2022

An Educational Program for Hospice Nurses about End-of-Life Protocols

Rhonda Coleman
Walden University

Walden University

College of Nursing

This is to certify that the doctoral study by

Rhonda Coleman

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Review Committee
Dr. Anna Hubbard, Committee Chairperson, Nursing Faculty
Dr. Cheryl Holly, Committee Member, Nursing Faculty
Dr. Rosaline Olade, University Reviewer, Nursing Faculty

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

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Abstract

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Rhonda Coleman

MSN, Walden University, 2020

BSN, the University of Arkansas at Pine Bluff, 2004

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Palliative care is specialized care for people living with a serious illness. This type of care is centered on providing relief from the symptoms and stress of the illness with a primary goal to improve the quality of life for both the patient and the family. A gap in nursing practice was identified in a hospice facility in the South Central United States.; the nurses did not use palliative care or end-of-life (EoL) protocols. This project focused, therefore, on the development of a nursing staff education program for hospice nurses to increase knowledge about the use of EoL protocols. The project was guided by Kolcaba's comfort theory and the analysis, design, development, implementation, and evaluation model. A literature review resulted in 35 peer-reviewed articles that supported program development. Nine staff nurses voluntarily participated in the project. A 15-question survey, including five demographic questions based on end-of-life nursing education consortium competencies and recommendations, was used as a pre-and post-test to determine knowledge gained from the staff education program. Data analysis revealed an increase in knowledge scores from the pretest (M=76.7) to the posttest (M=98.9) which was a statistically significant increase demonstrated by a paired *t-test* (p=.0038). This project has the potential to create social change by increasing nurses' knowledge and awareness of the importance of using EoL protocols.

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Dedication

I would like to dedicate this project to the almighty God. He alone gave me the grace, and the strength to finish this project. This project is dedicated to every person who has ever experienced or endured pain or discomfort in their mind, body, or soul. I also dedicate this project to every nurse, family member, or caregiver who has taken care of patients or loved ones during end-of-life.

Acknowledgments

I thank God for gracing me to go back to school and my husband for allowing me to fulfill my desire and destiny to attend school. I also wish to express gratitude to Dr. Anna Hubbard for her mentorship and immeasurable guidance in assisting me with the writing process and for her positive motivation when I wanted to give up. I want to thank Dr. Edna Hull for her words of encouragement. I want to thank Dr. Cheryl Holly and my project committee for their constructive feedback.

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Section 1: Nature of the Project

Introduction

A survey conducted by the end-of-life nursing education consortium (ELNEC) [ELNEC; 2015] revealed that nursing students are not well prepared to deliver palliative care. Nursing faculty rated student knowledge related to end of life as 5.4 on a scale of 1 to 10 (ELNEC, 2015). I identified a gap in nursing practice in a hospice facility in the South Central United States that mirrored this lack of knowledge. According to Dy et al. (2015), palliative care provides relief from symptoms and supports the quality of life for patients with serious advanced illness and their families**.** This facility did not have an EoL protocol. The nurses at this facility did not use EoL protocols. As a result, many hospice patients at this facility were not receiving the most current, evidence-based care. Staff education using evidence-based practice supports quality of life (QoL) and has the potential to increase knowledge.

My goal for this project was to increase nurses' knowledge regarding EoL protocols that will promote comfort and improve the QoL for their patients. I aimed to answer the following question: Does a nursing staff education program for hospice nurses increase knowledge related to EoL protocols?

This project has the potential to impact social change by educating nurses, increasing knowledge of addressing EoL protocols, and advancing nursing practice. Staff education improves patient care and influences decision-making and preparedness. Staff education using evidence-based practice increases knowledge that directly and indirectly influences nursing practice (McEwen, 2019a). Increasing knowledge of EoL protocols has the potential to improve health behavior and patient comfort.

