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DNP Final Project Report

Evaluation of Education Implementation in the Adult Palliative Care Population

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College of Nursing

Fall 2018

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Abstract

PURPOSE: The purpose of this study is to determine if staff nurses are knowledgeable concerning palliative care consults and to assess the effectiveness/outcomes of the education intervention that had been implemented in the emergency department and 4W surgical/oncology units at Norton Audubon Hospital.

METHODS: This descriptive, interventional study was done in two phases at Norton Audubon Hospital. The first phase of this study included educational intervention for 24 nurses on 4W and 22 nurses in the emergency department concerning palliative care in July 2018. The second phase of the study was a chart review on consults placed on 69 patients in the above-mentioned units and done after the education was implemented. The chart sampling spanned May 11, 2018, to September 27, 2018.

RESULTS: Staff that received palliative care education benefited from the intervention and scored higher on the post-testing done in September 2018. The post-assessment also found that these nurses were more likely to effectively implement the training instruction presented during the pre-assessment education phase. However, there was not an increase in the number of consults. These results included both emergency department and 4W, surgical/oncology ($p=0.05$).

CONCLUSION: Educating staff and patients, to become aware of their options can eliminate possible unnecessary medical procedures. An educational intervention has the potential for resulting in better outcomes for both the patient and the hospital organization. Although with this study, the educational intervention, although helpful, more research would benefit on how to

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produce the best outcome for consults placed on the palliative care patient recognition. This intervention did not result in an increase of consults, only an increase with education.

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Evaluation of Education Implementation in the Adult Palliative Care Population

Introduction

There is a dramatic increase in the proportion of our population in the United States who are greater than 70 years. Many of these people have chronic debilitating conditions such as cardiovascular disease, pulmonary disease, diabetes, dementia, and cancer. Palliative care needs to be offered to these patients due to its significance in end of life care. Therefore, it is imperative that palliative care is addressed as soon as the patients present to the hospital to help in alleviating the chronic pain. The primary objective of palliative care is to relieve pain during different stages of diseases (Bruera et al., 2010). Addressing these issues early, educating the patient/significant others, and making them aware of their options, empowers the patient to make better-informed decisions concerning their treatments and care. It gives them direction. The increasing elderly population is becoming vulnerable to different chronic illnesses. Such chronic illnesses cause symptoms that can reduce the quality of life of these patients (Bruera et al., 2010). As a result, there is a growing need for established palliative care within the hospital (Brody et al. 2010).

Many families, caregivers, and medical providers lack the knowledge of palliative care delivery and support of patients with chronic illnesses. As a result, the palliative care team should be available to help families and caregivers develop the right skills in managing the symptoms of the disease that is in the best interest of the patient. A palliative care team with professionals from different specialties is likely to integrate various models of care with the core objective of improving patients' quality of life. Undoubtedly, effective palliative care produces positive benefits for both the patient and the healthcare organization (Dietrich et al. 2010).

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Health care organizations that provide palliative care, provide positive patient outcomes and reduce the costs associated with the delivery of care (Dietrich et al. 2010). There is a significant reduction in readmissions and hospital stays if palliative care is available (Dietrich et al. 2010). The increasing number of elderly patients with multiple chronic conditions creates the need for a healthcare system that can be responsive to these individuals.

Patients who are dying or have chronic illness have a growing need for a hospital-based palliative care programs (Block et al., 2010). According to Bruera et al. and Block et al., palliative care should embrace a multidisciplinary perspective. This thought process specifies individuals from different multidisciplinary teams. This group should come together to form a palliative care team that can register high levels of effectiveness. Practitioners should work together with nurses and other healthcare professionals to promote positive patient outcomes. Transitioning care of the adult with chronic illness is one of the major principles of the palliative health care team.

Background

Health care organizations that provide palliative care provide positive patient outcomes and reduce the costs associated with delivery of care (Dietrich et al. 2010). There is a significant reduction of readmission cases and the periods of hospital stay if palliative care is available. A review of the existing literature indicates that the use of palliative care teams in other hospitals have proven valuable in that there was a decrease in the likelihood of intensive care unit (ICU) admissions, and decreased and lowered inpatient cost compared to hospitals that did not utilize palliative care (Deb et al., 2006). According to Cassel et al. (2015), palliative care consultation saved hospitals an average of \$6,900 per admission. Savings of approximately \$2,600 per

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admission were seen for palliative care patients discharged from the intensive care unit, and patients receiving palliative care spent on average 3.6 fewer days in intensive care.

