2022

Perceptions of Associate Degree Nursing Faculty of a Primary End-of-Life Care Course Within Prelicensure Nursing Curricula

KATHERINE ZAHARCHUK
Walden University

Walden University

College of Health Professions

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Katherine Zaharchuk

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Walden University
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Abstract

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MA, Walden University, 2012

BS, Kutztown University, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

February 2022

Abstract

The responsibility for educating U.S. nursing students on end-of-life (EOL) care concepts lies with prelicensure nursing programs; however, the majority of all prelicensure nursing programs offer only a few lectures, and only a small percentage offer EOL and palliative care courses. The lack of education on EOL care results in greater stress for nurses, poor symptom management for patients, and reduced support for family caregivers. There is limited knowledge on why primary EOL education has not yet been adopted by many Associate Degree in Nursing (ADN) programs. The purpose of this qualitative study was to explore the perceptions of ADN faculty regarding the inclusion of EOL care content within prelicensure nursing curricula. Ajzen's theory of planned behavior was the framework used to explore the perceptions of prelicensure nursing faculty. In-depth interviews were conducted with 10 full-time ADN faculty who were currently working in an ADN program and who had at least 2 years of didactic teaching experience in an ADN program. Interviews were audio-recorded and transcribed. Thematic coding was used to analyze the data. The key findings were that EOL care education is important for nurses in all areas of practice, but a primary EOL care course is not necessary in ADN curricula. However, removing barriers to allow for the inclusion of a primary EOL care course in ADN curricula may still benefit nursing students, nursing professionals, patients, and family caregivers. Positive social change may result from reduced stress and greater self-efficacy for nurses, improved symptom management and more prompt hospice referrals for patients and needed education and support for family caregivers.

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Dedication

I dedicate this research to my husband, to my children, and to the memory of my parents. To my loving husband, Dan, who never questioned why. Thank you for your unwavering love and support. To my children, Nick and Ellie, two of the greatest loves of my life. I hope that I have inspired you in some way to set the bar high and to never give up. Finally, to my late parents, John and P.A. Sauter. Mom, I know you would have been my biggest cheerleader. Dad, you inspired me to pursue this journey. I kept my eye on the prize like I promised you I would. I know you are proud.

Acknowledgments

I am eternally grateful to my chair, Dr. Kelly Fisher, for your patience and guidance throughout this process. Your prompt responses to my e-mails and texts were always appreciated and allowed me to keep moving forward. I also wish to thank my methods expert, Dr. Lynda Crawford. I could not have gotten to this point without the time you took to guide me with your expertise. I also want to thank my dear friends, Lea Ann VanBuskirk, Holly Lewis, and Megan Maurer who supported me through difficult life circumstances that occurred during this process. I would not have finished this journey without you.

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Chapter 1: Introduction to the Study

When prelicensure nursing students are faced with caring for a dying patient, the focus of care shifts from helping the patient to recover to meeting the complex physical, psychological, and spiritual needs of the dying patient their family. However, end-of-life (EOL) care knowledge is lacking in U.S. nursing students at all levels because prelicensure nursing programs do not provide enough EOL care education (O'Shea & Mager, 2019). Nurses provide EOL care in all settings, and the EOL care knowledge deficit continues after students graduate and transition into professional practice. As a result, nursing students and novice nurses experience increased stress, poor self-efficacy, and negative attitudes toward death; many patients receive inferior symptom management and delayed hospice referrals; and family caregivers lack needed education and support (Achora & Labrague, 2019; Desanto-Madeya et al., 2019; Washington et al., 2018).

The End-of-Life Nursing Education Consortium (ELNEC) developed an 8-module curriculum in 2000 designed to address the key components of EOL care (Dahlin et al., 2017). The American Nurses Association Professional Issues Panel (2017) issued a call for action in 2016 that a primary EOL care course become the standard for prelicensure nursing curricula. However, few U.S. prelicensure nursing programs offer primary EOL care courses, and most offer only few lectures throughout the curriculum (Thrane, 2020).

The need for primary EOL care instruction in prelicensure nursing curricula is supported by extensive research (DeSanto-Madeya et al., 2020). There is also evidence to suggest that prelicensure nursing curricula continues to lag the implemention of primary

EOL care education (Institute of Medicine, 2015; Mason et al., 2020; O'Shea & Mager, 2019; Thrane, 2020). Nearly all of the research has focused on Bachelor of Science in Nursing (BSN) programs, which suggests a need for more research on Associate Degree in Nursing (ADN) programs. Furthermore, BSN programs have a palliative/hospice care component in the curriculum (American Association of Colleges of Nursing [AACN], 2021) whereas ADN programs do not (National Council of State Boards of Nursing, 2019). Research on ADN faculty perceptions regarding the inclusion of EOL care content in prelicensure nursing curricula is lacking, according to my review of the literature. Nursing faculty in ADN programs help to drive the curriculum, and therefore, it is important to focus on the ADN nurse educator population to gain a better understanding of their attitudes toward primary EOL care education.

The purpose of this study was to explore the perceptions of ADN faculty regarding the inclusion of a primary EOL care course, or integrated EOL care content, in prelicensure nursing curricula. Understanding ADN faculty perceptions of EOL care content may provide insight as to why primary EOL care content is lacking in prelicensure nursing curricula and identify the barriers to its inclusion. This study has the potential to impart positive social change by understanding barriers that preclude adding a primary EOL course to ADN curriculum. As a result, a primary EOL course may be added to ADN curricula, and students and novice nurses may experience less stress, higher self-efficacy, and improved attitudes toward death; many patients may receive better symptom management and more timely hospice referrals; and family caregivers may be provided with needed education and support.

Chapter 1 will begin with the study background, which will include a summary of the existing literature that will highlight the research gap. Next, I will discuss the problem statement, purpose statement, and primary research question. Finally, an overview of the theoretical framework and nature of the study; definitions of key terms; and discussion of the assumptions, scope and delimitations, limitations, and significance of the study will be provided.

Background

Nurses in all clinical settings are key players in providing EOL care to patients and their families (AACN, n.d.b.), but research suggests that there is a need for more EOL care education in prelicensure nursing education. The ELNEC began an initiative in 2000 to develop a curriculum to improve EOL care education (Dahlin et al., 2017). The American Nurses Association Professional Issues Panel (2017) issued a call for action in 2016 to implement ELNEC curricula as the standard primary EOL care course for prelicensure nursing programs. One study reported that undergraduate nurses do not feel prepared to care dying patients and their families (Croxon et al., 2017). The authors of another study concluded that students think that caring for dying patients is too difficult, but this perception can change with education and support (Osterlind et al., 2016).

There is abundant research that supports the need for a primary EOL care course in prelicensure nursing curricula (The American Nurses Association Professional Issues Panel, 2017). There is also ample evidence to suggest that there is a lag in implementing a primary EOL care course into all types of prelicensure nursing curricula (Institute of Medicine, 2015; Mason et al., 2020; O'Shea & Mager, 2019; Thrane, 2020). I could not

find research on either BSN or ADN faculty perceptions of primary EOL care education. Most of the research on EOL care education in prelicensure nursing programs has focused on BSN programs, which underscores a need for more research on ADN programs. In addition, BSN programs have a palliative/hospice care component in the curriculum whereas ADN programs do not (AACN, 2021; Registerednursing.org, n.d.). Therefore, it is important to focus on the ADN nurse educator population to gain a better understanding of their attitudes toward primary EOL care education.

In this study, I addressed the research gap on the perceptions of ADN faculty of a primary EOL care course within prelicensure nursing curricula. Previous researchers have studied the perceptions of prelicensure nursing students and novice nurses on EOL care education, but not that of faculty (Bear & Chandran, 2019; Cerit, 2019; Croxen et al., 2017; Grubb & Arthur, 2016; Henoch et al., 2017; Jablonski et al., 2020; Osterlind et al., 2017; Smothers et al., 2019). The findings from this study may provide critical insight to barriers that have precluded a primary EOL care course from being implemented in to ADN curricula. With a better understanding of faculty perceptions, ADN program directors may be able to work to remove barriers and allow for the implementation of a primary EOL care course. Positive social change may result by adding a primary EOL care course to ADN curricula, which would ultimately benefit students and novice nurses by reducing stress, increasing self-efficacy, and improving attitudes toward death; many patients may receive better symptom management and more timely hospice referrals; and family caregivers may be provided with needed education and support.

Problem Statement

Prelicensure nursing programs are responsible for imparting EOL care concepts to students, but the problem is that these programs do not provide enough EOL care education (Mason et al., 2020; O'Shea & Mager, 2019; Thrane, 2020). Thrane (2020) found that 89% of all prelicensure nursing programs offer few lectures and only 11% offer primary EOL and palliative care courses (p. 42). As a result, patient care may be affected. For example, Smothers et al. (2019) posited that patients prefer to die at home, but it is common for patients to die in the acute care setting as nurses may be unfamiliar with the benefits of early hospice referrals. Furthermore, dying patients may not receive adequate symptom management (Smothers et al., 2019).

Another consequence of inadequate EOL care education is the negative impact on nursing students and novice nurses. In one study, nursing students described their first encounter with a dying patient as emotionally taxing (Osterlind et.al, 2016). Limited chances to discuss and reflect on the experience becomes a lost learning opportunity (Osterlind et. al, 2016). Novice nurses are ultimately impacted with experiences of anxiety, stress, and burnout from having to care for dying patients without proper EOL education. (Andersson et. al, 2016).

Furthermore, when nurses are not adequately prepared with EOL care knowledge and skills, they may not be able to provide needed support and preparation to family caregivers. Such caregivers face many challenges with taking care of a dying patient, and they may feel ill-equipped to do so (Aparicio et al., 2017). Not being able to provide

proper support and preparation to family caregivers can lead to anxiety, fatigue, self-care neglect, depression, and posttraumatic stress for nursing staff (Washington et al., 2018).

The ongoing COVID-19 has added to the problem as nurses have been tasked with supporting emotional needs of patients who die alone (Foli, Forster, Cheng, Zhang, & Chiu, 2021). The long-term effects of feelings of isolation and helplessness on nurses from the COVID-19 pandemic EOL care challenges are not yet known. What is known is that nurses have had to meet EOL care needs more than ever because of the pandemic.

The ELNEC launched an eight-module, online palliative and EOL care curriculum over 20 years ago to bridge the EOL care educational gap (Ferrell et al., 2018). Nevertheless, the continued need for EOL education is well documented (DeSanto-Madeya et al., 2020). ADN faculty are in a position to enrich nursing students' learning about how to care for dying patients; however, primary EOL care courses continue to be lacking in prelicensure nursing curriculum. Understanding the perceptions of ADN faculty may provide insight regarding why primary EOL care instruction has not been incorporated in to prelicensure nursing curricula.

