2020

Getting the End of Life Care Conversation Started

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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Lisa McCabe-Evans, CNP

MSN, Walden University, 2018

BSN, Winona State University, 2010

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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November 2020

Abstract

Education is needed among the health care collaborative team to address the lack of end of life conversation, the underutilization of hospice leading to patients' end of life wishes not being met, the increased depression among bereaved loved ones, and the increased health care costs at the end of life. Nurses reduce the patient's physical and emotional stress by helping guide conversations and answer questions to meet the needs of patients and their loved ones. This project addressed the practice-focused question to determine if nursing knowledge and expressed intentions about end of life care increase as shown via the difference between pretest and posttest scores following an educational event addressing hospice care and end of life conversation. Based on an exhaustive search of peer-review literature, the education program was developed using the theory of reasoned action and followed the analysis, design, development, implementation, and evaluation (ADDIE) model. Eight nurses attended a 1 hour Zoom educational event to include a PowerPoint, video, and open discussion. Descriptive statistics were used to describe findings. The mean change in pretest (M = 57.5%) and posttest (M = 92.5%) item scores suggests that education was effective in increasing knowledge. Expressed intentions related to getting the end of life care conversation started also increased by an average of 40% to 60%. Staff education to prompt early end of life care conversations has potential to create a positive social change by addressing individuals' end of life wishes, increasing early hospice admission, avoiding admission to the intensive care unit, lessening bereaved family depression, improving quality of life, and decreasing cost related to end of life care.

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Dedication

To my dad, Mark McCabe and Dr. Atul Gawande who taught me that everyone's wishes are different and should be respected. Ask the question and respect the answer.

Acknowledgments

Thank you, Dr. Susan Hayden, for the countless hours, your dedication, and leadership. I have learned so much. Dr. David Sharp your input has been invaluable. Thank you.

To my family, Bryan, Abi, Avery, Aiden, Axl, and mom, I could not have done this without you and your support. Thank you, for all of your sacrifices you have made to make this a reality. I cannot thank you enough, all my love and thanks to you.

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Introduction

The lack of end of life conversation and the underutilization of hospice has led to patients' end of life wishes not being met; moreover, when not having had the conversation, bereaved family members have an increase in depression (National Hospice and Palliative Care Organization [NHPCO], 2016). Ninety-two percent of Americans believe it is important to have the end of life conversation with their loved ones, but only 32% have had the conversation (Institute for Healthcare Improvement [IHI], 2019). Eighty percent of patients want to have the end of life conversation with their provider; unfortunately, only 18% have had the conversation (IHI, 2019). Advance care planning is one aspect of the end of life conversation and is defined as making decisions based on personal values, preferences, and discussions with loved ones about the care patients would want to receive if unable to speak for themselves; having the conversation, thus increasing communication about individual goals, values, and preferences, can improve the quality of care received by patients in end of life.

Advance care planning includes patients receiving information on the types of life-sustaining treatments available, deciding which of these treatments they would or would not want to undergo if diagnosed with a terminal illness, and completing advance directives that put these wishes in writing (NHPCO, 2016). According to the Henry J. Kaiser Family Foundation (2016), before 2016, advance care planning discussions with a primary care provider would only be paid by Medicare if the discussions were conducted during an appointment made for another reason. As of January 1, 2016, Medicare began providing financial coverage for advance care planning conversations with primary care providers and the collaborative team.

It is vital that nurses are armed with the education and tools to assist patients and loved ones about getting the end of life conversation started (American Nurses Association [ANA] Center for Ethics and Human Rights, 2019). The literature supports the need for early end of life conversations (IHI, 2019). Despite the literature, a gap in practice has been identified. A lack of conversations exist about end of life wishes and underutilization of hospice despite literature showing the need for communication with loved ones and providers about patients' wishes at the end of life (NHPCO, 2016). Staff education should bridge this gap in nursing practice and create a positive social change by addressing individuals' end of life wishes, lessening bereaved family depression, improving quality of life, and decreasing cost related to end of life care (Gawande, 2014).

Problem Statement

The practice problem that I addressed in this DNP project was the lack of end of life conversation and the underutilization of hospice leading to patients' end of life wishes not being met, bereaved family members having a higher rate of depression, and increased costs at the end of life (NHPCO, 2016). In 2019, the United States' national percentage of patients older than 65 years who were in hospice during their last 6 months of life was 54.4% (American's Health Ranking, 2019). Minnesota's percentage of patients older than 65 years who were enrolled in hospice during their last 6 months of life was 54.8%. Locally, the percentage of patients older than 65 years enrolled in hospice at their time of death is 45% (Medical Director, personal communication, January 10, 2020).

I have a diverse nursing background from critical care to long-term care and have witnessed firsthand the gap in practice and the need to have end of life wishes known. The gap was even more evident after talking to the key stakeholders, to include local long-term care and hospital facilities' directors of nursing, administrators, social workers, clinical managers, staff nurses, and nursing assistants. For instance, some residents and families are so uncomfortable and unprepared when talking about advance care planning that it can take multiple conversations with multiple health care providers, at times more than a couple weeks, to complete the end of life conversation with an admission to the long-term care facility (personal conversation, administrator, June 8, 2020). One element of advance care planning is to have a completed physician's order for life-sustaining treatment (POLST) form on admission to the long-term care facility. The local long-term care and inpatient facilities face some challenges; one example was seen during an interdisciplinary group meeting when a novice geriatric nurse practitioner cried as she told her story about two of the prominent primary care providers blatantly telling her she had no right to refer their patients to hospice care; these two primary care providers also informed nursing staff not to listen to the nurse practitioner. The community is challenged with hospice being a taboo subject, a deficiency in patient and providers' knowledge, and absence of patients making their wishes known; all of these challenges can be resolved through education and advance care planning or making end of life wishes known.

Getting the end of life conversation started holds significance for the field of nursing because it empowers nurses to be competent and more comfortable in the end of life discussion; competence leads to improved job satisfaction (Biagioli et al., 2018). Clear end of life wishes also would lead to a clear plan of care to facilitate collaboration between loved ones, the health care team, nurses, and patients (Kim et al., 2015).

Purpose

The gap in practice identified for the doctor of nursing practice (DNP) project, Getting the Conversation Started: A Staff Education project (GCS-SEP), was the lack of conversation about end of life wishes despite literature showing a need for communication with loved ones and providers about patients' wishes at the end of life (Lowry, 2015). An increasing number of older people are dying in the hospital; however, these hospitalizations may be against the patient's desires and will not improve the patient's condition or cure their disease, or the patient and family do not know or comprehend that their loved one was in their last phase of life (Ahearn et al., 2012). Having the end of life care conversation with loved ones and providers would address advance care planning and hospice. Referrals are an ongoing issue with patients enrolling in hospice care at late stages, resulting in unmet needs for patients and families. Education is needed among the health care collaborative team for earlier access to hospice care (Osta et al., 2008), which could be introduced in the end of life conversation. Discharging a dying patient from the hospital without hospice services set up, which may include the provision of equipment and medications, has been reported as an issue for patients dying in the hospital instead of at home where they want to be. The end of life conversation would address these issues.

The purpose of this GCS-SEP was to develop and implement a staff education program that increased knowledge and provided an educational program to raise awareness and knowledge of nurses on initiating the end of life conversation with patients, their loved ones, and providers. The practice focused question that guided this GCS-SEP was: In a long-term care facility, will nursing knowledge and expressed intentions about end of life care increase as shown via the difference between pretest and posttest scores following an educational event addressing hospice care and end of life conversation?

Through the GCS-SEP, I provided nurses with the education and tools to begin the end of life conversation. An educational event was an appropriate method for closing this gap and provided an answer to the practice focused question, yes knowledge and expressed intention did increased after a staff education event on getting the conversation started. The literature supports early and honest communication with providers about the patient’s wishes; early hospice admission, avoidance of intensive care admissions, and death at home have higher patient and family satisfaction and less long-term depression for the family members during bereavement (Gawande, 2014). Educating the licensed nurses at the long-term care facility on getting the end of life care conversation started could improve end of life issues (NHPCO, 2016) and increase nurse job satisfaction (Biagioli et al., 2018).

Nature of the Doctoral Project

Sources of Evidence

After little success in obtaining pertinent, available articles using The Kruger library, Wiley Online Library, and Google Scholar, I began a literature search through Walden University Library using CINAHL, Google Scholar, Cochrane, Wiley Online Library, CINAHL plus EBSCO, PSYCHINFO, Walden University online library, and PUBMED. Articles were limited to full text, between 2010 to 2020. Search terms were as follows: *hospice* AND *referrals* OR *home* OR *die* and *education* OR *advance care planning*. The selected articles had to meet the criteria that included communication of end of life choices, hospice referrals, advance care planning, statistics on hospice, and studies from the United States because I wanted the culture to be similar to the audience. I used two articles from the United Kingdom and one from Japan because they were closely connected to education with end of life care and relevant to the GCS-SEP. After an exhaustive literature review, I selected 30 articles for use in the GCS-SEP. I graded the selected literature using the Melynk and Fineout-Overholt’s (2011) grading tool and arranged in a literature matrix (Appendix A).

All individuals deserve a good death. Most individuals would describe a good death as dying at home with family and friends and without stressful physical symptoms such as nausea, vomiting, pain, dyspnea, respiratory tract secretions, anxiety, and agitation (Garfield, 2014). Early hospice referrals, avoidance of intensive care admissions, and death at home are associated with increased patient satisfaction and a decrease in depression for loved ones during bereavement (Gawande, 2014). Education is needed among the health care collaborative team for end of life conversations to start and to make end of life wishes known so they are more likely to be met (Osta et al., 2008), thereby increasing the likelihood of patients having a good death (Garfield, 2014).

Approach or Procedural Steps

The GCS-SEP aligned with Walden University's manual for staff education following the analysis, design, development, implementation, and evaluation (ADDIE) model (Jeffery et al., 2015). The first step in this GCS-SEP was to analyze the gap in nursing practice to include conducting a needs assessment. I identified the key stakeholders and I conducted discussions about the gap in nursing practice. During this discussion, I decided that education would be the best approach to address the gap in nursing practice because a deficiency exists in education and available tools for nurses to get the end of life conversation started.

The next step, development, was gathering sufficient peer-reviewed data supporting the nursing gap. I assembled education materials following the Walden *Staff Education Manual*, to include a curriculum plan with a teaching module. The teaching module included the documentary *Being Mortal* (Jennings, 2015), and I developed a PowerPoint based on the current literature, as well as the IHI conversation starter kit (2019). I included a format for an open discussion about making end of life wishes known to providers and loved ones. I developed a pretest/posttest (see Appendix B) based on the teaching module and selected a team of content experts to evaluate the teaching materials to include content validity on the pretest/posttest and a summative evaluation. I was able to apply for and give continuing education (CE) credit hours (see Appendix C) from the state board of nursing through the facility for the nurses who attended the educational event and completed the necessary paperwork after obtaining site agreement and Institutional Review Board approval from Walden University.

After I completed these initial steps, the implementation phase included changes to the teaching materials based on the input from the content experts until consensus was reached. Once the materials were approved, I shared them with administration for final approval. After the materials were fully approved, I conducted the education event, collected the data from the pretests and posttests, and analyzed the data (evaluation). Essentially, my long-term goal is to get the conversation started and educate all individuals about end of life care options. I envision the conversation to be on a continuum. Individuals’ lives change, and priorities and goals transform; therefore, the conversation not only needs to be started but also perpetual to adapt to people’s lives (IHI, 2019). This GCS-SEP was the first phase of my vision, to increase knowledge and provide tools for nurses to be more comfortable and competent to initiate the end of life conversation with patients, their loved ones, and providers. The education addressed the lack of conversation about end of life wishes and the underutilization of hospice, presented statistics and different ways to make end of life wishes known, and provided examples and tools on how to get the conversation started. This education should improve the communication with loved ones and providers about patients’ wishes at the end of life (NHPCO, 2016). Nurses are more prepared and comfortable in starting the discussion and ready to have the conversation with each admission. The open discussion after the event provided a platform for nurses to ask questions and share their stories that added to the discussions on the concerns of patients’ end of life wishes not being met and depression of bereaved family members.

Significance

Key stakeholders included the director of nursing, nurse manager, administrator, medical director, licensed staff, residents, and their loved ones of the long-term care facility. Caring for patients during end of life can be challenging at various levels, especially when education is lacking (Martins-Pereira & Hernadez-Marrero, 2016). Nurses benefited from this GCS-SEP with increased knowledge, confidence, and job satisfaction; nurses need to perceive themselves as effectively demonstrating their competence as nurses (Biagioli et al., 2018). Professional competence empowers nurses, with nurses reporting more confidence in preforming their job duties, feeling more prepared, and considering their jobs less demanding and more rewarding. All individuals benefited from this GCS-SEP through improved quality of life for themselves and family members during the last stages of their loved one’s life. Those who will benefit the most are dying patients and their loved ones, along with the nurses caring for these amazing patients.

Not only does having the end of life conversation significantly help nurses, patients, and their loved ones but will also decrease a significant financial burden by decreasing end of life costs (Kirolos et al., 2014). While studying for this GCS-SEP, I had a conversation about hospice with a few providers at a local hospital. One interesting comment about cost was from a local provider who is also a hospital board member (personal conversation, October 17, 2017) who said, “The 10 patients that cost this hospital the most amount of money were deceased within the year." This was not stated in a derogatory way, only adding to the conversation about hospice and the significant decrease in cost.

Contribution to Nursing

This GCS-SEP contributed to the field of nursing because it empowered nurses to be competent and more comfortable in the end of life discussion; competence leads to improved job satisfaction (Biagioli et al., 2018). Clear end of life wishes also lead to a clear plan of care to facilitate collaboration between loved ones, the health care team, nurses, and patients (Kim et al., 2015).

Transferability

This GCS-SEP is readily transferable to all nurses in all settings, regardless of where they work, because the need for the end of life care conversation and the need for patients to make their end of life wishes known to their providers and loved ones are the same in all settings. This GCS-SEP has the potential to be transferred to staff education and orientation for critical care nurses, long-term care nurses, medical-surgical nurses, hospice nurses, and in-home care nurses in other facilities and by other staff. This GCS-SEP is more than transferable; it is inclusive, broad, and varied. This GCS-SEP should improve nurses' job satisfaction and increase patients' end of life wishes being met; this is also true in all settings. Moreover, this GCS-SEP could decrease the depression of bereaved family members, not to mention decrease health care costs.

Social Change

Walden University describes positive social change as a method of creating and implementing concepts to promote the development of communities, cultures, and societies. This GCS-SEP supports Walden’s social change statement by getting the end of life conversation started and bringing patients and families closer to their loved ones. Early hospice admission, avoidance of the intensive care unit (ICU), decreased costs, and death outside the hospital are associated with excellent end of life care (Amano et al., 2015; Lowry, 2016), providing a positive social change. Still, an increasing number of older people are dying in the hospital instead of at home where they want to be (Ahearn et al., 2012). Four out of 10 patients are allowed to die at home when nine out of 10 want to die at home (Adams, 2015). Early and honest communication with providers about the patient’s wishes and carrying out those wishes provide higher patient and family satisfaction and less long-term depression for the family members during bereavement (Gawande, 2014), all leading to improved quality of life. Not only does having the end of life conversation significantly help patients and their loved ones, but the conversation will also decrease a significant financial burden.

Summary

The gap in practice identified for this GCS-SEP was the lack of conversation about end of life wishes and the underutilization of hospice despite literature showing a need for communication with loved ones and providers about patients’ wishes at the end of life (Lowry, 2015). Advance care planning not being completed, the lack of education for nurses about starting the end of life conversation, and the underutilization of hospice have led to end of life wishes not being met for our patients. I addressed this gap through answering the practice focused question that will drive the GCS-SEP: In a long-term care facility, will nursing knowledge and expressed intentions about end of life care increase as shown via the difference between pretest and post test scores following an educational event addressing hospice care and end of life conversation?

Nurses benefited from this GCS-SEP with increased knowledge, confidence, and job satisfaction. Not only does getting the conversation started significantly help patients and their loved ones, but it will also decrease financial burden. Through this GCS-SEP, I armed nurses with the materials necessary to initiate the end-of life conversation with patients, which they previously lacked. In the next section, I address the theory and model that will inform the GCS-SEP along with the relevance and provide a summary of the local background and my role as the DNP student.

Section 2: Background and Context

Introduction

The practice problem that I addressed in this GCS-SEP was end of life wishes not being met for patients due to their end of life wishes not being made known to the patient’s loved ones (IHI, 2019). Despite documented evidence on the need for communication with loved ones, a gap in practice exists related to starting the end of life conversation with family members and caregivers regarding end of life wishes. Thus, the purpose of this DNP project was to develop and implement an education program for nurses on evidence-based approaches for initiating end of life conversations with family members and caregivers. More specifically, I designed this project to answer the practice-focused question: Will a nursing education program improve the knowledge of staff nurses on end of life care? By developing and implementing an education program, I raised awareness and knowledge of nurses on initiating the end of life conversation with patients, their loved ones, and providers. Educating the nurses at the long-term care facility on starting the end of life care conversation improved end of life wishes being met (NHPCO, 2016) and is anticipated to increase nurse job satisfaction (Biagioli et al., 2018). In this section, I discuss the theory and model that informed the GCS-SEP along with the relevance of the gap in nursing practice and provide a summary of the local background. Moreover, I address my role as the DNP student along with my motivations to address this gap in practice.

Theory and Model

The ADDIE Model

I used the ADDIE (Jeffery et al., 2015) model to guide the development of the education materials. In 1975, the ADDIE model was created by the Center for Educational Technology at Florida State University for the United States Army and then by 1981, the rest of the armed forces started to use the model (Clark, 1995). The military is a leader in training and education with a large number of instructional designers so adapting the ADDIE model had a great influence on corporate and educational activities. The 1975 model had five phases and 19 steps; the five ADDIE phases have not changed since 1975 and include analysis, design, development, implementation, and evaluation.

The ADDIE model is a systematic approach and a design for educational events that has been shown to have a positive influence on learning outcomes (Quan, 2018) and has been systematically established from the phase of analysis to evaluation (Malik,et al., 2017). The ADDIE model achieves positive results because the model evaluates as a whole (systematically) and calls for review, revisions, reflection, and feedback for positive influence and evaluation (Quan, 2018). The analysis phase focuses on barriers, resources, and goals of the target audience. The design phase emphasizes the planning, tools, and learning objectives. The development phase concentrates on the model, schedules, teams, and information collected in the analysis and design phases. During the implementation phase, modification and redesign are addressed. Finally, the evaluation phase is the testing to determine if the learning objectives were reached along with the dissemination of the results.

