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Increase Knowledge and Attitude in End-of-Life for Long-Term Care Nurses

Lisa Mitchell
Walden University

Walden University

College of Nursing

This is to certify that the doctoral study by

Lisa Mitchell

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Barbara Niedz, Committee Chairperson, Nursing Faculty
Dr. Kelly Fisher, Committee Member, Nursing Faculty
Dr. Anna Valdez, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

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Abstract

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MS, Walden University, 2015

BS, Grand Valley State University, 2006

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Nurses are key health professionals in long-term care facilities who have an essential role in providing compassionate care at the end-of-life. The customary education that nurses receive in end-of-life care is inadequate to meet the complex care of dying patients. The purpose of this scholarly project was to implement an evidence-based end-of-life educational program to improve the nursing staff knowledge, attitudes towards care of the dying, and standards in long-term care. The theoretical framework to guide this project is Bandura's self-efficacy to support the confidence and attitude of nurses caring for the dying. The End-of-Life Nursing Education Consortium (ELNEC) Geriatric Curriculum was used to educate nurses on end-of-life care. The Frommelt Attitudes Toward Care of the Dying (FATCOD), Form B evaluated the education. Descriptive statistics analyzed a sample size of (n = 21), females 17 (81%) to males 4 (19%), ages ranged from 18-65 years, with 81% over 46 years. The sample had 11 (RN-LPN) with degrees compared to 10 (CNA-others) with high school degrees, and 85% have not previously taken an end-of-life course. The paired *t* test sample mean from the pretest 117.14 and posttest 121.90 suggested the nursing staff education was effective. The posttest scores improved 4.7 points after the education program. The paired sample test results t (20) = 3.368, $p < .002$ suggested the difference in mean increased between the pretest and posttest scores. This scholarly project achieved positive social change by providing the nursing staff with the necessary resources to increase knowledge, confidence and improve end-of-life care.

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Dedication

First and foremost, I thank God Almighty, the Provider, the Giver of Knowledge, Comforter, and Understanding. This project is dedicated to my mother, Dora Frances Mitchell, deceased brother Michael Bush and sister Donna Bush. I thank my loving mother for the inspiring values instilled in me as a child to help those in need in any trajectory of their illness. Secondly, I thank my children Candice Wright, John Mitchell, Andrew Mitchell, siblings Brenda Shelton, Aletha Patton, Linda Gant, Sharon Johnson, and Leonard Shelton for the support and encouragement throughout this educational journey. Thank you for listening when it mattered the most, the love, and understanding. Thank you, my loving family.

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I would like to thank the Doctoral of Nursing Practice Project Committee, Dr. Niedz, Dr. Fisher, and Dr. Valdez for mentorship and support through this journey. I send a special thank you to Bridgette Malchow my advisor for the guidance, resources, and encouragement to continue. I want to thank Walden University for providing me the opportunity to pursue my DNP. Without this great opportunity, none of this would have been possible.

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Section 1: Nature of the Project

Introduction

As the population ages with life-limited conditions and terminal illness, there is an increasing need for nursing care requiring living in long-term care. The American Community Survey (2016) estimated the number of people in the United States age 65 years and over at 49.2 million. Americans in this age group will experience complex health conditions and require nursing care (Roberts et al., 2018). Many residents in long-term care will require end-of-life care and the transition of palliative care to end-of-life is often not clearly defined. Though there is a great need for end-of-life care, the education nurses receive in end-of-life is inadequate to meet the multifaceted need of dying residents (Anstey et al., 2016). The lack of knowledge about end-of-life care and perceptions from caring for the dying effect nurse's ability to provide quality care (Hussin et al., 2018). This staff education project focused on end-of-life in long-term care.

Nurses spend more time at the bedside than any other health profession and are responsible for providing care through the progression of serious illness and at the end-of-life. Lewis et al. (2018) defined quality end-of-life as care that focuses on dignity, physical symptoms being met, support for emotional distress, and not prolonging death, with the care that is provided by competent and caring health professionals. End-of-life care is provided when people decide to stop treatment to control chronic diseases, terminal illnesses, and are near death (Miron, 2018). End-of-life care may include support

from palliative care to coordinate goals of care and hospice to control distressing symptoms. The World Health Organization ([WHO], 2020) defined palliative care as an approach that improves the quality of life for patients and their families facing life-threatening illness. The goal is to prevent and relief of suffering through early identification, correct assessment, treatment of pain, and other problems, whether physical, psychosocial, or spiritual (WHO, 2020).

Peden-McAlpine et al. (2015) found that professional nurses often lack education and knowledge to effectively provide palliative and end-of-life care. Per the director of nursing at the project site, the customary education that nurses receive related to end-of-life is inadequate to meet the complex care of residents. Eriksson et al. (2017) found a significant difference in end-of-life competencies among nursing staff in group residential and long-term care facilities in rural areas. The minimum education on end-of-life care provided in nursing schools is not enough to address the needs of dying patient (Carmack & Kemery, 2018).

Despite the increasing demand for nurses to be compassionate and experts, barriers exist in the lack of education in end-of-life. Nilsen et al. (2018) recognized evidence-based palliative and end-of-life care as the biggest barrier to the education nurses receive to care for dying patients. Carman et al. (2016) found that nurses with education and training in end-of-life care are more knowledgeable with a positive attitude, understanding, and confidence toward caring for dying patients. Samson and Shavartzman (2016) stated that nurses, can deliver better healthcare to dying patients and

their families because they are conscious of their feelings and thoughts about death. The purpose of this project was to make a change in nurses' knowledge and attitudes about end-of-life and the impact on the quality of dying for residents. This project has the potential to increase nurses' competency in end-of-life which could result in positive social change through less suffering, gentle, and compassionate death for residents.

Problem Statement

As Americans age, the complexity of health conditions, terminal illness, and end-of-life care in long-term care is a concern. At the end-of-life, residents rely heavily on nurses to meet their physical and emotional needs. Smets et al. (2018) reported long-term care staff have experience caring for the dying; however, they often lack formal training in end-of-life. Nurses are often unprepared to assess distressing symptoms like pain, terminal breathing, delirium, and the provision of emotional support during the dying process. The Institute of Medicine ([IOM], 2015) *Dying in America* report identified a deficiency in health professional education on end-of-life, palliative, and hospice care, which affects quality of care. Patients dying from acute and chronic conditions may experience a protracted death made possible through advanced life support technology that may cause greater suffering for patients (IOM, 2015). Yet, nurses may be uncomfortable or lack the confidence to discuss advance care planning preference at the end-of-life.

The leadership team at the project site observed the lack of knowledge in end-of-life care at a local long-term care facility in the north central United States. Employees of

this facility consist mainly of licensed practical nurses, and certified nursing assistants. The facility does employ several registered nurses per shift. The local facility has a nursing practice issue because nurses feel uncomfortable discussing advanced care planning preferences, unprepared in the assessment of end-of-life signs and symptoms (e.g., pain), and the administration of pain medication to dying residents. Nurses were uncomfortable and unsure when to assess physical symptoms to administer pain or anti-anxiety medications to dying residents. Nurses will wait for hospice transition for the resident's symptoms to be managed by the services with emotional support. Cagel et al. (2016) discovered understanding nursing staff perceptions about death and dying is critical to address the many challenges of end-of-life care. Therefore, an end-of-life education program can increase the nursing staff knowledge and attitude to meet a dying resident's need for distressing symptom relief and emotional support. This project holds significance for nurses because it could result in improved end-of-life experiences for patients, families, and staff.

Purpose Statement

The staff education program focused on a gap in current nursing practice identified by the leadership team at the project site. The aim of this staff education was to improve nursing staff knowledge and attitudes about providing quality end-of-life care to residents. An evidence-based education program in end-of-life can increase the standards of care in a long-term care facility and the nursing practice in the care of dying residents. The guiding practice-focused question is: Will an evidence-based education program on

end-of-life care improve the nursing staff knowledge and attitudes about caring for dying residents in long-term care?

Nature of the Doctoral Project

Evidence of nurses receiving minimal end-of-life education is documented in the literature. Nurses' lack of knowledge and confidence interferes with meeting the needs of the dying. Pivodic et al. (2018) found nursing homes are the most commonplace of death and the care patients receive at the end-of-life is inadequate. End-of-life care is an important component of quality patient-centered care. During the process of data collecting, the leadership team identified the nursing staff unpreparedness when caring for the dying. Additionally, several nursing staff have shared fears, feelings of discomfort, and perceptions about end-of-life care that support the need for additional education.

Sources of evidence for this project will include peer-reviewed publications from journals published in the past five years that are written in English. The Walden University online databases include, CINAHL, MEDLINE, CINAHL plus full text, EMBASE, ProQuest, Google Scholar, and PubMed. The literature review will consider clinical practice guidelines and standards of practice. The City of Hope and the American Association of Colleges of Nursing ([AACN], 2021) is a national and international education initiative to improve palliative care with the End-of-Life Nursing Education Consortium (ELNEC) training. The ELNEC Geriatric Curriculum was used as the evidence-based curriculum for this staff education project. Pretest and posttest data about

nurses' knowledge and attitudes related to end-of-life care was collected using the Frommelt Attitudes Toward Care of the Dying, Form B (FATCOD-B) scale, which is a valid and reliable tool (Frommelt, 2003, Mastroianni et al., 2015).

Following the Institutional Review Board (IRB) approval, I provided a staff education program at the project site using the previously appraised ELNEC training program from AACN. I have completed the train-the trainer education and purchased access to the program. Prior to the training the participants received a copy of the Consent Form for Anonymous Questionnaires from the Walden Staff Education Manual. Participants were then asked to complete the pretest using the FATCOD-B 30 item questionnaire. Following the pretest, I provide the education program. After the education program the participants were asked to complete the same exam again. The scores from the pretest and posttest were examined to measure the change in the nursing staff knowledge and attitudes in end-of-life care.

To protect the confidentiality of participants no names were collected on the forms used for this project. Participants were asked to select a four-digit number to write on all documents, which allowed for comparison results of the pretest and posttest scores using descriptive statistics and a paired *t* test. Findings from the pretest and posttest (Appendix A) and the course evaluation data collected permitted to determine if the staff education program was successful in improving knowledge and attitudes related to end-of-life care. The goal of this training was to empower nursing staff to be engaged in

evidence-based end-of-life care to improve the dying experience for patients, families, and staff.