Purpose of the Study

The purpose of this qualitative research was to explore the perceptions of ADN faculty regarding the inclusion of a primary EOL care course, or integrated EOL care content, within prelicensure nursing curricula. An understanding of ADN faculty attitudes on a EOL care content was necessary to identify factors that may prohibit the implementation of a primary EOL care course. Use of a qualitative approach allowed for open-ended questions and answers regarding the participants' attitudes on EOL care

content. This study is distinctive because it reported an underresearched area regarding the perceptions of ADN nursing faculty on a primary EOL care course within prelicensure nursing curricula. To address the gap in knowledge, I used a qualitative study approach in which I interviewed faculty within ADN programs.

Research Question

The guiding research question for this study was as follows: What are the perceptions of ADN nursing faculty on EOL care content within prelicensure nursing curricula?

Theoretical Framework

The theoretical basis for this study was Ajzen's theory of planned behavior (TPB). Ajzen (1985) suggested that an individual's intention is based on their beliefs and attitudes. In general, the more positive the attitude, the more likely the person will be to perform the behavior (Bosnjak et al., 2020). The TPB includes the concepts of belief, attitude, and intention, which together predict behavior (Fishbein & Ajzen, 1975). Ajzen (1985) added an additional element of control to the three concepts and posited that when a person perceives they have a high level of control over the intended behavior, then they are more likely to act.

The way the TPB informed the study was that the beliefs and attitudes of the ADN faculty participants may have helped with the understanding of why primary palliative care is not part of the curriculum in prelicensure nursing programs. Interview questions pertained to the concepts of belief, attitude, intention, and control. A more detailed explanation of the TPB will be provided in Chapter 2.

Nature of the Study

The nature of this study was basic qualitative research. According to Merriam and Tisdell (2016), the tenet of qualitative research is that people create their own reality based on their social environment. The goal of a basic qualitative study is to discover and interpret the meaning of constructed reality (Merriam & Tisdell, 2016). This study did not fall under the auspices of phenomenology, ethnography, grounded theory, narrative or case studies. Therefore, a basic qualitative approach was appropriate.

The key concept that was investigated was the perceptions of ADN faculty of a primary EOL care course in prelicensure nursing curriculum. I gathered data for this research study by conducting individual interviews via Zoom video conferencing with ADN faculty who had at least 2 years of didactic teaching experience and were currently working within a ADN program. In addition, strategies such as triangulation, thick description, and journal notes were used to ensure credibility.

Definitions

Key terms that were used throughout the study were *primary palliative care, specialty palliative care*, *hospice*, *primary end-of-life care course*, *Associate Degree in Nursing (ADN)*, and *Bachelor of Science in Nursing (BSN)*. Following are their definitions:

Associate Degree in Nursing (ADN): A 2-year program that provides didactic clinical training to prepare students for direct patient care (Nurse.org, n.d.).

Bachelor of Science in Nursing (BSN): A 4-year program that encompasses the same components as an ADN program with the addition of social science, management, research, community health, and leadership (AACN, n.d.c.).

Hospice: A multidisciplinary set of services that focuses on addressing the physical, psychosocial, spiritual, and emotional needs of a patient with a life limiting illness and a survival prognosis of 6 months or less and their family (AACN, n.d.b.; Kelley & Morrison, 2015).

Primary end-of-life care course: An eight-module curriculum developed by the ELNEC aimed at improving palliative care (Dahlin et al., 2017).

Primary palliative care: Improvements in the quality of life by relieving physical, psychological, social, and spiritual suffering of patients and families who are facing serious illness (Institute of Medicine, 2015).

Specialty palliative care: Primary palliative care that involves the addition of a team of specially trained RNs and advanced practice RNs who manage complex symptoms (American Nurses Association Professional Issues Panel, 2017).

Assumptions

I based the study on the following assumptions. First, I assumed that participants would be willing to take part in this research study. I informed participants that participation in my study was voluntary, and could they change their minds at any time. Second, I assumed that participants would answer the interview questions honestly. To help to ensure that participants were honest, I reiterated that names or any other identifying factors would not be associated with their answers. The assumptions were

necessary because they served as a basis on which the study could be conducted, and the study moved forward as expected.

Scope and Delimitations

This qualitative study focused on full-time faculty teaching in a ADN program with the intention of understanding their perceptions regarding the inclusion of a primary EOL course, or integrated EOL care content, in prelicensure nursing curricula. Delimitations develop from choices made by the researcher (Bloomberg & Volpe, 2019). One delimitation of this study was that participants were recruited during the ongoing Covid-19 pandemic. Participant availability and willingness to take part in a synchronous interview may have been limited due to increased time constraints brought on by the pandemic. Face-to-face interviews were not possible for pandemic safety reasons, so interviews using Zoom video conferencing were conducted instead. Another delimitation involved the exclusion criteria. ADN faculty who had been teaching full-time for less than 2 years were not eligible. Given that there were already recruiting barriers due to the pandemic, the exclusion criteria may have further limited available participants.

The purpose of this study was to explore the perceptions of ADN faculty regarding the inclusion of a primary EOL care course, or integrated EOL care content, in prelicensure nursing curricula. ADN faculty perceptions of EOL care content could help to identify prohibitive factors for implementing a primary EOL care course. I chose the TPB as the framework because it offered a context of understanding intentions based on attitudes, beliefs, and control. Other theories, such as the comfort theory and peaceful

end-of-life theory, are patient-focused and would not have informed this study, which centered on faculty.

Regarding transferability, this study's findings may only apply to ADN programs and not to BSN programs, which also include prelicensure nursing students. What I have found in the published literature pertains only to BSN programs. However, this study was the first time, according to my review of the literature, that ADN faculty were the focus of the study within the primary EOL care course phenomenon.

Limitations

Study limitations are design characteristics that impact the interpretation of the findings (Bloomberg & Volpe, 2019). Limitations included the timing of recruitment; participant assumptions that I was planning to implement a EOL care course; my own experiences, which could have biased my interpretation of the results; and the fact that the sample included only ADN nursing faculty. I will provide a detailed discussion of the study limitations in Chapter 5.

Significance

The ANA (2017) posited that all nurses in every care setting should have the knowledge to administer quality holistic primary palliative care to alleviate suffering at EOL. Up to 12% of content for the National Council Licensure Examination for Registered Nurses (NCLEX-RN) includes basic care and comfort, which is an integral part of EOL care (National Council of State Boards of Nursing, n.d., p. 5). Nursing students' knowledge, attitudes, and self-efficacy are improved with EOL care instruction,

however, few prelicensure programs provide primary EOL courses for students (Lippe, 2019).

The study filled a gap in understanding by focusing specifically on ADN faculty perceptions regarding the inclusion of a primary EOL care course, or integrated EOL care content, in prelicensure nursing curricula. ADN faculty help to drive prelicensure nursing curricula, and the results of the study provide crucial insights as to why primary EOL education has not yet been adopted by many ADN programs. The results of this study help to fill a gap in understanding by specifically focusing on ADN faculty perceptions of the inclusion of EOL care content in prelicensure nursing curricula. Study outcomes have implications for social change by shedding light on barriers that preclude the inclusion of EOL care content. Removing barriers may allow for the inclusion of a primary EOL care course in ADN curricula, which would ultimately be beneficial in the following ways: Students and novice nurses may experience reduced stress, increased self-efficacy, and better attitudes toward death; dying patients may receive better symptom management and more timely hospice referrals; and family caregivers may more frequently be provided with the needed education and support.

Summary

Nurses in all clinical settings are faced with the complex care needs of dying patients and their families. Primary EOL care education has been shown to improve prelicensure student nurses' self-efficacy and attitudes when caring for patients with life-limiting illnesses Osterlind et al., 2016. However, most U.S. prelicensure nursing programs do not offer a primary EOL care course (Mason et al., 2020; O'Shea & Mager,

2019; Thrane, 2020). In this chapter, I discussed the need for primary palliative care education in prelicensure nursing programs. The TPB was presented as the theoretical framework to support the exploration of ADN faculty perceptions regarding the inclusion of a primary EOL care course, or integrated EOL care content, in prelicensure nursing curricula. I also provided an overview of the study In Chapter 2, I will provide a detailed review of the literature.

Chapter 2: Literature Review

RNs are responsible for handling the complex needs of dying patients. However, prelicensure nursing programs in the United States do not provide enough EOL care education (Mason et al., 2020; O'Shea & Mager, 2019; Thrane, 2020). The purpose of this study was to explore the perceptions of ADN faculty regarding the inclusion of primary EOL care content, or integrated EOL care content, in prelicensure nursing curricula. In this chapter, I review the literature regarding the main theme of the lack of EOL care instruction in prelicensure curriculum and its consequences on students, nurses, patients, and families. Before reviewing the literature, I provide overviews of the literature search strategy and theoretical foundation.

Literature Search Strategy

The purpose of a literature review is to lay the foundation for what knowledge exists on the problem to demonstrate how new knowledge will contribute (Merriam & Tisdell, 2016). I conducted the literature review for this research through the Walden University Library. The databases and search engines that were used for the literature search were CINAHL, Medline, PsycInfo, ScienceDirect, Education Source, ERIC, Google Scholar, WorldCat, and Thoreau Multi-Database Search. Key words used for the search were *end of life, palliative care, death, dying, terminally ill, family care giver, nursing students, pre-licensure nursing students, prelicensure nursing curriculum, nursing faculty,* and *End of Life Nursing Education Consortium.*

I limited the search to the English language, however international studies were considered. Date parameters were set from 2016-2021, and most of the articles reviewed

were published within a 5-year time frame. Within these parameters, nothing specific to primary EOL education in ADN programs was found. Instead, EOL care education research in prelicensure BSN programs was prevalent. I expanded the search by opening the time-frame parameters, and one source that pertained to ADN programs and EOL care education was located. Sources that were older than 5 years were pertinent to establishing history and theory.

After determining the research gap of primary EOL care education in ADN programs, I turned my focus to studies on prelicensure BSN programs. An additional gap in understanding the perceptions of faculty on primary EOL education in prelicensure nursing programs was discovered. The research strategy was focused on primary EOL care instruction in pre-licensure nursing curriculum in general. Consequences of nursing EOL care knowledge deficits on students, novice nurses, patients and family caregivers were also researched. A detailed discussion of the results will be described in the following sections.

Theoretical Foundation

The theoretical basis for this research was Ajzen's (1985) TPB. Fishbein and Ajzen (1975) provided the foundation for the theory with their framework consisting of three concepts of belief, attitude, and intention. Overall, the assumptions are that intentions are based on a person's beliefs and that attitude can be a predictor of behavior (Fishbein & Ajzen, 1975).