The Theory of Reasoned Action

The theory of reasoned action was developed in the late 1960s and focuses on changing a person's behaviors (White & Dudley-Brown, 2012), associated with the individual's behavior toward their beliefs, attitudes, and intentions. White and Dudley-Brown (2012) defined the variables of this theory as follows:

- Behavior: a specific action or definite conduct that should occur so that the individual recognizes the needed action, for whom, when, and where.
- Intention: the best prognosticator that a conduct will occur and is influenced by attitude and norms.
- Attitude: the individual's positive or negative feelings toward accomplishment of the conduct.
- Norms: the individual's discernment of other's opinion of the actions (p 64).

White et al. (2016) stated if the individual has a positive attitude and feels in control of the change, change is more likely to occur, which is pertinent to the environment of this GCS-SEP. The theory of reasoned action has been used successfully with health-related behaviors and was also effectively used in a study to help bridge the knowledge gap in organ donation (Wong & Chow, 2017). The theory of reasoned action was also used positively in developing a peer enhanced concussion knowledge and reporting program with collegiate athletes (Ernst & Kneavel, 2020). The reasoned action model defines a direct change process that conceives a change in behavior that is reliant on behavioral and normative opinions.

This authors’ supposition was that the nurses staffing the long-term care facility would have a greater likelihood to change if their attitudes and beliefs of the norms were altered after attending the scheduled educational events. I selected the theory of reasoned action (White & Dudley-Brown, 2012) as a framework to guide this GCS-SEP because the theory addresses attitude and the need to feel in control of the change. It was my overall goal in the project that nurses have increased knowledge and expressed intentions about end of life care as shown via the difference between pretest and posttest scores following the educational event addressing the end of life conversation along with the tools to facilitate the discussion. With this knowledge and these tools, the nurses are more confident in starting the end of life conversation.

Relevance to Nursing Practice

Fewer than one-third of terminally ill patients have the end of life conversation with their providers (O’Rourke, 2015). The lack of education for nurses about starting the end of life conversation has contributed to end of life wishes not being met for patients and bereaved family members having an increase in depression (NHPCO, 2016). Education is needed among the health care collaborative team for end of life conversations to start and to make end of life wishes more likely to be met (Osta et al., 2008). This GCS-SEP increased communication about an individual’s goals, values, and preferences; moreover, this GCS-SEP will improve the quality of care received by patients in end of life filling the gap in nursing practice.

Education was needed among the health care collaborative team for end of life conversations to start and to make end of life wishes known so they are more likely to be met (Osta et al., 2008). This GCS-SEP should improve communication about an individual's goals, values, and preferences; moreover, this GCS-SEP should improve the quality of care received by patients at their end of life, filling the gap in nursing practice. If patients choose hospice care, family and caregivers' beliefs in their own ability to complete tasks and reach end of life goals by caring for their own family members will be increased (Kirolos et al., 2014). Next, I discuss existing scholarship and summarize the current state of nursing practice as well as the strategies and standard practices used in nursing as it pertains to making end of life wishes known.

End-of-Life Wishes

More than 90% of individuals say making their end of life wishes known to their loved ones is important, whereas only 30% of these same individuals have made their end of life wishes known to their loved ones (IHI, 2019). Individuals want to die at home, yet an increasing number of older individuals are dying in the hospital (Ahearn et al., 2012). A peer-reviewed study reported that in the United States, more individuals are dying in the hospital than ever before (Nassikas et al., 2020); however, it is acknowledged that the hospitalization is often against the patient's desires and not curative or even to improve the patient's condition, or the patient and family did not know or comprehend the patient was in the last phase of life (Ahearn et al., 2012). In one systematic review (Kirolos et al., 2014), two studies provided education on end of life without advance care planning and two studies assessed the effects of advance care planning programs; the recommendations included end of life education and advance care planning as approaches to address the issue of being able to meet patient's end of life wishes. Patients and their loved ones agonize over psychological harm and have a lower quality of life when unwanted therapies are implemented at the end of life (Nassikas et al., 2020).

Advance Care Planning

Advance care planning is defined as making decisions based on personal values, preferences, and discussions with loved ones about the care patients would want to receive if unable to speak for themselves (NHPCO, 2016). Advance care planning includes patients receiving information on the types of life sustaining treatments available, deciding which of these treatments they would or would not want to undergo if diagnosed with a terminal illness, and completing advance directives that put these wishes in writing. On January 1, 2016, Medicare began financial payment to cover the advance care planning conversation with the primary care provider and the collaborative team; before 2016, these discussions would only be paid by Medicare if they were discussed during an appointment made for another reason (Kaiser Family Foundations, 2016).

Nassikas et al. (2020) reported less than two thirds of chronically ill patients have an advance directive. The POLST is one form of advance care planning found to increase end of life wishes being met when an accurate POLST is completed (Kim et al., 2015). Of nursing home residents who have a completed POLST, 98% also have standing orders regarding medical interventions, antibiotics, or artificial nutrition and hydration, whereas only 16% of residents without a POLST documentation had similar standing orders (Kim et al., 2015). The POLST conversations were associated with increased trust, understanding, and emotional support.

Hospice

Advance care planning can lead to hospice care; hospice is more likely to fulfill patients' end of life needs than when patients do not have services set up at their end of life transition (Kirolos el al., 2014). Amano et al. (2015) completed a retrospective cohort study in Japan and concluded that early end of life conversations were associated with more inpatient hospice care utilization and less aggressive end of life care resulting in a better quality of care, fewer admissions to the ICU, and lower costs. Aggressive end of life care, such as emergency department visits, hospitalizations, ICU admissions, and chemotherapy administration, are associated with poor quality end of life care.

Kirolos et al. (2014) discussed the issue of underutilization of hospice at the end of life despite evidence that hospice care improved patient satisfaction and reduced cost. Secondary outcomes found included the benefits of the presence of advance health care directives and do not resuscitate orders. Interventions that provided advance care planning education to health care providers showed a median increase in referrals of 5% and interventions involving advance care planning in which hospice candidates were identified showed a median increase in hospice referrals of 19.5% (Kirolos et al., 2014). Another study showed that hospice care referrals increased from 8 to 155 after educating case managers on advance care planning (Beyea et al., 2013). According to the NHPCO (2016), the following are the common reasons primary care providers initiate late referrals to hospice:

- fear of telling patient/family that his/her illness is terminal (56%),
- lack of hospice education (39%),

- belief that a cure is possible (28%),
- fear of losing a patient (22%),
- personal beliefs on death/dying (17%), and
- other reasons (e.g., time, money, and Hippocratic Oath; 50%).

The key services hospice provides include pain management, expert medical care, spiritual support, and bereavement support for family members (NHPCO, 2015).

In a qualitative study, interviewing oncologists (Rhondali et al., 2013), 17 oncologists agreed that early referrals to hospice services are preferable but recognized the problems with timing and discussions with patients regarding the referral. Quest and Lamba (2020) found an increased number of cancer patients coming to the emergency room, with over half of adult cancer patients having an emergency room visit within their last 6 months of life and 27% of the visits occurring during their last 2 weeks of life. Having the end of life conversation can minimize these unwanted hospitalizations and increase quality of life (IHI, 2019). Kirolos et al (2014) reported hospice patients live 99% longer than their counter parts not participating in hospice care; Gawande (2014) stated hospice patients live 25 to 30% longer due to the improved quality of life, a positive attitude, how the patient is cared for, and who cares for the patient. Adams (2015) stated that at the end of life, 46% of patients have pain that is never under control. The dynamics of the patient (pain, fear, uncertainty) is compounded by the numerous factors the loved ones bring to the care environment. Discharging a dying patient from the hospital without hospice services set up, which may include the provision of equipment and medications, has been reported as an issue for patients dying in the hospital (Ahearn et al., 2012). Reports of a descriptive research study stated that 23.3% of providers waited until death was imminent before having the first hospice care discussion and 39.9 % waited until death was obviously imminent before talking about where the patient wanted to die (Lowry, 2015). Hospice services, if already in place, can aid in all of these previously discussed end of life dynamic situations, not to mention the patient and family members have a phone number that will be answered by a nurse 24 hours a day 7 days a week.

End-of-life medical care costs are 12% of the national healthcare budget (Brugger et al., 2013); locally, the patients with the highest costs to the inpatient acute care facility are deceased within the year (Medical Doctor and Board Member, personal conversation, October 17, 2017), hospice is effective at reducing end of life healthcare costs (Kirolos et al., 2014). Hospice care escalates family and caregivers' beliefs in their own ability to complete tasks and reach end of life goals by caring for their own family members and can reduce end of life health care cost by approximately 40% (Kirolos et al., 2014).

Other research articles were reviewed that did not meet the inclusion criteria; however, it is worth mentioning, because of hospice being seen as giving up, that there are pilot programs using a variation of hospice services accepting anywhere from one intervention or treatment to ongoing life sustaining treatments while still on hospice (Andrews, 2014; Evans, 2015). These studies are being conducted to break down barriers because hospice care is being viewed as taboo or seen as giving up (Adams, 2015; Ahearn et al., 2012; Andrews, 2014; Evans, 2015; Gawande, 2014; Kirolos et al, 2014; Lowry, 2015). These variations in hospice services break down the barriers to people who want hospice care but cannot receive it due to hospice's restricted policies. In these studies, once receiving hospice care people usually forgo the treatment or do not accept hospitalization.

Education

The literature review provided studies that resulted in increased end of life care conversation with other medical providers (Gazarian et al, 2019; Goode et al., 2019; Nassikas et al., 2020; Shepherd et al., 2018; Smith, 2020), demonstrating education may also work with nurses to increase the end of life conversation, which in turn should increase the end of life wishes being met for the patient. After a 30-minute education intervention, post graduate residents were more confident with the end of life discussions and more advance care planning was completed among the residents who completed the education (Nassikas et al., 2020). Healthcare provider discomfort and lack of time and skills are associated with why the end of life conversation is not completed. Shepherd et al (2018) reported, in their cross-sectional study, that nurses are least knowledgeable about

- the authority of medical decision makers (56%).
- financial decision makers (42%).
- preparations on their own advance directives (10%).
- the nurses own appointed medical (23%).
- their own financial end of life plan and decision maker (27%).
- organ donation (75%).

Overall, Shepherd et al (2018) in a cross-sectional study of 181 registered and enrolled nurses employed in acute and critical care wards, reported 15% of nurses had not engaged in any advance care planning practices and only 7% regularly engage in the end of life conversation with their patients. Nurses who had cared for 11–30 dying patients in the last 6 months were more likely to have an increased knowledge score in this study's evaluation tool. Elder nurses were more likely to participate in a greater number of advance care planning practices, whereas nurses with an increase in shifts worked per week led to a significant decrease in nurses' participation in advance care planning.

Nurses have an essential role in facilitating discussions and enacting decisions about end of life issues for patients; education should be provided to nurses that encompasses wholistic end of life care across cultures (Goode et al., 2019). Gazarian et al. (2019) reported, in their systematic review, that there are multiple advance care planning resources available to nurses but not one comprehensive approach. Therefore, it is essential nurses feel comfortable in providing advance care planning education to their patients as nurses have an integral role in supporting and educating patients in advance care planning (Gazarian et al., 2019). Education and support are needed to ensure that nurses have knowledge of advance care planning (Shepherd et al., 2018). Pereira-Salgado et al. (2019) reported, in their mixed methods pilot study, that education and training will help nurses better engage in advance care planning.

Lack of prognostic information is another reason why the discussion of end of life care conversation is not completed but EPrognosis is an algorithm that can assist providers in determining the likelihood of mortality which educates the provider on the likelihood and estimated time of death (Smith, 2020). The patient's expected prognosis should be considered when addressing risks and benefits of any test or treatment. Thus, understanding and communicating a prognosis is an important element of all clinical decision-making. For shared decision making to be effective, the provider must first understand the patients' prognosis. After patient education, ensuring patients have all the information to make their decision, wishes are more likely to be shared with their loved ones and the provider (Smith, 2020).

This GCS-SEP advanced nursing practice and fills the gap, making end of life wishes more known to loved ones and providers, resulting in increased patient end of life wishes being met, and is anticipated to increase nurse job satisfaction and decrease end of life costs. A good death reflects an individual's preferences for how they want to die. Variables that create a good death include dying at home with family and friends and without stressful physical symptoms such as nausea, vomiting, pain, dyspnea, respiratory tract secretions, anxiety, and agitation (Garfield, 2014). The educational event provided through this GCS-SEP increased the likelihood of patients having a good death.

Local Background and Context

Demographics

This GCS-SEP took place at a local rehabilitation and assisted living campus, an independent and assistive living apartment complex located in the rural Midwest with a population of 3,340. There is a total of 36 apartments; 10 of them are assisted living apartments on a hall adjacent to the nurses' desk and the rest of the 26 beds are independent living apartments. The local assisted living facility is also attached to a 65-

bed long-term care facility at which I currently work on an as-needed basis. The average age of the clients at the facility is 85 with 38% males, 62% females, and 0.02% Hispanic, 0.02% African American, and 95% Caucasian (personal conversation, administrator, June 8, 2020). The 37 nurses employed at the rehabilitation and assisted living campus were the population the education was directed towards and provided to. There was a lack of conversation about end of life care in this setting.

The local long-term care and inpatient facilities faced some challenges. The community is challenged by the end of life conversation being a taboo subject, a deficiency in patient and healthcare provider's knowledge, and absence of patients making their wishes known, all of which should be resolved through education and advance care planning or making end of life wishes known. Only 45% of the individuals who die over the age of 65 are enrolled in hospice services (Medical Director, personal communication, January 10, 2020). In 2019, the United States national percentage of patients older than 65 who were in hospice during their last 6 months of life was 54.4 (American's Health Ranking, 2019). Minnesota's percentage of patients older than 65 who were enrolled in hospice during their last 6 months of life was 54.8 (American's Health Ranking, 2019).

Governance

The Minnesota Department of Health (MDH), Health Regulation Division, under a cooperative agreement with the Centers for Medicare and Medicaid (CMS), is responsible for ensuring that facilities accepting Medicare and Medicaid payment for services provided to program beneficiaries meet federal regulations and certification rules

(MDH, 2019). The state surveys, following the laws and guidelines from MDH and CMS, evaluate the quality of care and services provided, as well as the appropriateness of the facility's building, equipment, staffing, policies, procedures, and finances. There have been incidences at the facility where the POLST was not complete or not completed correctly, to include a code situation, that brought in three team members from the department of health to complete an investigation that lasted three days and a plan of correction had to be developed by the facility. Long-term care facilities must comply with state regulations (CMS, 2019). There are no written policies at this facility that address end of life care; however, there has been a recent push towards and education on having a completed, signed POLST for every admission on the day of admission. Neither the mission statement nor the strategic vision mentions the end of life care conversation or end of life care but state the facility strives to provide services to make the lives of the residents easier and more pleasant.

State

There is not a state mandate to get the end of life conversation started, however, there is a state standardized POLST form (MDH, 2020). The POLST is not a federal mandate but is developed by each state (National POLST Paradigm, 2016). Advantages of having an up to date accurate POLST include communication; documentation; the collaboration between team members, and less unwanted aggressive, costly treatment of end of life issues. Goals of care conversations increase end of life wishes being met; improved end of life wishes are being met with an accurate, completed POLST. Of residents living in long-term care who have a completed POLST, 98% also have standing orders regarding medical interventions, antibiotics, or artificial nutrition and hydration, whereas only 16% of residents without a POLST documentation had similar standing orders (Kim et al., 2015). Having the POLST discussion could lead to the end of life conversation continuing to the discussion of hospice. There is currently not a statewide coalition addressing the POLST in Minnesota (Sabatino, 2016).

Federal

There is no federal law to make end of life wishes known or to have the conversation. In 1990 the Patient Self-Determination Act was enacted (MDH, 2020) requiring all Medicare-certified institutions to inform patients of their right to establish an advance directive (Nassikas et al., 2020). The Patient Self Determination Act of 1990, H.R.4449, amends titles XVIII of Medicare and XIX of Medicaid of the Social Security Act (MDH, 2020). This act requires healthcare facilities to inform patients of their rights under state law to make decisions concerning their medical care, intermittently inquiring if a patient wishes to execute an advance directive , not discriminate against persons who have executed an advance directive, ensure that legally valid advance directives to the extent permitted by state law, and provide educational programs for staff, patients, and the community on ethical issues concerning patient self-determination and advance directives (MDH, 2020). By 2014 only 18% to 30% of adults had an established advance directive (Nassikas et al., 2020). The Patient Self-Determination act is a federal law that addresses end of life care but does not require individuals to complete any form of advance directive (MDH, 2020) and moreover, this federal law forbids requiring an advance directive as a requisite for treatment.

Role of the DNP Student

Professional Context and Relationship to the DNP Project

My clinical experiences related to this GCS-SEP include being a nationally registered Emergency Medical Technician, volunteering for the local ambulance service, and a first lieutenant in the United States Army Reserves. My first experience with ICU nursing was on deployment in Afghanistan, where I was the noncommissioned officer in charge of a 12-bed ICU; I worked as an ICU nurse for 10 years, the patients I cared for required complex assessment, high intensity therapies and interventions, and continuous nursing vigilance. As an as needed or supplemental employee of a long-term care facility, I further diversify my clinical experience, specifically in the geriatric population. The needs of the geriatric long-term care population differ significantly from the ICU but also, as the population ages and medicine become more advanced, many long-term care facilities are quickly taking patients as complex as many inpatient hospitals. It gives me tremendous pleasure to know that I play an active role in ensuring my patients the advocacy they need and deserve in addition to helping them reduce unnecessary and unwanted hospitalizations.

My role in this GCS-SEP was that of the educator who was responsible for developing and presenting the getting the conversation started educational program and acting as a patient advocate and change agent. I developed and implemented the education materials. I wanted to get the information out and have individuals comprehend that dying is a normal process and should neither be hastened nor postponed. My hope and belief is that through proper care and a nurturing community sensitive to their needs, patients and their loved ones can receive the support they need to achieve mental and spiritual preparation for death through getting the conversation started; changes will be made in the way conversations about death and dying and hospice should no longer be perceived as distasteful. This GCS-SEP empowered staff, patients, and their loved ones to be comfortable when talking about death and dying and what their wishes are for end of life care.

Motivation

As stated, I have a diverse nursing background. I could tell hundreds of stories about death and dying. My stories range from the 84-year-old man with dementia being treated aggressively for diabetic ketoacidosis who was restrained and literally thought we were torturing him as he was getting poked every two hours or less; the sweet, 94-year-old female who has metastatic bone cancer being treated in the ICU and given Narcan when her respirations decreased and her oxygen saturations level dropped to 90% and then cried “owwie” for the next hour; my father who gave the hospice provider the finger because he did not want hospice and was strong armed into it; the mother in the ICU in Afghanistan whose son was dying in the next ward but the interpreters would not let her be with him because it was against their culture; to my grandma who passed on hospice and the wonderful things my mother has to say about the support and bereavement. Overall, all that matters is that we did the best we could to fulfill an individual’s end of life wishes, whatever they could be. I continue to work at my local nursing home to advocate for the elderly.