Problem Statement

Palliative care and hospice are comfort measures for people with advanced and incurable diseases (Coelho et al. 2017). Kolcaba's comfort theory suggests comfort satisfies the basic human needs for relief, ease, or transcendence that come from stressful health care situations related to physical, social, psycho-spiritual, and environmental circumstances (Coelho et al. 2017). Providing comfort also shows caring. Parker and Smith (2015) suggested that the concept of caring involves commitment, confidence, conscience, competence, and compassion. Comfort is vital in practicing holistic care at the EoL. An objective of hospice is to improve the QoLby providing palliative care or end-of-life care (EoLC). EoLC and palliative care are commonly inter-changeable in daily practice and literature (Thorn, et al. 2017). ELNEC recognizes the need to educate nurses on EoL protocols (ELNEC, 2020). Currently, the ELNEC has provided the train-the-trainer course on EoL protocols for 30,720 nurses (ELNEC, 2020).

I identified a gap in nursing practice in a hospice facility in the South Central United States. This facility did not have current EoL protocols. The nurses at this facility did not up-to-date EoL protocols. As a result, many hospice patients at this facility did not receive the most current, evidence-based care.

This project holds significance for nursing practice as nursing staff received education on current evidence-based EoL protocols. Evidence-based practice increases preparedness and improves patient care, decision-making, knowledge, and skills by validating and refining existing knowledge and by generating new knowledge that directly and indirectly influences nursing practice (McEwen, 2019a; McEwen, 2019b). In this educational project, I provided the current evidence-based interventions for EoL

protocols, such as symptom management, administering pain medication, communication, and ethical principles.

Purpose

I identified a gap in nursing practice in a hospice facility in the South Central United States. This facility did not have current EoL protocols. The nurses at this facility did not use up-to-date EoL protocols. The gap is due to a lack of knowledge concerning current evidence-based EoL protocols.

The guiding practice-focused question for this doctoral project was: Does a nursing staff education program for hospice nurses increase knowledge related to EoL protocols? The purpose of this project was to provide education regarding the most up-to-date evidence-based EoL protocols. I achieved this by developing, implementing, and evaluating the effectiveness of an evidence-based staff education project. Staff education using evidence-based practice has the potential to increase knowledge. This project may be used to address the gap in practice by increasing knowledge, with the overall goal to promote patient comfort and ensure that EoL needs are met.

Nature of the Doctoral Project

Literature indicated there was evidence to address the gap in nursing practice. Literature suggested that knowledge deficit and a lack of clinical practice skills impacted the quality of life and prevented end-of-life care (EoLC) patients from receiving evidence-based care. Evidence sources for this project included using the education program guidelines from the ELNEC. I completed a comprehensive literature review using electronic databases such as MEDLINE, OVID, and PubMed. Search terms included *comfort theory, palliative care, hospice care, comfort care,* and *end-of-life*

protocols. Inclusion criteria were full-text articles with a publication date of fewer than 5 years, systematic reviews and other literature reviews, and randomized controlled trials (RCT). Exclusion search criteria included cohort studies, case studies, observational studies, and nonexperimental studies. The Boolean search strings were AND /OR. The keyword search terms included: *comfort, comfort theory, end-of-life, palliative care,* and *hospice care.* Surrogate terms for comfort included *caring, ease, relief, satisfaction, support,* and *comfort*.

The approach that I used to address the practice problem was to review evidence-based literature that supported the need for this project and delivered this information to the staff as a means of increasing their knowledge regarding EoL protocols. I looked at primary and secondary resources that related to my practice question. The Walden Staff Education Manual was the guide for this project. I received approval from the facility and Institutional Review Board (IRB) approval (12-07-21-0667262) from Walden.

I used the analyze, design, develop, implement, and evaluate (ADDIE) instructional design model to develop the curriculum with input from expert training programs that use ELNEC as a guideline and a resource for evidence. I used International Business Machines Statistical Package for the Social Sciences (IBM; SPSS) software to organize and summarize data. I used descriptive statistics to collect and analyze data. I used a self-assessment questionnaire using a pre-and post-test to determine knowledge gained from the staff education program.