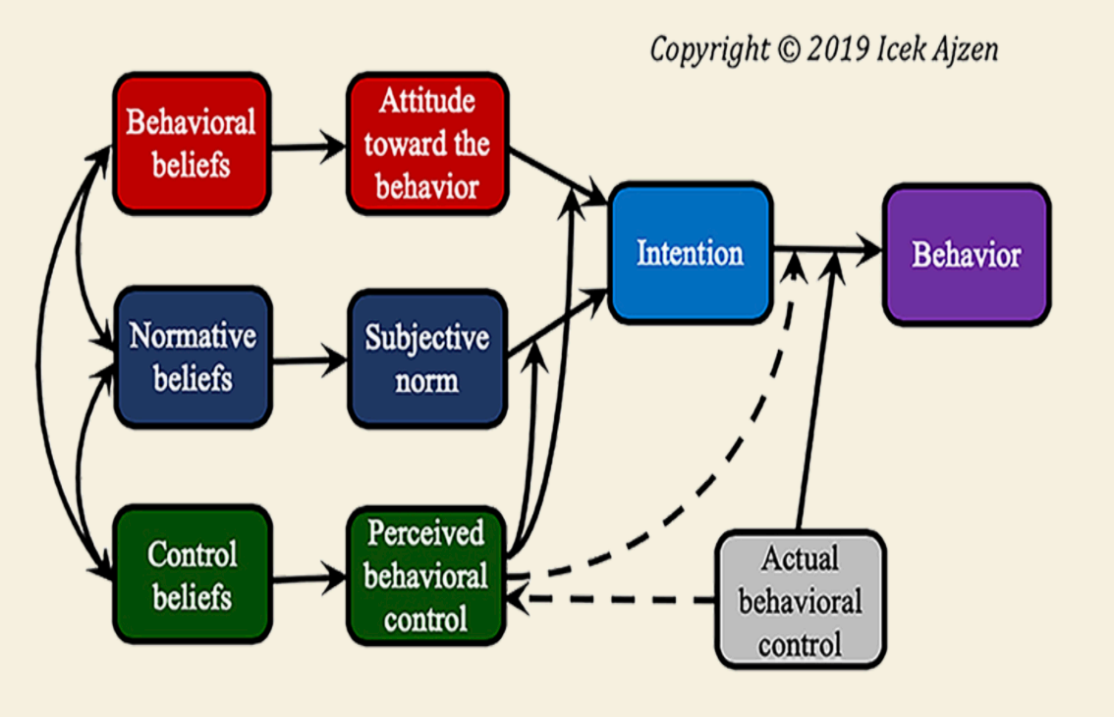
The three concepts are tied together in that a person's beliefs serve as information that influence their attitudes, intention, and behaviors; attitudes are based on beliefs, and

if the person's beliefs are positive, then their attitude will be favorable as well; and intention to perform the behavior is related to the attitude about the topic (Fishbein & Ajzen, 1975). The concepts can be used to understand the collective action of a group, such as faculty members contributing to, or building, a curriculum. I used Ajzen's TBP to develop the interview questions.

Ajzen (1985) took the three concepts of belief, attitude, and intention and added an additional concept of consideration of control. When a person perceives that they have a high level of control over the intended behavior, then they are more likely to act. Conversely, when a lower level of control is perceived, then action is less likely (Ajzen, 1975). Predictions are based on the attempt at the behavior and not necessarily on a successful outcome of the behavior (Ajzen, 1975). In addition, the TPB further discriminates between belief types: behavioral, normative, and control (Ajzen, n.d.). Behavioral beliefs are influenced by positive or negative attitudes, normative beliefs are based on subjective norms and approval of others, and control beliefs come from the perception of the level of control over the behavior (Ajzen, n.d.). Figure 1 is a diagram of the TPB.

Figure 1

Theory of Planned Behavior Diagram



Note. Ajzen produced this graphical representation in 2019. From *Theory of Planned Behavior Diagram*, by I. Ajzen, 2019 (https://people.umass.edu/aizen/tpb.diag.html#null-link). Copyright 2019 by Icek Ajzen. Reprinted with permission (see Appendix A).

Previous Applications of Ajzen's Theory

A search of Ajzen's theory showed that it had been used over 25,000 times within academic journals between 1985 and 2021. I then narrowed the search to the use of Ajzen's theory in studies of nurse educators from 2015 to present, which yielded one

result. The search was subsequently backdated to 2010, and two additional articles were found.

Kim et al. (2017) used TPB to measure outcomes of faculty related to online simulation training. Considering that TPB suggests that intention is based on attitudes, norms, and perceived control, the researchers used TPB to gauge the intention of faculty to adopt simulation into their teaching. The researchers used a pre-posttest design to measure faculty's knowledge, perception, and intention to implement simulation after a training course was implemented. Knowledge and attitudes were increased after the training, and the researchers concluded that faculty intentions to adopt simulation were influenced significantly by attitudes.

Jones et al. (2013) studied the effectiveness of a simulation training for baccalaureate nursing faculty. The TPB was used to guide the training evaluation and to determine the intention of faculty to use simulation as a teaching tool. Results revealed that faculty's intention to use simulation increased after the training was completed.

The TPB was the most relevant theory for this study. Exploring the attitudes and beliefs of prelicensure nursing faculty related to primary and integrated EOL care content may provide insight on their intention to implement such content into the curriculum. Faculty attitudes and beliefs may also help with the understanding of why a primary EOL care course is absent in most prelicensure nursing curricula.

Literature Review Related to Key Variables and/or Concepts

In this literature review, I will focus first on defining the concepts of palliative and hospice care, primary EOL care course, and ADN programs. Second, studies that

have been conducted on EOL care education in prelicensure nursing programs will be revealed. Third, I will discuss the impact of lack of EOL care education has on nursing students, novice nurses, patients, and family caregivers.

Palliative and Hospice Care

Palliative care has been defined as improving the quality of life by relieving physical, psychological, social, and spiritual suffering of patients and families who are facing serious illness (Burgermeister et al., 2020; Buss et al., 2017; Institute of Medicine, 2015; Lippe, 2019; Wallerstedt et al., 2019; WHO, 2018). The AACN (n.d.b.) asserted that palliative care centers on both the patient and the family with the goal of optimizing quality of life. Primary palliative care in nursing refers to lessening the severity of a disease and its symptoms whereas specialty palliative nursing involves RNs and advanced practice RNs roles manage complex symptoms (American Nurses Association Professional Issues Panel, 2017). By contrast, hospice is a multidisciplinary specialty that addresses the palliative care needs of patients and their families who are facing a life-limiting condition (Institute of Medicine, 2015). The AACN (n.d.b.) similarly defined hospice as a multidisciplinary set of services that focuses on addressing the physical, psychosocial, spiritual, and emotional needs of a dying patient and their family. Hospice is considered a separate entity of care for the terminally ill, and patients must have a survival prognosis of 6 months of less to qualify for services (Kelley & Morrison, 2015). Although both palliative care and hospice are considered specialties, all nurses must be equipped for the role of primary palliative care to recognize the needs of dying patients and their families. For the purpose of this research, primary EOL care refers to palliative

care for the dying who are not under the service of a specialty palliative care or hospice team.

Primary End-of-Life Care Course

A primary EOL care course in ADN curriculum is a stand-alone course that educates students on key components of care. Recognition of the EOL care needs of patients and their families is important so that early referrals can be made to the palliative care or hospice specialty teams. The ELNEC project began in 2000 as a palliative care improvement initiative (Dahlin et al., 2017). A curriculum was developed that included the following courses: Introduction to Palliative Care Nursing; Pain Management; Symptom Management; Ethical Issues; Cultural Considerations; Communication, Loss, Grief, and Bereavement; and Final Hours of Life (Dahlin et al., 2017). The ELNEC curriculum was updated in 2017 to reflect the AACN's Competencies and Recommendations for Educating Undergraduate Nursing Students (CARES; Dahlin et al., 2017). The purpose of CARES palliative care competencies was to provide a framework of essential care that new nurses should complete by the end of their nursing education (AACN, n.d.b.). The ELNEC offers several curricular options that target various health care provider and patient populations. For example, the ELNEC-Core curriculum can be used to teach undergraduate and graduate nurses, among others, who work in the acute care setting (AACN, n.d.a).

Associate Degree in Nursing programs

An ADN is a 2-year program that provides didactic and clinical training to prepare students for direct patient care (Nurse.org, n.d.). The ADN is the fastest route to

becoming a RN, and ADN roles include patient education, assessment, medication administration, and collaborating with other health care professionals (Nurse.org, n.d.c). The BSN is a 4-year program that encompasses the same components as an ADN program with the addition of social science, management, research, community health, and leadership (AACN, n.d.c.). Both degrees prepare students to take the NCLEX–RN in order to begin entry-level practice in the nursing field.

Nursing leaders implemented ADN programs a result of the nursing shortage from World War II (American Nursing History.org, n.d.). When the war ended, some nurses chose to stay in the military while others decided to marry and expand their families. In addition, medical field advancements, facility upgrades, and more Americans gaining access to private insurance contributed to increasing numbers of ADN programs (American Nursing History.org, n.d.). There are approximately 1,200 active ADN nursing programs and nearly 730 prelicensure BSN programs in the United States, as of 2021 (Nursing Explorer, n.d.). Despite their quest over the last 17 years to make the BSN the minimum entry-level education for nursing practice, the ACCN (n.d.d.) continues to support the need for licensure of students who graduate from ADN programs. The RN workforce in the United States is expected to increase by 7% by 2030 due to the aging of baby boomers, nurse retirements, and nurses exiting the workforce (AACN, n.d.d), so it would not be prudent to limit the number of RNs providing patient care to only BSN-prepared nurses.

Synthesis and Review of Studies

It is widely recognized that nurses in all clinical settings play an important role in EOL care for patients and families (AACN, n.d.b). EOL care knowledge is lacking in prelicensure nursing students at all levels, and the result is increased stress, lack of confidence, and negative attitudes toward death (Achora & Labrague, 2019; Bear & Chandran, 2019; Cerit, 2019; Dimoulou et al., 2019; Gorchs-Font et al., 2020; Grubb & Arthur, 2016; Heise et al., 2018; Joblonski et al, 2020; Kirkpatrick et al., 2019; Li et al., 2019; Rotter & Braband, 2020; Smothers et al., 2019). For practicing nurses, lacking knowledge in EOL care affects self-efficacy, which may lead to stress, burnout, and inferior patient care (Andersson et al., 2016; DeSanto-Madeya et al., 2019).

