Text

Table 5

Research Question

Do social workers and nurses as a team provide quality of life for hospice patients?

(Parker-Oliver, Bronstein, & Kurzejeski, 2005; Dugan, 2012; Neimeyer et al., 2011; Arnold et al., 2006; Ewing, 2012; Wilson, 2011; Hindmarch, 2012; Kaasalainen et al., 2013)

Table 6
Synthesis of Key Articles

Author/Date	Type of Study	Purpose	General Comments	Strengths and Limitations
Dugan (2012)	Qualitative, Interview and Observation	To explore two processes in team pain palliation: communication and collaboration.	The study revealed that leadership and structure of IDTs can be improved with protected work time and training. Also the study suggests that social workers need to take leadership in team pain palliation.	Participants were already involved in a larger study; self-report allows responses to be shaped; observers were present in team meeting rooms which influenced team interactions.
Parker-Oliver, Bronstein & Kurzejeski (2005)	Qualitative, Survey	To determine if collaboration of social workers as a part of an interdisciplinary team in a hospice setting is effective.	Most of the social workers that participated in the study viewed collaboration positively.	Variance of IIC scores cannot be explained by study variables; response rate of 52.7%; provided option to mail or fax back with 62% using the faxing option.
Neimeyer et al. (2011)	Quantitative; Qualitative, interviews	To examine the relative impact of demographic characteristics on death attitudes and psychological well-being.	Factors examined were significantly correlated to death attitudes and emotional health, while each factor has a unique impact.	Used reliable and validated assessments of the study factors. Reliance on self-report and use of study findings to provide causal links are limitations.
Arnold et al. (2006)	Qualitative, Survey	To examine experiences of hospice social workers in working with hospice patients who had unmet needs at the end of life.	Results revealed that hospice social workers perceived patients to experience a wide variety of unmet needs most often decreased ability to participate in activities.	The need to collect sufficient data to be able to make recommendations. Use of the Family Evaluation of Hospice Care (FEHC) obtaining data from decedents of hospice patients. New methods of assessing patient and family needs must be developed.
Ewing & Grande (2012)	Qualitative	To develop a carer support needs assessment tool suitable for use in everyday practice.	Carer’s needs fell in two groups: support to enable them to provide care to their relative and more direct personal support for themselves.	The Carer Support Needs Assessment Tool (CSNAT) is an evidence-based direct measure of carers’ support needs in 14 domains resulting in a comprehensive in approach and suitable for end-of-life care research and practice.

Daveson et al. (2011)	Qualitative, Survey	To examine and compare doctors' and nurses' views and experiences regarding outcome measurement in hospice settings.	Respondents shared similar views and experiences influenced by similar factors. Multidisciplinary outcome measurement education and training is feasible and required.	Findings are relevant to policy development in relation to outcome measurement type and implementation. One of the first surveys to solicit views and experiences of those in Europe and Africa. Methods for national and cross-national comparisons are needed.
Hindmarch (2012)	Commentary	People with terminal illnesses from minority or marginalized groups are less likely to seek end-of-life care.	The Widening Access through Nurse Leadership report encourages hospices to join forces to reach more patients.	Misconceptions surrounding hospice care can prevent people from accessing care. People who do not see themselves as traditional hospice patients may be unaware that they are eligible for care.
Kaasalainen et al. (2013)	Qualitative, Descriptive Design	To explore the role of nurse practitioners in providing palliative care in long-term care homes.	Nurse practitioners provide care for residents and their families, consult and educate, and collaborate with other health-care providers.	The sample size was small and not generalizable. Some NPs volunteered to participate and might have biases. Limited demographic information was collected on residents and family members.