I developed an evidence-based staff education program for hospice and palliative care nurses using the eight-core modules of the ELNEC. Core modules include:

1. Symptom management.

2. Pain management.
3. Palliative care.
4. Ethical and legal issues.
5. Culture and Spiritual.
6. Communication; Loss, Grief, Bereavement.
7. Final Hours/Days (ELNEC, n.d.).

I completed a comprehensive literature review using electronic databases such as MEDLINE, OVID, and PubMed. I identified over 60 articles on EoLC. Of the 60 articles, 35 are published between 2014 and 2020 and were selected for inclusion in the literature review. I used peer-reviewed articles based on relevance, titles, and/or abstracts to support the education program.

I identified a gap in nursing practice in a facility in the South Central United States. This facility did not have an EoL protocol. My goal for this project was to use this education program to educate hospice and palliative care nurses on EoL protocols and to improve the QoL for their patients. The nurses at this facility did not use EoL protocols. As a result, many hospice patients at this facility were not receiving the most current, evidence-based care. Staff education using evidence-based practice has the potential to increase knowledge, and preparedness, and improve patient care, and decision-making skills by validating and refining existing knowledge and generating new knowledge that directly and indirectly influences nursing practice (McEwen, 2019c).

Significance

This project has significance because of its potential contributions to nursing practice. The stakeholders related to this project include palliative care and hospice

nurses, long-term care nurses, intensive care unit (ICU) nurses, emergency room nurses, and hospice facilities. The DNP staff education program can contribute to nursing practice as increasing knowledge can improve the quality of care for EoLC patients. Using ELNEC guidelines to implement an education program can potentially change practice standards by incorporating evidence-based EoL protocols for terminally-ill patients. Nurses who use evidence-based EoL protocols have the potential to improve symptom management, comfort, and quality of life for patients at EoL. Nurses are required to attain the necessary competence for current practice situations (American Nurse Association [ANA] 2016). This project has the potential for transferability as this model can be used in other facilities that care for EoLC patients.

This project can potentially impact social change by educating nurses to increase their knowledge of addressing EoL protocols. In this project, I developed support for the education of hospice and palliative care nurses, which makes this project significant to nursing practice. An EoLC protocol has transferability to similar practice areas such as long-term care facilities, intensive care units, and nursing education programs. ELNEC recognizes the need to educate nurses on EoL protocols (ELNEC, 2020). In this project, I sought to answer the following question: Does a nursing staff education program for hospice nurses increase knowledge of EoL protocols?

Summary

In Section 1 I introduced the topic/problem, the nature of the DNP doctoral project, and the potential positive social change implications of the doctoral project. I explained the significance, described the gap in practice, stated the purpose, and identified the sources of evidence. I summarized the approach that will be used in this

doctoral project to organize and analyze the evidence. In Section 2, I will discuss the background and context, concept models and theories, definition of terms, relevance to nursing practice, local background and context, my role as a Doctor of Nursing Practice (DNP) student, and the role of the project team.

Section 2: Background and Context

Introduction

I identified a gap in nursing practice in a hospice agency in the South Central United States. The nurses at this facility do not use up-to-date EoL protocols. As a result, many hospice patients at this facility do not receive the most current, evidence-based care. The purpose of this project was to address a gap in practice. The gap is linked to a gap in care delivery for patients receiving EoLC. Nurses are not using the most current evidence-based care protocols for EoL. Through this educational project, I provided the current evidence-based interventions for EoL protocols. I attempted to answer the following question: Does a nursing staff education program for hospice nurses increase knowledge of EoL protocols?

In this section, I will address concepts, models, and theory, relevance to nursing practice, local background and context, the role of the DNP student, and the role of the project team.