Significance

End-of-life care in long-term care is different than the care provided in hospitals because physicians are relatively absent, and nurses are the key healthcare professionals (Nasu et al., 2019). The local project site leadership team consists of the director of nursing, administrator, social workers, and unit managers. The leadership team identified the nursing staff unpreparedness when caring for the dying patient. The significance of this nursing practice issues is that nurses are key health professionals in long-term care facilities, and the lack of knowledge in end-of-life impacts the care of residents during a critical time of need.

As a result of this identified nursing practice issue, the leadership team supports this nursing staff education program to improve end-of-life care. The recognition of the need for end-of-life education in long-term care can result in improved care of dying residents and increase nursing staff knowledge (Pesut & Greig, 2018). Implementing an education program on end-of-life care for the nursing staff assisted the leadership team in quality standards of care for residents. Key stakeholders for this doctoral project are facility leadership, staff, patients, and the community.

This doctoral of nursing practice (DNP) scholarly project is an example of Walden University's Mission Statement for a career professional to have an opportunity to transform evidence-based implementation as a scholar-partitioner with a positive

impact on social change (Walden University, 2022). My aim for this project is to educate the nursing staff on end-of-life, promote nurses' empowerment when caring for dying residents, and improve the quality of care. The goal is to promote a positive social change cultural with the nursing staff in end-of-life care to improve resident's outcome. Findings from this project could be replicated at other sites in improving staff knowledge and attitudes about end-of-life.

Summary

Nurses are at the bedside more than any other healthcare professionals. Residents who are approaching end-of-life rely on nurses to provide compassionate evidence-based care. In the identified long-term care facility, nursing staff lacks the proper end-of-life knowledge that has a significant impact on the quality of dying. Nurses with education and training in end-of-life are more knowledgeable in the care delivered to a dying resident (Cagel et al., 2017). A staff education program has the potential to improve the nursing staff knowledge in end-of-life care and a social change in the long-term care facility. In section 2, I discuss the theoretical framework to support this project, the relevance to nursing practice, the background of the project site, my role, and the role of the project team.

Section 2: Background and Context

Introduction

Nurses spend more time at the bedside than any other healthcare profession and have the best opportunity to influence the dying process. At the end-of-life, patients rely on nurses to respect dignity, manage symptoms, and provide emotional support. Recognizing nurses' perceptions, fears, and attitudes from previous unsuccessful experience in caring for the dying can hinder the confidence and compassionate standards of care. Andersson et al. (2016) found that nurses' unpreparedness in end-of-life care experience is from inadequate education and training. As previously stated, an evidence-based education program can improve knowledge and attitudes in end-of-life care. The practice-focused question is as follow: Will an evidence-based staff education program on end-of-life care improve the nursing staff knowledge and attitude about caring for dying residents in long-term-care? In Section 2, I will describe the model used to guide this project, the relevance to nursing practice, local background and context, the role of the doctoral of nursing student, and the role of the project team.

Theoretical Framework

Nurses are often unsure how to initiate advance care planning discussions due to inadequate education and training in the care for a dying patient. An end-of-life education program can support the knowledge and attitudes of nurses when caring for a dying patient. The theoretical framework to guide this evidence-based project is Albert Bandura's (2000) self-efficacy theory. Bandura defines self-efficacy as an individual

belief in their capability to perform in a way that gives control over events that affect their lives (Bandura, 2000). In context to self-efficacy, nurses can gain confidence in their ability to control fears or perceptions that affect the care at the end-of-life.

Self-Efficacy in Nursing Practice

Perceived self-efficacy belief is a grounded concept to form human agency (Bandura, 2000). Nurses can remove obstacles that limit their ability to care for the dying and act upon their capability to change. Bandura stated, individuals are not efficacious in all things under all conditions and to develop a strong sense of efficacy is through four assumptions, (a) mastery experience, (b) modeling, (c) social persuasion, (d) physical and emotional states. Bandura's self-efficacy theory is used extensively in nursing education, research, and practice.

One study focused on self-efficacy in nurses and found low self-efficacy contributed to a lack of mastery, vicarious experiences, and negative emotions in end-of-life communication (ten Kopple et al., 2019). High self-efficacy in the discussion on prognosis was associated with mastery from nurses with 10 years or more experience, higher education. Long-term care facilities where physicians are offsite, and were nurses provided more onsite care (ten Koppel et al., 2019), communication is crucial in end-of-life nursing care, where patients and families often need extensive care (Coyle et al., 2015). Ineffective communication is a barrier to self-efficacy in managing distressing symptoms, emotional support, and dignity to a dying resident. Bandura's self-efficacy theory can advance nursing staff to resilient beliefs and explain cognitive, motivational,

and decisional mechanisms through which self-efficacy beliefs produce their effects (Bandura, 2019). Higher perceived self-efficacy can lead to accomplishments and successful performance. The guidance from Bandura's self-efficacy theory is essential to nursing staff knowledge, attitudes, and efficacy toward end-of-life. Table 1 aligns Bandura's (2000) self-efficacy theory to the education program to improve nursing staff knowledge and attitudes towards end-of-life care.

Table 1

Self-Efficacy Model for Nursing Staff Education Program

Level	Self-Efficacy Theory Assumption	Staff Education
1	Mastery experience – Development of a sense of efficacy from experience in overcoming barriers through perseverant efforts	Improve nursing staff knowledge and attitude in end-of-life. The project site does not have an end-of-life education program.
2	Modeling – An individual sees others succeed by sustained efforts, believing in their ability influence to perform tasks successfully.	End-of-life scenarios to increase staff confidence to initiate end-of-life conversations and communicate effectively.
3	Social persuasion – Individuals are motivated by their ability to perform tasks. Effective social persuaders do more to convey faith in individual capability.	Provide the nursing staff with new knowledge to understand the important role nurses have in end-of-life outcomes.
4	Physical and emotional state – Individuals recognize their tensions, anxiety, and depression as signs of personal deficiency	Recognize personal barriers that interfere with end-of-life care and overcome perceptions.

Bandura's self-efficacy model is the foundation for this doctoral of nursing practice staff education project. Successful experiences with end-of-life can improve nursing staff self-efficacy to care for dying residents.

Key Terms

The following definitions address key terms used in this doctoral project.

Advanced care planning: Allows individuals to define their goals, preference for further care, and the direction of care if they are no longer capable (Bui et al., 2020).

End-of-Life: Refers to various phases in a terminal illness, such as the last few years of life, the last six months when a patient becomes eligible for hospice, or the final days to actively dying (Davies, 2016).

Long-Term care: Interchangeable nursing homes. A range of services and support to meet personal care needs for individuals with functional limitations and may receive services in adult day services, home, skilled nursing facility, and residential assisted living. (United States Department of Health & Human Services, 2021).

Palliative care: Provide care for individuals with serious illness, manage symptoms, support patient, family goals, and preferences in care. Palliative care attends to physical, functional, psychological, practical, and spiritual consequences of a serious illness (National Coalition for Hospice and Palliative Care [NCHPC], 2018).

Relevance to Nursing Practice

Nurses have an essential role in providing compassionate care at the end-of-life. Patients expect nurses to be competent in end-of-life care to manage their physical symptoms, provide emotional support, and maintain dignity. Barriers exist for nurses to provide end-of-life care from the traditional education provided in nursing program curricula. Nurses are unprepared to discuss advance care planning, manage physical

symptoms, and provide emotional support due to the lack of education (Agarwal & Epstein, 2018). The nursing profession has an ethical and societal responsibility to concede inadequate end-of-life education in the nursing school curriculum.

Nurses Role in End-of-Life Care

The American Nurses Association ([ANA], 2016) position statement on *Nurse's Roles and Responsibilities in Providing Care and Support at the End-of-Life* reported that nurses are obligated to provide care that includes the promotion of comfort, pain relief, symptom management, and support for patients and families. Nurses are responsible when caring for the dying to assess, manage symptoms, take measures within their scope of practice, collaborate with other professionals, and deliver support at the end-of-life (ANA, 2016). Nurses can contribute to conversations about what to expect and decisions at the end-of-life with patients and families. The appreciation of nurses' role and responsibility of care at any level can improve nursing practice at the end-of-life. The acknowledgment of the gap in nursing education emphasizes the importance for nurses to obtain further education and training.

Nurses' Role in Communication and Collaboration

The Gallup (2020) survey among Americans has identified nurses as the most trusted profession for the past 18 years. Nurses rated 85% in the Gallup 2019 survey on honesty and ethics, which is higher than any other profession (Gallup, 2020). Nurses take pride in being the most trusted discipline upholding responsibility and obligations for advocacy. Communication is key to trustworthiness in the role of nurses in patient-

centered care. End-of-life communication is necessary for nurses to evaluate the patient or family goals of care, educate on the dying process, and provide emotional support. Yet, nurses may be unaware of the uniqueness of their profession and role in collaboration in patient-centered care at the end-of-life.

Wittenberg et al. (2018) found that the most challenging communication contexts identified by nurses include conversations regarding the initial diagnosis, treatment options, and end-of-life care. Nurses lack essential training on advance care planning, collaboration in patient-center care, meeting goals of care, and communication in the dying process to patients and families. Nurses will need end-of-life knowledge and confidence to communicate effectively to meet a dying patient need for symptom relief, emotional support and to honor their dignity in the final days.

Distressing Symptoms Assessment and Management

In the final days of life, the focus of nursing should be to promote comfort and alleviate suffering. However, changes in the physical state from advanced disease can manifest through distressing symptoms such as pain, restlessness, agitation, and dyspnea (Miron & Grigorescu, 2018). Frequent pain and symptom assessments with medication management will be required to assure patients are comfortable. Nurses play an essential role in pain and other symptom management at the end-of-life.