The ongoing COVID-19 pandemic has added a new layer to the already existing problem of lack of EOL care knowledge for nurses. Beginning in March 2020, the COVID-19 pandemic greatly impacted the EOL experience for nurses and patients (Stilos & Moore, 2020). Whether a dying patient had COVID-19 or not, U.S. hospitals did not allow visitors until the last 2 days of life. The likelihood of the dying patient having a meaningful connection with family during the last stages of the dying process was significantly decreased, which was devastating for loved ones. Consequently, nurses had to increase emotional support for the family and patients in addition to providing a physical presence so that patients did not have to die alone (Foli, Forster, Cheng, Zhang, & Chiu, 2021). The long-term effects of the feelings of isolation and helplessness on nurses from the COVID-19 pandemic EOL challenges are not yet known. What is known is that nurses have had to work and meet EOL care needs more than ever as a result of the

pandemic. Nurses and nursing students identified a lack of EOL care knowledge (Croxen et al., 2017) prior to the pandemic, so it is plausible that nurses may experience increased stress and burnout as a result of the changes that COVID-19 has brought with it.

The lasting changes in the EOL care brought on by COVID-19 have yet to be researched. However, by the year 2030, 1 out of 5 United States residents will be retirement age (United States Census Bureau, 2018) which means that the number of people living with progressive diseases will increase. Reyes-Ortiz et al (2015) studied the impact of early palliative care (PC) referrals of elderly patients and found that there were fewer inpatient deaths and more hospice admissions. Research has shown that patients prefer to die at home, but it is common for patients to die in the acute care setting as nurses may be unfamiliar with the benefits of early hospice referrals (Smothers et al., 2019). Therefore, it is more important than ever for ADN programs to provide primary EOL care instruction in their curricula.

A review of the literature by Gillan et al. (2015) revealed that despite evidence suggesting that prelicensure nursing programs should provide a substantial amount of EOL care instruction, many prelicensure nursing programs do not offer a primary EOL course. The American Nurses Association Professional Issues Panel (2017) asserted that EOL care is a nursing responsibility in all practices, and they issued a call for action that the ELNEC curricula become the standard primary palliative care course for prelicensure nursing programs. However, EOL care is still generally absent from prelicensure nursing school curricula (Institute of Medicine, 2015; Mason et al., 2020; O'Shea & Mager, 2019; Thrane, 2020). Currently, 89% of prelicensure nursing programs offer few lectures

and only 11% offer primary EOL care courses (Thrane, 2020, p. 42). Furthermore, research has shown that when nursing students receive EOL care education, their attitude, self-efficacy, and ability to care for dying patients improves (Lippe, 2019).

A qualitative study conducted by Croxon et al. (2017) explored the perception of new graduate nurses on their readiness to care for dying patients. Seven nurses, who had graduated from a BSN program within two years, participated in semistructured individual interviews. Gaps in undergraduate EOL care educational preparation was a main theme that emerged. The authors concluded that undergraduate nurses do not feel adequately prepared for EOL care and that there is a need for quality EOL care education in undergraduate nursing curricula.

A qualitative longitudinal study done by Osterlind et al. (2016) was conducted at three universities in Sweden to explore prelicensure BSN program students' perceptions of caring for dying patients. The study was phenomenological in nature and data was collected by using individual semistructured interviews. Seventeen nursing students from 3 universities who had completed their first year of nursing school agreed to be interviewed. Interviews were conducted at each student's university, and findings indicated that nursing students perceive caring for dying patients as difficult, but student perceptions of death and dying can change over time with support. The authors concluded that educators should prepare nursing students for EOL care.

Henoch et al. (2017) studied the development of nursing students' attitudes toward dying patients and their perception of how prepared they were to perform EOL care. This longitudinal study involved 117 BSN students from six Swedish universities.

Students completed the Frommelt Attitude Toward Care of the Dying Scale (FATCOD) questionnaire at the start of the first and second years and again at the end of the program. Theory-based education was provided over a five-week period during the students' program. ANOVA was used to compare the FATCOD scores of the three different times it was administered. Results showed that education significantly impacted attitudes toward caring for dying patients in a positive way.

Bear & Chandran (2019) conducted a qualitative study on students' perceptions on EOL care. Students first participated in EOL care training that focused on role of support staff, communication, pain management, and coping. Students reported that they found value in learning about non-verbal communication and care, culture and pain, and grief. There were 42 participants, 22 of which were BSN students and 20 were human services students. The results still showed a clear benefit to EOL care education.

Three other studies used the Frommelt Attitude Toward Care of the Dying Scale (FATCOD) to study BSN nursing students' attitudes toward EOL care after completing specific EOL care training. The results of all three studies showed a significant increase in attitude and comfort levels after receiving EOL care education (Cerit, 2019; Grubb & Arthur, 2016; Smothers et al., 2019).

Jablonski et al. (2020) studied students' feelings from a EOL simulation after they had completed the ELNEC undergraduate modules. Whether the students were ADN or BSN students was not specified. Students reported that they felt that the ELNEC course was valuable prior to simulation and that they felt more confident and prepared in EOL care after the simulation. EOL care education improves student attitudes, self-efficacy,

and comfort levels, and students have acknowledged that there is more discomfort when communication and emotions are part of the care rather than just tasks (Jablonski et al., 2020).

The literature search revealed only one article on nursing faculty's perception of EOL education, and it was in the clinical setting. Jeffers (2014) interviewed 10 full-time clinical faculty within a baccalaureate program. The author concluded that BSN faculty believe that educating nursing students on EOL care is essential to future nursing practice, and nurses who learn about EOL care may feel better-prepared to care for dying patients. There remains a gap in the literature of ADN faculty perceptions of EOL education.

Nearly all of the studies that I found focused on prelicensure BSN students while some did not specify ADN or BSN. This underscores the fact that there is a gap in research of ADN programs and EOL care instruction. There was a plethora of studies regarding the benefits of EOL care education for prelicensure nursing students, but in my literature review, I did not find any research on the perceptions of faculty regarding EOL care instruction in ADN programs. This research is distinctive because it will report an under-researched area regarding the perceptions of ADN nursing faculty on the inclusion of a primary EOL care course, and integrated EOL care content, in prelicensure nursing curricula. Study outcomes may contribute to positive social change by adding EOL care education within prelicensure ADN curricula which would ultimately be beneficial in the following ways: Students and novice nurses may experience reduced stress, increased self-efficacy, and better attitudes toward death; many patients may receive better

symptom management and more timely hospice referrals; and family caregivers may be provided with needed education and support.

Impact on Patients and Family Caregivers

Terminally ill patients prefer to die at home, but it is common for them to die in the acute care setting as nurses may be unfamiliar with the benefits of early hospice referrals (Smothers et al., 2019). Hospice may improve the quality of life of the dying patient, but referrals are often late in the course of the illness. (Voisine et al. 2014). Wiesenthal et al. (2017) conducted a retrospective review of medical records of 695 patients who died in the hospital. The authors found that most patients received medications for comfort, but little else to promote comfort as death approached. In another study conducted to determine the perception of families on the use of hospice and quality EOL care, the authors interviewed 2307 families of hospice patients who had died. Results showed that families associate hospice care with better symptom management and better quality of life at the end of life (Kumar et al., 2017).

Family caregivers face many challenges with taking care of a dying patient, and they may feel ill-equipped to do so (Aparicio et al., 2017). When nurses are not adequately prepared with EOL knowledge and skills, family caregivers may not receive the needed support which can lead to anxiety, fatigue, self-care neglect, depression, and posttraumatic stress (Washington et al., 2018).

Kumar et al., (2016) studied the perspectives of families on the hospice experience of cancer patients. There were 1970 patients who were enrolled in the final cohort; 985 who did not enroll in hospice and 985 who were enrolled in hospice. Post

death interviews were conducted with participants' families, and propensity score matching was used to balance cofounders that were measurable between those who received hospice and those who did not. Results showed that families reported better pain management and quality EOL care the longer the patient was enrolled in hospice care. This data supports the need for earlier hospice referrals, and thus underscores the need for EOL care education for nursing student so that those earlier referrals can be made.

Summary and Conclusions

In this chapter, I provided insight in to Ajzen's TPB, which frames this research study. I defined key concepts and history of palliative care, hospice care, primary EOL care course, and ADN programs. Within the literature review, I found that EOL care education is lacking in prelicensure nursing programs although there are clear benefits to EOL care education. The consequences of nursing EOL care knowledge deficits on students and nurses were stress, burnout, and poor self-efficacy. The impact on patients is delayed hospice referrals which may mean poor symptom management and lesser quality of life. Family caregivers may experience lack of support, burnout, and depression. Despite the highlighted benefits of EOL education, there is a dearth of literature on the perception of ADN faculty on a primary EOL course. I discuss the methodology for this study in chapter 3.

Chapter 3: Research Method

Introduction

The purpose of this qualitative research was to explore the perceptions of ADN faculty of a primary EOL care course, or integrated EOL care content, within prelicensure nursing curricula. I focused on prelicensure ADN faculty perception and did not include prelicensure BSN faculty. The ACCN (2021) has updated its accreditation standards to include hospice/palliative care as one of its four spheres of care for entry-level professional nursing education. Hence, because prelicensure BSN students acquire EOL care education, BSN faculty were not included in this study. In this chapter, I discuss the research design and rationale; role of the researcher; instrumentation; recruitment, participation, and data collection procedures; and issues of trustworthiness.

Research Design and Rationale

The guiding research question for this study was as follows: What are the perceptions of ADN faculty of EOL Care content within prelicensure nursing curricula? To answer the research question, I used a basic qualitative research design or this study. According to Merriam and Tisdell (2016), the premise of qualitative research is that people create their own reality based on their social environment. There are several types of qualitative research (Merriam & Tisdell, 2016). This study did not fall under the auspices of phenomenology, ethnography, grounded theory, narrative, or case studies. Therefore, a basic qualitative approach was appropriate.

Role of the Researcher

A characteristic of qualitative research is that the researcher is the primary instrument for collecting and analyzing the data (Merriam & Tisdale, 2016). The goal of qualitative research is understanding, and the human instrument is able to respond, adapt, and gain insight from both verbal and nonverbal communication (Merriam & Tisdale, 2016). Therefore, I was the primary instrument for this study.

Critical self-reflection and exploration of biases is essential for the qualitative researcher so that prejudices can be confronted (Ravitch & Carl, 2016). I am a full-time faculty member for a ADN program, and oncology is my nursing area of expertise. In addition, my mother died under the care of palliative care nurses in the hospital setting, and my father died under hospice care at home. Given my personal and professional experiences, reflexivity during the study was important to minimize researcher bias which I will discuss later in the chapter.