Concepts, Models, and Theories

According to McEwen and Willis (2019), the comfort theory is patient-focused, measurable, holistic, positive, and nurse-sensitive. Kolcaba, who developed the theory, defined comfort as encompassing three forms: comfort relief, ease, and transcendence. Physical, psychospiritual, sociocultural, and environmental are comfort needs (Boudiab & Kolcaba, 2015; McEwen & Willis, 2019). According to Kolcaba, the more comfortable a patient is the less stress, tension, and negative situations they will experience (Boudiab & Kolcaba, 2015; McEwen & Willis, 2019). The author also suggests that the more comfort the patient has the better the outcome and health-seeking behaviors. The comfort

theory is observed in nursing when patients experience pain or stress (Kolcaba, 1992 & Kolcaba 2006).

Pain and stress can delay the body's healing process. Nurse's use comfort measure interventions such as obtaining vital signs, providing a quiet environment, observing for nonverbal indicators of pain, and administering pain medication (Kolcaba, 1992 & Kolcaba 2006). Stress intensifies the patient's pain. Other interventions are listening to the patient, coaching, and encouraging relaxation exercises or massage therapy to reduce anxiety, and offering comfort foods to promote the patient's wellbeing. The comfort theory is patient-centered, measurable, holistic, positive, and nurse-sensitive (McEwen & Willis, 2019). Since the development of the Kolcaba comfort theory, numerous concepts of comfort are in use. The concept of comfort is essential in practicing holistic care and is still being tested.

Parker and Smith (2015) associated the concept of caring with commitment, competence, competence, confidence, conscience, and compassion. It is sometimes difficult to remain in a caring mode when facing problematic patients. The caring model suggests that in difficult situations the nurse must respond and acknowledge the other person as caring. This requires the nurse to find a basis for respect and commit to knowing and nurturing the patient as a caring person. EoL protocols on how to deal with a dying patient are not readily available. The caring model provides opportunities for nurses to mentally put themselves in the patient's situation to better understand their needs. Nurses must promote caring environments (Parker & Smith, 2015).

Definitions of Terms

The following definitions of terms were used for this project:

Caring: Commitment, confidence, conscience, competence, and compassion (Parker & Smith, 2015).

Comfort: Experiencing relief and ease from stressful situations that affect basic needs (McEwen & Willis, 2019).

Comfort needs: Comfort needs can be defined as physical, psycho-spiritual, sociocultural, and environmental (Boudiab & Kolcaba, 2015; McEwen & Willis, 2019).

End-of-Life Care (EoLC): Care that helps all those with an advanced, progressive, incurable illness to live as well as possible until they die; It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement; It includes management of pain and other symptoms and provision of psychological, social, spiritual, and practical support (Lim, 2016).

*Quality-of-life: (QoL) "*the set of outcomes that contributes to a patient's well-being or overall health" (Fayers & Machin, 2016, p.4).

Relevance to Nursing Practice

In my review of the literature, I found that nurses are not prepared by education or experience to fulfill the palliative care and comfort needs of dying patients or even to assist them to receive required services from other providers. Palliative care education needs to be evidence-based (Riahi & Khajehei, 2019). This lack of knowledge led to patients at a South Central United States hospice facility not receiving the most recent evidence-based EoL protocols. Nurses at the project site did not use EoL protocols. This was due to a lack of education. Evidence-based practice (EBP) is the explicit and

judicious integration of best evidence with clinical expertise and patient values (Hamric et al., 2014).

Many nurses on a national level lack knowledge of current EoL protocols. According to Zalot (2020), palliative care nurses should anticipate, prevent, and manage physical symptoms like pain, fatigue, and nausea, which are caused by illness, or the interventions used to treat it. A primary goal of palliative care and hospice is to relieve the burden of care of the patient's family by easing symptoms such as physical, psychological, and spiritual, and working to improve the patient's overall QoL (Zalot, 2020). Both hospice and palliative care nurses' emphasis should be on symptom management, including physical, emotional, psychological, and spiritual support (Zalot, 2020). Hospice and palliative care nurses must be able to communicate effectively with EoLC patients. EoLC communication includes issues related to incurable disease, advance care planning, discussing the transition to palliative care, and/or talking about dying (Brighton et al. 2017).