The International Association for the Study of Pain (2020) defined pain as, “an unpleasant sensory and emotional experience associated with or resembling that associated with actual or potential tissue damage.” Pain is reported as the most distressing

and feared symptom at the end-of-life (Stitzlein, 2016). In addition to pain, terminal breathing is distracting to family members with the belief their loved one is suffering. Nurses need to assess respiratory difficulties, communicate the dying process, and what measures to take to alleviate distressing symptoms. Nurses with little to no experience in alleviating distressing symptoms can learn negative perceptions while caring for the dying (Cagle et al., 2017). Therefore, nurses should be experts in the assessment of distressing symptoms to assist patients in being comfortable at the end-of-life.

Nurse Debriefing

Nurses are at risk for experiencing multiple forms of distress as they respond to patients and families at the end-of-life (Whitehead et al., 2015). Nurses experience moral distress when there is a conflict between action and values towards inappropriate end-of-life care (McAndrews et al., 2016). An essential part of caring for patients at the end-of-life is debriefing to relieve or reduce stress (Coutinho et al., 2016) before it manifests into compassion fatigue (Andrews et al., 2020). Debriefing will help the nursing staff to recognize stress, discuss what is stressful, and engage in self-compassionate care. Zheng et al. (2017) studied how nurses cope with patient death and found it beneficial to discuss the experience to relieve stressful perception. Although debriefing has a profound effect on releasing stress, support in the environment is often unavailable (Zheng et al., 2017). Nurses will need to be educated on debriefing to build confidence to perform self-care for positive experiences from providing end-of-life care. Self-care is just as essential for nurses to care for themselves to care for the dying.

End of Life Care in Long-Term Care

The number of older adults with complex health conditions and terminal illnesses is increasing and will require long-term care (Greenwood et al., 2018). Death occurs more often in long-term care than in any other setting (Johnson, 2016). The quality of end-of-life care throughout the healthcare system needs improvement (IOM, 2015). In long-term care facilities, the nursing staff is often incapable of managing complex patients. Most direct care is by certified nursing assistants who lack training in end-of-life (Anstey et al., 2016). As healthcare attention is focused on advance care planning, the desire of an individual preference at the end-of-life could be influenced by nursing staff inability to provide quality end-of-life care (Spacey et al., 2018).

Guidelines for Palliative Care at the End-of-Life

The IOM (2015) consensus reported all clinicians across disciplines and settings who care for people with serious illnesses should provide quality end-of-life care. The IOM identified five barriers to quality end-of-life in the healthcare system and recommended improvement in the delivery of care; clinician-patient communication (advance care planning); professional education and development; policies and payment systems; and public education and engagement. Guidance from the report emphasizes palliative care training for all clinician with encounters with people with serious illnesses.

In 2018, the National Coalition for Hospice and Palliative Care (NCHPC) published the *National Consensus Project's (NCP) Clinical Practice Guidelines for Quality Palliative Care*. The NCP guidelines promote quality palliative care in

transforming patient and family center care, developing, refining education programs, enhancing or expanding existing programs, and measuring the effectiveness of improving care (NCPHC, 2018). Clinicians can deliver quality palliative care from the NCP eight domains: (a) structure and processes of care; (b) physical aspect of care, (c) psychological aspects of care; (d) social aspects of care, (e) spiritual aspects of care, (f) cultural aspects of care, (g) cultural aspects of care; and (h) care of the imminently dying (NCPHC, 2018).

As previously stated, the City of Hope and the AACN (2020) is a national and international education initiative to improve palliative care. The ELNEC project provides training in palliative care for undergraduates, graduates, advanced practice nurses, nursing faculty, continuing education providers, staff development, specialties nurses in pediatric, oncology, critical care, and geriatrics (AACN, 2020). The ELNEC is an evidence-based and structured training in palliative nursing. The course in detail to this education program is the ELNEC Geriatric Curriculum consisted of eight modules specifically designed in end-of-life care to educate nurses, certified nurse assistants, and unlicensed personal (Appendix B). The ELNEC modules prepare nurses in proactive planning, good communication skills, and the role in caring for older adults and their families during the final days (AACN, 2020). As defined for the scope of practice for licensed practical and certified nurse assistants was considered in the education program.

In support of the ELNEC project, the Hospice and Palliative Nurses Association and the ANA (2017) partnered to develop the *Call for Action: Nurses Lead and*

Transform Palliative Care in all settings for seriously ill, injured patients, families, and the community. Recommendations included the ELNEC project as the standard primary palliative nursing education and for nurses to be prepared to provide principles as outlined by the NCP guidelines (ANA, 2017). Therefore, this staff education program integrated the ELNEC Geriatric Curriculum and the NCP guidelines as standard practices to address the gap in practice in end-of-life care.

Educational Outcomes in End-of-Life Care

A literature review supports the need for education and training for standards in practice at end-of-life care. Percival and Johnson (2013) conducted interviews and focus groups on factors that influence quality end-of-life care. They concluded the nursing home staff had received little or no training and would like to receive education to improve confidence and professional practice. Staff perceptions in end-of-life have an impact on the care provided to dying residents.

Anstey et al. (2016) performed a systematic review to evaluate the effectiveness of end-of-life education and training for nursing home staff. Twenty-one studies were identified and assessed on educational interventions and outcomes. Anstey et al. found the credibility of the education interventions was questionable, various studies outcome measures were poor, and challenging to establish whether the reported changes achieved by the interventions were sustainable. Although end-of-life education is the most significant way of improving care, barriers exist to fill the gap in practice.

Malik and Chapman (2017) focused on educational interventions to improve end-of-life knowledge for certified nursing assistants in long-term care. Certified nursing assistants are first-line caregivers to residents and encounter the same challenges related to end-of-life care as nurses (Malik & Chapman, 2017). A quality improvement project evaluated certified nurse assistant knowledge from training material provided by the Hospice and Palliative Nurses Association (Malik & Chapman, 2017). An improvement in knowledge was evident from the posttest results of the training. The researchers found the importance of further education and training for certified nurse assistant to improve care for patients and families at the end-of-life.

A quasi-experimental study by O'Shea and Mager (2019) found the ELNEC education program improves knowledge among nurses. O'Shea and Mager recruited participants from a local community clinical agency that included nurses from acute, long-term, and home care settings. One hundred and thirty-four nurses participated in a six-week, 12-hour ELNEC education program. The Palliative Care Quiz for Nursing (PCQN) and the Thanatophobia Scale (TS) evaluate practicing nurse' knowledge and attitudes in end-of-life care. Results from the PCQN posttest in knowledge increased (t = -7.498; p = .000) and attitudes improved TS (t = 3.944; p = .000), which supported the use of the ELNEC education program. Although the ELNEC curricula have been established for over two decades, many nurses in current practice lack the necessary knowledge because they graduated from programs that had not incorporated this content (O'Shea & Mager, 2019).

In the literature, the ELNEC curricula is the standard of end-of-life education for nurses with evidence-based geared toward the care of specific patient subpopulations. The Geriatric Curriculum educates nurses, certified nurse assistants, and unlicensed personal who provide care to residents in assisted living, nursing homes, skilled nursing facilities, and hospice (AACN, 2021). The ELNEC project has repeatedly shown to be the standard in end-of-life education and training to improve knowledge, attitudes, and practice.

Gillian et al. (2013) conducted a literature review focused on the significance of integrating the ELNEC education program into the nursing education curriculum. Gillian et al. (2013) found 18 articles that evaluated the mode of end-of-life education delivery and education initiatives. Three studies with the ELNEC education and the FATCOD scale measured nursing student knowledge and attitudes towards caring for the dying. Barrere et al. (2008), Weissman (2011), and Wallace et al. (2009) concluded nursing student knowledge and attitudes improved from the ELNEC education program. Findings from these studies contribute to the existing body of literature supporting the ELNEC program integration.

Moto-Romero et al. (2021) three-phase study evaluated nursing home staff knowledge with a complex intervention in basic palliative care training, standards from the National Institute for Health and Care Excellence, objectives in self-efficacy, and attitudes towards end-of-life care. The Self-Efficacy in Palliative Care scale and the FATCOD-B scale found improvements in the staff self-efficacy and attitudes towards

EOL care. The interventions represented in the end-of-life education program expanded staffs' knowledge and attitude to provide quality of care (Moto-Romero et al., 2021). This current doctoral of nursing project has the potential to address a practice gap related to end-of-life care at the project site.

Local Background and Context

This doctoral of nursing education project has taken place in a 116-bed long-term care facility located in the central region of the United States with many older adult residents who will be approaching or are at the end-of life. The leadership at the facility expressed that nursing staff required more education in end-of life (administrator, personal communication). The facility currently does not have the ELNEC Geriatric Curriculum for the staff. Nurses are unprepared in end-of-life symptom assessment and management, advance care planning discussions, and emotional support.

On the federal and state level, the facility must ensure compliance with requirements regarding advanced directives (Centers for Medicare & Medicaid Services [CMS], 2022]. Skilled nursing facilities and nursing facilities must comply with federal requirements to receive Medicare or Medicaid program. The State Operations Manual for Long Term Care Facilities *F678*, index *483.24a* Quality of Life regulation requires facilities to establish, maintain, and implement written policies and procedures to formulate advanced directives and provide information on advance care planning (CMS, 2017). The CMS recognizes advance care planning as an integral aspect for facilities comprehensive care planning process and assures re-evaluation of residents' desires on a

routine basis and when there is a significant change in the resident condition (CMS, 2017). An end-of-life education program for the nursing staff in this local facility is in the federal and state context to inform on advance care planning, maintain and establish advanced directives.

Role of the DNP Student

My role in this scholarly project is to demonstrate the ten competencies of the AACN (2021) *Essential: Core Competencies for Professional Nursing Educations* for Advanced-Level Nursing Education. l demonstrated leadership and knowledge in translating an evidence-based education program within a long-term care environment to improve end-of-life standards and quality of care. I have completed the ELNEC education for advanced practice nurse practitioners and was the primary educator for the ELNEC Geriatric Curriculum at the project site. The goal is to improve the staff knowledge and attitude in end-of-life care to promote better outcomes for residents. As the project leader, I have established and maintain a collaborative relationship with the project team. I have communicated the progress of the scholarly project with frequent meetings for feedback from the project team.