I have strong beliefs in fulfilling my patients' end of life wishes, however, sometimes these beliefs do not allow for family dynamics. I believe this conversation should not be taboo or depressing to talk about. Moreover, my goal is to get the end of life conversation started for all individuals regardless of age and for this conversation to be an ongoing lifelong discussion. Changes in end of life preferences and the factors influencing the transition make it essential for periodic reassessment for planning end of life care (Gallo et al., 2019). However, getting the conversation started and fulfilling patients' end of life wishes does not necessarily consider family resources, time, and emotional exhaustion. This GCS-SEP design did not have any identified design biases present that would affect the GCS-SEP outcome.

Summary

This GCS-SEP provided staff education to fill the identified gap in practice, the lack of conversation about end of life wishes and the underutilization of hospice despite literature showing there is a need for this (Gazarian et al, 2019; Goode et al., 2019; Nassikas et al., 2020; Shepherd et al., 2018; Smith, 2020). The GCS-SEP was implemented in a small, rural Midwest rehabilitation and assisted living campus and my role was as an educator, patient advocate, and change agent in getting the conversation started. The GCS-SEP was guided by the theory of reasoned action which assesses the individual's intentions to engage in the anticipated change which is related to the individual's attitudes and beliefs related to change. Moreover, the theory implies the change was the individual's idea instead of them being made to change. The GCS-SEP is relevant to nursing practice as the education provided nurses with the needed tools for getting the end of life conversation started and fulfilling dying patients’ end of life wishes, which is likely to increase job satisfaction by nurses being more confident and comfortable with starting the end of life conversation. In the next section I discuss the collection and analysis of evidence.

Section 3: Collection and Analysis of Evidence

Introduction

The staff education GCS-SEP addressed the lack of conversation about end of life wishes and the underutilization of hospice to improve quality of life in the last phase of life (Ahearn et al., 2012; Lowry, 2015). Without the conversation, a patient's wishes are often unknown, and they have no voice in their end of life care choices. Education was needed among the health care collaborative team to get the end of life care conversation started and increase informed choices for advance care directives, with the intent to fulfil patients' end of life wishes. The purpose of this GCS-SEP was to develop and implement an education program to increase knowledge and provide tools for nurses to be more competent and comfortable in initiating the end of life conversation with patients, their loved ones, and providers. In Section 3, I discuss sources of evidence, participants, ethical issues, procedures, and the analysis and synthesis methods that I used during the implementation phase of the GCS-SEP.

Practice-Focused Question

A local long-term care facility served as the context for this GCS-SEP. Lack of knowledge on steps for initiating conversations on end of life care was noted among nursing staff members. Close examination indicated that the topic of end of life care was considered taboo with patients and family members avoiding the conversation. Additionally, onsite observations indicated that patients were not making their respective wishes known to family members and caregivers. The gap in practice identified for the GCS-SEP was the lack of conversation about end of life wishes and the underutilization of hospice despite literature showing a need for communication with loved ones and providers about patients' wishes at the end of life (Lowry, 2015). The practice-focused question that guided the GCS-SEP was: In a long-term care facility, will nursing knowledge and expressed intentions about end of life care increase as shown via the difference between pretest and posttest scores following an educational event addressing hospice care and end of life conversation? Nurses make up the largest number of the collaborative health care team and spend the most time with patients and families; nurses reduce the patient's physical and emotional stress by helping guide conversations and answer questions to meet the needs of patients and their loved ones holistically (American Association of Colleges of Nursing, 2019). Nurses were the ideal individuals to educate on end of life care to help the patients and their families start the conversation. The GCS-SEP, an educational event, provided nurses with the education and tools to begin the end of life conversation. By educating nurses and providing tips on starting the end of life conversation, I equipped nurses with confidence and the tools to begin the conversation, thus addressing the practice problem.

Sources of Evidence

I conducted an in-depth literature search through Walden University's Library to gather current evidence-based literature. The literature chosen to be included in the education for getting the end of life care conversation started module included articles written in English and published between 2010 and 2020. I graded the evidence using Melynk and Fineout-Overhold's (2011) hierarchy of evidence decision making matrix and then I synthesized the evidence to apply the best practice from the literature to the educational module. Evidence used to answer the evidence-based question included the evaluation and validation tools. These evaluation tools included an evaluation of the curriculum and content validation of the pretest/posttest items by the content experts, and the change percentage of the pretest/posttest scores. This evidence supported the purpose of this GCS-SEP which was to increase knowledge and provide tools for nurses to be more competent and comfortable with initiating the end of life conversation with patients, their loved ones, and providers.

Participants

The participants for this GCS-SEP included two groups, the content experts and the learners who were the nurses employed at the long-term care facility who attended the education event. There was also a PhD-prepared nurse who is a professor at the local university who provided oversight for the pretest/posttest construction. Three content experts were involved with this GCS-SEP. The first of the content experts was a masters-prepared, licensed health care administrator who is responsible for the direct supervision of the facility and campus operations to meet the regulatory and compliance requirements set by CMS and the MDH, and to assure the facility staff are providing quality care while meeting the expectations clinically and operationally set by the organization. The second content expert was the director of nursing at the local facility, who is also responsible for the training and education for all certified and licensed staff. A masters-prepared, licensed social worker who works at the facility where this GCS-SEP took place was the third content expert. I selected the content experts because they are subject matter experts in education, long-term care, social change, and end of life care. These three individuals reviewed my staff education curriculum plan for relevance and validity, assessed the pretest/posttest for content validity, and provided a summative evaluation.

The learners for the GCS-SEP consisted of the nurses, registered nurses and licensed practical nurses employed at the local rehabilitation and assistant living center where the GCS-SEP was implemented. I selected these individuals because they are the ones who are positioned to start the end of life conversation, and they are the individuals who will ultimately made the change. It is the expectation that after the education event, the nurses will start the end of life conversation with patients and the education will increase nurses' job satisfaction, improve end of life care for patients, and support patients' loved ones.

Procedures

The projected outcomes of this GCS-SEP were to start the end of life conversation between staff, patients, and their families, which should increase patients' end of life wishes being met, increase nurse satisfaction, and lessen the depression of loved ones (Biagioli et al., 2018; Gawande, 2014; Gazarian et al, 2019; Goode et al., 2019; Nassikas et al., 2020; Shepherd et al., 2018; Smith, 2020). I completed a thorough needs assessment then conducted an exhaustive literature review. After an extensive review of the literature, I developed a literature matrix with the pertinent articles, using evidence-based guidelines by Melynk and Fineout-Overhold (2011) on the grading of the evidence-based sources. I developed the curriculum plan to include the learning objectives and a teaching module (see Appendix D). The curriculum plan with the learning objectives were based on the peer-reviewed literature and the DNP Essentials

(American Association of Colleges of Nursing, 2006). I created the teaching materials to include the pretest/posttest, from the curriculum plan. The teaching module for getting the conversation started included a PowerPoint (see Appendix E), the IHI (2019) conversation starter kit (see Appendix F), showing the documentary *Being Mortal* (Jenning, 2015), and an open discussion about making end of life wishes known to providers and loved ones. The curriculum plan, to include the educational materials and pretest/posttest, was presented to the content experts for review. The pretest/posttest contained multiple choice questions and questions related to intention using a Likert scale. The content experts evaluated my curriculum plan and literature review matrix using the Curriculum Module Content Expert Evaluation (see Appendix G). A nursing education professor reviewed the pretest/posttest construction. Their responses were recorded on a document scoring how the education module addresses the health care facility needs as it pertains to getting the end of life conversation started. I reviewed and summarized the content experts' evaluations (see Appendix H) and I made revisions as recommended. The content experts also evaluated the pretest/posttest for content validity (see Appendix I). All knowledge and intent questions scored 100% very relevant by the content experts.

Protections

I obtained a site agreement with the local rehabilitation and assisted living campus and Walden University's Institutional Review Board approval (08-12-20-0732009). I protected human subjects by numbering the pretests and posttests, asking for no identifying information, assuring anonymity. Data collection followed Walden

University’s IRB approval, completion of the pretest implied consent. The pretests and posttests will be shredded after 5 years of being in a locked file cabinet in the director of nursing office with the director of nursing and the administrator being the only persons having access. The region of the data source was described without naming the specific location. There are no foreseen potential ethical issues present for this GCS-SEP.

Analysis and Synthesis

I reviewed the results of the evaluation tools from the content experts, averaging scores and reviewing comments, no changes were needed to the curriculum plan or teaching model. However, the platform of an in-person face-to-face education event was changed to virtual. Data analysis of pretest and posttest responses took place after the educational event and are kept on a Microsoft Excel spread sheet by me. Because of the number coding per participant, the correlation between individual pretests and posttests was possible. I used change range or percentage of change when evaluating and comparing the pretest and posttest scores.

Summary

The staff education GCS-SEP addressed the lack of conversation around end of life wishes being made and the underutilization of hospice to improve quality of life in a patient’s last phase of life. I explored the literature related to starting the end of life conversation, hospice, and end of life care. The thorough literature review showed the benefits of education for nurses on starting the end of life care conversation. Research has demonstrated that early and honest communication with loved ones and health care providers about the patient’s wishes, early hospice admission, avoidance of intensive care admissions, and death at home result in higher patient and family satisfaction and less long term depression for the family members during bereavement (Beyea et al., 2013; Gawande, 2014; IHI, 2019; Kirolos et al., 2014; Lowry, 2016). After I developed the curriculum plan and the literature review matrix, the content experts evaluated them. Data collection followed Walden University’s IRB approval, completion of the pretest implied consent. I used a percentage range or change of percentage to compare the pretest/posttest. In the next section, Section 4, I discuss the findings, implications, recommendations, and strengths and limitations of the GCS-SEP.

Section 4: Findings and Recommendations

Introduction

The local problem addressed in the GCS-SEP was unmet end of life wishes for residents. More specifically the problem consisted of POLST forms, advance directives, and code status positions not being completed in a timely manner. Some long-term care residents and loved ones are so uncomfortable talking about end of life that these conversations were engaged during multiple visits lasting weeks. The gap in practice was the lack of conversation about end of life wishes despite literature showing a need for communication with loved ones and providers about patients' wishes at the end of life (Lowry, 2015). An increasing number of older people are dying in the hospital (Ahearn et al., 2012). Late referrals are an ongoing issue with patients enrolling in hospice care at late stages, resulting in unmet needs for patients and families. Having the end of life care conversation with loved ones and providers would address advance care planning and hospice.

The practice-focused question that guided this GCS-SEP was: In a long-term care facility, will nursing knowledge and expressed intentions about end of life care increase as shown via the difference between pretest and posttest scores following an educational event addressing hospice care and end of life conversation? The purpose of this GCS-SEP was to develop and implement a staff education curriculum plan and teaching module providing an educational program to raise awareness and increase knowledge and intentions of nurses on initiating the end of life conversation with patients, their loved ones, and providers. I conducted an extensive literature review selecting 30 peer-reviewed, full-text articles published between 2010 and 2020 to develop this staff education module. Pretests and posttests were given before and after the educational event was sent out via SurveyMonkey. I used change percentage to analyze the pretest and posttest results.

Findings and Implications

Once I discovered that the educational event needed to be virtual because of facility policy related to the pandemic, email addresses were obtained from the director of nursing (DON) at the long-term rehabilitation and assistant living campus. The DON was able to obtain only 27 email addresses of the 37 nurses employed at the facility. She sent an email approximately 6 days prior to implementation informing the nurses of the educational event.

Because the implementation platform changed to virtual and not an in-person staff meeting as planned, I decided to make advertisement posters (see Appendix J). The advertisement posters were displayed in the breakroom, on the time clock, the door leading to the floor, and report room, and I emailed the nurses. I personally spoke to the nurses I saw while at the field site to ask for their support and invited them to join the educational event; some said they would but did not join, others said they had connectivity issues, and others replied that they did not have a camera on their computer and did not have a phone. I sent a Zoom meeting invitation the night before the implementation and again 30 minutes prior to implementing to the 27 nurses whose email addresses I had received from the DON. An unanticipated limitation was having to change venue and being able to contact only 27 of the nurses with only eight participating. These unanticipated limitations transpired despite there being a poster for advertisement; the DON sending out emails; and my in-person approach, emails, and texts. The results may not be representative of the whole group due to the small sample size.

The pretest and posttest were sent via SurveyMonkey to the same nurses who received the emails. SurveyMonkey allowed for the pretest and posttest to be sent at specific times, 5 minutes prior to implementation and 10 minutes prior to completion. Only five of the eight participants completed both the intent pretests and posttests; and only four participants completed both the knowledge pretests and posttests. Therefore, I was able to complete only a percentage change on those where both the pretest and posttest were completed. I maintained individual responses on an Excel spreadsheet, used for data analysis and to detail which participant completed which pretest and posttest and how they answered each question. One participant completed only the pre intent and pre knowledge test, another participant completed only the pre intent test and post knowledge test, one did not complete the post intent test, and two other participants did not complete either knowledge test.

SurveyMonkey numbered the email participants for anonymity. Three of the participants had no change in intent on whether they would have the end of life conversation with their provider or put their end of life wishes in writing. Two of the participants' Likert scale ratings decreased when asked about their comfort and competent levels by an average of 7 points. Because the participants' scores were anonymous, I could not identify whose score decreased to ask why their comfort and competent levels decreased. One speculation is that they felt more comfortable and competent until learning additional information through the educational event. All the intent questions increased an average of 40% to 60%.

For the four-knowledge tests that were completed, I analyzed the data, and most scores improved overall. The mean change in pretest (*M* = 57.5%) and posttest (*M* = 92.5%) item scores suggests that education was effective in increasing knowledge. There was one score that remained the same, with different answers being wrong (see Table 1). Question k7, addressing end of life medical care costs, had an average score of 25% for both the pretest and posttest; though answers were changed, the average score did not. Below is the table of percentage change per knowledge question.

Table 1

Percentage Change in Knowledge Posttest Scores (*n* = 4)

Knowledge Question	Pretest Score %	Posttest Score %	Percent Change %
k1	50	100	50
k2	75	100	25
k3	0	50	50
k4	0	100	100
k5	50	100	50
k6	25	100	75
k7	75	75	0
k8	100	100	0
k9	100	100	0
k10	100	100	0
M	57.5	92.5	35

The pretest and posttest findings indicated that the educational event was effective in meeting the learning objectives and improving staff knowledge and expressed intentions. Potential implications to social change include bringing patients and families closer to their loved ones, more end of life care wishes being met, an increase in nurse satisfaction, and a decrease in costs for end of life care. Earlier hospice admissions, an increase in the avoidance of the ICU, and more death outside the hospital are associated with a good death and excellent end of life care (Amano et al., 2015; Garfield, 2014; Lowry, 2016), contributing to a positive social change. Institutions and systems would benefit not only because it would limit use of valuable resources in engaging in these conversations multiple times over multiple visits with patients and loved ones who are too uncomfortable with having the end of life care conversation but also in the way they can start to engage in fulfilling their patients end of life wishes. Also, if these conversations are started before death is imminent more valuable resources can be directed towards care instead of multiple attempts over weeks to reapproach the conversation. Meaningful end of life conversations with family and loved ones about their end of life care wishes before serious illness occurs improves quality of life as death is near, having a positive social change.

Recommendations

End-of-life and goals of care conversations need to be started early and continued. Education is needed among all members of the healthcare collaborative team. The key stakeholders at the facility agreed that this was a needed educational offering. Recommendations based on the findings of the GSC-SEP include incorporating the education for staff orientation and annual education. Administration agrees this was meaningful and plan on implementation immediately. This staff education model will not only be implemented for initial and annual training for all nurses, but the documentary will be shown in all the nursing assistant training programs at the facility. This facility also uses a computer-based continuing education platform for all staff quarterly mandated education. There is also talk of having this GCS-SEP project configured into a computer-based education program.

A recommendation for future staff education events includes repeating the education program. In person is better, but virtual is doable in meeting the learning objectives. Besides, this is the wave, we are going virtual and with distance learning, COVID-19 has given us a not so gentle thrust in the virtual direction. Plus, we must learn to be fluid. Community education along with the showing of *Being Mortal* (Jennings, 2015) is another recommendation. Community members need to be aware of the importance of having the end of life conversation and take action, letting their preferences be known to loved ones and providers. Death is an inevitable reality and we need to make our needs known. Also, staff members who have had the education may encourage their loved ones to attend the community educational event - this would be a wonderful opportunity for the whole family to engage in conversation. As said earlier, lives change, priorities and goals transform, this conversation needs to be on a continuum.

Strengths and Limitations of the Project

Limitations

Limitations of this project included sample size, time, delivery platform, and data collection. Until one week prior to implementation, I was approved to do a face-to-face class. Because of pandemic restrictions, CMS and MDH guidelines, the facility policy changed, no longer allowing face-to-face meetings. Once the format was changed to virtual, I was under the assumption I could use the field site's Zoom account. Two days prior to implementation I received access to the account and discovered it was a free Zoom account which limits meetings to a 40-minute time frame. I purchased my own account for $14.99 a month. Also, because this was no longer going to be an in-person educational event, I had to figure out a way to virtually send and receive the pretest and posttest while maintaining anonymity. SurveyMonkey was selected, but the free version did not offer the tool for anonymity; the upgraded SurveyMonkey account cost $26.00 a month. I did investigate Microsoft teams, stream, and files without success. Initially, I considered postponing the educational event because of the last-minute changes to the platform. However, knowing the content experts and medical director wanted this project implemented sooner than later, after balancing the priorities and considering the organizational and stakeholder needs, I chose to proceed with the implementation.

The project timeframe was not long enough to evaluate the sustainability of the intentions and knowledge gained by the nurses. Similarly, the timeframe was not long enough to appraise the transference of the gained knowledge into practice, to assess if nurses' job satisfaction increased or if end of life costs decreased.

Data collection limitations consisted of technical issues with using SurveyMonkey and the delivery of the pretests and posttests. The tests were scheduled via SurveyMonkey to be sent to the same email addresses as the Zoom invites went to at the preset times, however, there was inconsistencies with participants receiving the tests. For instance, I did not receive all of the results from the pretests and posttests that participants stated were completed. Despite the limitations, the education was well received, and the facility was excited about the results.