It is unacceptable to only use external evidence to make practice decisions (Hamric et al., 2014). EBP is using the best most up-to-date information or practice and applying that to everyday care. EBP promotes effective nursing practice, and efficient care improves outcomes for patients and provides the best evidence for decisions related to clinical, educational, and administrative decisions (Stewart & Denisco, 2015).

The practice problem for this project was does a nursing staff education program for hospice nurses increases knowledge of EoL protocols? According to a peer-reviewed, evidence-based literature review, a lack of knowledge exists concerning decision support interventions, comfort, palliative care, communication, pain relief, spirituality, advanced

planning, lifestyle interventions, QoL, and symptom management. The staff education program provided knowledge to address the gap in these areas.

EoLC is defined as medical care and support provided to near-death National Institute on Aging ([NIA]; 2016). EoLC should be consistent with the patient's wishes. Kelechi et al. (2017) suggested that palliative wound management guidelines for symptom management and comfort are important at the EoL. According to the National Institute on Aging (2016), it is essential to provide comfort at EoL. Preventing and relieving suffering should be a major goal. Evidence-based literature exists that addresses specific gaps in the knowledge I aim to fill.

Fahey (2017) conducted a systematic review examining Comfort Theory. The review revealed that creating comfortable EoL rituals help comfort and impact the perception of caring. Holistic healing modalities, such as prayer, light, color, water, music, and touch, are elements of ritual that may enhance the healing of the body, mind, and spirit (Fahey 2017). The author collected data on the effectiveness of the ritual on nurse and family perception of care and anxiety/comfort levels by using a simple Likert-type scale as an evaluation tool. Fahey (2017) found that rituals provide emotional and spiritual comfort.

Unnecessary suffering at EoLC is mitigated by improving the EoLC knowledge of nurses and the EoLC experience as perceived by family members of dying patients Stacy et al. (2019). Hospice is usually chosen at EoL. Hospice can be provided in any setting such as a hospital, nursing home, or assisted living facility. Hospice provides comprehensive comfort (Stacy et al., 2019). Hospice is for terminally ill patients at the

end of their disease. Care is focused on alleviating pain and improving the QoL. Hospice care is based on palliative care (Stacy et al., 2019).

Lafond et al. (2019) conducted an evidence-based systematic review examining the evidence on Comfort Theory. Comfort is a major goal of palliative care. The findings suggested that palliative care improves access to symptom control and QoL care. Palliative care allows patients to make choices about their care. Palliative care is not dependent on prognosis and can provide curative treatment. Palliative care provides medical, social, emotional, and practical support. Palliative care is provided in a variety of places such as homes, hospitals, specialized clinics, nursing homes, or outpatient palliative clinics (Lafond et al., 2019).

Palliative Care in the Management of Pain, Odor, and Exudate in Chronic Wounds at the End of Life (Kelechi et al. 2017), is a cohort study that used the Comfort Theory as a framework to stress the importance of wound care to relieve pain at EoLC. Findings suggest that topical RGN107 reduces pain, odor, and exudate in a population with wounds at the EoL. Application of Kolcaba's Comfort Theory to the Management of a Patient with Hepatocellular Carcinoma by Shu Hua (2017) is an observational study using Katharine Kolcaba's comfort theory as a framework to show the importance of applying comfort to patients with hepatocellular carcinoma. The Comfort Theory as a Theoretical Framework Applied to a Clinical Case of Hospital at Home, by Puchi, et al. (2018) is a case study using the comfort theory as a framework for person-centered nursing care, incorporating family into the care plan to comfort the family and the patient (Puchi et al., 2018). The study concludes that holistic care decreased symptoms of distress, promoted relief of troubling symptoms, and enhanced functional status which

brought comfort to patients and families (Puchi, et al. 2018). Wang and Creel-Bulos (2019) addressed the importance of managing symptoms of pain, anxiolysis, agitation, delirium, and secretions. Circulatory support, compassionate extubation, compassion, attention, and care are needed even in emergencies.