Role of the Project Team

The project team have served as content experts based on their years of experience and expertise in end-of-life care in the long-term care setting. The project team expert panel included the director of nursing with 15 years of nursing experience, registered nurse with six years' experience in long-term care, and registered nurse with

ten years in hospice care. The expert panel reviewed the education program, pretest, and posttest content applicable to the practice site. The staff education program was incorporate the expert panel recommendation before implementation. The Staff Education Agreement and Form A required the facility administrator to sign and the doctoral of nursing student to submit to Walden IRB for approval.

Summary

Nurses must be knowledgeable in end-of-life care to meet the needs of dying patients. Nurses lack of education in end-of-life care is a barrier to providing optimal care to a dying patient. An education program on end-of-life using self-efficacy theory, ELNEC Geriatric Curriculum, and NCP guidelines can fill a recognized gap-in-practice. The project question is: Will an evidence-based staff education program on end-of-life care improve the nursing staff knowledge and attitude about caring for dying residents in long-term care? Section 3 will discuss the source of evidence, analysis, and synthesis results of this project.

Section 3: Collection and Analysis of Evidence

Introduction

The purpose of developing this educational program is to improve the nursing staff knowledge and attitudes towards end-of-life care. The education nurses receive in end-of-life is inadequate to meet the complex needs of dying residents. Nurses have experience in caring for the dying; however, they often lack formal training in end-of-life to improve the outcomes of residents (Smets et al., 2018). Perceptions, fears, and uncertainly when caring for the dying can hinder confidence and compassionate standards of care. This DNP project incorporated Bandura's (2000) self-efficacy theory to enhance individual belief in their capability to perform successfully. In context to self-efficacy, nurses can gain confidence in their ability to control perceptions and fears that may interfere with end-of-life care.

The number of older adults with complex health conditions and terminal illnesses will require nursing care. Death occurs more often in long-term care than in any other setting, and the care provided is a concern (Johnson, 2016). Nurses are key health professionals in long-term care. In current practice, nurses lack the education on end-of-life for graduating from nursing programs that had not incorporated the ELNEC curriculum (O'Shea & Mager, 2019), training in the NCP guidelines on early integration of palliative care regardless of setting, diagnosis, prognosis, or age (NCHPC, 2018). This scholarly project is an evidence-based educational program in end-of-life care designed for long-term care nursing staff. The theoretical framework is from Bandura's self-

efficacy to support the confidence and attitude of nurses caring for the dying. The ELNEC Geriatric Curriculum and NCP guidelines are standard practices to educate nurses on end-of-life to address nursing practice gap. Section 3 describes the project planning, implementation, and evaluation of the data.

Practice-Focused Question(s)

The local long-term care facility has a nursing practice issue in end-of-life care for nurses to feel uncomfortable discussing advance care planning preferences, managing distressing symptoms, and emotional support to residents. Health professional education is deficient in end-of-life, palliative, and hospice care, which affects the quality of care (IOM, 2015). Nurses with education and training in end-of-life can gain knowledge, confidence, and compassion to deliver quality care to patients and families. The context for this scholarly doctoral project is to develop an educational program for the nursing staff on end-of-life care. The practice-focused question for this project is: Will an evidence-based staff education program on end-of-life care improve the nursing staffs' knowledge and attitudes about caring for dying residents in long-term care?

Sources of Evidence

The source of evidence for this project were peer-reviewed publications from journals assessed through the CINAHL & MEDLINE combined search; CINAHL plus full text, EMBASE, ProQuest Nursing & Allied Health, Google Scholar, and PubMed. The key terms were*, end-of-life, end-of life education outcomes, long-term care, nurses' attitude, quality of care, palliative care, and staff education.* Additional resources for

standards in practice are from the City of Hope and AACN ELNEC Geriatric Curriculum, NCHPC- NCP guidelines, and the FATCOD-B scale to collect relevant data to address the practice-focused question. Evidence-based articles were identified as sources of information to discuss a nursing gap in practice on end-of-life and the value an educational program can improve the knowledge and attitudes in caring for the dying.

An additional source of evidence from the leadership team is relevant to the gap-in-practice. Nurses' fears and unpreparedness in managing distressing symptoms were evident from the pain management report. Several nursing staff shared fears for providing pain and anti-anxiety medications for dying residents and preferred hospice to manage. This information was the foundation of the staff education program for the site. The collection and analysis of the evidence for this project will focus on nurses' knowledge and attitudes to improve the overall standards of end-of-life care.

Evidence Generated for the Doctoral Project

The leadership team at the project site observed nurses unprepared in end-of-life care. The facility currently does not have end-of-life education or the ELNEC Geriatric Curriculum for the staff. I discussed the proposed evidence-based education project with the leadership team and stakeholders to improve the nursing staff knowledge and attitudes in end-of-life. The evidence generated for this doctoral project includes pretest and posttest scores from the FATCOD-B scale.

Participants

The participants in this project were the staff members at the long-term care facility who have direct contact with residents. The nursing gap-in-practice on end-of-life is relevant at the project site for nurses to have perceptions, fears, and unpreparedness to provide quality care to dying residents. All nursing staff were invited to participate in the educational program.

Procedures

Approval from Walden IRB was granted to proceed with implementing the project. I planned the staff education program with the expert panel advice. I coordinate with the leadership team dates and times present the project. I recruited staff members from flyers posted on the unit bulletin boards, nurse station, and break room. Participants completed the FATCOD-B tool before and after the presentation to measure staff attitude in caring for dying patients. The FATCOD-B was chosen as a more accurate tool to measure nurses and certified nurse assistant attitudes in caring for dying residents at the project site.

Dr. Katherine Frommelt created the FATCOD scale in 1989 to measure nursing students' attitudes toward caring for the terminally ill (Frommelt, 1991). Several studies have assessed nurses' attitudes in caring for the dying using the FATCOD tool with an educational intervention and found higher scores after the education (Frommelt, 1991; Mahan et al., 2019; Mastroianni et al., 2015). The FATCOD-B (Appendix E) was altered

in 2003 to be applicable for various program of study or professional backgrounds (Frommelt, 2003).

The FATCOD-B consists of 30-item questionnaires with 15 positively and 15 negatively worded items, rated on a five-point Likert scale (1- strongly disagree to 5-strongly agree). Possible scores from the questionnaire range from 30 to 150 (Frommelt, 2003). The higher scores indicate more positive attitudes. The tool was computed by the content validity index, expert judges in the field of death and dying with the validity of 1.00 (Frommelt, 2003). The test, re-test of the tool from the Pearson's coefficient computed .9269, adequate support for the reliability of the FATCOD-B (Frommelt, 2003). The FATCOD-B tool has been found to be valid and reliable in several languages, including English (Leombruni et al., 2014: Leora et al., 2018: Sadowska et al., 2020). Studies that evaluated staff and health care professional attitudes from the FATCOD-B found improved attitudes in the altered tool (Frommelt, 2003: Bui et al., 2020: Moto-Romero et al., 2021).

Demographic data will examine factors on age, gender, education, role (position), experience with end-of-life, education in end-of-life, and the correlation to the FATCOD-B tool. Participants will receive a Power Point handout to use in the future to guide their knowledge in end-of-life care. Participants completed a program evaluation of the effectiveness of the presentation on end-of-life.

Protections

The proposed project commenced until the IRB approval has been obtained from Walden University. Participants received information on voluntary participation and withdrawal from this education program at any time. The project organization remained confidential. All information is confidential, and the names of individuals are protected. Participants received Form B Consent for Anonymous Questionnaire from Walden University prior to collecting questionnaire responses. I used a secured drop box to collect Form B consent, anonymous questionnaire data, and the program evaluation. The data collected from the project remained confidential and stored in a locked cabinet. Participant information was safely stored as I analyze the data and input it into my password protected personal computer. There were no physical or emotional risks beyond that experienced in normal life with this project. I completed form A and collect the signed site agreement form for Walden IRB approval prior to implementing the education program.

Analysis and Synthesis

The FATCOD-B tool was used to collect data from the pretest and posted questionnaire. The pretest was given before the education to provide a baseline of knowledge and attitudes of the nursing staff. The posttest was given immediately after the education intervention to compare the nursing staff knowledge and attitude following education. The data was double checked and entered to into the International Business Machines (IBM) statistical package for the social science (SPSS) version 28 software.

Pretest and posttest scores were analyzed using a paired t test. Demographics were collected to allow for anonymity. Findings from the data analysis determined the education intervention improved the nursing staffs' knowledge and attitudes in caring for dying residents.

Summary

This education project explored whether an education program on end-of-life care can improve nursing staffs' knowledge and attitudes caring for dying residents in long-term care. Participants were direct nursing staff at the project site. Section 3 discussed the planning, implementation, evaluation, and protections related to the project. Analysis and synthesis of the data were identified. Section 4 presents the completions of this scholarly project collection of data with finding, implications, and recommendations, strengths, and limitation.

Section 4: Findings and Recommendations

Introduction

Nurses are in a unique position to provide good quality end-of-life care. The minimum education nurses receive one end-of-life influences the care provided. The lack of end-of-life knowledge and perceptions about caring for the dying affects nurses' ability to provide quality care (Hussin et al., 2018). The local project site had nursing practice issues from the observation of the leadership team. The customary end-of-life education nurses received at the site was perceived to be inadequate to meet the complex care of dying residents. The practice-focused question to address this project was: Will an evidence-based education program on end-of-life care improve the nursing staff knowledge and attitudes about caring for dying residents in long-term care? The purpose for the project was to evaluate the nursing staff knowledge and attitude in end-of-life care before and after implementing the ELNEC Geriatric curriculum.

I conducted an evaluation at the project site using the FATCOD-B scale to determine if ELNEC education improved nurses' knowledge and attitudes in the care of dying residents. The education training was 1-hour. There were four sessions over a 3-day period. Before starting the education program, I provided participants with Walden University consent forms for anonymous questionnaires as per the guidance in the manual. Participants were informed that participation in the project was voluntary, consent signatures were not needed, and respondents' anonymity was protected. The FATCOD-B scale was provided before and after the ELNEC Geriatric intervention. The

nursing staff was allowed enough time to complete the pretest and posttest questionnaire. Participants were encouraged to complete a program evaluation on the effectiveness of the DNP student, the education on end-of-life, and the overall presentation of the program.