A research conducted by Dr. Katie Roach at Norton revealed that those who spend fewer days in the intensive care unit reap the most benefits from the education programs. Set to determine the effect of palliative care screening, Dr. Roach's study employed the use of a palliative care screening tool to help identify critically-ill patients with the need for palliative care. The outcome of the study demonstrated that there is a significant number of patients who are not receiving palliative care programs yet would greatly benefit from palliative care educational programs. This points to the need for palliative care screening tools and protocol to increase the number of palliative care consults among the patients. The current study builds on Dr. Roach's work by investigating the need for palliative care educational programs. The provision of palliative care screening tools alone would not increase the number of consults if the patients and their family remain uninformed of certain aspects of palliative care. For instance, patients and their family need education on the benefits of palliative care, how to use the screening tools, and the possibility of not receiving palliative care when necessary. A growing body of literature shows that a majority of patients with chronic diseases rarely notice when they need palliative care because they have become accustomed to the chronic condition. Hence, this study was conducted to identify if education would increase the volume of palliative care consults by increasing awareness among patients and their family.

Conceptual Framework

A majority of jurisdictions use Wagner's Chronic Care Model (CCM) as the foundation for chronic disease care paradigms. Those paradigms comprise various interdependent components: (1) collaboratively helping clients and their families acquire the skills and

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confidence to manage their chronic illness; (2) providing self-management tools; (3) routinely assessing problems and accomplishments; (4) productive interactions between patient. The integration of all these factors ensures a significant improvement in the care outcomes.

Therefore, Wagner's CCM is one of the most effective methods to use in the integration of patient and family education (Chronic care model, 2006). This model serviced as a great structure to facilitate education amongst this population. This model worked well with this study in that it allowed both the nurse and the patient to become aware of palliative care options.

Informing both the nurse and the patient in this study, provided collaborative education.

Education provided to the nurse, will allow for the capability for extended teaching to the patient and family. With this knowledge, the nurse and patient can make an informed decision that will hopefully lead to a better outcome. The aim of this study is not only educating but also providing better outcomes for this population. This method worked well with this study, although, including practitioners in the educational session would be beneficial to look into with future studies.

Cost-Effectiveness of Palliative Care

The most common metric for gauging the success of cost containment and reduction in hospital length of stay. Reducing the length of stay produces large savings. The evidence has been that by discharging patients more quickly, hospitals reduce overall health care costs, even if patients continue to receive care on an outpatient basis. The length of stay directly affects the total and indirect costs of care. The extended length of stay may be unnecessary and prolonged by failing to establish a plan of care early upon admissions, administering aggressive treatment, or failing to establish a family meeting. Discharge planning is the key to limiting the length of stay (Dietrich et al., 2010).

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The study by Dietrich et al. (2010), found out that most patients would prefer not to die in hospitals and not to die in an intensive care unit. In this study, Dietrich et al. (2010) focused on identifying goals of care and treatment preferences and found reductions in the use of intensive care for patients who died in the hospital. Nurse-based and interdisciplinary palliative consultations that focused specifically on the intensive care setting, have been shown to produce similar reductions in intensive care length of stay (Dietrich et al., 2010).

According to Cassel et al (2015) palliative care teams that are not limited to only intensive care units, can produce appropriate care for patients and family. Palliative care teams were found to produce cost savings across hospital settings. The findings by Cassel et al. (2010) support the delivery of palliative care consultation to seriously ill hospital patients, regardless of location in the hospital. Finally, according to Dietrich et al. (2010) patients who survived hospitalization, palliative care teams not only were associated with lower costs but also helped identify safe and sustainable discharge options.

Improvement of Palliative Care Transitions

Palliative care programs promote the delivery of coordinated, communicated, and patient-centered care by directing hospitals, specialists, and procedures. The motivation for the implementation of palliative care programs includes financial gain for the quality of care, better training in the management of patients with chronic illnesses, stronger primary care organization, and better financial and structure between the acute and the post-acute care settings for health care. Palliative care programs are invaluable by addressing pain and symptoms that might otherwise increase hospital complications and lengths of stay, meeting with patients and families to establish clear care goals, tailoring treatments to those goals in consultation with the patients and their families, and developing comprehensive discharge plans. Both hospital and

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community-based palliative care can reduce costly and preventable hospitalizations, readmissions, and emergency department visits (Brody et al., 2010). More hospital admissions will go directly to the palliative care service instead of a high-cost intensive care unit (ICU). Patients not benefiting from an ICU setting are transferred to more supportive settings and non-beneficial or harmful imaging and painful procedures are avoided (Brody et al. 2010).