Nurses should be educated and knowledgeable about symptom management. A systematic review of general practice EoL symptom control is a systematic review by Mitchell et al. (2018) that revealed gastrointestinal problems such as nausea, vomiting, loss of appetite, constipation, and pain were reported as the most prevalent complaints during EoL. Conversations about death and spirituality, effective cancer pain management, patients' roles in EoLC, advance care planning, artificial nutrition and hydration, and the understanding of sedation versus euthanasia concerning pain management, were viewed as the most troubling assessment of suffering. Other problems identified were depression and palliative sedation.

Anticipatory prescribing of injectable medications for adults at the EoL in the community is a systematic literature review and narrative synthesis by Bowers et al. (2019). The results showed that management of pain and distress is a shared goal for patients, their family caregivers, and healthcare professionals at EoL but prescribing strong injectable medications ahead of need has potential risks. Appropriate administration is dependent on nurses correctly diagnosing those symptoms are not reversible and that the patient is dying.

There was also research on the importance of communication. The effectiveness of communication-skills training interventions in EoL non-cancer care in acute hospital-based services, by Lord, et al. (2016) is a systematic review that was conducted to

explore the effectiveness of communication-skills training interventions in EoLC with non-cancer acute-based healthcare staff. The results revealed that communication about the EoL with patients and families had a positive effect on staff behavior. Based on the systematic review by Lord, et al. (2016), and the use and impact of QoL assessment tools in clinical care settings for cancer patients, with a particular emphasis on brain cancer: insights from a systematic review and stakeholder consultations, by King et al. (2016), I concluded that the use of QoL tools in cancer patients may improve patient-physician communication and have the potential to improve care. Dying adults' transition process from cure-focused to comfort-focused care, by Meeker, et al. (2019) focus on communication and shared decision-making at EoL. Meeker et al. (2019), like Lord et al. (2016), revealed the importance of communication at EoL. The study confirmed that patients need to receive clear and consistent information to achieve an understanding of change in the aims of care.

Research showed the importance of advanced care planning at EoL. Advance care planning by Zwakman et al. (2018) is a systematic review of the experiences of patients with a life-threatening or life-limiting illness. A need for planning at EoL was identified. Although planning may cause unpleasant feelings it should be personalized in a form that is both feasible and relevant at moments suitable for the individual patient at EoL. The results of a systematic review of the effects of advance care planning facilitators' training programs, by Chan et al. (2019), like Zwakman et al. (2018), revealed that nurses have a valuable role in leading advanced care planning (ACP) implementation and in creating system-wide cultural changes to improve EoLC care. The results of the study also proved training for healthcare professionals in ACP had positive effects on their knowledge,

attitudes, and skills. Dementia Care at End of Life: Current Approaches by Bartley et al. (2018), like Chan et al. (2019), and Zwakman et al. (2018), alluded that ACP was one of the most important areas to address at EoL, especially with dementia. Comfort-based care is usually the goal of the caregiver. According to the results of the study effective palliative care of patients with advanced dementia can reduce distressing symptoms, optimize quality of life, lessen caregiver burden, and ensure treatment decisions are consistent with patients' wishes and articulated goals of care (Bartley et al. 2018).

There was research to support the importance of spirituality. The Importance of Providing Spiritual Care for End-of-Life Patients Who Have Experienced Transcendence Phenomena, a thematic literature review by Broadhurst and Harrington (2016) establishes the importance of transcendence phenomena being accepted as spiritual experiences by health care professionals. The authors suggest transcendence experiences of dying patients provide comfort to the bereaved and assist with grieving. According to Broadhurst and Harrington (2016), spirituality enables dying patients to cope with their prognosis, and being able to make amends enhances patients' inner peace and leads to a good and peaceful death.