Instrument

Data were collected from questions on age, sex (gender), degree, position, previous education on death and dying, previous experience caring for terminally ill patients, previous experience of loss, and present experience. The FATCOD-B scale measured staff attitudes toward caring for the dying. The scale consists of 30-items with 15 positively and 15 negatively worded questions. The scale is rated on a 5-point Likert scale of 1-strongly disagree, 2-disagree, 3-uncertain, 4-agree, and 5- strongly agree. I followed the scoring instructions for the FATCOD-B scale, which indicated items (1, 2, 4, 10, 12, 16, 18, 20, 21, 22, 23, 24, 25, 27, and 30) are all positively worded statements and scored from the 5-point Likert scale (Frommelt, 2003). All other items are negatively worded statements. The scoring instructions are reversed on the Likert scale from (5-strongly disagree) to (1-strongly agree). The questionnaire scores ranged from 30 to 150. The higher scores indicate more positive attitudes toward caring for a dying patient (Frommelt, 2003). The FATCOD-B scale has established reliability and validity from studies that measured nursing students and other professional attitudes toward caring for dying patients (Frommelt, 1991; Mahan et al., 2019; Mastroianni et al., 2015). The Walden University IRB approval number for this project was 01-26-22-0427005.

Findings and Implications

A total of 22 staff members volunteered to participate in this education project. One participant did not complete the posttest, which was excluded. The sample included (n = 21) participants. Data were entered into IBM SPSS version 28 to analyze descriptive statistics, pretest, and posttest scores using a paired t test. Descriptive statistics analyzed demographics and experience in caring for dying patients. The sample had a large presence of females, 17 (81%) to males, 4 (19%), more women participated; ages ranged from 18-65 years, with 81% over 46. The sample had 11 (RN-LPN) with degrees (associate, bachelor's, master's) compared to 10 (CNA-others) with high school degrees. Previous experience with death, 85% have not taken an end-of-life course; 81% had previous experience in dealing with the terminally ill; 47% had previous experience with loss, and 23% are presently experiencing a loss.

The pretest and posttest scores were analyzed using a paired t test to determine if the nursing staff knowledge and attitude improved on end-of-life care after the education. The FATCOD-B posttest scores are highly positive, demonstrating the ELNEC intervention improved nursing staff knowledge and attitudes in caring for the dying Table 2. The paired sample mean from the pretest 117.14 and posttest 121.90 suggests the nursing staff education was effective. The posttest scores improved 4.7 after the education program. The paired sample test results t (20) = 3.368), p = .002 suggest the difference in mean increase between FATCOD-B pretest and posttest scores; the null hypothesis is rejected (see Table 3).

Encouraging nursing staff to take an interest in end-of-life education can help to improve the quality of dying for residents. The findings of this project helped the project team and the nursing staff to acknowledge a gap in nursing practice on end-of-life care and to adopt a social change when caring dying residents. This staff education has the potential to promote social change other facilities within this organization.

Table 2

Pretest and Posttest Results

	Mean	N	*SD*	Std Error Mean
FATCOD-B Pretest	117.14	21	10.631	2.31
FATCOD-B Posttest	121.90	21	8.932	1.94

Table 3

Paired t Test Results

	Mean	*SD*	Std. Error Mean	95% Confidence Lower	Upper	*t*	*df*	Sign (One-Sided p)
FATCOD-B Scale Pretest – FATCOD-B Scale Posttest	-4.761	6.48	1.414	7.171	-1.817	-3.368	20	.002

Recommendations

This project identified a gap in nursing practice on end-of-life from the results of a large portion of the sample size had no previous education and training in end-of-life care. The ANA (2017) identifies the ELNEC project as the standard primary palliative

nursing education and for nurses to be prepared to provide palliative principles as outlined by the NCP guidelines. This evidence-based educational program has the potential to make a difference in social change for the nursing staff to improve end-of-life outcomes in long-term care. Further disseminating the findings of this project can have a profound effect on social change for the nursing staff and improved outcomes in this organization.

Contribution of the Doctoral Project Team

The project team played an essential role with end-of-life resources and protocols for long-term care facilities to accomplish the project objectives. The project team focused on the end-of-life competencies of the nursing staff and CMS regulations on advance directives and advance care planning as an integral aspect of residents' comprehensive care planning process (CMS, 2017). The project team reviewed the education program, pretest, and posttest content applicable to the practice site, approved this project, and allowed staff to participate voluntarily. This staff education has the potential to be appropriate in other facilities within this organization.

Strengths and Limitations of the Project

There were strengths and limitation to this project. One major strength of this nursing staff education is the valuable information delivered impacts the nursing staff knowledge and attitude in end-of-life care. Another strength is the results from this project revealed a significant increase in the nursing staff knowledge on end-of-life following the education. The limitation included the small sample size (n=21)

participants affected the generalization of the program results, organization time constraint, and cost factors. This project was intended to educate the nursing staff on end-of-life care, promote a positive social change environment to improve outcomes in long-term care.

Summary

The project site desired a staff education intervention on end-of-life care. The ELNEC Geriatric Curriculum was the evidence-based intervention to educate the nursing staff on end-of-life care to improve the outcomes for dying residents. The FATCOD-B scale measured the nursing staff knowledge, perceptions, and attitudes in caring for the dying. The comparison results from the FATCOD-B pretest and posttest showed increased knowledge of end-of-life care and improved attitudes toward caring for the dying. The findings obtained from the *t* test data validate that the staff education intervention effectively addressed one gap in the nursing practice on end-of-life care. In section five, I discussed the dissemination, analysis of self, and summary.

Section 5: Dissemination Plan

Introduction

The translation of evidence-based to clinical practice is essential to safe, transparent, effective, efficient healthcare provision, meeting the expectations of patients, families, and society (Curtis et al., 2017). This staff education goal was to increase nurses' knowledge in end-of-life care and improve attitudes in the care of dying patients. Providing education on this topic promotes a supportive environment for nurses to focus on patient-centered care at the end-of-life. The project team was engaged early throughout the planning, implementation, and the audience for the dissemination of this outcome. The engagement of stakeholders on multiple layers increases recognition of the value of research dissemination to study participants and the community-at-large (Cunningham-Erves et al., 2020).

I plan to disseminate at the project site morning meetings using a verbal and visual approach with a PowerPoint presentation. The objectives for the project, scores from the pretest, posttest support the accomplishment of this education intervention with increased knowledge and improved attitudes of the nursing staff. Successful dissemination and uptake of research evidence requires identifying the appropriate audience and tailoring messages via appropriate mediums (Curtis et al., 2017). There is an opportunity to disseminate the results of this staff education within this organization to further promote change in nursing practice. To reach a broader audience in the nursing

profession at conferences with an interest in end-of-life education across the care continuum.

Analysis of Self

My clinical nursing practice is influenced by this project as a knowledgeable practitioner with evidence base motivation to improve outcomes. The experience from this project as manager has inspired my long-term goal to make a difference in the care provided at the end-of-life through the translation of evidence-base into nursing practice. As a scholar, I will contribute knowledge to the nursing profession by sharing research findings in the gap in nursing practice on end-of-life care. The challenges encountered throughout this project includes the organization time constraints and social changes. I embrace these challenges as growth in leadership skills and effective communication to deliver quality care. The insight gained from the completion of this project is how evidence-based practice promote positive social change, increase the knowledge of nurses, and improve outcomes. I planned the nursing staff education program with the expert panel advice. I coordinate with the leadership team dates and times to present the project and recruited staff members from flyers posted on the unit bulletin boards, nurse station, and break room. I empowered the leadership and knowledge in translating an evidence-based education program within a long-term care environment to improve end-of-life standards and quality of care.

Summary

Nurses are in a unique position to provide quality end-of-life care. The minimum education nurses receive on end-of-life influences the care provided. Nurses are key health professionals in long-term care facilities, and the lack of knowledge in end-of-life impacts the care of residents during a critical time of need. An evidence-based education program in end-of-life care can increase the standards and the nursing practice in the care of dying residents. The results of this evidence-based education project increased the nursing staff knowledge, competency in end-of-life, and attitudes in the care of the dying, which resulted in positive social change, and improved outcomes for residents.

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Appendix A: Pretest/Posttest

Demographic Data Sheet

1. Age _____18-22 years _____23-27 years _____28-35 years _____36-45 years
_____46-55 years _____56-65 years _____66 years and over

2. Sex _____Female _____Male

3. Highest degree held: _____High School Equivalency (GED) _____High School Diploma
_____Associate Degree _____Bachelor's Degree
_____Master's Degree _____Education beyond masters
_____Other (please specify)

4 Position: Registered nurse_____ certified nurse assistant _____ other (specify) _____

5 Previous education on death and dying

_____I took a course in death and dying previously
_____I did not take a specific course on death and dying, but material on the subject was included in o other courses.
_____No information dealing with death and dying was previously presented to me.

6. Previous experience in dealing with terminally ill persons:

_____I have cared for terminally ill persons and their family members previously.
_____I have had *no* experience caring for terminally ill persons and their family members previously.

7. Previous experience of loss
_____I have lost someone close to me within the past year.
Specify: _____immediate family (husband, wife, mother, father)
_____significant other
_____child
_____I have not previous experience with the loss of someone close to me.
_____I have *not* lost someone close to me within the past year.

8. Present experience:

_____I am presently anticipating the loss of a loved one.
_____I presently have a loved one who is terminally ill (life expectancy one year or less).
_____I am not dealing with any impending loss at the present time.

Frommelt Attitude Toward Care of the Dying [FATCOD], Form B Scale

In these items, the purpose is to learn how nonfamily, caregivers feel about certain situations in which they are involved with patients. Nonfamily caregiver is defined as anyone who is giving care to the dying person, professional or nonprofessional, who is not a member of the patient's family.
All statements concern the giving of care to the dying person and/or his/her family. Where there is reference to a dying patient, assume it refer to a person who is considered to be terminally ill and to have six months or less to live.