Strengths

I had tremendous support and encouragement from the field site to include management and the medical director, and my place of employment to implement this GSC-SEP. Even when I expressed discontent with the limitations and challenges of implementation my administrator stated, “I have been on numerous Zoom calls and there is always some kind of technical difficulty. It was how you handled the mishaps that counts. You didn’t get upset or breakdown, you solved the issue and continued to drive on without getting flustered” (personal conversation, September 23, 2020). Despite the last-minute changes the educational event was successfully implemented and learning objectives were met. I have had verbal commendations from all participants, the administrator, director of nursing, and the clinical manager.

Future projects on getting the end of life conversation started should include studying the long-term sustainability of the gained intent, knowledge, and implementation among the educated providers to measure transference of the gained knowledge to practice. Furthermore, presenting the educational event to providers in all health care practices i.e. hospice, acute care, clinic, family medicine would also be beneficial.

Summary

The lack of conversation about end of life wishes despite literature showing there is a need for communication with loved ones and providers about patients’ wishes at the end of life (Lowry, 2015) is the issue I addressed in this GCS-SEP. Through the GCS-SEP, I provided a successful educational event that met the objectives, despite the challenges, and the facility is eager to implement the teaching into practice. Short-term future plans are to take the project into the community. Long-term recommendations would entail evaluating the sustainability of the intentions and the knowledge gained by the nurses, the transference of the gained knowledge into practice, nurses’ job satisfaction increase, and the decrease of end of life costs. In section 5, I will discuss my dissemination plan and complete a self-analysis.

Section 5: Dissemination Plan

The results of the data analysis and evaluation of GSC-SEP were presented to the content experts, collaborative team, and participants as an in-person presentation during a staff meeting. The medical director and other members of the collaborative team were given the information during a Zoom meeting 2 days later. Again, even though I was envisioning a larger number of participants and greater increase in percentage change with the posttest scores the content experts, collaborative team, participants, and medical director agreed the GCS-SEP was a success and they were impressed with the educational event. All are excited to continue to use the GCS-SEP at the facility.

The GSC-SEP would be appropriate for conventions, online learning, staff education, and even in the collegiate environment for all members of the health care collaborative team to include community events. The audience and learning platform should not be limited to geriatrics or palliative care, they should also include family practice and all health care disciplines, it is always the right time to have the conversation. I will submit an article to the journal of *Hospice and Palliative Nursing*; throughout the literature review I have read various journals, and this is the one I best connect with and continue to return to.

Analysis of Self

I started on this journey towards being a DNP prepared nurse not only for myself but also my family and community. As I saw my family growing, I was personally encouraged to be an active member in my community, making it a safe and healthy place for my family and friends to prosper. My goal for the DNP degree and professional development was to and still is to create a healthy, safe community. I believe that I will be able to obtain these aspirations by giving back to my community by working with rural and underserved communities, focusing on health education and preventative care. I have increased my skills and, in turn, will make a difference in the lives of the people in my community, as well as my own family. Extensive community service, leadership, military service, and clinical experiences have prepared me; however, the Walden University DNP program and this GCS-SEP have provided the means to gain skills and knowledge to fulfill my dreams.

As a practitioner, I am responsible for the collaboration of health care focused on quality of life, wholistic care, and health care cost. Developing the educational plan helped me learn more about the challenges associated with end of life care and changes in health care practice. As an RN, I am a patient advocate, determined to ensure that patients receive the best possible care. My personal nursing philosophy is caring for the person as a whole, including their support system. Technical skills and critical thinking are very important aspects of this philosophy. Nursing is a profession with technical focus on assisting individuals, families, and communities in attaining, maintaining, and recovering optimal health and functioning. I also view nursing as a science and an art, promoting quality of life for persons and families, throughout their life experiences from birth to end of life care. By implementing the project, I improved my practice skills on the continuous influence that learning has on my practice and patient outcomes. My roles as a practitioner, scholar, and project manager align with the promotion of high-quality care provided to patients and their loved ones at all stages of life.

It is my dream to implement this project throughout the community and surrounding areas. The educational events would be successful at the Elder Networks, YMCAs, all denominational churches, public libraries, Friendship Centers, other healthcare facilities in the area. All of the community educational events should be open to the public, and it would not be necessary to administer the knowledge pretest and posttest but the intent pretest and posttest would add to the knowledge base of the effects of the project.

Completion of the Project

The GCS-SEP was completed with success, objectives were met, and the collaborative team including the content experts and medical director were delighted and enthusiastic to continue the education. The GCS-SEP project is completed; however, my movement in getting the conversation started is not finished, and the education will continue throughout the facility and community.

Challenges and Solutions

During the implementation phase, I addressed modification and redesign. For the GCS-SEP this included finding out 7 days before the scheduled implementation that the staff educational event needed to be virtual. I did practice the new platform of implementation. Zoom and the SurveyMonkey pretest and posttest were also tested with fellow peer nurses for flow and analysis assessment. Several technical issues occurred during implementation even though I practiced the virtual platform prior to the implementation of the educational event. During the showing of the documentary the participants could not see or hear the video, it took a few minutes for me to realize this. I was able to get the video stared after a few minutes and then following a few more minutes the audio sound began. Also, I thought I had minimized myself during the viewing of the documentary, I had not. I was minimized on my screen, but the participants could see me during the viewing. So, I did all the things you do when you think no one can see you. I was horrified. It is worth stating the only experience I have had with virtual teaching was the practice session prior to implementation. I believe if I had been more versed in virtual education such as Zoom, and SurveyMonkey, implementation of the program would have been completed with fewer technical issues.

Even though the learning objectives were achieved, a significant number of nurses, despite continuing education units being offered and being paid from the facility for a nurses' meeting, did not participate. I do believe my plan that was developed was grandiose, however, the implementation definitely could have been better, especially with more participants and all four of the SurveyMonkey pretests and posttests being completed by all the individuals who did participate. My insight through this GCS-SEP is to continue as best I can no matter how challenging the work may get, you have to stay fluid with a positive attitude. You can tell a lot about an individual in how they act under stress.

Summary

Education is needed among the health care collaborative team, to include nurses, about the importance of, and how to get the end of life care conversation started. The lack of end of life conversation and the underutilization of hospice has led to patients' end of life wishes not being met; moreover, when not having had the conversation, bereaved family members have an increase in depression (NHPCO, 2016). Ninety-two percent of Americans believe it is important to have the end of life conversation with their loved ones but only 32% have had the conversation (IHI, 2019). The literature supports early and honest communication with providers about the patient's wishes; early hospice admission, avoidance of intensive care admissions, and death at home have higher patient and family satisfaction and less long-term depression for the family members during bereavement (Gawande, 2014). Early hospice admissions, avoidance of the ICU, decreased costs, and death outside the hospital are associated with excellent end of life care (Amano et al., 2015; Lowry, 2016), providing a positive social change. The findings of the GCS-SEP were consistent with the existing literature regarding the effectiveness of staff educational plans on improving knowledge and competence among nurses. The GSC-SEP curriculum plan and teaching module is an effective template for addressing the lack of end of life conversation and the underutilization of hospice leading to patients' end of life wishes not being met, bereaved family members having a higher rate of depression, and increased costs at the end of life and should be shared and implemented throughout all the disciplines of the healthcare collaborative team and community.

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Appendix A: Literature Review Matrix

Melynk, B. & Fineout-Overholt, E. (2011)

DNP Project Title: Getting the End-of-Life Care Conversation Started

Lisa McCabe-Evans, DNP Student

Author/ Date	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Methodology**	**Analysis & Results**	**Conclusions**	**Implication for future research/ practice**	**Comments**	**Level of Evidence**
1. Adams, S. (2015). Being an advocate: Knowing when hospice is right for your patient. *Tar Heel Nurse, 77*(4), 13-19.	n/a	Giving hospice facts	Informing.	Death is a part of life. Most individuals want to leave this world with dignity and comfort, surrounded by those we love.	The best way to care for patients throughout life is to be informed of all aspects in the process.	Encourage individuals to ask is the test going to change the outcome or make a difference for the better? Be a patient advocate.	9 out of 10 people would choose to pass away at home. Only 4 out of 10 are allowed to.	VII
2. Ahearn, D., Kallat, A., Adenwala, Y., & Varman, S. (2012). Offering older hospitalized patients the choice to die in their preferred place. *Postgraduate Medical*	n/a	Would routinely asking about preferred place of death at the time of discussions of resuscitation status help plan to allow	Retrospective descriptive study of the case notes. 100 patients sample size.	ACP could have avoided death in hospital.	In few cases are the preferred places of death discussed in older people who die in hospitals. This could be prevented with ACP. ACP and	What other barriers exist that prevent healthcare staff from discussing alternative places to die in older hospitalized patients? Are staff fearful of broaching these sensitive issues? The end of life conversation needs to happen.	UK Identify the people dying in hospital where the likelihood of ending life elsewhere was explored. Recognize variables that could support staff to help wishes to be met.	VI

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
Journal. 12(1), 9-12 doi:10.1136/postgradmedj-2012-131161		patients to die at home where appropriate? What would the views and experiences of patients and staff to such a measure be? What other barriers exist that prevent healthcare staff from discussing alternative places to die in older hospitalized patients? Are staff fearful of broaching these sensitive issues? Since previous research was			code status discussions need to happen routinely.			

Author/ Date	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Methodology**	**Analysis & Results**	**Conclusions**	**Implication for future research/ practice**	**Comments**	**Level of Evidence**
		performed, have the practical barriers for example, rapid availability of care packages or equipment (such as mattresses) improved or worsened? Why is advance care planning still not performed as a matter of course in people known to have life-limiting illnesses?						
3. Amano, K., Morita, T., Tatara, R., Katayama, H., Uno, T., & Takagi, I.	n/a .	Do palliative care referral and use on inpatient hospice decrease the	Retrospective cohort study in a cancer-designated hospital in Japan. 265	Measured by a composite score adapted from Earle and colleagues. Assessed by 6	The rate of inpatient hospice utilization was significantly	Impatient palliative care consult with inpatient need to happen earlier than they are currently being completed.	Japan.	IV

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
(2015). Association between early palliative care referrals, inpatient hospice utilization, and aggressiveness of care at the end of life. *Journal of Palliative Medicine*, *18*(3), 270-273. doi:10.1089/jpm.2014.0132		amount of aggressive care at end of life.	patients included.	indicators in the last month of life. (use of chemo or targeted agent, more than one ED visit, more than one hospital admission, more than 14 days of hospitalization, an ICU admission, or death in a hospital) An association between early palliative care referral (> 3 month) and inpt hospice use as primary end points.	higher in the early referral group $p < 0.001$.			
4. American Nurses Association Center for Ethics and Human Rights. (2016). Nurses’	The American Nurses Association position statement provides a	1. Increase the integration of evidence-based care across the dimensions	Position Statement	Practice and education	The provision of excellent end of life care requires, first and	End-of-life care where people die must be consistently available without causing a severe depletion of family resources. Nurses		VII

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
roles and responsibilities in providing care and support at the end of life. Position Statement. https://www.nursingworld.org/~4af078/globalassets /docs /ana/ethics/endoflife-positionstatement.pdf	framework for discussion.	of end of life care. 2. Develop best practices for quality care across the dimensions of end of life care, including the physical, psychological, spiritual, and interpersonal. 3. Support the use of evidence-based and ethical care, and support decision-making for care at the end of life. 4. Develop best practices to			foremost, an excellent knowledge of the pathophysiology of terminal illness or injuries.	are obliged to provide comprehensive and compassionate end of life care.		

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
		measure the quality and effectiveness of the counseling and interdisciplinary care patients and families receive regarding end of life decision-making and treatments. 5. Support research that examines the relationship of patient and family satisfaction and their utilization of health care resources in end of life care choices.						
5. Beyea, A., Fischer, J.,	n/a	Aim was to evaluate an	Quasi-Experimental.	Training resulted in an	Trained (a one-day	No future research suggested. The	Nice graphs.	III

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
Schenck, A., & Hanson, L. C. (2013). Integrating palliative care information and hospice referral in Medicaid primary care. *Journal of Palliative Medicine*, *16*(4), 376-382. doi:10.1089/jpm.2012.0483		intervention to improve communication about advance care planning and symptom distress, and to facilitate referral to PC and hospice.	Statewide intervention and collected data with participant surveys and tracking of key quality measures. 510 Medicaid care managers	increase in ACP and hospice.	session) on effective advance care planning.	training is effective. Statewide one-day education session with Medicaid care managers to increase communication and hospice referrals. (longer follow up may be needed to determine effects on hospice use).		
6. Biagioli, V., Prandi, C., Nyatanga, B., & Fida, R. (2018). The role of professional competency in influencing job satisfaction and organizational citizenship behavior among palliative care nurses. *Journal of Hospice and Palliative*	Humanistic nursing theory.	Hypothesis: the more palliative care nurses believe in their professional competency, the more they are satisfied with their job and show altruism, civic virtue, and	Cross-sectional correlational study.	Professional competency was positively associated with both job satisfaction (β = 0.39) and organizational citizenship behavior (β = 0.53).	Confirmed the hypothesis.	Future studies should examine the predictive role of professional competency over time. Provide education and training for nurses to feel more confident in caring for palliative patients.		VI

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
Nurses. 20(4), 377-384. doi: 10.1097/NJH.0000000000000454.		conscientiousness (organizational citizenship behavior). This means that, if a nurse feels highly confident in caring for palliative patients, he/she is more likely to have a positive appraisal of his/her own job experiences, conscientiously perform in the own job, help colleagues who have work-related problems, and attend meetings						

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
		that are not mandatory but important. 107 palliative care nurses. Eighty-five percent of the participants were women, with a mean age of 42 years completed the survey.						
7. Brugger, C., Breschi, L., Hart, E., Kummer, M., Lane, J., Morrow, P., Smith, F., Williuam, T., Beffel, M., Brehany, J., Buscher, S., & Marker, R. (2013). The	POLST paradigm	White paper considers in detail one potentially problematic response to this attitudinal shift in the form of a new type of EOL document	Ethical decision making.	Commentary.	Discusses end of life care.	Legal implications.	Medical care at the end of life consumes 10–12 percent of the total healthcare budget, and 10 percent of the Medicare budget is spent during the last 30 days of life.	VII

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
POLST paradigm and form: Facts and analysis. The *Linacre Quarterly*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6026997/		known as Physician Orders for Life Sustaining Treatment (POLST)2 and an organized campaign to encourage its widespread use.						
8. Centers for Medicare & Medicaid Services. (2019). Quality safety & oversight - guidance to laws & regulations. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations	n/a	The Medicare requirements for nursing facilities are sets of requirements for acceptable quality in the operation of health care entities.	Skilled Nursing Facilities.	State Surveys.	Nursing facilities are subject to certification.	Laws and regulations. Facilities are surveyed in accordance with the appropriate protocols based on the substantive requirements in the statute and regulations to determine compliance.	If facilities fail to comply with one or more of the subsidiary standards during any given survey, it cannot participate in Medicare unless it meets conditions or attains substantial compliance with requirements.	

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
/index?redirect=/GuidanceforLawsAndRegulations/12_NHs.asp								
9. Gallo, J. J., Abshire, M., Hwang, S., & Nolan, M. T. (2019). Advance directives, medical conditions, and preferences for end of life care among physicians: 12-year follow-up of the Johns Hopkins Precursors Study. *Journal of Pain and Symptom Management*, *57*(3), 556–565. https://doi.org/10.1016/j.jpainsymman.2018.12.328	N/A	Estimated the stability of preferences for end of life treatment over 12 years and whether advance directives and medical conditions were associated with change in preferences for end of life treatment.	Longitudinal cohort study of medical students. Mailed survey of older physicians.	End-of-life preferences grouped into three classes: most aggressive (wanting most interventions; 14% of physicians), least aggressive (declining most interventions; 61%), and an intermediate class (declining most interventions except intravenous fluids and antibiotics; 25%).	Transitions in end of life preferences and the factors influencing change and stability suggest that periodic reassessment for planning end of life care is needed.	Continued research and reassessment for planning end of life care is needed	Transition probabilities from class to class did not vary over time. Persons with cancer expressed preference for the least aggressive treatment, whereas persons with cardiovascular disease and depression had preferences for more aggressive treatment.	IV
10. Garfield, C.,	A good	Dying	Charles	End of life	A good	Honor wishes at		VII

Author/ Date	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Methodology**	**Analysis & Results**	**Conclusions**	**Implication for future research/ practice**	**Comments**	**Level of Evidence**
(2014). Seven keys to a good death. Greater *Good the Science of a Meaningful Life.* http://greatergood.berkeley.edu/article/item/seven_keys_to_good_death	death.	should be treated as living human beings.	Garfield draws on decades of experience to explore how to create the conditions for a good death.	wishes should be made known and honored; a good death is achievable.	death is no oxymoron.	death. Potential for growth through dying. If the conditions for a good death, we known they are more apt to prepare ourselves and the ones we love to die with dignity and the sense of a life well-lived, rather than treating death as a calamity requiring a trip to the hospital.		
11. Gawande, A. (2014). *Being mortal: Medicine and what matters in the end*. Metropolitan Books.	n/a	What do our patients really want, what are their wishes,	249 references. He is practicing surgeon who examines its ultimate limitations and failures in his own practice and others Evidence from the opinion of a practicing surgeon and	Medical experience can increase suffering for patients and loved ones and provides insight into ways to do things differently.	Interviews of professionals, patients, family members, various research articles to include his own experiences.	Know what patient's what in the end; before death is imminent, what are the patient's wishes.		VII

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
			his interviews					
12. Gazarian, P. K., Cronin, J., Dalto, J. L., Baker, K. M., Friel, B. J., Bruce-Baiden, W., & Rodriguez, L. Y. (2019). A systematic evaluation of advance care planning patient educational resources. *Geriatric Nursing*, *40*(2), 174–180. https://doi.org/10.1016/j.gerinurse.2018.09.011	Transtheoretical Model	To be effective ACP should encompass discussion and documentation of goals and preferences with family members and the health care team.	Systematic evaluation of general ACP educational resources. Combined public ACP aids and resources. PEMAT. score for each resource.	Including Advance directive/Healthcare proxy, POLST, living will, values, preferences, and goals. Microsoft Excel.	No one resource is comprehensive enough to provide ACP guidance to all patients in all situations.	End-of-life wishes should be researched to improve ACP. The reasons patients cite for not having ACP conversations are potentially amenable to education and coaching. The need for education and support for ACP is widely recognized. The Patient Self-Determination Act of 1990 directs health care organizations in the United States to inform patients of their right to make decisions related to their health care, determine if an individual has an advance directive (AD) and, if not, to find out if the individual wishes to create one. All clinicians,	Excluded the conversation project because in incorporate other resource from their analysis. Because nurses have a constant presence across settings and are vested in the patient care process, they are well positioned to be leaders in improving processes related to ACP.	V