Early Communication

Palliative care helps the patient and the family to communicate better with each other and with health care professionals. It helps them identify the priorities and set goals for the future that can lead to a meaningful life for both the patient and themselves. Gries et al. (2008) reveal that palliative care ensures the care of the patient's wishes and meets the emotional and spiritual needs of the patient. The needs caused by the disease are better understood by the palliative care team members as they are able to spend time with the patient, and their services can be utilized both during treatment and also at the end of life.

According to Bruera et al. (2015) and Gries et al. 2008), patients who were referred to palliative care earlier and as outpatients had improved quality of care compared with those who were referred late and as inpatients, with lower quantities of patients having emergency room visits, hospitalizations, and ICU admissions. The findings support the need to increase early palliative care services to improve the process of palliative care referral. Bruera et al. also noted that a large proportion of patients received aggressive care at the end of life. According to Bruera et al., patients who reported having had end-of-life discussions had improved medical use in the last week of life, such as decreased ICU admission, ventilator use, and resuscitation and increased hospice referral. Also, Block et al indicated that end-of-life discussions that occurred earlier were associated with improved end-of-life outcomes. Early palliative care discussions

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play a key role in simplifying discussions.

The overall consensus according to Bruera et al. (2015) and Block et al. (2010) is that early palliative care is associated with improved end-of-life outcomes. Early involvement allows patients to develop a beneficial relationship with the palliative care team over multiple visits. This will assist many important discussions, such as goals of care and advance care planning. Also, early involvement allows the discovery of symptoms such as pain and depression through routine screening, early interventions, and patient education can help reduce the risk of health decline from overwhelming symptoms that require emergency room visits and hospital stays, which are particularly common at the end of life (Bruera et al., 2015 and Block et al., 2010). Palliative care can address a broad range of issues, integrating an individual's specific needs into care. Implementing education on palliative care is expected to improve access to palliative care services. The focus includes the number of patients receiving palliative care consults, number of days from admission to consultation, length of stay, and patient disposition at discharge.

Purpose

The purpose of this study was to determine the effectiveness of a palliative care education intervention, in improving the identification of patients with a high likelihood of unmet palliative care needs. Education occurred or took place at Norton Audubon Hospital (NAH) within the emergency department (ED) and surgical/oncology (4W). The nurses on these units received education regarding palliative care in the adult chronically ill inpatient population, assessing knowledge and perceptions. The specific aims of this study were:

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- Specific Aim #1: to educate Norton Audubon Hospital (NAH) ED and 4W staff nurses on the rationale of palliative care in the adult chronically ill inpatient population, assessing knowledge and perceptions related to palliative care.
- Specific Aim #2: to identify a number of patients in the participating units with a palliative care consult before education and after education implementation.

In order to achieve these aims, this study had three objectives:

- Objective #1: To measure baseline knowledge of nursing staff, at NAH within the emergency department and 4W units. This was measured with a pre-assessment tool of their knowledge on palliative care. Education was implemented after baseline knowledge obtained. This process took place in July 2018.
- Objective #2: To measure the volume of palliative care consults at NAH, within the emergency department and 4W between May 1, 2018, and September 27th, 2018. Measuring the statistical comparison of the pre-assessment and post-assessment data to determine if an educational intervention has the potential to improve access to palliative care services in this patient population.

Methods

This study was an interventional, retrospective report of the impact of palliative care education on the acquisition of knowledge and provision of quality palliative care. The study employed a retrospective quasi-experimental pre and post-test descriptive design to evaluate the use of an educational tool in identifying patients with unmet palliative care needs and improving access to these services.