Please circle the statement that corresponds to your own personal feelings about the attitude or situation presented.

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
1.Giving care to the dying person is a worthwhile experience. Death is not the worst thing that can happen to a person.	1	2	3	4	5
2.Death is not the worst thing that can happen to a person.	1	2	3	4	5
3.I would be uncomfortable talking about impending death with the dying person.	1	2	3	4	5
4.Caring for the patient's family should continue throughout the period of grief and bereavement.	1	2	3	4	5
5.I would not want to care for a dying person.	1	2	3	4	5
6.The nonfamily caregivers should not be the one to talk about death with the dying person.	1	2	3	4	5
7.The length of time required giving care to a dying person would frustrate me.	1	2	3	4	5
8.I would be upset when the dying person I was caring for gave up hope for getting better.	1	2	3	4	5
9.It is difficult to form a close relationship with the dying person.	1	2	3	4	5
10.There are times when the dying person welcomes death.	1	2	3	4	5

11.When a patient asks, “Am I dying? “I think it is best to change the subject to something cheerful.	1	2	3	4	5
12.The family should be involved in the physical care of the dying person.	1	2	3	4	5
13.I would hope the person I’m caring for dies when I am not present.	1	2	3	4	5
14.I am afraid to become friends with a dying person	1	2	3	4	5
15.I would feel like running away when the person actually died.	1	2	3	4	5
16. Families need emotional support to accept the behavior changes of the dying person.	1	2	3	4	5
17. As a patient nears death, the nonfamily caregiver should withdraw from his/her involvement with the patient.	1	2	3	4	5
18. Families should be concerned about helping their dying member make the best of his/her remaining life.	1	2	3	4	5
19. The dying person should not be allowed to make decisions about his/her physical care.	1	2	3	4	5
20. Families should maintain as normal an environment as possible for their dying member.	1	2	3	4	5
21.It is beneficial for the dying person to verbalize his/her feelings.	1	2	3	4	5
22.Care should extend to the family of the dying person.	1	2	3	4	5
23.Caregivers should permit dying persons to have flexible visiting schedules.	1	2	3	4	5
24.The dying person and his/her family should be the in-charge decision-makers.	1	2	3	4	5

25.Addiction to pain relieving medication should not be a concern when dealing with a dying person.	1	2	3	4	5
26.I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.	1	2	3	4	5
27.Dying persons should be given honest answers about their condition.	1	2	3	4	5
28.Educating families about death and dying is not a nonfamily caregiver responsibility.	1	2	3	4	5
29.Family members who stay close to a dying person often interfere with the professional's job with the patient.	1	2	3	4	5
30.It is impossible for nonfamily caregivers to help patients prepare for death.	1	2	3	4	5

Please use a nonidentification four-digit number_____

(Frommelt Attitude Toward Care of the Dying [FATCOD], Form B Scale, Frommelt, 2003)

Appendix B: ELNEC Geriatric Curriculum

ELNEC Geriatric Eight Module

Module	Topic	Overview
Module 1	Principles of Palliative Nursing	Basic principles of palliative care, the role of the nurse as a member of the interdisciplinary team in providing quality care.
Module 2	Pain Assessment and Management	Basic principles of pain assessment and management palliative care at end of life.
Module 3	Syndromes and Symptoms	Common geriatric syndromes and symptoms and the role of the nurse in managing these symptoms.
Module 4	Ethics and Goals of Care	Describes ethics as the foundation in palliative care. Describe the purpose of goals of care, advance care planning, and advance directives.
Module 5	Culture and Spiritual Considerations	Describes the element of culture and spirituality in palliative care. Recognize the value of respecting cultural and spiritual diversity.
Module 6	Communication	Emphasizes good communication as an essential competency in palliative care.
Module 7	Loss Grief Bereavement	Address the challenging aspects of grief, loss, and bereavement. Describes staff grief and need for self-care.
Module 8	Final Days	Focus on days before and actual time of death, emphasizing the preparation necessary to ensure the best care at this critical event in the illness trajectory.

Appendix C: Course Evaluation

EDUCATION EVALUATION FORM

As a learner please assist in the evaluation of this presentation. Please circle the number beside each statement that best reflects the extent of your agreement. Thank you.

	Disagree			Agree
Content				
1. The content was interesting to me	1	2	3	4	5
2. The content extended my knowledge of the topic	1	2	3	4	5
3. The content was consistent with the objectives	1	2	3	4	5
4. The content was related to my job	1	2	3	4	5
5. Objectives were consistent with purpose/goals of activity	1	2	3	4	5
Setting				
1. The room was conducive to learning	1	2	3	4	5
2. The learning environment stimulated idea exchange	1	2	3	4	5
3. Facility was appropriate for the activity	1	2	3	4	5
Faculty/Presenter Effectiveness				
1. The presentation was clear and to the point	1	2	3	4	5
2. The presenter demonstrated mastery of the topic	1	2	3	4	5
3. The method used to present the material held my attention	1	2	3	4	5
4. The presenter was responsive to participant concerns	1	2	3	4	5
Instructional Methods				
1. The instructional material was well organized	1	2	3	4	5
2. The instructional methods illustrated the concepts well	1	2	3	4	5
3. The handout materials given are likely to be used as a future reference	1	2	3	4	5
4.The teaching strategies were appropriate for the activity	1	2	3	4	5
Learner Achievement of Objectives (to be added)	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

Comments:

Appendix D: Dr. Frommelt Permission

October 28, 2021

Dr. Katherine H Murray Frommelt, PhD, RN, PDE, CGC, FT, Professor Emerita

Email message: Permission to use FATCOD-B scale

- Hi Dr. Frommelt, I spoke with you earlier on the phone. I am a DNP student at Walden University. I plan to research nursing staff knowledge and attitude in the care of dying residents in a local long-term care facility. Your tool, the Frommelt Attitudes Toward the Care of the dying (FATCOD) form B questionnaire will help me to measure the knowledge and attitudes of the nursing staff pre and post an education program on end-of-life care. I plan to educate the staff from the End-of-Life Nursing Education Consortium Geriatric Curriculum. Your tool will help to evaluate the outcome of the nursing staff knowledge and attitudes in end-of-life. I have your original research article with the FATCOD, form B. Please feel free to email your permission to use the tool. I appreciate your time.

October 29, 2021

Dear Lisa,

- I am happy to approve your request. Permission is hereby granted. I got my PhD at Walden and worked on my FATCOD, FORM B, while I was there. Best of luck with your studies. Katherine H Murray Frommelt, PhD, RN, PDE, CGC, FT, Professor Emerita

Appendix E: Staff Education

SINCE 2000
ELNEC
END-OF-LIFE NURSING EDUCATION CONSORTIUM
Advancing Palliative Care

ELNEC Project Office • City of Hope • 1500 E. Duarte Rd, Building #173 • Duarte, CA 91010
Division of Nursing Research & Education • Tel: (626)218-2346 • Fax: (626)218-8941 • www.aacnnursing.org/elnec

Objectives

- Provide Palliative care education to nursing staff
- Fill a gap in nursing practice
- Improve knowledge and attitude in end-of-life
- Increase standard of care in long-term care
- Walden Consent for Anonymous Questionnaire
  - Frommelt Attitude Toward Caring for the Dying FATCOD-B
- Education Evaluation

ELNEC-Geriatric, 2021

SINCE 2000

ELNEC

END-OF-LIFE NURSING EDUCATION CONSORTIUM

Advancing Palliative Care

Celebrating Over 20 Years of Providing Palliative Care Education

ELNEC-Geriatric Curriculum Modules

- Module 1: Principles of Palliative care
- Module 2: Pain Assessment and Management
- Module 3: Syndrome and Symptoms
- Module 4: Ethical & Goals of Care
- Module 5: Cultural and Spiritual Considerations
- Module 6: Communication
- Module 7: Loss, Grief, and Bereavement
- Module 8 Final Days

SINCE 2000
ELNEC
END-OF-LIFE NURSING EDUCATION CONSORTIUM
Advancing Palliative Care

ELNEC-Geriatric 2021

National Coalition for Hospice & Palliative Care published *the National Consensus Project (NCP) Guidelines for Quality Palliative Care 2018*

- Domain 1: Structure and processes of care
- Domain 2: Physical Aspects of Care
- Domain 3: Psychological and Psychiatric Aspects
- Domain 4: Social Aspect of Care
- Domain 5: Spiritual, Religious, and Existential Aspects of Care
- Domain 6: Cultural Aspects of Care
- Domain 7: Care of the Patient Nearing the End of Life
- Domain 8: Ethical and Legal Aspects of Care

NATIONAL CONSENSUS PROJECT
FOR QUALITY PALLIATIVE CARE

NCP, 2018

What is Palliative Care?