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
						including physicians, nurses, social workers, and chaplains, are trusted and valued information sources and can be instrumental in promoting completion of ACP.		
13. Goode, D., Black, P., & Lynch, J. (2019). Person-centered end of life curriculum design in adult pre-registration undergraduate nurse education: A three-year longitudinal evaluation study. *Nurse Education Today*, *82*, 8–14. https://doi.org/10.1016 /j.nedt.2019.07.	n/a.	Explore student evaluation of EOL care learning within a three-year undergraduate adult nursing degree program.	3-year quantitative longitudinal design. Participant who were 3 yr nursing student's. 66% response rate (n = 336). information sheets and questionnaires were distributed and time to complete them descriptive statistics SPSS 24 and	Students expressed satisfaction with their learning, positive impact on their knowledge. more confidence and competence in most aspects of end of life care.	Structured EOL care within the curriculum is essential to equip graduate nurses. person-centered end of life care across cultures.	EOLlearning must take. Educators need to recognize emergent trends in delivery of EOL care. In 2014, the WHO questioned the sustainability of end of life care within specialist settings. The WHO (2014) estimates that worldwide, in 2011, over 20 million individuals required specialist care at the EOLconceptualized provision of quality end of life care as a global public	Provision of quality EOL care as a global public health and health systems problem. To have relief of pain and dignity in death is seen as an international human rights, address a range of barriers .	III

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
009			thematic analysis used for open questions.			health and health systems problem and emphasized the need for public health and health systems problem and emphasized the need ford of life education for nurses.		
14. Institute for Healthcare Improvement. (2019). The conversation projects. https://theconversationproject.org/	n/a	Form to aid individuals in making their end of life wishes known.	Surveys From the Conversation project, Californians by the California HealthCare Foundation, Kaiser Family Foundation Serious Illness in late life.	One conversation can make a difference.	EOL care where people die must be consistently available without causing a severe depletion of family resources.	Did the conversation increase the number of individuals who have the conversation? Encourage to have the conversation.	This is one of the items the GCS-SEP will be handed out and review during the educational event.	VII
15. Jenning, T. (2015) Being Mortal: Medicine and what matter in the end. United States.					Tell in a few lines what it covers		The documentary *Being Mortal.*	VII

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
Frontline. Public Broadcasting Service.								
16. Kim, H., Ersek, M., Bradway, C., & Hickman, S. E. (2015). Physician orders for life-sustaining treatment for nursing home residents with dementia. *Journal of the American Association of Nurse Practitioners, 27*(11), 606–614. https://doi-org.ezp.waldenulibrary.org/10.1002/2327-6924.12258 org.ezp.waldenulibrary.org/10.1080/13607863.2018.1452899	n/a	Life-Sustaining Treatments (POLSTs) paradigm is a strategy to enhance EOL care. NH residents.	Review of the literature.	Several studies have documented improved EOL care and other outcomes associated with the POLST paradigm.	Implementation of POLST in NH residents with dementia include increased communication, documentation, increased concordance, and lower rates of unwanted, burdensome treatments at EOL.	Paradigm encourages goals-of-care discussions and shared decision making. Providers should assess and optimize their knowledge and skills to conduct goals of care discussions, including POLST discussions.		V
17. Kirolos, I.,	n/a	Synthesize	Systematic	MEDLINE	ACP	Medical team to	Hospice saves an	I

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
Tamariz, L., Schultz, E., Diaz, Y., Wood, B., & Palacio, A. (2014). Interventions to improve hospice and palliative care referral: A systematic review. *Journal of Palliative Medicine, 17*(8), 957-964. doi:10.1089/jpm.2013.0503		evidence interventions to increase hospice referrals.	review. Six of 419 met eligibility criteria.	search. Education. The interventions varied some from study to study but all six implemented staff training on end of life issues.	programs increase hospice referrals, education addresses the misunderstanding of hospice by provider and patients.	assess patients' treatment goals and that involves the treating physician are successful.	average of $2,309 per patient a year. Providers receive little training on giving "bad" news.	
18. Lowry, F. (2015). End-of-life talks for hematologic cancers often 'too late'. *Medscape Nurse* 1-2. http://www.medscape.com/viewarticle/856233	n/a	Concept of making palliative care a part of ongoing cancer care has not been incorporated in hematology, largely because the prognoses	Descriptive. A survey was sent to 609 Hematologic oncologists who were providing direct care for adults with hematologic cancers. 349 (57.3 %) completed the	Respondents median age was 52 y/o. 75.4% were men. 42.9% practice in tertiary care hospitals. 55.4% practice in community center.	Hematologic oncologists who work in tertiary care centers are more likely to report late EOL discussions than their counterparts who work in centers	Staging for hematologic malignancies different than solid malignancies could certainly contribute to this difference in their care, but there needs to be more research to fully understand this difference. More than half of	EOL talks for hematologic cancer often too late.	VI VI

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
		and trajectories of patients with hematologic malignancies are different. Hematologic oncologist reported EOL discussion with their patients occur too late.	survey.		based the community. Of the respondents 23.2% waited until death was imminent before having the first hospice care discussion. 39.9% wanted until death was imminent before having talked about where the patient wanted to die.	the hematologic oncologist report that EOL discussion with their patient are too late.		
19. Lowry, F. (2016). Early admission to hospice key to good end of life care. *Medscape Nurses.* 1-3. http://www.med	n/a	The way cancer patients die influences how family members feel about the quality	Descriptive Study. Surveys to 11146 family members of pts who died from colorectal or	Admit to hospice for 3 or more days? Admitted to the ICU within 30 days of death? Where did the	EOL care was perceived by family members as excellent in the patients were	Earlier hospice admittance with evading ICU admissions and inpatients death greatly improves end of life care as perceived by the	Admission requirements for hospice creates a barrier. needs to be policy early admission to hospice is key to good end of life	VI

Author/ Date	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Methodology**	**Analysis & Results**	**Conclusions**	**Implication for future research/ practice**	**Comments**	**Level of Evidence**
scape.com/viewarticle/957574		of care their loved ones received during their final days.	lung cancer.	patient die?	admitted to hospice care for more than 3 days vs less than three days, had not been admitted to the ICU within 30 days of death, the patient did not die in the hospital.	family.	care.	
20. Martins-Pereira, S. & Hernandez.Marrero, P. (2016). Palliative care nursing education features more prominently in 2015 than 2005: Results from nationwide survey and quality analysis of curricula. *Palliative*	n/a.	Has palliative care curriculum increased from 2005 to 2015?	Survey 19 undergrad schools.	All participant schools integrated palliative care in their curricula.	Inclusion of palliative care within nursing undergraduate curricula strongly increased from 2005 to 2015.	Understand the contribution of education in the access, care provision, quality and development of palliative care in this country, requires effective policies, education. ethical and legal responsibility to ensure quality palliative care.		V

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
Medicine, 30(9), 884-888.								
21. Minnesota Department of Health. (2020). Questions and answers about health care directives. https://www.health.state.mn.us/facilities/regulation /infobulletins/advdir.html				Give brief overview			Minnesota Law ACD	VII
22. Minnesota Department of Health. (2019). Nursing and boarding care home survey inspection findings. https://www.health.state.mn.us/facilities/regulation/directory/surveyfindings.html	State operations manual.	Quality operation of health care facilities, State Surveys.	Conditions for coverage and requirements for skilled nursing facilities.	The minimum of yearly state surveys.	If facilities do not follow guidelines, they will not be able to participate in Medicare.	Fines or loss of participating in Medicare if statutes or regulation are not followed. The State survey process. Nursing and Boarding Care Home Survey Inspection Findings.		VII
23. Nassikas, N. J., Baird, G. L., & Duffy, C. M.	Provide a framework for ACP	The primary aim of this study was to	The study was a pre- and post	Pre-intervention survey	A relatively modest intervention	Extending the follow-up period to 1 year to give		VI

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
(2020). Improving advance care planning in a resident primary care clinic. *American Journal of Hospice & Palliative Medicine, 37*(3), 185–190. https://doi-org.ezp.waldenulibrary.org/10.1177/1049909119872757	discussions.	develop an intervention to increase the documentation of advance directives in elderly adults in an internal medicine resident primary care clinic. The secondary aims were to improve resident confidence in discussing advance care planning and increase the number of discussions. Methods: The study was a pre- and postintervention study.	intervention study. The study intervention was a 30-minute educational session on advance care planning. Study participants were patients aged 65 years and older who were seen in an internal medicine residency primary care clinic over a 6-month period and internal medicine residents. Clinic encounters were reviewed for the presence	revealed that residents feel they lack training and practice to acquire this skill. A CI and Likert scale increased after the education.	to increase advance care planning discussions is feasible in an internal medicine primary care clinic and can improve the confidence of residents with end of life discussion.	patients adequate time to complete the document and return it to clinic. Discussing advance care planning during a routine clinic visit.		

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
			of advance care planning discussions before and after the intervention. Resident confidence was measured on a Likert scale.					
24. National Hospice and Palliative Care Organization (2016). Advance care planning. http://www.nhpco.org/advance-care-planning					Review of what is covered		NHPCO ACP	VII
25. National POLST Paradigm. (2016). http://www.polst.org/wp-content/uploads/2016/04/2016.04.03-POLST-FAQs.pdf					Same as above		National POLST Paradigm Task Force approved a business strategy for the National POLST Paradigm.	VII
26. Osta, B.,	n/a	1404	Descriptive	Chart review	The ratio of	Should or are early		IV

Author/ Date	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Methodology**	**Analysis & Results**	**Conclusions**	**Implication for future research/ practice**	**Comments**	**Level of Evidence**
Palmer, J., Paraskevopoulos, T., Pei, B., Roberts, L., Poulter, V., Chacko, R., & Bruera E. (2008) Interval between first palliative care consult and death in patients diagnosed with advanced cancer at a comprehensive cancer center. *Journal of Palliative Medicine. 11*(1): 51-57. doi:10.1089/jpm.2007.0103		comprehensive cancer center.	Retrospective chart review.	respectively.	consults decreased from 0.30 to 0.26 over the 5 half-year periods.	referrals needed for better patient outcomes at the end of life or before death is imminent?		
27.Pereira-Salgado, A., Philpot, S., Schlieff, J., O'Driscoll, L., & Mills, A. (2019). Advance	Jeffries' simulation design framework.	The aim of this study was to develop and pilot an ACP SBL intervention for nurses	A cross-sectional study using mixed methods (quasi-experimental pre-post and	Confidence and clinical practice for nurses increased after the ACP education using.	With appropriate training, nurses may be better engaged in ACP.	How long will the education be effective? Training for nurse in the end of life conversation.		IV

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
Care Planning Simulation-Based Learning for Nurses: Mixed Methods Pilot Study. *Clinical Simulation in Nursing*, *29*, 1–8. https://doi.org/10.1016/j.ecns.2018.11.006		1. examine differences in participants' knowledge, self-confidence, and behaviour (before and after training); 2. explore participants' perceptions of benefits, suggestions for improvements, and impact on clinical practice.	qualitative description).					
28. Rhondali, W., Burt, S., Wittenberg-Lyles E., Bruera E., & Dalal, S. (2013). Medical oncologists' perception of	n/a.	Examine oncologists' perceptions of the supportive care program.	Qualitative study used semi-directed interviews. 17 oncologists.	Analysed data using grounded theory and qualitative methods.	Supportive care was perceived as an important time-saving activity, and symptom management,	Limitation consist of recruitment process; further research is needed to confirm findings is warranted. Communication is an issue with early referrals.		V

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
palliative care programs and the impact of name change to supportive care on communication with patients during the referral process. A qualitative study. Palliative and Supportive Care. 11(5), 397-404 doi.10.1017/S1478951512000685					transitioning to end of life care, family counselling, and improving patients' ability to tolerate cancer therapies were cited as important functions.			
29. Shepherd, J., Waller, A., Sanson-Fisher, R., Clark, K., & Ball, J. (2018). Knowledge of, and participation in, advance care planning: A cross-sectional study of acute and critical care	n/a.	Determine in a sample of nurses working in acute and critical care hospital wards: 1. their knowledge of advance care planning,	306 nurses. Cross-sectional study, questionnaire based.	Multiple linear regression analyses. multiple regression model. Chi-square analyses. Assessing nurse's knowledge	Further education and support is needed to ensure that nurses have an accurate knowledge of advance care planning practices, including	Nurses need education in end of life conversation.	Nurses have a core role in facilitating discussions and enacting decisions about end of life issues.	IV

Author/ Date	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Methodology**	**Analysis & Results**	**Conclusions**	**Implication for future research/ practice**	**Comments**	**Level of Evidence**
nurses' perceptions. International *Journal of Nursing Studies*, *86*, 74–81. https://doi.org/10.1016/j.ijnurstu.2018.06.005		including the authority of substitute decision-makers and legal validity of advance directives; 2. their own participation in advance care planning decision-making practices; and 3. associations between nurses' socio-demographic characteristics; clinical expertise; and knowledge and behaviour in			how, when and with whom wishes should be discussed and can be enacted.			

Author/ Date	Theoretical/ Conceptual Framework	Research Question(s)/ Hypotheses	Methodology	Analysis & Results	Conclusions	Implication for future research/ practice	Comments	Level of Evidence
		relation to advance care planning practices.						
30. Smith, A. (2020). Communication of prognosis in palliative care. *Up to Date.* https://www.uptodate.com/contents/communication-of-prognosis-in-palliative-care?sectionName=THE%20SCIENCE%20OF%20ESTIMATING %20PROGNOSIS&topicRef=2200&anchor=H11773296&source=see_link#H117 73296	n/a	Focus primarily on communicating prognosis for life expectancy or survival.	Prognostic calculators for patients with specific conditions are available in UpToDate.	More accurate at predicting short-term than long-term prognosis. Western medicine has slowly transitioned from a paternalistic model to a model based on informed shared decision-making.	Clinicians frequently articulate the concern that discussing prognosis will “take away hope.	When and how to start the conversation. Step wise or all at once. Does not harm pt provider relationship. Patients are making decisions with little prognostic awareness.		VII

Note. Evidence graded using the hierarchy of evidence model from "Evidence-based Practice Step by Step: Critical appraisal of the evidence: Part I," by E. Fineout-Overholt , B. M. Melnyk, S. B Stillwell, and K. M Williamson, 2010, *American Journal of Nursing*, *110*(7), p.47-52.

***Levels of Evidence:**

Level 1 Evidence obtained from a systematic review or meta-analysis of all relevant RCTs randomized controlled trial.

Level 2: Randomized controlled trails

Level 3: Evidence obtained from well-designed controlled trials without randomizations, quasi experimental

Level 4: Evidence from well-designed case-control or cohort studies.

Level 5: Systematic reviews of descriptive or qualitative studies.

Level 6: Evidence obtained from a single descriptive or qualitative study

Level 7: Evidence obtained from the opinions of authorities and or report of expert committees.

Reference

Melynk, B. & Fineout-Overholt, E. (2011). *Evidence-based practice in nursing & health care: A guide to best practice.* Philadelphia. Lippincott Williams & Wilkins

Appendix B: Pre/Posttest

One conversation can make all the difference!

1. According to the Institute of Healthcare Improvement what percent of individuals say that talking with their loved ones about end of life care is important?

a. 10% b. 50% c. 90% d. 30%

2. According to the Institute of Healthcare Improvement what percent of individuals have had the end of life care conversation with their loved ones?

a. 10-20% b. 20-30% c. 50-60% d. 80-90%

3. What factors are associated with excellent end of life care? * select all

a. early hospice admission

b. avoidance of the intensive care unit

c. increase in depression for loved ones

d. death outside the hospital

e. lower end of life cost

f. decreased cost

4. Hospice patients, on average, live how much longer than their counterparts not on hospice?

a. days b. weeks c. months d. years

5. What are the benefits of hospice care? *select all that apply

a. dying at home with family and friends

b. dying/living without stressful physical symptoms such as nausea, vomiting, pain, dyspnea, respiratory tract secretions, anxiety, and agitation

c. increased patient satisfaction

d. a decrease in depression for loved ones during bereavement

6. The reasons Hospice patients live longer is because * select all that apply

a. better-quality of care b. how and who cares for the patient.

c. cure or improvement in their terminal illness d. a positive attitude

7. End-of-life medical care costs are _____% of the national healthcare budget.

a. > 10 b. > 50 c. > 75 d. > 90

8. **True or False?**

In 2016 Medicare started covering costs for the advance care conversation between patients and primary care providers.

9. **True or False?**

Hospice care escalates family and caregivers’ depression and end of life cost.

10. **True or False?**

Dynamics associated with advance care planning include making treatment decisions based on personal values and preferences before becoming unable to speak for themselves.

Intentions

1. Have you had the end of life conversation with your loved ones?

a. yes b. no c. planning on it d. thinking about it

2. Have you had the end of life conversation with your provider?

a. yes b. no c. planning on it d. thinking about it

3. Do you have your end of life wishes in writing?

a. yes b. no c. planning on it d. thinking about it

Using the scale below please indicate where you rate yourself by placing an X.

4. How comfortable are you with initiating the end of life conversation with your residents?

1---------------------2---------------------3---------------------4---------------------5

Not very comfortable Somewhat comfortable Very comfortable

5. How competent do you feel with having the end of life care conversation with your residents?

1---------------------2---------------------3---------------------4---------------------5

Not very competent Somewhat competent Very competent

6. How do you rate your knowledge of end of life care?

1---------------------2---------------------3---------------------4---------------------5

No knowledge Very knowledgeable

Thank you, for your participation

Appendix C: Continuing Education Certificate

The Minnesota Board of Nursing certifies that

Has participated and completed the educational program titled:

Getting the End-of-Life Care Conversation Started

Green Prairie Rehabilitation & Assisted Living Campus
Plainview, MN
September 17, 2020
And is awarded 2 Continuing Education Hours/ 2 MN Board of Nursing Hours

- Presented by Lisa McCabe-Evans

Objectives:

By the end of the educational event the nursing staff at the local rehabilitation and assistive living center will be able to
1. understand why the EOL conversation is so essential.
2. have an increase in knowledge on initiating the EOL conversation with their patients and the patient's loved ones.
3. have and increase in expressed intentions about end of life care.
4. be more prepared in starting the EOL discussion and ready to have the conversation with each admission to the local rehabilitation and assistive living center.
5. ensure more advance directives, POLST, code status, end of life conversations being completed on admission to the rehabilitation and assistive living center.

This activity has been designed to meet the Minnesota Board of Nursing continuing education requirements.
The activity has been approved by Green Prairie Rehabilitation & Assisted Living Campus.
However, the licensee/nurse is responsible for determining whether this activity meets the requirements for acceptable continuing education.
Please keep this for your licensure needs.
*formatted to fit this paper

Appendix D: Curriculum Plan with Teaching Model

Student: Lisa McCabe-Evans

Title: Getting the End of Life Care Conversation Started.