There was research such as EoLC in patients with advanced lung cancer by Lim (2016) that identified four key areas of EoLC in advanced lung cancer. The key areas consisted of

1. Recognizing when a patient is approaching EoL.
2. Appropriate communication (helping the patient and family understand where they are in the trajectory and what to expect).
3. Symptom management focuses on the goal to provide comfort and dignity.

4. Understanding the ethical principles applied to EoLC interventions (Lim, 2016).

Lim (2016), like Wang and Creel-Bulos (2019), identified similar symptoms that were common toward EoL such as pain, dyspnea, delirium, and respiratory secretions. The authors identified the clinical signs and symptoms of the dying phase as

1. Extremely lethargic: progressively weak with reducing mobility till bed bound.
2. Reduced cognition and consciousness: from drowsy and confused to delirious, and finally, comatose.
3. Poor oral intake: increasing difficulty tolerating oral medications and food till only able to take sips of fluid with frequent aspiration.
4. Changes in respiration: including patterns of Cheyne–Stoke breathing, frequent apnea, and finally mandibular breathing.
5. Terminal secretions: rattling, gurgling sound on breathing due to secretions vibrating in airways as air passes during breathing.
6. Decreased vital signs: reduced blood pressure, oxygen saturation, peripheral cyanosis, feeble pulses, and mottling (Lim, 2016).

Research such as Hematological malignancy: Are we measuring what is important to patients? Goswami, et al. (2019) provided a comprehensive list of QoL issues important to patients suffering from hematological malignancies identified through the literature; a list of health□related quality□of□life (HRQoL) instruments used in

hematological malignancies in both daily clinical practice and research; and evaluated the relevance and comprehensibility of the identified instruments in hematological malignancies. EoLC pathways for improving outcomes in caring for the dying by Chan, et al. (2016) is a systematic review. The conclusion of the study reveals plans for EoLC should be developed in open consultation with the patient and significant others.

Research showed the importance of EoL decision support. End-of-Life Decision Support in the ICU: Where Are We Now? Pignatiello, et al. (2018) were conducted to identify interventional studies that describe how effective decision support interventions are when administered to critically ill patients or their surrogate decision-makers. One in five Americans dies while receiving life-sustaining care in an ICU (Pignatiello, et al. 2018). Critical care practitioners are sometimes limited in their ability to effectively provide decision support to critically ill patients and their families faced with EoL healthcare decisions (Pignatiello, et al. 2018). The authors identified 22 decision support interventions for family members who were faced with making EoL decisions for a critically ill patient. The authors suggested that decision support interventions should be adaptable to the individual receiving the intervention.

There was research such as Lifestyle interventions are feasible in patients with colorectal cancer with potential short-term health benefits, by Moug, et al. (2017) that assessed the evidence for the feasibility of performing lifestyle interventions in colorectal cancer (CRC) patients and evaluated short and long-term health benefits. The focus of the study was on low-fat and/or high-fiber diets within a multimodal lifestyle intervention.

In summary, providing QoL for EoL patients requires knowledge of comfort, palliative care, communication, pain relief, spirituality, planning, symptom management,

lifestyle interventions, and decision support. To improve QoL for EoL patients the latest evidence-based practice EoLC protocols should be used. My education program provided hospice and palliative care nurses the opportunity to receive knowledge regarding the most recent EBP protocols for EoL.

Local Background and Context

I was motivated to do this project because I am passionate about EoLC. Both of my parents and two of my sisters were diagnosed with cancer. My father died from terminal cancer and my mother and sisters are cancer survivors. My father was a hospice patient, and he had a positive experience. I want to educate other nurses so that other terminal patients can have a similar experience.

There are two cancer centers and three hospice agencies in the area of the study site. I contacted the three hospice agencies in the area and this facility was very open to an education program on EoLC. The staff education program took place at a hospice agency in the South Central United States. I was not an employee at the facility. The facility has centers to serve patients with advanced illnesses who have physical symptoms that cannot be managed in other settings. To improve the QoL for those who are suffering from significant sickness or loss, the organization surrounds them with love and embraces them with the highest level of medical treatment available, including physical, mental, and spiritual care.