The first phase involved the participating nursing staff from Norton Audubon (NAH) in

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the Emergency Department (ED) and 4W. The second phase of the study involved a chart review of palliative care consults placed and nursing staff post assessment knowledge. Phase one of the study nurses attended a face-to-face informational session that was built into their standard “shift starter” meeting, this occurred July 19, 2018. These meetings occurred daily with each oncoming shift at NAH, ED, and 4W. This educational session occurred for both day and night shift staff on four consecutive days. A signed consent for participation in the study and a baseline/pre-assessment of knowledge and perceptions concerning palliative care consults was obtained. A copy of the signed consent was provided to participating nurses. The education for participating staff nurses included the rationale of palliative care consults. Educational rationale for use of the palliative care was covered verbally. Participating nurses were asked to complete a demographic questionnaire that would allow for analysis of unit demographics, education and experience level. Again, the face-to-face research procedure just described occurred on four consecutive days to reach both day and night shift nurses during sessions. The post-assessment of phase two occurred September 2018. This phase evaluated the adherence to education implemented in phase one. The records of all patients with a palliative care consult on these two units were collected between the time frame of May 11, 2018, and September 27, 2018, for a comparison of consults placed.

Setting

Norton Healthcare is comprised of five inpatient hospitals in the Louisville, Kentucky region. Of the five hospitals within the hospital system, Norton Audubon Hospital was chosen as the site for this study Norton Audubon Hospital, located in Louisville, is a 432-licensed bed acute care hospital. This hospital was chosen as the site for this study because it is the newest location in the Norton Healthcare system with a palliative care team.

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Sample

The sample for the nursing staff education phase of this study consisted of 24 nurses on 4W and 22 within the ED at Norton Audubon Hospital, for the pre-assessment baseline data. The study sample for the post-assessment data consisted of 20 of the same participating nurses on 4W and 20 for the ED at Norton Audubon Hospital. Some participants did not return to take the post-test. The population of interest was Norton employed nurses who worked on either 4W or ED at Norton Audubon Hospital. The study timeframe spanned between May 11, 2018, and September 29, 2018. A secondary sample included in-patients admitted to 4W and ED at Norton Audubon Hospital, during the specified study timeframe and patients aged eighteen years or older. Exclusion criteria for patient record to be used in the study: patients admitted to other units at Norton Audubon Hospital and patients aged less than eighteen years.

Data Collection

Approvals from the University of Kentucky Institutional Review Board (IRB) and the Norton Healthcare Office of Research and Administration (NHORA) were obtained prior to the collection of data. Electronic medical records for patients that met inclusion criteria for this retrospective chart review were identified by the Research Compliance Analyst at the Norton Healthcare Research Office. All patient records were obtained from the Norton Hospital electronic patient database. Each medical record was accessed electronically using the Medical Record Number (MRN). Demographic data were obtained from nursing staff that participated during face to face meetings. This data was then transferred to an electronic spreadsheet. All demographic variables examined in this study are listed in (Table 1).

Data Analysis

Descriptive statistics were used to analyze demographic data for the study sample. The

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categorical variables sex, ethnicity, and years of experience were described in terms of frequencies and percentages. Continuous outcome variables were compared using independent sample t-tests. A chi-squared test for independent samples was used for categorical variables, with Fisher's exact test used in comparisons with values of less than five in any cell. The Mann-Whitney U-test was used to compare total correct answers with the pre and post-test assessment. All data analysis was conducted using SPSS, with the alpha value of 0.05 used to determine statistical significance.

Results

Sample Characteristics

The sample consisted of 24 nurses on 4W and 22 within the ED for the pre-assessment. The study sample for the post-assessment consisted of 20 of the same participating nurses on 4W and 20 for the ED. The nurses ranged in age from twenty-five to forty-six, with a mean age of thirty-three and a standard deviation of 6.2 years for 4W. The study population consisted slightly less than half Caucasian nurses (41.6%) with the next prominent, African American nurses (29.2%). Experience ranged from one to four years, with a mean of 3.2 years. More than half of the nurses within 4W had a bachelor's degree (66.6%). The ED had a mean age of thirty-one with a standard deviation of 5.3 years. The study population was primarily Caucasian (68.2%), and a majority of nurses were female (90%). Caucasians were the majority (68.2%) and African Americans following closely after (27.3%). The years of experience ranged from one to four years, with a mean of 3 years. Most obtained a bachelor's degree (86.4%). The demographic characteristics of the study sample are displayed in (Table 1).

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The study sample of 69 patient medical records was reviewed for this study. All patients were included if received a palliative care consult at an Audubon hospital within 4W or ED within the timeframe of May 11, 2018, and September 29th, 2018. Data characteristics are displayed in (Table 2).