Problem: The lack of end of life (EOL) conversation and the underutilization of hospice has led to patients' end of life wishes not being met, an increase in depression for bereaved loved ones, and there is a significant cost of end of life care (National Hospice and Palliative Care Organization [NHPCO], 2016).

Specific problem: Unmet EOL wishes for residents. Moreover, Physician Orders for Life-Sustaining Treatment (POLST) forms, advance directives, and code statuses not being completed in a timely manner. Some long-term care residents and loved ones are so uncomfortable talking about end of life, that these conversations are engaged during multiply visits lasting weeks

Purpose: To raise awareness on initiating the EOL conversation to increase nurses' comfort in having the conversation with patients, their loved ones, and providers.

Practice Focused Question: What information and resources do nurses need to gain confidence and competence in having the end of life conversation with patients, their loved ones, and providers?

Objectives: By the end of the educational event the nursing staff at the local rehabilitation and assistive living center will be able to

1. will understand why the EOL conversation is so essential.
2. have an increase in knowledge on initiating the EOL conversation with their patients and the patient's loved ones.

3. have and increase in expressed intentions about end of life care.
4. be more prepared in starting the EOL discussion and ready to have the conversation with each admission to the local rehabilitation and assistive living center.
5. ensure more advance directives, POLST, code status, end of life conversations being completed on admission to the rehabilitation and assistive living center.

Target Population: The 37 nurses employed at the rehabilitation and assisted living campus.

Equipment: Television, digital versatile disc player, computer, and conversation starter kit.

Materials: *Being Mortal* documentary on digital versatile disc player and educational handouts,

Components: PowerPoint presentation, documentary *Being Mortal* (Jennings, 2015), and the Institute of Healthcare Improvement IHI conversation starter kit (2019), open discussion, and a document of local resources.

Educational Event: The educational event will start with an introduction, pretest, a PowerPoint developed by me based on the current literature, showing of the documentary *Being Mortal* (Jennings, 2015), introduction to the IHI conversation starter kit (2019), then an open discussion about making EOL wishes known to providers and loved ones and end with a posttest based on the teaching module. The nurses who attend will receive 2 hours continuing education credits from the State Board of Nursing through the facility.

Educational Curriculum Plan

Objectives at the conclusion of this educational event the nurses will be able to	**Content Outline**	**Evidence**	**Method of Presenting**	**Method of Evaluation**	**Evidence Grade**
1. will understand why the EOL conversation is so essential.	• PowerPoint Slides 1-3, 6-8 • *Being Mortal* • IHI conversation starter kit page 3.	Biagioli et al., 2018 Shepherd et al., 2018. Ahearn et al., 2012. Jennings, 2015. Gawande, 2014. Martins-Pereira & Hernadez-Marrero, 2016. Pereira-Salgado et al., 2019 Jennings, 2015. Gawande, 2014. IHI, 2019	PowerPoint presentation *Being Mortal* (2015) documentary IHI conversation starter kit (2019) open discussion.	pre/ posttest questions K1-K3.	VI IV VI VII V IV VII VI
2. have an increase in knowledge on initiating the EOL conversation with their patients and the patient's loved ones.	• PowerPoint Slides 1, 6-8 • *Being Mortal* • IHI conversation	Biagioli et al., 2018. Adams, 2015. Jennings, 2015. Gawande, 2014 Smith, 2020 Jennings, 2015. Gawande, 2014.	PowerPoint presentation *Being Mortal* (2015) documentary IHI conversation	pre/ posttest questions K1-K10, I6.	VI VII VII VII VII

	starter kit page 3.	IHI, 2019	starter kit (2019), and open discussion.		VI
3. have and increase in expressed intentions about end of life care.	• PowerPoint Slides 5-8 • *Being Mortal* • IHI conversation starter kit.	White, Dudley-Brown, & Terhaar, 2016. Gallo et al., 2019 Rhondali et al., 2013 Jennings, 2015. Gawande, 2014. IHI, 2019	PowerPoint presentation *Being Mortal* (2015) documentary IHI conversation starter kit (2019), and open discussion.	pre/ posttest questions I1-I4.	IV V VII VI
4. be more prepared in starting the discussion and ready to have the conversation with each admission to the local rehabilitation and assistive living center.	• PowerPoint Slide 5 • *Being Mortal* • IHI conversation starter kit.	National Hospice and Palliative Care Organization, 2016. Biagioli et al., 2018. Jennings, 2015. Gawande, 2014 Gazarian et al., 2019 Smith, 2020 National POLST Paradigm, 2016). Jennings, 2015. Gawande, 2014. IHI, 2019	PowerPoint presentation, *Being Mortal* (2015) documentary IHI conversation starter kit (2019), and open discussion.	pre/ posttest questions I1-I5.	VII VI VII V VII VII VII VI
5. ensure more advance directives, POLST, code status, end of life conversations	• PowerPoint Slides 6-8	IHI, 2019. Garfield, 2014. Osta et al., 2008. Amano et al., 2015. Beyea et al., 2013. Brugger et al., 2013.	PowerPoint presentation,	pre/ posttest questions 1-3	VII VII IV IV III VII

being completed on or even prior to admission to the rehabilitation and assistive living center.		Jennings, 2015.			
		Gawande, 2014.			VII
		Goode et al., 2019.			III
		Kim et al.,2015.			V
		Kirolos et al., 2014.			I
		Lowry, 2015.			VI
		Nassikas et al., 2020.			VI
	• *Being Mortal*	Jennings, 2015.	*Being Mortal* (2015) documentary		
		Gawande, 2014.			VII

***Defining the numbering K 1-10 = knowledge questions and I 1-6 = Intent questions**

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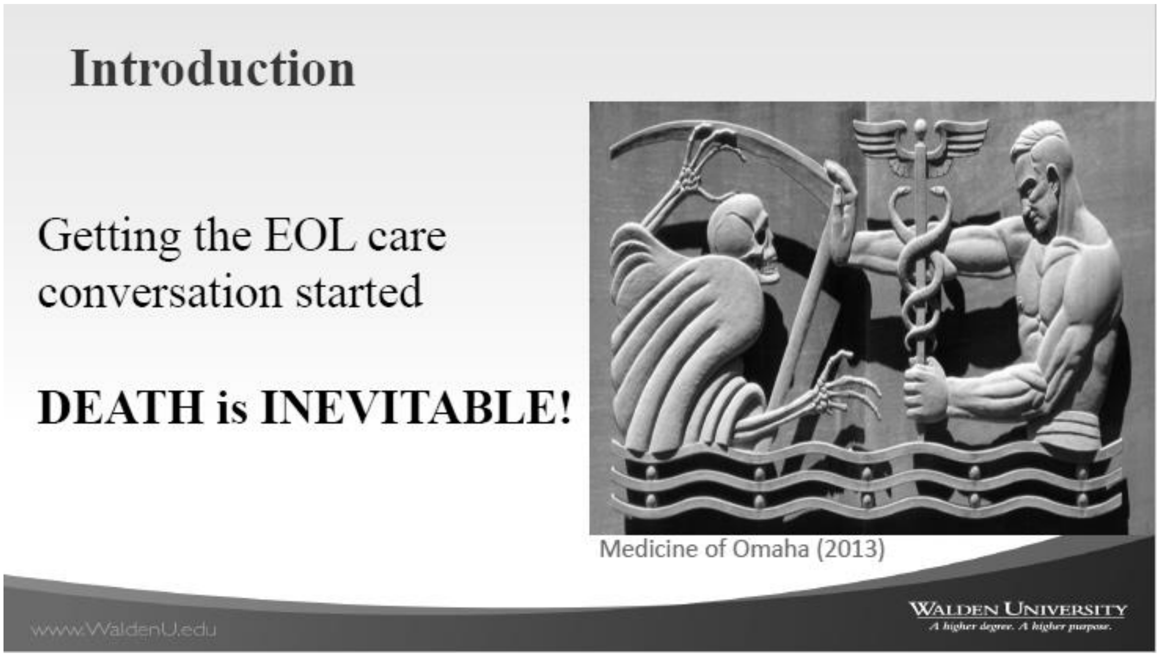
Appendix E: PowerPoint Presentation for GCS-SEP



Introduction

Getting the EOL care conversation started

DEATH is INEVITABLE!

Medicine of Omaha (2013)

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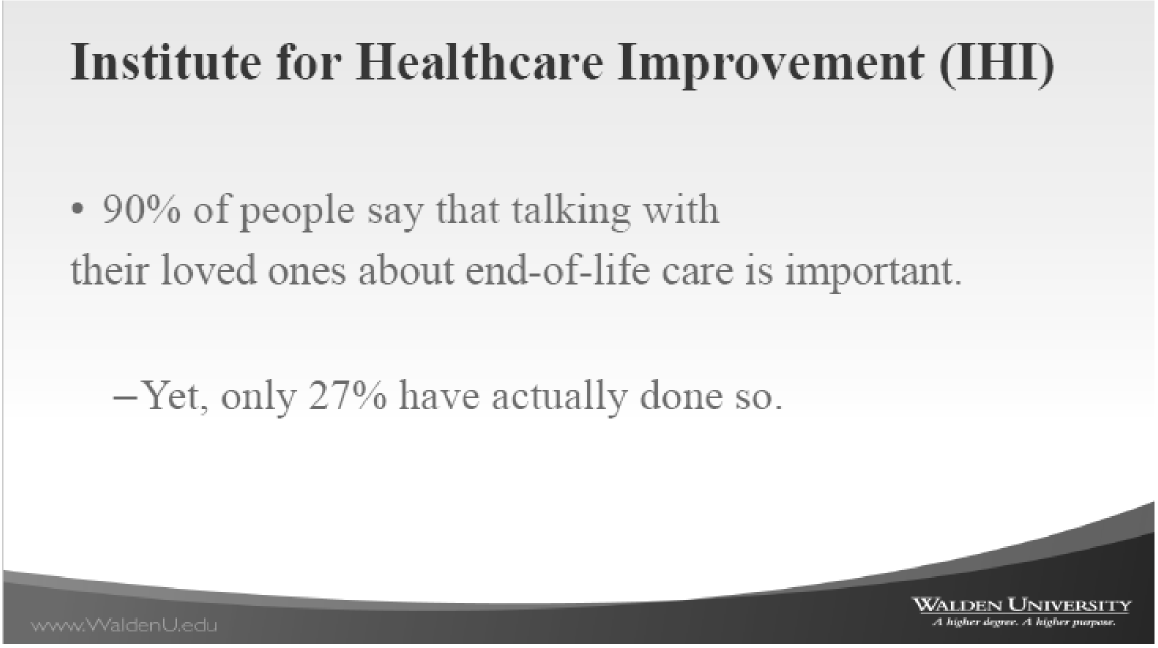

Institute for Healthcare Improvement (IHI)

- 90% of people say that talking with their loved ones about end-of-life care is important.
  - Yet, only 27% have actually done so.

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Institute for Healthcare Improvement (IHI)

- 80% of people say that if seriously ill, they would want to talk to their doctor about wishes for medical treatment toward the end of their life.
  - 7% report having had this conversation with their doctor

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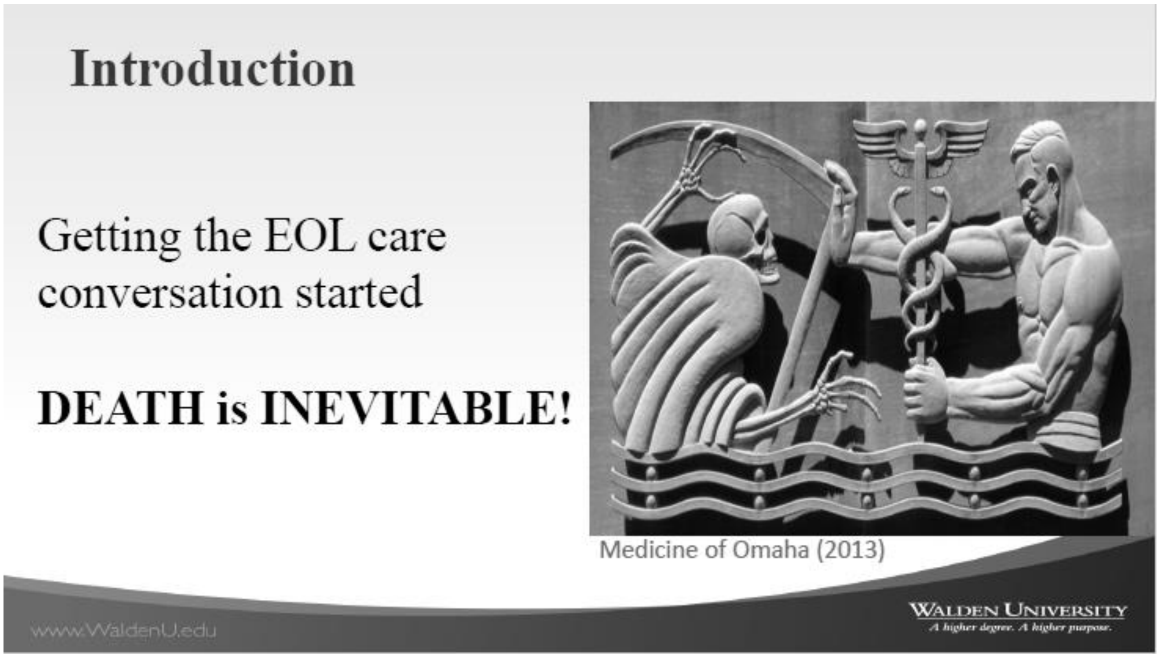

Introduction

Getting the EOL care conversation started

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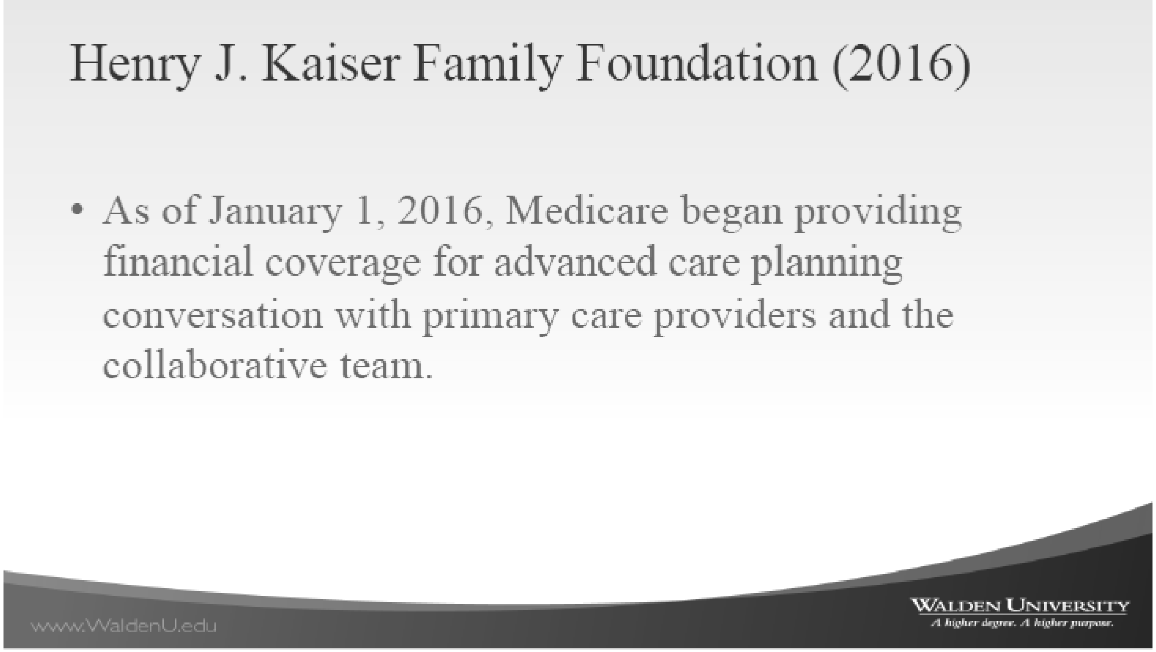

Henry J. Kaiser Family Foundation (2016)

- As of January 1, 2016, Medicare began providing financial coverage for advanced care planning conversation with primary care providers and the collaborative team.