I addressed confidentiality by providing written and oral assertions that identifiers, such as participant name and school of nursing, would be kept separate from the data. Also, each participant was assigned a number as a unique identifier. Information that could potentially identify the participant is kept in a digital file on a password-protected computer.

I avoided ethical issues by only identifying myself as a RN who was in the doctoral dissertation process. I did not share my personal or professional experiences so that the risk of influencing participant responses would be minimized. Prior to participant recruitment, I sought approval from Walden University's Institutional Review Board

(IRB) so that ethical treatment of participants could be ensured. When recruitment and interviews began, I reminded participants that they could end the interview at any time or retract permission to use their data without repercussion or a negative impact on the study.

Methodology

I used a basic qualitative research approach for the study. According to Merriam and Tisdale (2016), basic qualitative research is used to understand how knowledge is constructed and how participants create meaning out of a situation or phenomenon, and the researcher looks to understand perspectives and views of other people involved. For this study, the goal was to understand ADN faculty perceptions regarding the inclusion of EOL care content in prelicensure nursing curricula.

Participant Selection Logic

I used purposive sampling for this study with the following inclusion criteria: full-time faculty currently working within an ADN program who have at least 2 years of didactic teaching experience within an ADN program. Purposive sampling is the primary sampling method in qualitative research, and it ensures that participants meet the core constructs within the research question (Ravitch & Carl, 2016). To recruit participants, a study flyer was posted on social media. The flyer was also emailed to faculty directors from ADN program listservs within the United States. Participant demographic information was collected to have a basic understanding of their characteristics. Semistructured participant interviews were conducted until thematic saturation was reached. According to Merrium and Tisdale (2016), saturation has occurred when new

interviews yield no new insights on the phenomenon and the same information is being repeated. A similar study conducted by Jeffers (2014) accrued 10 participants when data saturation was reached. Therefore, I strove for a sample size of at least 10 participants.

Instrumentation

The instrumentation for the study included semistructured interview questions to answer the research question. Rubin and Rubin (2012) described semistructured interview questions as developed questions on the topic with a plan for the researcher to ask follow-up questions. I conducted one-on-one interviews using open-ended questions to understand faculty perceptions regarding the inclusion of primary and integrated EOL care content in prelicensure nursing curriculum. An interview guide was used for all interviews (see Appendix B). Interview questions were as follows:

1. Tell me about your area of clinical practice
2. What course(s) do you currently teach in your program?
3. Have you taught EOL care to ADN students? If yes, tell me about your experience teaching nursing students EOL care in the classroom.
4. Describe your view on the importance of a primary EOL care course in prelicensure nursing curricula. If there is not a primary EOL care course, what general concepts of EOL care are taught through the curricula?
5. Does the program for which you currently teach have a primary EOL care course? If not, discuss your belief about why a primary EOL care course has not been implemented in your program's curriculum.

6. Tell me how much influence you feel you have over making curricular changes, such as the addition of a primary EOL care course, within your program.
7. Describe the barriers that might preclude the implementation of a primary EOL course in a prelicensure ADN program? In what way do these barriers influence your feelings about a primary EOL care course in your program?
8. Do you have any additional information you would like to share?

The ongoing COVID-19 pandemic precluded the possibility of face-to-face interviews. Therefore, I conducted interviews via Zoom video conferencing. The interviews were audio recorded on the Zoom video conferencing platform and transcribed using the Microsoft Word dictation feature. The interviews were also simultaneously recorded on a smartphone using an application called Notability. Both audio-recording features were used in case one did not function properly. All recordings have been stored on password-protected devices accessible only by me. Transcribed interviews have been stored on a password-protected computer that only I use.

Procedures for Recruitment, Participation, and Data Collection

I conducted interviews using Zoom, which is a cloud-based video conferencing platform, so that nonverbal cues could be noted. The interviews were not video recorded; the audio recording feature of Zoom was utilized instead. The interviews were also recorded on a smartphone using an application called Notability in case one recording method did not function properly. All recordings have been stored on password protected devices used only by me.

I recruited participants using a flyer (see Appendix C) posted to the Colleges of Associate Degree Nursing Listserv and also on my personal Facebook and Instagram pages. The social media posts were made public so that anyone who had Facebook and Instagram was able to view the flyer. The flyer provided instructions for full-time ADN program faculty with at least 2 years of experience teaching for an ADN program who were interested in participating in a research study to contact me via email or telephone. Once I was contacted by an interested participant, I emailed the informed consent. The participant read the informed consent and returned an email stating, "I consent." Once consent was received, I scheduled an interview at a time that was convenient for them. A reminder email was sent the day before to confirm the appointment. I conducted the interviews in the privacy of my home office which was free from distractions, and I encouraged participants to do the same if possible.

Interviews began promptly at the scheduled time. For Zoom conferencing interviews, the participant was expected to log in via the link provided. If the participant had not logged in at the scheduled time, I had planned on contacting the participant via telephone if a contact number was provided. If a contact number was not provided, I would have emailed the participant to either proceed with the interview or reschedule. All 10 participants logged in at the expected time. I addressed the expected interview time frame of 20-30 minutes with participants beforehand to ensure that they would not have to terminate the interview before its completion. Participants were reminded that participation was voluntary and that they have a right to stop the interview at any time without penalty or fear of negatively impacting the study. Permission to record the

interview was addressed at the beginning, and all participants agreed. Interviews were recorded and transcribed verbatim.

Data Analysis Plan

The goal of data analysis in research is to make meaning out of the data to answer the research question (Merriam & Tisdell, 2016). I had planned to use NVivo as qualitative analysis involves large amounts of data. NVivo is a computer software program that is used by qualitative researchers to organize and analyze data (Predictive Analysis Today, 2016). However, I decided to use a Microsoft Excel spreadsheet instead. I was able to use the Microsoft Excel spreadsheet to organize and compare my data, so it was not necessary for me to learn a new software. Journal notes were recorded during and after the interview for nonverbal and other cues that might be helpful to data analysis.

In qualitative analysis, themes, categories, and patterns are identified by the researcher (Merriam & Tisdell, 2016). Qualitative analysis is both inductive and comparative, and the researcher must immerse themselves in the data (Merriam & Tisdell, 2016). Once I transcribed each interview, I began coding the data by reading the transcripts line by line. According to Saldana (2016), coding allows the researcher to split the data into individual segments that may subsequently be categorized by similarity. I carefully reread the transcripts several times after the initial coding to ensure that I had extracted as many codes as possible. I also met with my committee methods expert to ensure that I was performing the analysis correctly. I then began to note similarities between the coded data of each participant, and six main themes emerged as a result. Themes should meet the following criteria: respond to the purpose of the research, be

exhaustive, be mutually exclusive, names should be sensitizing to the data, and be conceptually congruent (Merriam & Tisdell, 2016). All data were organized into the themes that were created, and I ensured that the themes met the suggested criteria. Throughout the process, I was careful to consider biases that could have potentially impact the analysis. Recordings, transcriptions, journal notes, and data analysis have been secured on a password-protected computer. The data will be deleted after 5 years.

Issues of Trustworthiness

Trustworthiness in qualitative research refers to how effective the researcher was in providing evidence that their analysis provides a true picture of reality (Merriam & Tisdell, 2016). Four criteria that I used to help to ensure trustworthiness were dependability, credibility, transferability, and confirmability. In addition, Walden University IRB approved the study prior to recruitment and data collection.

Dependability

Dependability refers to how well data collection and interpretation processes can be tracked (Merriam & Tisdell, 2016). To ensure dependability, I instituted triangulation in addition to an audit trail of transcriptions and journal notes. My triangulation strategies included member checking and reflective journaling.

Credibility

Credibility pertains to whether the researcher's interpretation of the data matches up with the perceptions of the participants (Merriam & Tisdell, 2016). To ensure credibility, I applied reflexivity through journaling, thick description, and triangulation.

Transferability

The goal of transferability in qualitative research is that findings could be broadly applied in other settings, and that lessons learned could be useful in other settings (Merriam & Tisdell, 2016). I used purposive sampling, thick description, and detailed information to verify transferability.

Confirmability

Confirmability refers to the researcher's exploration and acknowledgement of biases that may impact the interpretation of data (Merriam & Tisdell, 2016). Reflexivity through journaling, triangulation, and an audit trail were strategies that I used to demonstrate confirmability.

Ethical Procedures

Researchers are morally bound to minimize the risk of harm when conducting research (Merriam & Tisdell, 2016). I obtained approval from the Walden University IRB before the commencement of recruitment or data collection. Participants who met the eligibility criteria were emailed an informed consent form, and verbal confirmation of consent to participate was verified prior to the interview. All 10 participants completed their interviews.

All data collected will continue to be kept confidential. I assigned a number to each participant, and identifiers such as names or institutions of work were not recorded in any way. Data have been stored on a personal password-protected computer and smartphone used only by me.

My own personal and professional experience could have presented ethical issues if not managed carefully. I am a medical oncology nurse who has cared for dying patients, I am currently an associate professor for an ADN program. Moreover, both of my parents died under the specialties of palliative care and hospice. I was cautious and aware of my experiences and potential bias so as not to impact the participants during interviews. My personal story was not shared with participants, and I was cognizant to avoid body language that may have conveyed my agreement or disagreement with what was being said. Reflexivity was important throughout data collection and analysis. I do not feel that my experiences impacted participants, the data, or data analysis.

Summary

In this chapter, I discussed the method I used to answer the research question, What are the perceptions of ADN faculty on EOL care content within prelicensure nursing curricula? A basic qualitative design was used, and as the researcher, I was the primary instrument. Inclusion criteria for participant selection were as follows: full-time faculty currently working within an ADN program who had at least 2 years of didactic teaching experience within an ADN program. Semistructured interviews were conducted and audio-recorded for data collection. Data analysis was done using qualitative methods of codes and themes. I addressed issues of trustworthiness, including dependability, credibility, transferability, and confirmability, in this chapter. Ethical procedures were also discussed. In Chapter 4, I will provide more information on the collection and analysis of the data, including procedures for ensuring credibility, transferability,

dependability, and confirmability of the results. I also present interview results, trends, and patterns.

Chapter 4: Results

Introduction

In this chapter, I will present the results of this qualitative research study. The purpose of this qualitative research was to explore the perceptions of ADN faculty regarding the inclusion of a primary EOL care course, or integrated EOL care content, within prelicensure nursing curricula. The guiding research question for this study was as follows: What are the perceptions of ADN faculty on EOL care content within prelicensure nursing curricula? I will discuss the setting, participant demographics, data collection, data analysis, trustworthiness, and results.