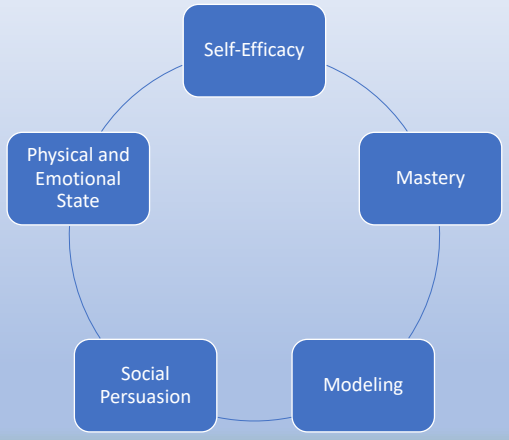
The NCP defines palliative care as, beneficial at any stage of a serious illness. Palliative care is an interdisciplinary care delivery system designed to anticipate, prevent, manage physical, psychological, social, and spiritual suffering to optimize quality of life for patients and their families. Palliative care can be delivered in any care setting through the collaboration of many types of providers. Through early integration into the care plan of seriously ill people, palliative care improves quality of life for both the patient and the family. (NCP, 2018)

Palliative care is team care, Nurses, Certified Nurse Assistant (CNA), and Unlicensed Personal (ULP) are a part of the interdisciplinary Team

NCP Domain 1

ELNEC-Geriatric, 2021

Theoretical Foundation is Bandura 's (2000) Self-Efficacy Theory: Four Assumptions



ELNEC-Geriatric, 2021

Nursing Staff End-of-Life (EOL) Education

- By 2020, up to 40% of deaths may occur from chronic illness in nursing homes (NHs)
- By 2030, the percentage of deaths that takes place in NHs is expected to increase dramatically
- More NH patients receive hospice services at the EOL
- Challenges to provide EOL care in NHs
  - Lack of EOL education.
  - Studies have shown that many nurses feel inadequately prepared to provide comprehensive care at the EOL
  - Lack of role models and training for healthcare providers

(Gardiner et al., 2011; Kavalieratos et al., 2014; Stephens et al., 2018)

ELNEC-Geriatric, 2021

Nurses are in a Unique Position

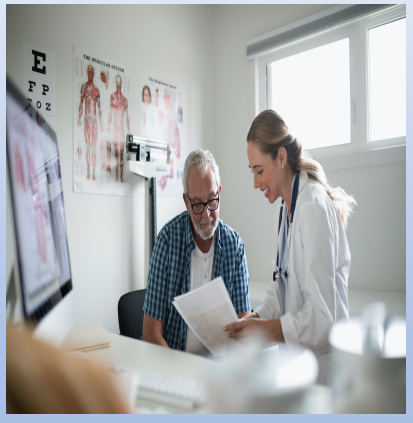
- Nurses spend more time with patients and families facing end-of-life (EOL) than any other health professional.
- Nurses are intimately involved in all aspects of EOL care, and they address the myriad of needs facing individuals at this time of life.
- Nurses have the potential to greatly reduce the burden and distress of those facing life's end and the ability to offer support for many physical, psychological, social, and spiritual needs of geriatric patients, nursing home residents, and their families.

ELNEC-Geriatric, 2021

The Facts About Dying in America Today

- 60% of American adults live with at least one chronic condition
  - ➢28% have 3+ chronic illnesses
  - ➢12% have 5+ chronic illnesses
- Over 2.7 million people die/year in the US
- Top 5 leading causes of death
  - ➢ Heart disease (647,457)
  - ➢ Cancer (599,108)
  - ➢ Unintentional injuries (169,936)
  - ➢ Chronic lower respiratory disease (160,201)
  - ➢ Cerebrovascular diseases (146,383)

(Ahmad & Anderson, 2021; Butteroff et al., 2017)



Heart Failure

- Complex cardiac syndrome
  - ➢Inability of heart to pump and maintain cardiac output
  - ➢Low ejection fraction of 40% or less
- 6.2M adults in US have heart failure
- Accounts for 1 in 9 deaths in the US
- Classifications:
  - ➢The American College of Cardiology and The American Heart Association Classification of Heart Failure
  - ➢New York Heart Association Functional Classification

(Heart Failure Society of America [HFSA], 2019)

Heart Failure (cont.)

- Causes: likely etiologies
  - CAD
  - HTN
  - Cardiomyopathy
  - Valvular disease
- Prevalence
  - Afflicts 6.5 million in US
  - Increases with aging
  - Common cause of hospitalization
  - Accounts for 8.5% of all heart disease deaths in the US

https://www.heart.org

Heart Failure (cont.)

- Symptoms and suffering
  - Symptoms create suffering and distress
  - Psychosocial intervention is key to complement pharmacologic strategies
  - Need for interdisciplinary care
  - Ethical emphasis on beneficence and nonmaleficence
- Management
  - Pharmacological interventions (Ace inhibitors, B-blockers, aldosterone antagonist, digoxin, diuretics, oxygen or opioids for hypoxemia)
  - Benefits and burden of treatment option
  - Repeat hospitalization
  - Invasive procedure
  - Goals of care
- Poor illness trajectory

(Dionne-Odom et al., 2019)

ELNEC Module 3; NCP Domain 3, 4

ELNEC-Geriatric, 2021

Case Study

- Charlie is 88 y/o with a history of symptomatic combine heart failure (EF 35%), 2 L oxygen dependent, recurrent pleural effusion, recurrent infection, and recurrent hospitalization. Charlie at baseline is confusion, verbal to some question, decrease appetite, incontinent, and required two-assist with turns. Several goals of care conversations with Jordan (son) DPOAH, palliative care NP, and the facility attending service on advance directives. Charlie remained FULL code.
- Charlie returns to facility from his latest hospitalization with notes from the cardiologist not a candidate for cardiac cath. Recommendations for follow up with cardiothoracic surgeon o/p for recurrent pleural effusions, and nephrologist for renal insufficiency. Changes were made to Charlie's code status his last stay to do not resuscitate (DNR). Jordan was not ready for hospice. Patient discharge back to the facility for comfort care. Charlie is less arousable, decrease appetite, requiring more nursing care, and on baseline 2 L NC.

Origin of Advance Directives

Patient Self-Determination Act (1991)

- Purpose of the law: to ensure the rights of individuals "to accept or refuse medical or surgical treatment"
- Healthcare institutions: inform individuals about their right to participate in decisions about their healthcare and the right to make advance directives

(Chovan, 2019; HR 4449, 1990)

Advance Directives

- Written instructions (directives) to a health care provider before (advance) the need for medical treatment
- Allows people to make decisions about treatments in case a future accident or illness makes it impossible to communicate their choices
- In an AD, people can refuse or choose treatments
- Advance directives is addressed each hospitalization and re-admission to facilities.

(Prince-Paul & Daly, 2019)

Decisions at the End of Life

If I can no longer make decisions for myself, who should make the decisions for me?

Case Study: Charlie had chosen Jordan as his DPOAH at some point before he was unable to make decisions.

Types of Advance Directives

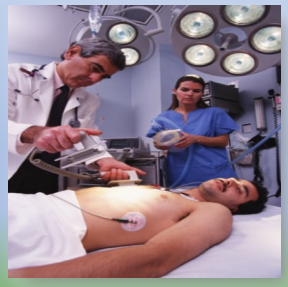
- Living Will (Health Care Directive)
- Durable Power of Attorney for Health Care (DPOA- HC; Health Care Proxy)
- No Code/Do Not Resuscitate (DNR or DNAR)
- Do Not Hospitalize (DNH)
- Organ/body donation
- Physician Order for Life Sustain Treatment (POLST)

Older adults who don't want life-sustaining treatments still require “intensive caring”

- Case Study: Report from the hospital, patient returned on comfort without hospice care. Charlie’s nurse assessed his serious illness, his progressive weakness. CENA reported past information on patient previous discussion of not wanting to be in pain. Charlie’s nurse called Jordan for guidance on his care, provided emotional support. Jordan confirmed comfort care and DNR. Hospice care was recommended Jordan agreed.
- Charlie’s nurse and another staff nurse filled out the DNR order for documentation at the facility and confirmed physician signature.

Purposes of Advance Directives

- Written instructions to a healthcare provider before the need for medical treatment
- Guidance to healthcare professionals how to proceed
- Provides immunity for healthcare staff



Treatment Options:

- CPR/mechanical ventilation
- Kidney dialysis
- Diagnostic tests
- Hospitalization
- Antibiotics
- Blood transfusions
- Tube feeding/intravenous fluids
- Internal cardiac device
- Pain management and comfort care
- Organ donation (Izumi, 2019)

ELNEC Module 4,;NCP Domain 8

ELNEC-Geriatric, 2021

Goals of Care, Preferences, and Choices

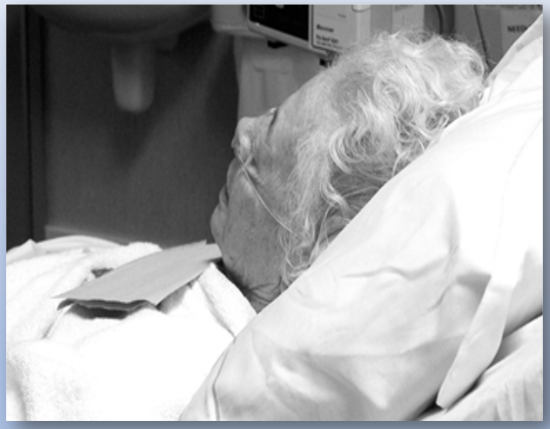
- Why is it so important to identify and document the goals of care and personal preferences?
- How do goals of care align with advance care planning?
- Advocacy and advance directives
  - Having the conversation
  - Be sensitive to religion, spiritual, and cultural issues
  - Review ADs at regular intervals
  - Be aware of policies regarding instituting & documenting advance directives

ELNEC 5, 6; NCP Domain 6 & 8

ELNEC-Geriatric, 2021

Nurse as Advocate

Know	Provide	Present	Guide
Older adult and family preferences and ensure that care is consistent with their goals of care.	Information about the older adult's condition	Data on the risks and benefits of medical therapies	Guide conversations without dictating



Case study: Charlie's nurse advocate for patient and family preferences. Charlie nurse communicated the dying process, comfort medications, and EOL care to make him comfortable until he signs onto hospice.

ELNEC Module 4, 6

ELNEC-Geriatric, 2021

Comparing Hospice and Palliative

Palliative Care	Hospice
Throughout the course of progressive illness	Last 6 months of life
Can occur in any setting	Home, inpatient hospice unit, long-term care setting
Allowance of curative therapies	Patient decides against life-sustaining, life-prolonging therapies
Includes end of life	End of life
Payment: philanthropy, fee for service, direct hospital support	Medicare, Medicaid, private insurers

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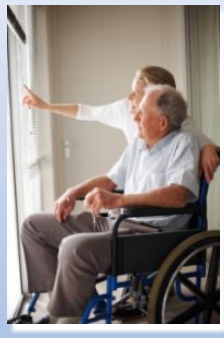
Hospice Care

- Program of care: comprehensive medical & support services
- Unit of care: patient and family
- Promotes the idea of "living until you die"
- Integrated model of palliative care
- Care provided in many settings, primarily home, LTC facilities (NHPCO, 2020)



Case Study: Hospice signs patient on, Jordan is informed on the hospice role at the EOL.