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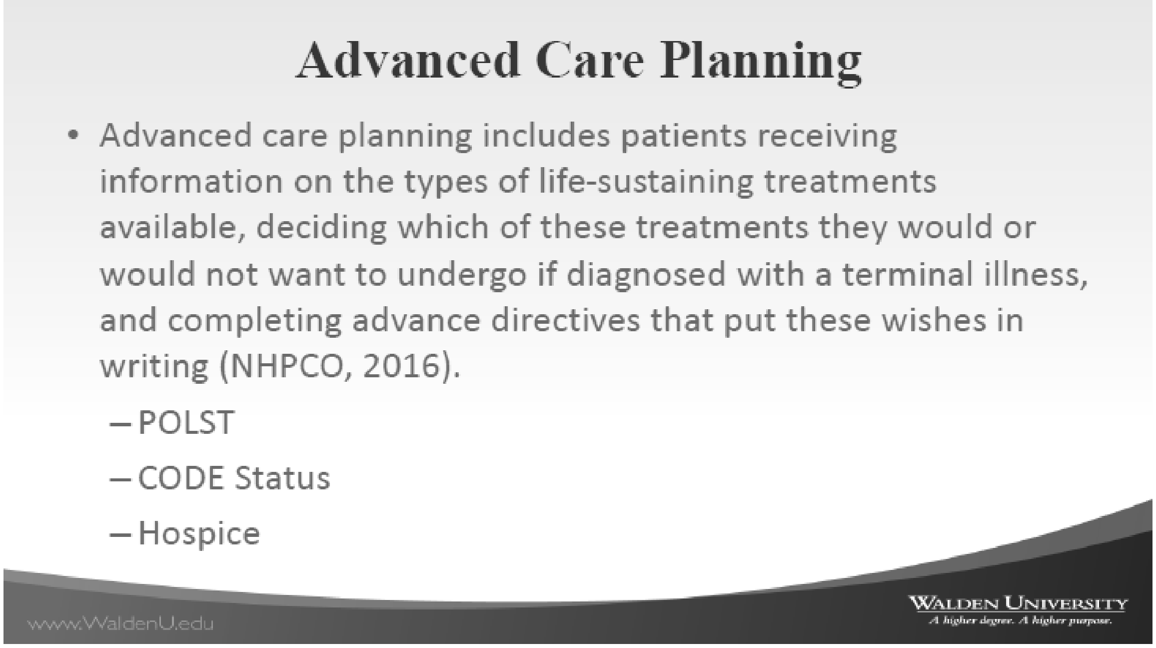

Advanced Care Planning

- Advanced care planning includes patients receiving information on the types of life-sustaining treatments available, deciding which of these treatments they would or would not want to undergo if diagnosed with a terminal illness, and completing advance directives that put these wishes in writing (NHPCO, 2016).
  - POLST
  - CODE Status
  - Hospice

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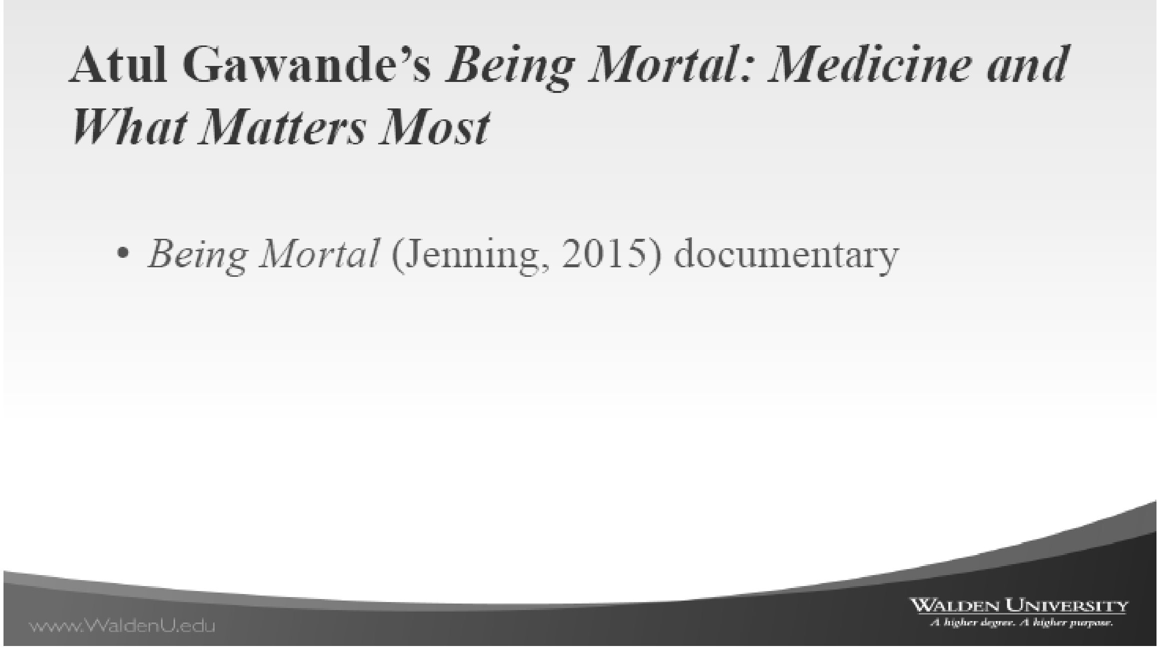

Atul Gawande’s *Being Mortal: Medicine and What Matters Most*

- *Being Mortal* (Jenning, 2015) documentary

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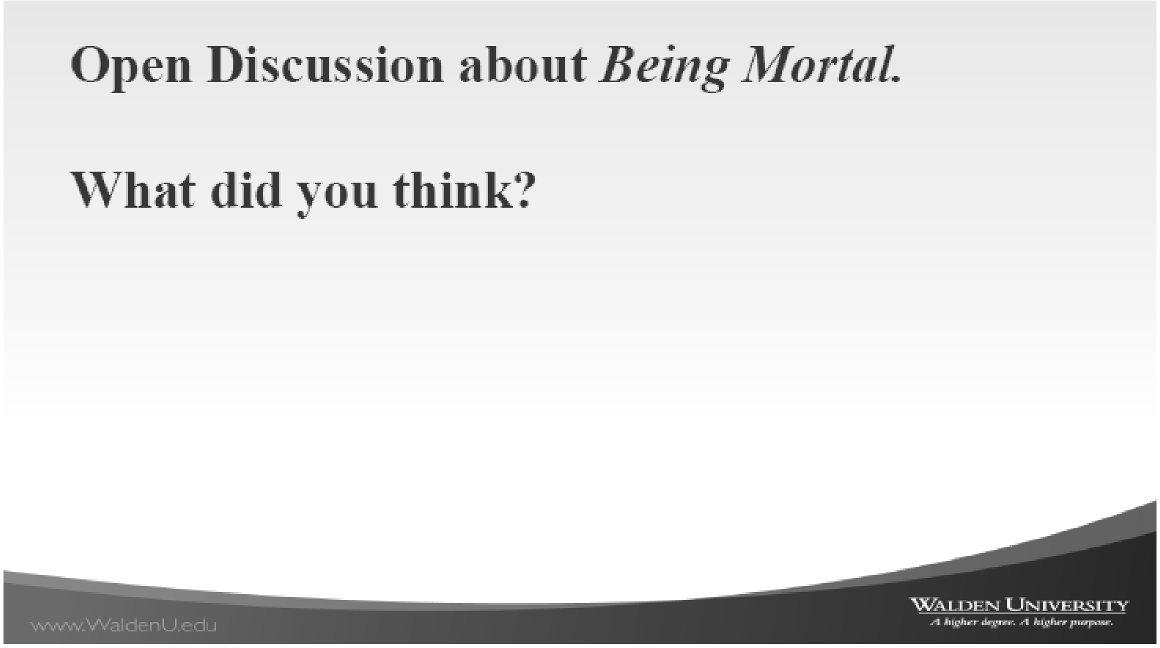

Open Discussion about *Being Mortal.*

What did you think?

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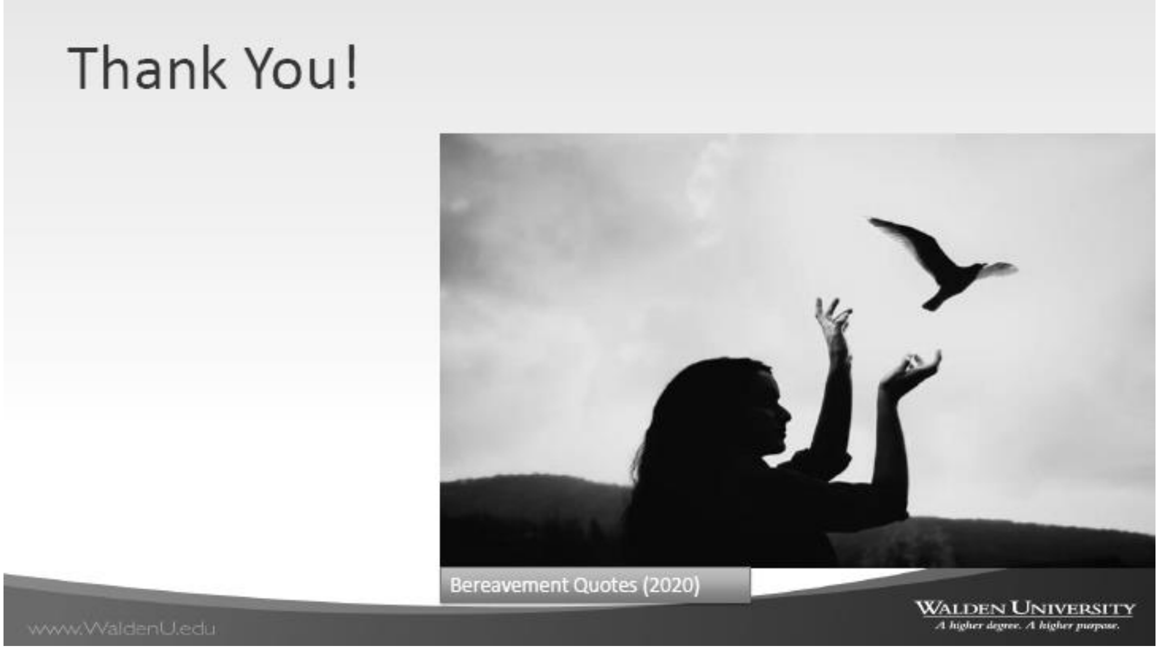

Thank You!

Bereavement Quotes (2020)

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Questions?

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Resources

- Folders
- Resources

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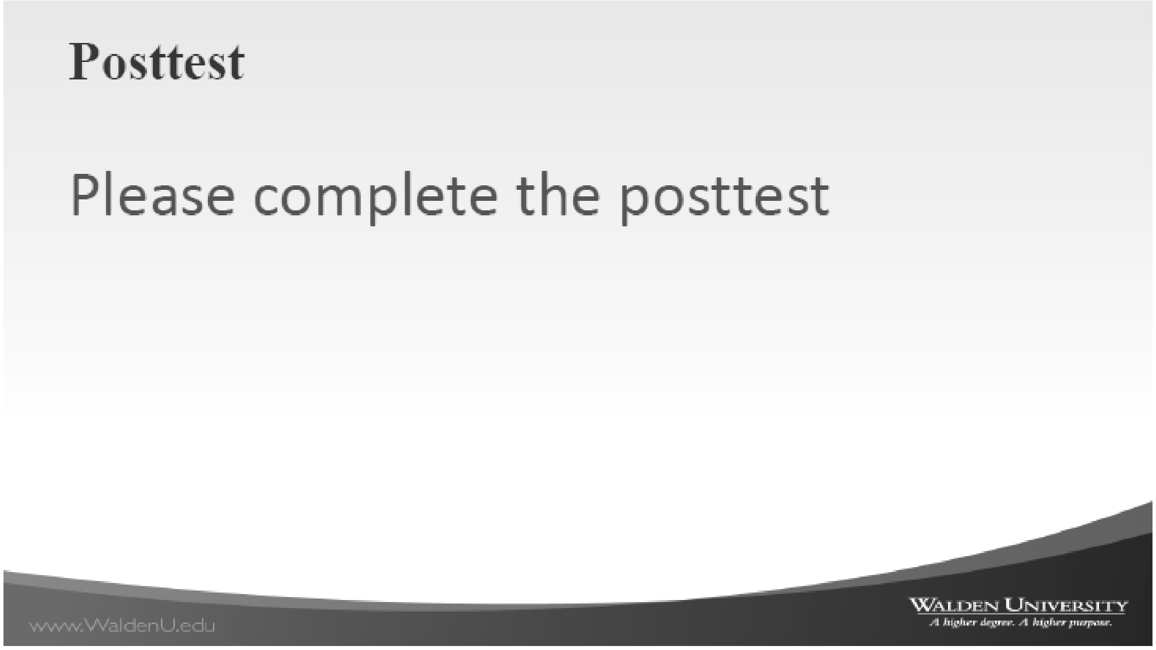

Posttest

Please complete the posttest

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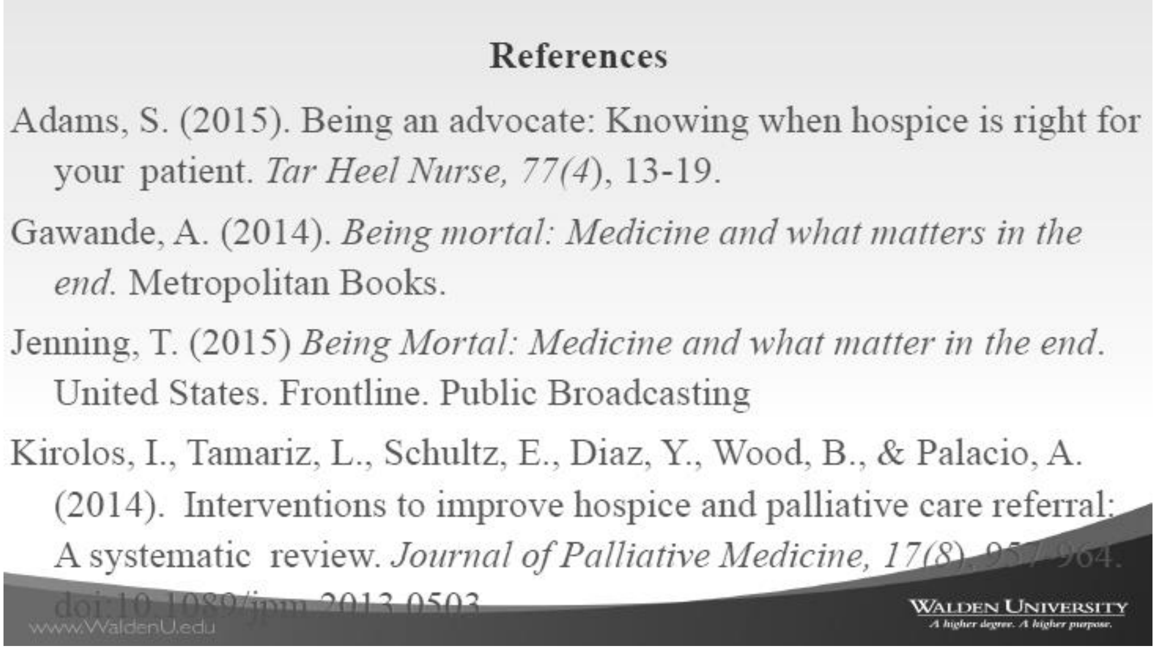

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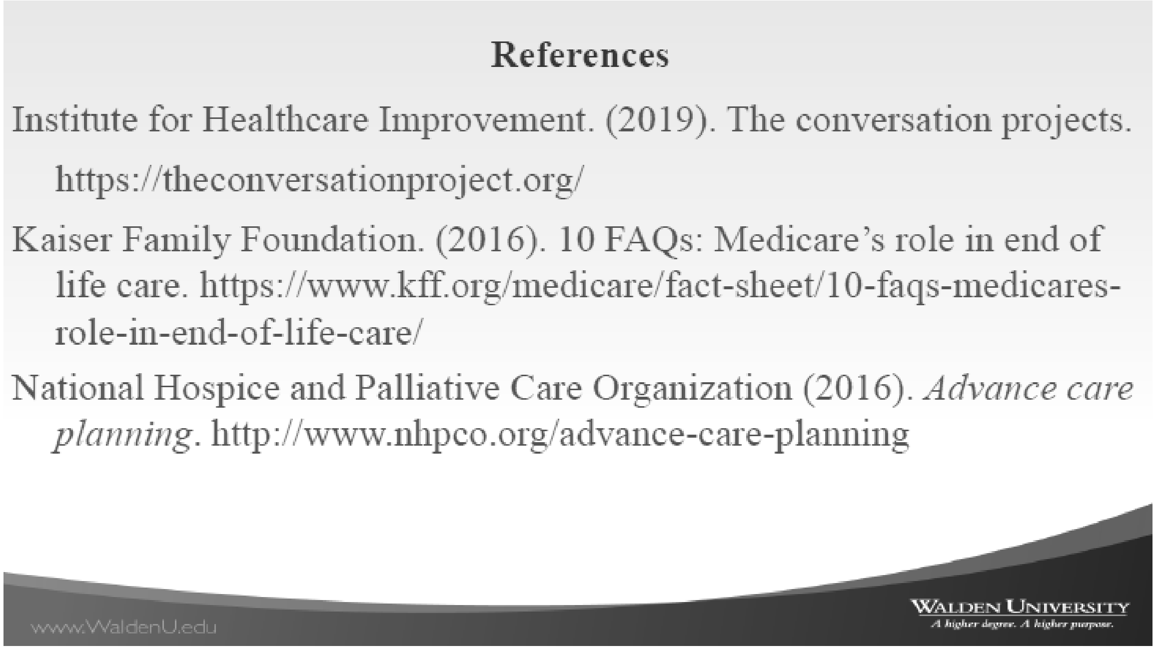

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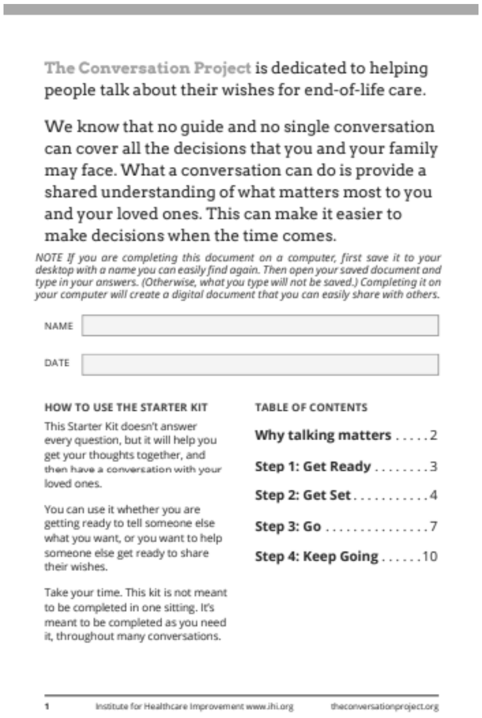
Appendix F: The Institute for Healthcare Improvement Conversation Starter Kit

Your Conversation Starter Kit

When it comes to end-of-life care, talking matters.

Institute *for* Healthcare Improvement the conversation project



The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care.

We know that no guide and no single conversation can cover all the decisions that you and your family may face. What a conversation can do is provide a shared understanding of what matters most to you and your loved ones. This can make it easier to make decisions when the time comes.

NOTE If you are completing this document on a computer, first save it to your desktop with a name you can easily find again. Then open your saved document and type in your answers. (Otherwise, what you type will not be saved.) Completing it on your computer will create a digital document that you can easily share with others.

NAME

DATE

HOW TO USE THE STARTER KIT

This Starter Kit doesn't answer every question, but it will help you get your thoughts together, and then have a conversation with your loved ones.

You can use it whether you are getting ready to tell someone else what you want, or you want to help someone else get ready to share their wishes.

Take your time. This kit is not meant to be completed in one sitting. It's meant to be completed as you need it, throughout many conversations.

TABLE OF CONTENTS

Why talking matters

Sharing your wishes for end-of-life care can bring you closer to the people you love. It's critically important. And you can do it. **Consider the facts:**

92% of people say that talking with their loved ones about end-of-life care is important.

32% have actually done so.

Source: The Conversation Project National Survey (2018)

21% of people say they haven't had the conversation because they don't want to upset their loved ones.

53% say they'd be relieved if a loved one started the conversation.

95% say they are willing or want to talk about their end-of-life wishes.

Source: The Conversation Project National Survey (2018)

80% of people say that if seriously ill, they would want to talk to their doctor about wishes for medical treatment toward the end of their life.

18% report having had this conversation with their doctor.

Source: Survey of Californians by the California HealthCare Foundation (2012) and Kaiser Family Foundation Serious Illness in Late Life Survey (2017)

97% of people say it's important to put their wishes in writing.

37% have actually done it.

Source: Kaiser Family Foundation Serious Illness in Late Life Survey (2017)

A conversation can make all the difference.