Setting

The recruitment process for the study took place at the end of August and into the beginning of September 2021. I posted a recruitment flyer on my personal social media sites, including Facebook and Instagram. The recruitment flyer was also posted on nurse educator social media platforms with permission from the administrators. Participants responded from various areas within the United States. An unintentional limitation was the time of year that the interviews took place. The beginning of the fall semester is a busy time for ADN nursing faculty, and it is possible that considering new or additional EOL care content during a busy time may have influenced participant responses.

Demographics

Ten full-time ADN program faculty participated in this study. Participant ages ranged between 35 to older than 65 with the majority being over the age of 55 years. The number of years of experience in nursing practice ranged from 8 to 50 years with an

average of 31 years. The number of years as nursing faculty in an ADN program ranged from four to 27 averaging 15 years. Table 1 provides a summary of the demographics of the study participants.

Table 1

Demographics of Participants (N = *10*)

Variable	*n*
Age	
25-35	0
35-45	2
45-55	2
55-65	4
> 65	2
# of years of RN experience	
1-10	2
11-20	0
21-30	5
31-40	1
41-50	3
# of years as faculty in ADN program	
1-10	3
11-20	5
21-30	1
31-40	1

Note. ADN = Associate Degree in Nursing.

Characteristics of Participants

The 10 study participants had a wide range of nursing clinical experience, each in more than one field. Most of the experience was in the fields of medical/surgical, cardiac, and gerontology. The sample included faculty who were teaching in all levels of the nursing program. All participants were seasoned nurses with years of teaching experience

within an ADN program. Table 2 provides a summary of the characteristics of the study participants.

Table 2

*Characteristics of Participants (*N = *10)*

Characteristic	*n*
Nursing clinical practice experience	
Medical/surgical	4
Cardiac	4
Community health	1
Gerontology	4
Critical care/Trauma	3
Mental health	1
Pediatrics	2
Maternal/child	1
ADN classroom teaching experience	
Beginning level (Fundamentals)	4
Intermediate level (Med/Surg)	3
Advanced level (Advanced med/surg and specialties)	3

Note. ADN = Associate Degree in Nursing.

Data Collection

Number of Participants

Fifteen people initially volunteered to participate in the study. Twelve of the 15 sent an email to inquire about the study and how to participate. Twelve emails were sent back that included study details and the consent. Eleven people returned signed consent forms, but only 10 arranged for interview times. Hence, the study included 10 volunteers who willingly participated in the interviews. All 10 volunteer participants met the inclusion criteria, which included faculty working full-time within an ADN program and who had at least 2 years of didactic teaching experience within an ADN program. One

consenting participant was not included because they did not respond to set up an interview.

Location, Frequency, and Duration of Data Collection

I conducted individual interviews with volunteer participants who were working full-time as faculty within an ADN program and who had at least 2 years of didactic teaching experience within an ADN program. Walden University's IRB granted permission to conduct human subject research prior to my starting the recruitment effort. The IRB approval number was 08-23-21-0282389 and was received on August 23, 2021. I posted a recruitment flyer (see Appendix C) on my personal Facebook and Instagram pages as well as on The Lecture Breakers and Nurse Educators Group Facebook pages with permission from the administrators. The flyer was also emailed to the Colleges of Associate Degree Nursing Listserv. The recruitment flyer contained a brief description of the study, purpose of the study, participant inclusion criteria, and contact information.

Friends shared the flyer on social media, which may have increased the number of eligible individuals who the flyer reached. Almost immediately, I received social media comments from interested individuals, and I responded to each one asking them to contact me via email or text. When I received a response, I emailed the study details with the consent and instructed them to email the reply "I consent," as instructed by the Walden University IRB. Eleven people consented to participate, but one did not follow through with setting up an interview. Interviews began on August 25, 2021 and concluded on September 8, 2021.

I conducted all 10 interviews via Zoom video conferencing. Each interview began with an assurance of privacy and the ability to stop at any time, verbal confirmation that the participant still consented as indicated in their email, and that their participation would be kept confidential. All participants were informed that they would receive a summary of the study results.

Data Recording

I asked each participant for permission to audio-record their interview, and all were agreeable. All 10 interviews were recorded using the audio record feature on Zoom and simultaneously recorded on a smartphone using an app called Notability. Two audio-recording features were used in case one did not function properly. Both recordings were stored on password-protected devices accessed only by me. I also took notes on a Microsoft Word document recording my thoughts and impressions as each participant talked so that I could reflect on them later.

I transcribed each interview. I played the recordings and enabled the Microsoft Word dictation feature, and then I listened again and corrected mistakes. I chose to transcribe the interviews myself so that I could begin immersing myself in the data.

I assigned participants a participant number to ensure privacy. No names or other identifying factors were associated with the interviews. When a participant mentioned the name of their state or institution, the names were removed from the final transcription. All emails, recordings, and Microsoft Word documents are stored on a password-protected computer. The additional recordings are stored on a password-protected iPhone that can only be accessed by me. My dissertation chair and committee are the only other

individuals who have access to the data if necessary. All data will be securely stored for the required 5 years. After the 5-year period has expired, all data will be destroyed.

Variation From Original Data Collection Plan

The only variation from my original plan was the addition of posting the flyer to The Lecture Breakers and Nurse Educators Group Facebook pages after obtaining permission from the administrators. I do not know whether participants came from posting flyers to these groups, but I was able to recruit the necessary number of participants and reach data saturation with interviews. Therefore, no further recruitment efforts were necessary.

Data Analysis

Coding Process

I began the data analysis process by transcribing the audio recordings of each interview myself so that I could begin immersing myself in the data. I read and reread the transcripts and my journal notes. I uploaded the interview data on a separate Excel sheet column that was labeled with the participant's assigned number to make comparisons easier. I began coding the data by reading the transcripts line by line. According to Saldana (2016), coding allows the researcher to split the data into individual segments which may subsequently be categorized by similarity. I carefully reread the transcripts several times after the initial coding to ensure that I had extracted as many codes as possible. I also met with my committee methods expert to ensure that I was performing the analysis correctly. I then began to note similarities between the coded data of each participant, and six main themes emerged as a result (see Table 3).

Table 3

Main Themes and Codes

Theme	Code
Theme 1: EOL Care Education Is Important Because EOL Care Is Universal in All Nursing Practice	Aging population COVID-19 pandemic deaths Everyone dies
Theme 2: Faculty Have Varied Perceptions of What EOL Care Education Entails	Value of a person Communication Symptom management Cultural issues Psychosocial issues The dying process Ethics
Theme 3: Acute Care Nursing Does Not Include EOL Care	Faculty are acute care focused Focus is tasks Preventing death General practice Focus is on treatment
Theme 4: The Necessary EOL Care Content Is Incorporated Throughout the Curriculum	Information spread throughout curriculum Lifespan woven throughout Already an oncology course Well-integrated throughout Touches on all aspects throughout Standalone course not needed Covered in fundamentals
Theme 5: There Is a Stigma of Death and Dying	Students want to make people better Death is minimized to students Limited life experience with death Faculty want to create positive experiences
Theme 6: Faculty Have Limited Control	Credit limit NCLEX-RN test blueprint Concept-based program Administrative inflexibility

Note. EOL = end of life. NCLEX-RN = National Council Licensure Examination for Registered Nurses.

Evidence of Trustworthiness

Triangulation and member-checking were strategies that were used to ensure trustworthiness. I used social media to recruit the small sample of participants from different parts of the United States. My recruitment flyer was also e-mailed to faculty directors from an ADN program listservs within the United States.

Dependability

I was able to observe each participant through Zoom video conferencing, and I audio recorded each interview. I also recorded journal notes as thoughts came to me during the interviews. Each interview was transcribed verbatim by me, and the transcriptions and journal notes are stored on a password-protected computer.

Credibility

I utilized member-checking to be sure that I was understanding the participants' statements. Member-checking allowed participants to correct me if I misunderstood or to concur if I interpreted what they said correctly. I explained to each participant that I wanted to hear their own perception and not what they think I wanted to hear. I was also careful to not offer my opinions or demonstrate facial expression of agreement or disagreement. The use of an interview guide helped me to keep focused on the questions I had prepared, and I was able to keep participants on topic by asking open-ended questions. Each participant will receive a copy of the study findings.

Transferability

I used purposive sampling to recruit participants who were current, full-time ADN faculty who had at least 2 years of didactic teaching experience. Thick description and

detailed information were used to ensure transferability so that findings can be broadly applied to other settings.

Confirmability

Prior to each interview, I used reflexivity and considered my own beliefs and judgments. My clinical experience has been as a medical oncology nurse, and I teach full-time within an ADN program. In addition, both of my parents died under palliative and hospice care. I was careful to not convey that information to participants, and I made it a point to remind them how important it was that they share their perceptions and not what they think anyone else wanted to hear.

Results

Interview questions were carefully developed to answer the following guiding research question: What are the perceptions of ADN faculty of EOL care content within prelicensure nursing curricula? Therefore, the themes that emerged addressed the research question.

Theme 1: End-of-Life Care Education Is Important Because End-of-Life Care Is Universal in all Nursing Practice

All participants agreed that it is important to teach EOL care education because death can occur in any area of nursing practice. Participants pointed to the fact that the population is aging which included the following examples: “I think it’s very important to know considering the population of aging” (Participant 2). Participant five said, “I think that we need to be realistic and make sure students see the realistic side of things as

our population grows older and sicker and has more comorbidities as they age." According to participant nine,

> I think for years we haven't really thought about it because we saw a younger population, now we've seen an elderly population, an older population, and more acute and sicker population, so these questions are more in the forefront than we've ever seen.

Participants also mentioned COVID-19 deaths that continue to impact nurses with the following examples: Participant 2 stated, "You know the other thing I thought of was the life expectancy and COVID deaths." Participant 8 said, "What we've seen with the COVID pandemic and, I mean, the amount of death that has happened, and nurses not being prepared to deal with that."

Participants 1 and 8 mentioned that death occurs at all ages: "One of the threads of the program is lifespan, health continuum and developmental stages, so all of those things, I think, I'm believing, are being woven in at some level" (Participant 1). Participant 8 said,

> No matter where you work, you're going to have people die and you know if you're working in an emergency room, I mean, it could be trauma that comes in, it could be somebody with a heart attack, and certainly in the nursery, I mean, you're going to have babies die.

Theme 2: Faculty Have Varied Perceptions of What End-of-Life Care Education Entails

All faculty felt that EOL care content was important, but what EOL care concepts are important to include in educating prelicensure nursing students varied among participants:

> The value of a person being not defined by that person's productivity, but the person has value in and of himself just because he was created by God…We look at cultural perspectives and religious practices around death…we talk about Erikson's psychosocial stages so looking at the last one, ego integrity verses despair…we look at mortality and morbidity statistics (Participant 2).