Education

Of the 24 nurses on 4W, 58.3% answered the pre-assessment questions correctly prior to education. The sample of 20 nurses on 4W had a post-assessment score of 85.0%. This score reflects post education implementation. The sample of 22 ED nurses, yielded a pre-test score of 63.1% correct answers and 88.3% post-test answers. A chi-square test was performed on this data to determine if there was a statistically significant difference between the pretest and post-test. This was statistically significant (Sig. value = 0.05, indicating that there is a statistically significant association between using an educational implementation tool versus not using a tool for palliative care education.

Palliative Consults

A time cross tabulation was performed to separate consults placed on patients admitted to 4W and ED during the timeframe of May 11, 2018, and September 27, 2018. This data was separated per the pre-implementation and post-implementation period. During the pre-implementation period, there were a total of 36 consults placed on both units. These consults were measured during the timeframe of May 11, 2018, and July 19, 2018. After July 19, 2018, the education tool was implemented. The consults placed were measured during the timeframe of July 19, 2018, and September 27, 2018. There was a total of 33 patients with palliative consults. A reduction in the number of consults after the education program does not reflect the real outcome of the study.

Discussion

The two groups had a significant statistical difference ($p < 0.05$), which makes the differences in the findings statistically significant, regarding education, but not consults placed. The first assessment conducted revealed that nurses, both in the ED and 4W had inadequate knowledge of palliative care. The difference is seen in the outcome of the pre and post-training period. Before the training, both participants had limited knowledge on the best process for providing palliative care needs. For instance, for the ED nurses, their pre-test score was 63.1% while their post-score was 88.3%. Therefore, following the education program, the knowledge level of the 22 nurses tested improved by 25.2%. A similar trend also occurred among the 4W nurses. The respective scores for pretest and posttest were 58.3% and 85.0%. The nurses in the 4W showed an improvement in the knowledge in palliative care by 26.7%.

These findings relate to the outcome in most studies. Education is one of the factors that contribute to an improvement in nurses' performance. When nurses enter the workplace, they have to acquire different skills, from those learned in school. Therefore, constant training helps them to acquire adequate knowledge, which they can use to improve the level of palliative care offered to patients.

As per the results of palliative care, the number of consults made before the training was 36 patients (52%), whereas after the training, the number reduced to 33 patients (48%). The reduction may not have relation to the impact of education. Although, this study shows that more education, or different process might be more beneficial for consults placed. Factors such as the small number of nurses educated, with the short study period, this may not have fully reflected the knowledge gained or to be applied. Also, different learning methods may have

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improved the number of consults. Also, another consideration that could have had an effect, is that not only a small group of nurses were educated, no practitioners were educated during this study. As for Norton, all consults are ordered per the practitioner, although it can be initialized by the nurse, the final say so, will be determined by the practitioner. Not having both the practitioner and nursing staff collaborating may have affected the consult numbers as well. Moving forward to future studies, comparing actual consults placed with a chart review of patients that qualify for palliative care, using a screening tool, would be beneficial. This would measure the actual patients that may have been over looked.

As the outcome of this study shows, training nurses contributes to an increase in the level of knowledge acquired in palliative care but it did not increase palliative care consults. The respondents to the questions had some knowledge on palliative care. Hence, a significant number managed to average scores during the pre-test. However, they only had general knowledge on the provision of the palliative care, a factor that made it difficult to determine accurate consults placed. Improved values for post-training are an indication that the participants had acquired new knowledge of palliative care.

The level of education also determined the outcome of the study in each department. All the participants were categorized into either ADN or BSN. The 4W department had a high number of ADN nurses (33.3%) compared to 13.6% in the ED. On the other hand, the ED department had the highest number of nurses with a BSN qualification at 86.4% whereas the 4W department has 66.6%. Due to these differences, the post-test score in the ED was 88.3% compared to 85.0% in the 4W department. These differences show that advancement of education or level of knowledge contributes to improvement in the quality of palliative care. These findings related to a study conducted by Balicas (2018), which proved that the level of