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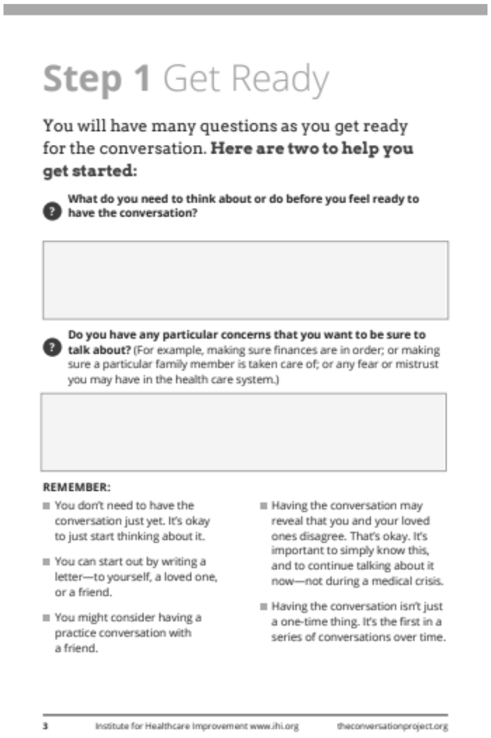

Step 1 Get Ready

You will have many questions as you get ready for the conversation. **Here are two to help you get started:**

What do you need to think about or do before you feel ready to have the conversation?

Do you have any particular concerns that you want to be sure to talk about? (For example, making sure finances are in order; or making sure a particular family member is taken care of; or any fear or mistrust you may have in the health care system.)

REMEMBER:

- You don't need to have the conversation just yet. It's okay to just start thinking about it.
- You can start out by writing a letter—to yourself, a loved one, or a friend.
- You might consider having a practice conversation with a friend.
- Having the conversation may reveal that you and your loved ones disagree. That's okay. It's important to simply know this, and to continue talking about it now—not during a medical crisis.
- Having the conversation isn't just a one-time thing. It's the first in a series of conversations over time.

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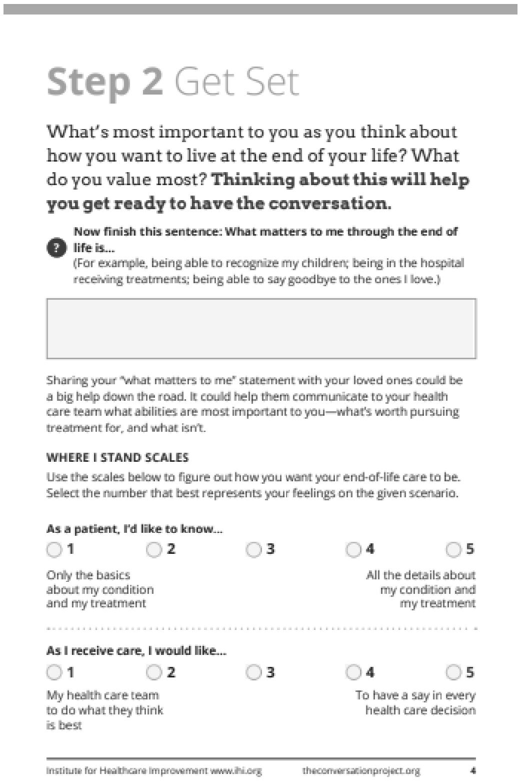

Step 2 Get Set

What's most important to you as you think about how you want to live at the end of your life? What do you value most? **Thinking about this will help you get ready to have the conversation.**

Now finish this sentence: What matters to me through the end of life is...
(For example, being able to recognize my children; being in the hospital receiving treatments; being able to say goodbye to the ones I love.)

Sharing your "what matters to me" statement with your loved ones could be a big help down the road. It could help them communicate to your health care team what abilities are most important to you—what's worth pursuing treatment for, and what isn't.

WHERE I STAND SCALES

Use the scales below to figure out how you want your end-of-life care to be. Select the number that best represents your feelings on the given scenario.

As a patient, I'd like to know...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Only the basics about my condition and my treatment	All the details about my condition and my treatment

As I receive care, I would like...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

My health care team to do what they think is best	To have a say in every health care decision

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If I had a terminal illness, I would prefer to...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not know how quickly it is progressing	Know my doctor's best estimation for how long I have to live

Look at your answers.
What kind of role do you want to have in the decision-making process?

How much medical treatment do you want to try?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I want to try every treatment available, no matter how uncomfortable I become	Quality of life is more important to me than quantity

What are your concerns about medical treatments?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I worry that I won't get enough care	I worry that I'll get too much care

What are your preferences about where you want to be?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I want to spend my last days in a health care facility	I want to spend my last days at home

Look at your answers.
What do you notice about the kind of care you want to receive?

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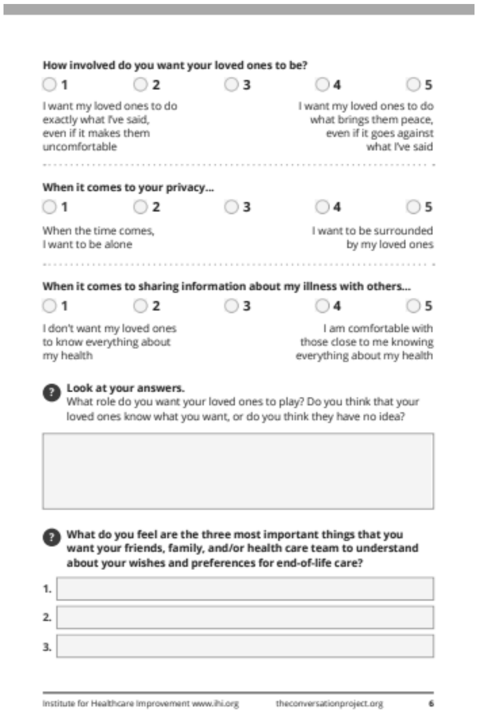

How involved do you want your loved ones to be?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I want my loved ones to do exactly what I've said, even if it makes them uncomfortable

I want my loved ones to do what brings them peace, even if it goes against what I've said

When it comes to your privacy…

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

When the time comes, I want to be alone

I want to be surrounded by my loved ones

When it comes to sharing information about my illness with others…

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I don't want my loved ones to know everything about my health

I am comfortable with those close to me knowing everything about my health

Look at your answers.
What role do you want your loved ones to play? Do you think that your loved ones know what you want, or do you think they have no idea?

What do you feel are the three most important things that you want your friends, family, and/or health care team to understand about your wishes and preferences for end-of-life care?

1.

2.

3.

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Step 3 Go

When you're ready to have the conversation, think about the basics.

MARK ALL THAT APPLY:

WHO do you want to talk to now?

☐ Parent(s)
☐ Chosen family member(s)
☐ Child/Children
☐ Spouse/Partner(s)
☐ Sibling
☐ Faith leader (Minister, Priest, Rabbi, Imam, etc.)
☐ Trusted friend
☐ Health care provider
☐ Caregiver
☐ Other:

WHEN would be a good time to talk?

☐ The next holiday
☐ Before my child goes to college
☐ Before my next trip
☐ Before I get sick again
☐ Before the baby arrives
☐ The next time I visit with family
☐ On a video or phone call
☐ Other:

WHERE would you feel comfortable talking?

☐ At the kitchen table
☐ At a favorite restaurant
☐ In the car
☐ On a walk
☐ Sitting in a park
☐ At my place of worship
☐ Other:

WHAT do you want to be sure to say?
If you wrote down your three most important things at the end of Step 2, you can use those here.

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How to start

Here are some ways you could break the ice:

"I need your help with something."

"Remember how someone in the family died—was it a 'good' death or a 'hard' death? How will yours be different?"

"I was thinking about what happened to ☐, and it made me realize…"

"Even though I'm okay right now, I'm worried that ☐, and I want to be prepared."

"I need to think about the future. Will you help me?"

"I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I'm wondering what your answers would be."

What to talk about:

☐ When you think about the last phase of your life, what's most important to you? How would you like this phase to be?

☐ Do you have any particular concerns about your health? About the last phase of your life?

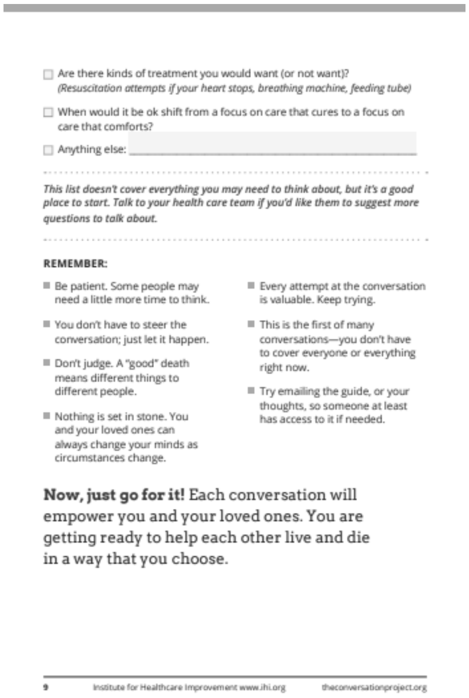
☐ What affairs do you need to get in order, or talk to your loved ones about? *(Personal finances, property, relationships)*

☐ Who do you want (or not want) to be involved in your care? Who would you like to make decisions on your behalf if you're not able to? *(This person is your health care proxy.)*

☐ Are there any disagreements or family tensions that you're concerned about?

☐ Are there important milestones you'd like to be there for, if possible? *(The birth of your grandchild, your 80th birthday.)*

☐ Where do you want (or not want) to receive care? *(Home, nursing facility, hospital)*



☐ Are there kinds of treatment you would want (or not want)? *(Resuscitation attempts if your heart stops, breathing machine, feeding tube)*

☐ When would it be ok shift from a focus on care that cures to a focus on care that comforts?

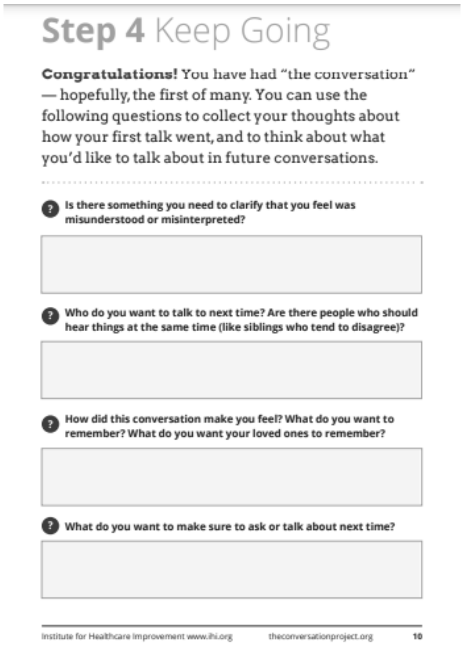
☐ Anything else: ____________________

This list doesn't cover everything you may need to think about, but it's a good place to start. Talk to your health care team if you'd like them to suggest more questions to talk about.

REMEMBER:

- Be patient. Some people may need a little more time to think.
- You don't have to steer the conversation; just let it happen.
- Don't judge. A "good" death means different things to different people.
- Nothing is set in stone. You and your loved ones can always change your minds as circumstances change.
- Every attempt at the conversation is valuable. Keep trying.
- This is the first of many conversations—you don't have to cover everyone or everything right now.
- Try emailing the guide, or your thoughts, so someone at least has access to it if needed.

Now, just go for it! Each conversation will empower you and your loved ones. You are getting ready to help each other live and die in a way that you choose.



Step 4 Keep Going

Congratulations! You have had "the conversation" — hopefully, the first of many. You can use the following questions to collect your thoughts about how your first talk went, and to think about what you'd like to talk about in future conversations.

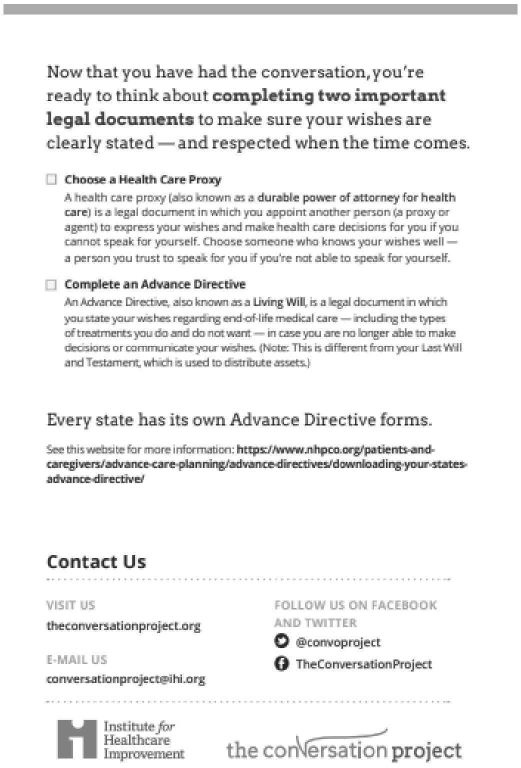
? Is there something you need to clarify that you feel was misunderstood or misinterpreted?

? Who do you want to talk to next time? Are there people who should hear things at the same time (like siblings who tend to disagree)?

? How did this conversation make you feel? What do you want to remember? What do you want your loved ones to remember?

? What do you want to make sure to ask or talk about next time?

Institute for Healthcare Improvement www.ihi.org theconversationproject.org **10**



Now that you have had the conversation, you're ready to think about **completing two important legal documents** to make sure your wishes are clearly stated — and respected when the time comes.

☐ **Choose a Health Care Proxy**

A health care proxy (also known as a **durable power of attorney for health care**) is a legal document in which you appoint another person (a proxy or agent) to express your wishes and make health care decisions for you if you cannot speak for yourself. Choose someone who knows your wishes well — a person you trust to speak for you if you're not able to speak for yourself.

☐ **Complete an Advance Directive**

An Advance Directive, also known as a **Living Will**, is a legal document in which you state your wishes regarding end-of-life medical care — including the types of treatments you do and do not want — in case you are no longer able to make decisions or communicate your wishes. (Note: This is different from your Last Will and Testament, which is used to distribute assets.)

Every state has its own Advance Directive forms.

See this website for more information: **https://www.nhpco.org/patients-and-caregivers/advance-care-planning/advance-directives/downloading-your-states-advance-directive/**

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Appendix G: Content Expert Evaluation of the Curriculum Plan

Title of Project: Getting the End-of-Life Care Conversation Started.
Student: Lisa McCabe-Evans DNP Student
Date: September 8, 2020
Name of Reviewer:

Products for review: Literature review Matrix, Curriculum Plan with Complete Curriculum Content and Teaching Model, PowerPoint presentation, Content Expert Evaluation Plan Form

Instructions Please review each objective related to the curriculum plan, content and matrix. The answer will be a "yes" or "no" with comments if there is a problem understanding the content or if the content does not speak to the objective.

By the end of the educational event the nursing staff at the local rehabilitation and assistive living center will be able to

Objective 1: will understand why the EOL conversation is so essential.

Met **Not Met**

Comments:

Objective 2: have an increase in knowledge on initiating the EOL conversation with their patients and the patient's loved ones.

Met **Not Met**

Comments:

Objective 3: have and increase in expressed intentions about end of lifeend of life care.

Met **Not Met**

Comments:

Objective 4: be more prepared in starting the EOL discussion and ready to have the conversation with each admission to the local rehabilitation and assistive living center.

Met **Not Met**

Comments:

Objective 5: ensure more advance directives, POLST, code status, end of life conversations being completed on admission to the rehabilitation and assistive living center.

Met **Not Met**

Comments:

Appendix H: Content Expert Evaluation of the Curriculum Plan Summary

Not Met = 1 Met = 2

By the end of the educational event the nursing staff at the local rehabilitation and assistive living center will be able to

Objective Number	Evaluator 1	Evaluator 2	Evaluator 3	Average Score
1. will understand why the EOL conversation is so essential.	2	2	2	2
2. have an increase in knowledge on initiating the EOL conversation with their patients and the patient's loved ones.	2	2	2	2
3. have and increase in expressed intentions about end of life care.	2	2	2	2
4. be more prepared in starting the EOL discussion and ready to have the conversation with each admission to the local rehabilitation and assistive living center.	2	2	2	2
5. ensure more advance directives, POLST, code status, end of life conversations being completed on admission to the rehabilitation and assistive living center.	2	2	2	2

Appendix I: Pretest/Posttest Expert Content Validation by Content Experts

Getting the End-of-Life Conversation

Date: September 8, 2020
Student Name: Lisa McCabe-Evans, DNP Student

Reviewer's Name:

Packet: Curriculum Plan, Pretest/Posttest with answers, Pretest/Posttest Expert Content Validation Form

INSTRUCTIONS: Please check each item to see if the question is representative of the course objective and the correct answer is reflected in the course content.

The first 10 questions are knowledge based the second set of questions measure intent using a Likert scale.

Test Item #

1. Not Relevant_ Somewhat Relevant____ Relevant ____Very Relevant____
Comments:

2. Not Relevant____Somewhat Relevant____ Relevant ____ Very Relevant____
Comments:

3. Not Relevant____Somewhat Relevant____ Relevant ____ Very Relevant____
Comments:

4. Not Relevant____Somewhat Relevant____ Relevant ____ Very Relevant____
Comments:

5. Not Relevant____Somewhat Relevant____ Relevant ____Very Relevant____
Comments:

6. Not Relevant____Somewhat Relevant___ Relevant ____ Very Relevant____
Comments:

7. Not Relevant___Somewhat Relevant____ Relevant ____ Very Relevant____
Comments:

8. Not Relevant____Somewhat Relevant____ Relevant ____ Very Relevant____
Comments:

9. Not Relevant____Somewhat Relevant____ Relevant ____ Very Relevant____
Comments:

10. Not Relevant___Somewhat Relevant____ Relevant____ Very Relevant__
Comments:

1. Not Relevant__Somewhat Relevant__ Relevant____ Very Relevant__
Comments:

2. Not Relevant__Somewhat Relevant__ Relevant____ Very Relevant__
Comments:

3. Not Relevant__Somewhat Relevant__ Relevant____ Very Relevant__
Comments:

4. Not Relevant__Somewhat Relevant__ Relevant___ Very Relevant__
Comments:

5. Not Relevant__Somewhat Relevant__ Relevant____ Very Relevant__
Comments:

6. Not Relevant__Somewhat Relevant__ Relevant____ Very Relevant__
Comments:

Appendix J: Advertisement for the Zoom Educational Event

Thursday, September 17, 2020 @ 1800-2000

Getting the End of Life Conversation Started

All Nurses:

Please join Lisa McCabe-Evans via Zoom for her final doctor of nursing practice project and receive 2 hours of continuing education credits. Grab some popcorn and a beverage and be ready for an open discussion after the viewing of *Being Mortal, 2015.*

One conversation can make all the difference!

(FRONTLINE, 2015)

Thank you for your support!