Participants 3 and 7 discussed developmental aspects and teaching students' what children can understand in terms of death. Participants 3, 4, and 6 mentioned that communication is important, and participant 4 focused on the physical aspect by stating,

> Basic care of somebody at end-of-life, you know, the use of oxygen, what about fluids, what about feeding tubes? All of these things that people think we have to do, you know, what's the purpose of it? What are the benefits of it when you're at the end of life?

Participant 5 said that cultural issues are important:

> I believe number one, the concept that some people are ready to pass on, are ready to go wherever, I believe that we need to address cultural issues and we need to ensure that students understand the need to provide for patients at the end of life

> what it is that makes their life, end-of-life, experience meaningful to them whatever that may be.

Participant 5 also discussed teaching physical changes in the dying person, and participant 8 explained the importance of the psychosocial impact of death on students: "I actually get my students prepared for talking about this topic by having them kind of, you know, reflect on what their own thoughts are on it…"

Participant 10 focused on symptom management: "I've been there when people were dying, so I think it is very important for nurses to understand pain control, symptom control for patients at end-of-life."

Prior to each interview, I explained that EOL care education in a prelicensure nursing program does not refer to the specialties of hospice or palliative care, but I did not elaborate on what EOL care content includes. Each participant shared their own perception of topics they thought were important.

Theme 3: Acute Care Nursing Does Not Include End-of-Life Care

After learning that faculty have different perceptions of EOL care, I was excited to hear about why faculty believed that a primary EOL care course was not in their ADN curriculum.

> It would be a little bit of a mental change, I think, for faculty who are very acute care focused. Almost, I mean, almost all of our clinical is acute care focused as if we were producing only hospital nurses. I think a lot of, this is just my perception, that the AD program is very much focused on tasks, people being able

> to do safe practice and tasks, and I think that this is seen as a nice to know and not necessarily a need-to-know level of nursing care (Participant 1).

Participant 3 said, “It’s just that the whole time we’re in nursing school it’s always about preventing death.” Participant 4 stated, “I think it’s not viewed as being important because when people think of nursing, they’re thinking of, you know, we’re saving people.” Other statements included, “I’m not sure that it would take priority over some of the other pressing issues” (Participant 5), “They’re meant to be general practitioners, not specialists” (Participant 6), and “When you’re dealing with your patients, you know, you also have to address this, but there’s still so much focus on the treatment of, you know, physiological processes and that’s what I see anyway” (Participant 8).

I concluded that faculty believe that the focus of the ADN program is on acute care and therefore, EOL care education is not as imperative within ADN curriculum.

Theme 4: The Necessary End-of-Life Care Content Is Incorporated Throughout the Curriculum

For theme 1, participants identified that EOL care content is important. However, theme 4 presented evidence that faculty believe that the necessary content is already incorporated throughout the curriculum, and a primary EOL care course is not necessary.

> Whether we need a standalone course on that in a curriculum that has concept-based where—that’s how we deal with everything as a concept and spreading it through rather than separating it out---I’m not so sure that would work here. I don’t believe that faculty are not teaching this, ok, I don’t believe that for a couple of reasons: One is because the faculty is a very solid faculty, and many of the

> people who are teaching these specialty areas are quite seasoned nurses (Participant 1).

Participants 2, 4, 6 asserted that the content is covered in an oncology course within their programs and participant 6 said that incorporating basic ideas of EOL care is good enough, and "They're meant to be general practitioners, not specialists."

"I believe that if it's done properly in a prelicensure program it's better if it's well-integrated into the curriculum" (Participant 5). Participant 7 felt that EOL care is not priority in terms of what needs to be present in ADN curricula.

Participant 10 indicated that EOL care content is included in fundamental courses:

> I think it's important that there is something. Now, like you said, does it need to be a standalone course? Probably not, but those concepts need to be threaded through so that the students understand that. I think the concepts you are talking about are very much covered in fundamentals.

Theme 5: There Is a Stigma of Death and Dying

Participants identified that students and faculty would rather avoid dealing with EOL patients and focus on other areas of nursing. This suggests that a stigma continues to surround the topic of death and dying.

Participants 1, 4 and 8 said that students do not want to deal with death. While participant 1 mentioned that attitudes on death and dying have come a long way, they went on to state, "Students want to go in to Maternity or Obstetric and psych and so forth, so they're not thinking of the end-of-life perspective." Participant 4 said, "…there are a lot of students who are very young and have not dealt with end-of-life care with a family

member, and to have a patient that is at end-of-life is very different and scary for them." Participant 8 also remarked that students want to avoid the topic of death: "I think the interesting thing, too, is that you know, so many nursing students, they don't want to deal with it." Another participant pointed out that nurses and faculty are impacted by death as well:

> I think we minimize what death does to nurses and so what the nurses do is they kind of bottle it all up and put it away and avoid it, and again, that's just making things worse. Because we don't know how to deal with it because nobody helped us through that (Participant 3)

Participant 5 stated, "…many faculty would rather have [students] see positive things and not necessarily negative." Participant 9 said, "I think people have a difficult time dealing with it. I mean, it is a difficult topic and oftentimes a very personal topic for even students and faculty sometimes."

Theme 6: Faculty Have Limited Control

ADN faculty feel they have limited control over the curriculum, and the most commonly recurring statements were regarding the number of credits within the programs. For example, Participant 1 said,

> I mean, even if you had a one credit course for adding to the course load, you know, to the total number [of credits], that barrier is far above us in the college's administrative structure, so those things are coming down from there, but that's a hard barrier to jump.

Participant 2 stated, “I think probably trying to limit the number of credits a student in the AD program needs means they are cutting out some content,” and participant 3 said, “We’re already one of the highest credit associate degree prelicensure nursing programs. We have had to cut our credits multiple times over the years…it would be very difficult to justify adding more credits.” Participants 6, 7, 8, 9, and 10 also identified the credit limit as a barrier to adding content or courses to the curriculum.

Another barrier to curricular changes is that participants felt that the state board of nursing drives the curriculum.

> I got online and looked at the _____ State Board of Nursing curriculum for LPN and RN, and it’s not there. They’re very general about what they talk about anymore, but I mean so sometimes, this kind of thing, these changes don’t happen unless it’s regulated (Participant 1)

Participant 3 stated, “It’s not heavily looked on by the State Board of Nursing,” and participant 8 said, “I honestly feel that the focus of associate degree in nursing programs is to prepare them to pass the NCLEX exam, the licensure exam.” Participant 10 also mentioned the state board of nursing:

> We can’t teach everything and so, you have to like, you know, really look a the NCLEX blueprint. What are they going to be tested on because you, know, I hate to say that, but that’s what we have to teach to.

All participants mentioned that their programs are concept-based, which means that content is covered and built upon throughout the curriculum. This proves to be a barrier

to adding content because it would impact all of the courses within the program. For example, participant 7 said,

> If you create a class, how many credits? Where do we go with everything integrated? You have to like, pull all of that content out of each place that it's in and tweak it to replace other stuff, and then like the movement, you know, it's a lot of little moving parts.

Participants generally felt that there is a process for their input on the curriculum, but committees and administration have jurisdiction over what happens. When asked how much influence they have over curricular changes, Participant 1 said, "Absolutely none." Participant 7 said, "I have very little."

Discrepant Cases

Some of the participants were not in favor of a EOL care content for prelicensure nursing students. For example, Participant 6 stated, "I don't necessarily feel a whole course on end-of-life care is needed because they are meant to be general practitioners not specialists." Participant 7 said, "I guess quite honestly, my perception is that it might not, I don't think it's, you know, the top three or in the top of the list as far as what needs to be taught." While there were differing views on the importance of EOL care education in prelicensure nursing curricula, all participants verbalized that EOL care content is important for nurses to know in any setting. Different clinical nursing experience and limited control on making curricular changes may have impacted perceptions.

Summary

Through interviews and careful analysis of audio-recordings and transcripts, I was able to explore the perceptions of 10 ADN faculty on EOL care content within prelicensure nursing curricula. Table 1 includes participant demographics, Table 2 provides participant characteristics, and Table 3 presents a matrix of themes and codes. The six themes that emerged were as follows: EOL care education is important because EOL care is universal in all nursing practice, faculty have varied perceptions of what EOL care education entails, acute care nursing does not include EOL care, there is a stigma of death and dying, and faculty have limited control.

I learned from the interviews that individuals who teach for an ADN program believe that EOL care education is important because nurses face it in all areas of nursing practice. Factors such as the aging population, everyone dies, and COVID-19 associated deaths were commonly discussed. It was interesting to find that ADN faculty have varied perceptions of what EOL care education for prelicensure nursing students entails. Concepts such as the value of a person, communication, developmental aspects, culture, physical changes, student self-reflection of death, and symptom management were mentioned by different participants.

Another finding was that participants indicated that acute nursing care does not include EOL care. This theme was gleaned from participants comments that ADN curriculum is focused on acute care, preventing death, and cure. Therefore, EOL care education is not as imperative within ADN curriculum. Participants also identified that the EOL care content that is necessary for ADN students to learn is incorporated

throughout the curriculum and that a primary EOL care course is not necessary. Participants also felt that there is a stigma related to death and dying and that faculty and students would prefer to avoid the topic. Finally, participants indicated that they have limited to no control over curricular changes because of the need to limit credits, the State Board of Nursing does not focus on EOL care content for the NCLEX, programs of those interviewed are concept-based, and administration may be inflexible. In Chapter 5, I will provide an interpretation of findings, study limitations, recommendations, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative research study was to explore the perceptions of ADN faculty regarding the inclusion of a primary EOL care course, or integrated EOL care content, in prelicensure nursing curricula. Chapter 5 will begin with a discussion and comparison of major findings as they are related to the literature on EOL care content in prelicensure nursing curricula. I will also connect the findings to Ajzens's theory of planned behavior. Finally, study limitations, future research recommendations, and social change implications will be considered.

Interpretation of the Findings

A review of the literature reveals that EOL care education impacts nursing students' perceptions of EOL care in a positive way (Bear & Chandran, 2019; Cerit, 2019; Grubb & Arthur, 2016; Henoch et al., 2017; Smothers et al., 2019). Moreover, the American Nurses Association Professional Issues Panel (2017) asserted that EOL care is a nursing responsibility in all practices, and they issued a call for action that the ELNEC curricula become the standard primary palliative care course for prelicensure nursing programs. However, EOL care is still generally absent from prelicensure nursing school curricula (Institute of Medicine, 2015; Mason et al., 2020; O'Shea & Mager, 2019; Thrane, 2020). This research study contributes knowledge to the discipline of nursing on the perceptions of ADN faculty regarding the inclusion of EOL care content in prelicensure nursing curricula. The findings may help to explain why EOL care content continues to be lacking in prelicensure nursing curricula.