ELNEC Module 8, NCP 7

ELNEC-Geriatric, 2021

Open, Honest Communication

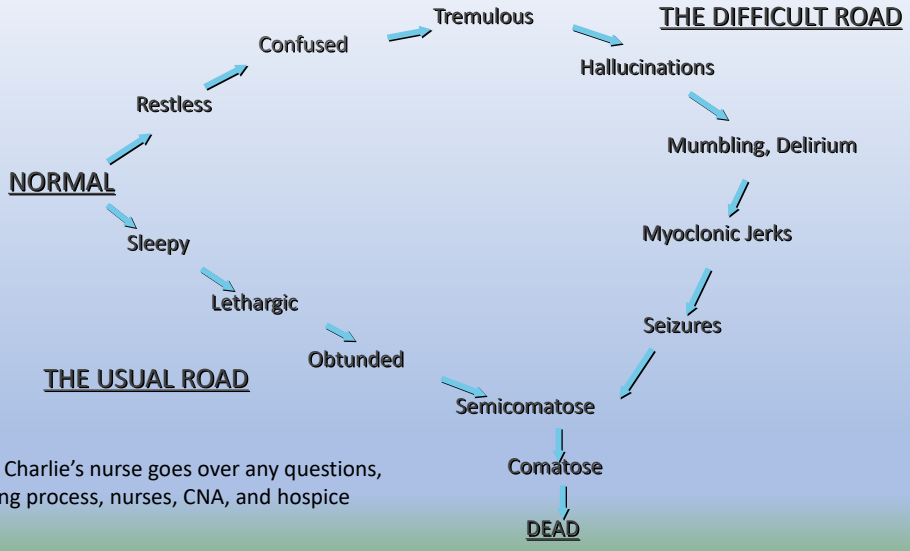
- Convey caring, sensitivity, compassion
- Provide information in simple terms
- Explore concerns and fears
- Provide needed education to families
- Maintain presence and hope
- Help to normalize the grief experience for families

(Dahlin & Wittenberg, 2019; Kehl, 2019)

ELNEC 6; 7; NCP Domain 1, 3, 4

ELNEC-Geriatric, 2021

Two Roads to Death



Case Study: Charlie's nurse goes over any questions, explains dying process, nurses, CNA, and hospice roles.

ELNEC Module 6, 8

ELNEC-Geriatric, 2021

Nursing Roles at End of Life

- Support older adults' families and staff prior to and following the death
- Coordinate care & collaborate
- Advocate for patients and families
- Being present, bearing witness
- Provide pain and symptom management
- Role model self-care behaviors

ELNEC Module 1, 2, 6; NCP Domain 1, 2, 3, 4

ELNEC-Geriatric, 2021

Advocacy: Comfortable Environment

- Objects and views
- Lighting
- Sound
- Family space
- Privacy

ELNEC Module 7, 8; NCP Domain 3, 4, 5,

ELNEC-Geriatric, 2021

Pain and Symptom Management

Frequency of Symptoms in the last 48-hours

- Death rattle: 92%
- Pain: 70-80%
- Delirium: 80%
- Agitation: 35%
- Dyspnea: 35%
- Myoclonus: 12%

(Lacey, 2015)

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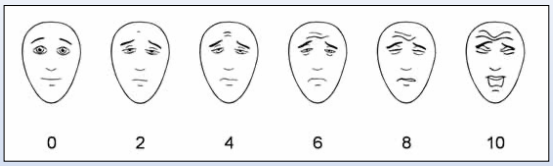
Pain Assessment (cont.)



- As patients approach death, changes in consciousness mean that staff must rely on behavior cues, physical exam, history of pain, surrogate reports, and medical conditions to determine if pain is present. (Berry & Griffe, 2019; Fink et al., 2019)
- Patient who were able to report pain and no longer are able to, the use of behavioral observation tool to ascertain the pain intensity. (Fink et al., 2019)
- Pain may increase prior to death.
  - Look for behavioral and other cacues; through pain assessment
  - Assume pain is present after fuling out other possible causes of distress
  - Explore the need to use alternative routes for pain
  - Aggressively treating pain at the end of life does not hasten death

Pain Management (cont.)

Non-Pharmacological Management

- Continue or institute new measures that are effective
- Cognitive-Behavioral:
  - Relaxation
  - Soft music
  - Hymns and prayers
- Physical interventions:
  - Reposition
  - Massage
- Incorporate family members

Pharmacological Management

If the older adult is on opioids…

- Roxanol, oxycodone, fentanyl
- Assess for renal failure and accumulation of metabolites
- Consider other routes
  - Oral
  - Rectal
  - Subcutaneous
  - Transdermal
- No evidence that opioids hasten death
- Never abruptly discontinue an opioid

Other Distressing Symptoms and Management

- Non-pharmacological and Pharmacological Treatments

- **Terminal secretions**
  - ➢Reposition
  - ➢Stop IV, enteral feeds
  - ➢Gentle suction
  - ➢Oral care
  - ➢Anticholinergics, scopolamine, levsin

- **Terminal delirium**
  - ➢Environment changes
  - ➢Gentle communication
  - ➢Avoid restraints
  - ➢No FDA approval medications for delirium
  - ➢Off-label

(Burhenn, 2016; Donesky, 2019)

Anxiety

- ➢Relaxation
- ➢Distraction
- ➢Calm and quiet surrounds
- ➢Lorazepam, (Haldol and Valium rarely used in HNs)

ELNEC Module 2, 3, 6, 8; NCP Domain 2, 3, 4, 7

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Daily Priorities

- As death nears, care priorities change
- Discuss changing goals of care with team members
- Provide comfort care
- Establish daily priorities (frequent assessment for pain and other distressing symptoms)
- Create a comforting physical environment
- Support older adults and families
- Observe and report symptoms
- Care to maximize comfort and dignity

ELNEC Module 6, 7, 8; NCP Domain 1, 2, 3, 4, 7

ELNEC-Geriatric, 2021

CNA/ULP Roles at EOL

- Observe and report
  - Presence and characteristics of EOL symptoms
    - ❖ Pain
    - ❖ Secretions
    - ❖ Dyspnea
    - ❖ Delirium
  - Effectiveness of therapies
  - Side effects of medications
- Deliver nondrug treatments
- Support and get help for older adults experiencing EOL symptoms
- Provides emotional & physical comfort to patients and families
- Provides care at the time of death

ELNEC Module 2, 6, 7, 8; NCP Domain 1, 3, 4, 7

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CNA/ULP Roles in End-of-Life Care (cont.)

- Helps identify expected outcomes as guided by the goals of the patient and family.
- Contributes to the patient and family plan of care.
- Puts into action the plan of care under the supervision of the nurse and as a partner with other team members
- Combing hair, arranging blankets
- Oral care
- Hygiene and management of urinary and bowel incontinence
- Skin care

ELNEC Module 2, 6, 7, 8; NCP Domain 1, 3, 4, 7

ELNEC-Geriatric, 2021

Offering Support During the Death Vigil

- Family vigil
- Explore presence of common fears
- Gain insight into family wishes
  - Privacy
  - Presence
  - Needs
  - Practices

ELNEC Module 6, 8; NCP Domain 3, 4, 7

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Nearing-Death Phenomena

- "The Rally"
- Symbolic language
- Near-death awareness in patients
- Visions
- Inability to let go
- Saying good-bye

ELNEC 6, 8; NCP Domain 2, 3, 4

ELNEC-Geriatric, 2021

Imminent Death

Symptoms of Imminent Death

- Decreased urine output
- Cold and mottled extremities
- Vital sign and breathing changes
- Lethargy
- Respiratory congestion or “death rattle”
- Delirium/confusion
- Restlessness

(Berry & Griffie, 2019)

ELNEC Module 8; NCP Domain 7

ELNEC-Geriatric, 2021

Signs That Death Has Occurred

- Absence of breathing
- Absence of heartbeat
- Lack of response
- Pupils fixed
- Pale color
- Body temperature drops
- Muscles, sphincters relax

Case Study: Charlie’s nurse communicated his passing to Jordan.

ELNEC Module 6, 7,8; NCP Domain 7

ELNEC-Geriatric, 2021

Death Pronouncement

- Site of death: who can pronounce
- State laws vary
- Follow organizational policy
- Customary practice
  - General appearance of body
  - Detailed information including notification

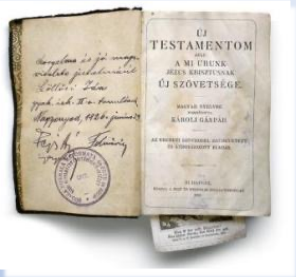
Case Study: Charlie's nurse communicated the process after Charlie's passing. Charlie's nurse contacts attending physician and informs the IDT.

ELNEC Module 6, 7, 8; NCP Domain 7

ELNEC-Geriatric, 2021

After-Death Care

Remove medical equipment and supplies; double check if medical examiner case	Ask and family preferences, religious and cultural practices	Place dressings on leaking wounds
Bathe and dress the body, properly position, anticipate bowel and bladder incontinence	Respect cultural practices	Leave a peaceful impression
Normal postmortem changes and care	Rigor mortis 2-4 hrs after death	



ELNEC Module 7, 8, NCP Domain 7

ELNEC-Geriatric, 2021

Bereavement

- The state of having experienced the death of a loved one
- Includes grief and mourning
- Bereavement period
- Spousal bereavement programs

Case Study: Hospice involvement, bereavement services provided by hospice care.

ELNEC Module 7, 8; NCP Domain 3, 4, 7

ELNEC-Geriatric, 2021

Staff Bereavement Support in the Workplace

- Enable staff to attend memorial services
- Encourage staff to express their grief
- Review deaths and their effects on staff
- Encourage self-care

Case Study: Charlie's nurse and CNA expressed Grief to each other. They expressed less stress because they meet his needs (collaboration on goals of care, managed distressing symptoms, emotional support, hospice involvement for quality EOL).

ELNEC Module 8

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Conclusion

Families will always remember those last moments, as those who:

- Provide excellent physical assessment skills
- Manage those physical symptom's
- Tend to the psychological, emotional , social, and spiritual needs.
- Honor the family's culture
- Prepare them for the death
- Communicate with other IDT members as needed
- Listen
- Bear witness

ELNEC-Geriatric, 2021

References

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