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nurses' knowledge determines the quality of palliative care offered to patients. According to Balicas (2010), only nurses with adequate education in palliative care are allowed to offer palliative care services to patients. It's important for nurses to recognize and understand how to provide needs, especially to patients with chronic diseases and those nearing their end of life. Such patients require patient-centered care, which will ensure they get love, compassion and develop a strong mental health, factors that will ease the pain. Therefore, with adequate training, nurses can acquire skills on how to provide palliative care to patients. It's important to be able to identify patients with palliative care needs. Thus, through the educational program, the majority of nurses understood factors to consider when identifying patients that require palliative care. The first step for assessing their needs is through intensified consultation. During this phase, nurses need to inquire about the patients' health history, the onset of the medical condition and the type of care they have been receiving. As Balicals (2018) notes, nurses need to establish the best-personalized approach for caring for the patients through the consultation process. In this study, it was difficult to determine the number of successful consultations due to not being able to formally identify or do a chart review of the population of patients admitted during the given timeframe. In essence, the knowledge acquired in this study can help to establish the best methods and strategies for providing personalized care to the patients who require palliative care, although this does not significantly help with consultations placed.

Limitations

There were several limitations related to the design of this study. This study was conducted using data collected from the population of one acute care hospital within the Norton

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Healthcare system. In addition, the retrospective descriptive design of the study only obtained consults placed during a specified timeframe. The retrospective design of the study only extracted consults on patients after discharge, which may have lessened the accuracy of screening tool results. This study demonstrated that the implementation tool for palliative education would likely improve the identification of patients that would benefit from palliative care services, but further research is needed to verify this impact and optimize the educational tool. The study involved a relatively small group of nurses, which might not provide a fair representation of the whole unit. Hence, the outcome of the study cannot be adequately relied upon to have a conclusive view of the palliative care consultations. Additionally, some of the respondents in the pre-assignment did not turn out for the post-assessment, which imposes a disparity in the findings of the study. The other limitation of the study is that the participant nurses did not have adequate authority to place consults in the absence of or without the approval of healthcare providers. This could have impacted the data in places where the respondents were not able to conduct the consults as per the specifications of the study.

Recommendations for Future Studies

Recommendations for future studies would involve organizational outcomes after an educational tool is implemented. Palliative care has shown improvement in patient outcomes that were not addressed in this study, prioritizing patient goals with treatment plans, and patient and family satisfaction. The timing of palliative care consults would ensure that the greatest number of patients with unmet palliative care needs are identified and achieve the best results for patients and the organization. The collaboration of both nursing staff and provider would benefit the the study results within the organization. The ability to screen for potential patients to measure

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against actual consults placed. This would allow a clear vision of which patients are being overlooked, that are becoming admitted more frequently than necessary. But furthermore, there is much need on the cost-effectiveness of a palliative care program.

Conclusion

The palliative care educational tool applied to this study was effective for education, not consults. As per the findings, the level of knowledge improved following the implementation of the education program. Unlike the pretest scores, nurses working in the ED and 4W departments showed improved post-test scores. The implication of the education tool led to the acquisition of new knowledge on the best methods for identifying patients requiring palliative care and how to meet their needs. However, it was difficult for the tool to identify the number of patients who were possibly overlooked, for potential consults. Nevertheless, the study helped to identify a gap existing between the level of education offered to staff nurses and consults for patients that require palliative care. Education is an important tool to implicate, as it can produce communication skills that can help healthcare workers interact well with this patient population. Although beneficial, further research should focus on the provision of the best educational tools for both nurses and practitioners for identifying and collaborating with patients that have unmet palliative care needs.

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Table 1. Demographic Characteristics of the Sample at Baseline

	4W (n=24)	ED (n=22)
	<i>Mean (SD) or n (%)</i>	<i>Mean (SD) or n (%)</i>
Age in years	33.0 (6.2)	31.5 (5.3)
Gender:		
Male	6 (25.0%)	2 (10.0%)
Female	18 (75.0%)	20 (90.0%)
Race:		
White	10 (41.6%)	15(68.2%)
African American	7 (29.2%)	6(27.3%)
Indian	3 (12.5%)	0(0.0%)
Hispanic	4 (16.7%)	1(4.5%)
Years' experience:	3.2 years	3 years
Degree:		
ADN	8(33.3%)	3(13.6%)
BSN	16(66.6%)	19(86.4%)

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Table 2. Palliative Consults: (May 11, 2018 - September 29, 2018)

location		Pre- assessme nt	Post- assessme nt	Total
AUD 4W MED/SURG ONC		29	27	56
AUD ED		7	6	13
Total		36	33	69

Figure 1. Pre/Post Results