The participants acknowledged that EOL care education is important for nurses in all areas of practice because death is universal. Considerations such as the aging population, COVID-19 pandemic deaths, and the fact that everyone dies were commonly discussed. However, participants had varied perceptions on what EOL care content entails, and they posited that a primary EOL care course is not necessary in prelicensure nursing curricula.

Participants identified that ADN curriculum largely focuses on the acute care setting which includes tasks, preventing death, general practice, and treatment. Therefore, EOL care is not a priority in prelicensure nursing programs. Many participants felt that any necessary EOL care content is already incorporated throughout the curriculum.

Other key findings from the study were that there is a stigma of death and dying that may preclude stakeholders from wanting to implement more EOL care content. Moreover, faculty identified that barriers such as credit limits, the NCLEX-RN not focusing on EOL care, the fact that all participants' programs are concept-based, and administrative inflexibility limit their control over curricular additions and changes.

Theoretical Framework

Ajzen's TPB informed this research study. Assumptions of TPB are that belief, attitude, intention, and control are predictors of behavior (Ajzen, 1985). Participants said they believed that ADN programs focus on acute care which does not include EOL care and that the necessary content is incorporated throughout the curriculum. Participants conveyed that there continues to be a stigma of death and dying. Participants indicated that they do not intend to pursue adding more EOL care content to their curriculum, and

they have limited control on curricular changes even if they wanted to. Based on the application of TBP to this study, ADN faculty do not intend to pursue adding a primary EOL care course, or any additional EOL care content, in to prelicensure nursing curricula.

Limitations of the Study

A limitation was the timing of recruitment. I received IRB approval and began recruiting participants at the end of August 2021. Fall semester was just beginning, which is a busy time for ADN faculty. The ongoing COVID-19 pandemic may have also impacted time constraints. I got the impression from nearly all participants, whether they knew me or not, that they thought I was trying to implement a EOL care course into the curriculum. I was careful to explain the purpose of the study, but I felt that some participants were trying to convince me personally that adding EOL care content was not a good idea while others were trying to help me figure out how it could be done. Responses may have been different during a less busy time of year.

A second limitation to the study included my own experience. My area of clinical nursing practice is medical oncology nursing. I also experienced the loss of each of my parents in recent years while either on palliative or hospice care, and I work as full-time faculty within a ADN program. Although I was careful to use an interview guide and not assert my opinion during the interviews, a few of the participants were aware of my experience, which could have impacted their responses. To minimize this risk, I reminded all participants that it was important to share their own perspectives. I also transcribed each interview verbatim to ensure that I was not asserting my own opinion of what the

participants said. The third and final limitation was that the sample only included ADN nursing faculty. BSN faculty may have shared different perspectives than what the ADN faculty did.

Recommendations

Nurses and nursing students have reported a lack of EOL care knowledge (Croxen et al., 2017). EOL care content is still generally absent from prelicensure nursing school curricula (Institute of Medicine, 2015; Mason et al., 2020; O'Shea & Mager, 2019; Thrane, 2020). This study provides evidence that ADN faculty believe that EOL care education is important for nurses in all practice areas and that necessary EOL care concepts are already embedded in the curriculum. However, ADN faculty also believe that the inclusion of a primary EOL care course is not necessary in prelicensure nursing curricula because of the acute care focus. One recommendation for further research is to repeat the study and interview during a different time of year when time-constraints are not as pronounced. It would also be interesting to learn how ADN faculty perceptions on the inclusion of EOL care content have changed after the COVID-19 pandemic is better controlled. Another recommendation is to conduct the study with a sample of prelicensure BSN faculty. A final recommendation would be to repeat the study with participants who do not know the researcher.

Implications

The results of this study help to fill a gap in understanding by specifically focusing on ADN faculty perceptions regarding the inclusion of a primary EOL care course, or integrated EOL care content, in prelicensure nursing curricula. ADN faculty

shape the curriculum, and the results of the study provide crucial insight as to why primary EOL care education has not been adopted by many ADN programs. Study outcomes have implications for social change by shedding light on barriers that preclude the inclusion of EOL care content. Removing barriers to allow for the inclusion of a primary EOL care course in ADN curricula would ultimately be beneficial in the following ways: Students and novice nurses may experience reduced stress, increased self-efficacy, and better attitudes toward death; dying patients may receive better symptom management and more timely hospice referrals; and family caregivers may more frequently be provided with the needed education and support.

Conclusion

Prelicensure nursing programs are responsible for imparting EOL care concepts to students; however, prelicensure nursing programs do not provide enough EOL care education (Mason et al., 2020; O'Shea & Mager, 2019; Thrane, 2020). As a result, patients, nursing students, nurses, and family caregivers are negatively impacted (Aparicio et al., 2017; Kumar et al., 2017; Smothers et al., 2019). This study revealed the perceptions of ADN faculty regarding the inclusion of EOL care content within prelicensure nursing curricula. The results provide crucial insights as to why primary EOL care education has not yet been adopted by many ADN programs. When entities such as the American Nurses Association Professional Issues Panel become more aware of how ADN faculty perceive barriers to the inclusion of EOL care content, they may adopt strategies to highlight the importance of EOL care content to those who regulate

the content within prelicensure nursing curricula. The inclusion of this content may benefit nursing students and professionals, patients, and family caregivers.

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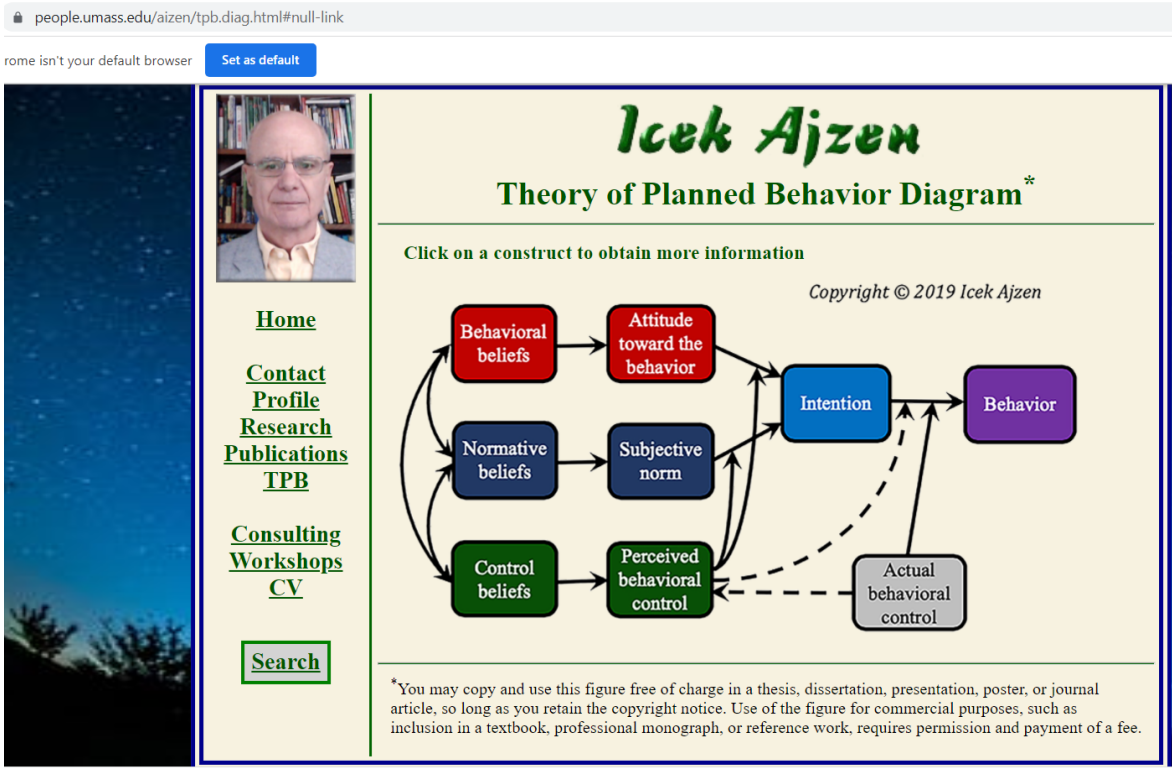
Appendix A: Permission to Use Theory of Planned Behavior Diagram

Reproduction of the theory of planned behavior diagram is permitted with source attribution and retention of the copyright notice, per the author's website.



Appendix B: Interview Guide

Thank you, (participant's name) for your willingness to participate in my research study. My name is Kathy Zaharchuk, and I am a Ph.D. student in nursing education program at Walden University. The interview will take approximately 30 minutes. I will be audio recording (if by phone)/video recording (if by ZOOM) during the interview. Do you agree to this?

As reviewed in the Informed Consent, you can stop the interview at any point for any reason as your participation is voluntary. You may choose to not answer questions if you are uncomfortable. By choosing to answer the questions, you will be assisting in research to explore the perception of nursing faculty on a primary EOL care course in prelicensure nursing curricula. Your responses will remain confidential.

For the purpose of this interview, it is important to understand the definitions of primary end-of-life care and a primary end-of-life care course. Primary EOL care refers to palliative care for the dying who are not under the service of a specialty palliative care or hospice team. The role of the nurse in primary end-of-life care is to recognize and meet the needs of dying patients and their families and should not be confused with the specialties of palliative or hospice care. A primary EOL course in prelicensure nursing curriculum is a stand-alone course that educates students on key components of end-of-life care.

Interview Questions

Question Focus	Question
General icebreaker	1. Tell me about your area of clinical practice
General icebreaker	2. What course(s) do you currently teach in your program?
General	3. Have you taught EOL care to ADN students? If yes, tell me about your experience teaching nursing students EOL care in the classroom.
Attitude	4. Describe your view on the importance of a primary EOL care course in prelicensure nursing curricula. If there is not a primary EOL care course, what general concepts of EOL care are taught through the curricula?
Belief	5. Does the program for which you currently teach have a primary EOL care course? If not, discuss your belief about why a primary EOL care course has not been implemented in your program's curriculum.
Belief/Control	6. Tell me how much influence you feel you have over making curricular changes, such as the addition of a primary EOL care course, within your program's curriculum?
Attitude/Belief/Intention/Control	7. Describe the barriers that might preclude the implementation of a primary EOL course in a prelicensure ADN program? In what way do these barriers influence your feelings about a primary EOL care course in your program?
Closing	8. Do you have any additional information you would like to share?

I appreciate you taking the time to complete this interview, and your input will contribute to learning more about the perception of nursing faculty on a primary end-of-life care course within prelicensure nursing curricula