There are RNs on-site 24 hours a day. Twenty-four hospice/palliative care nurses have the opportunity to participate in the education. The director of nursing (DON) supported the project. The ADDIE model was used as a framework to design and develop

the educational program. Several states have death with dignity laws however, there was currently no state or federal laws such as death with dignity in this state.

There was a gap in nursing practice as many hospice patients at this facility did not receive the most current, evidence-based care. The gap in practice, the problem statement, and the problem-focused question impacted social change by promoting awareness of end-of-life protocols. The context for the doctoral project and the source of evidence aligned with a staff education project (Walden University, 2020). Ethical issues were considered in the planning of this project. Providing a sound nursing staff education program, using input from experts, and current evidence-based practice had the potential to increase knowledge, promote comfort, and improve the QoL for EoL patients.

EoLC is provided either palliative or supportively to patients who are terminally ill to achieve the best possible QoL (McQuade, 2019). Medicare part A provides reimbursement for patients who meet certain criteria.

EoL protocols have the potential to improve the quality of life by providing current evidenced-base palliative care or EoLC. EoLC has the potential to provide comfort and relieve the suffering of terminally ill or dying patients. Palliative care addresses the intellectual, emotional, social, spiritual, and existential needs of patients and their families (McQuade, 2019). Findings suggest that palliative care improves access to symptom control and QoL care (Lafond et al., 2019).

The education program for this project involved educating hospice nurses on the most current up-to-date evidence-based protocols for EoL. The goal of this project was for nursing staff to use this education program to increase knowledge of EoLC protocols.

This knowledge had the potential to improve the quality of life of their patients. Staff education using evidence-based practice increases knowledge and preparedness and improves patient care, decision-making, knowledge, and skills by validating and refining existing knowledge and generating new knowledge that directly and indirectly influences nursing practice (McEwen, 2019).

Educational training for palliative and EoL training should include legal and ethical concerns, pharmacologic and non-pharmacologic related symptoms, communication, and culture (Manning, et al. 2020). Research showed that the implementation of an ELNC increased knowledge of EoLC for patients and their families (Manning, et al. 2020). Palliative care needs are on the increase. Palliative care training is not a common core competency. One million patients per year require palliative care services and nurses are inadequately trained and prepared for the unique challenges (Bishop et al. 2019). With the aging population, primary palliative care knowledge and skills are critical (Bishop et al. 2019). There were no state and federal regulations that would impact this project.

Role of the DNP Student

My role in this project was as a DNP student. I was not employed by the agency. I am passionate about EoLC because both of my parents and two of my siblings were diagnosed with cancer. I assimilated my doctoral-level knowledge into a DNP project and focused on a change that impacted nursing practice and/or health care directly or indirectly. I developed the program and protocols using the ADDIE framework and Kolcaba's Comfort Theory as well as ELNEC guidelines to empower other nurses and to improve patient QoL and patient outcomes. I used this education program to make

improvements in the care of EoLC patients. I used this education program to develop additional competencies in direct practice related to EoLC patients. I was responsible for designing, developing, implementing, and evaluating an intervention to improve outcomes.

My role in this project was to collaborate with My DNP chair, my committee, the Director of Nursing, and the nurses of the project site. I designed, developed, conducted, and evaluated the education program. I made sure my project was supported by reliable evidence provided through existing literature. I referred to ELNEC. I received permission from the hospice agency and IRB approval (12-07-21-0667262) from Walden. I consulted with my DNP mentor and members of the committee for input concerning the education program. I did not anticipate any bias.

Role of the Project Team

The project team consisted of a medical director, a nursing supervisor, and a nurse educator. The team advised, critiqued, evaluated, and provided guidance, feedback, expertise, and recommendations regarding the educational program. They were presented with background information, evidence and all data used to support the doctoral project. I sought feedback from the agency medical director. The medical director reviewed the education program.

The nursing supervisor:

- Disseminated information related to the education program and gave me the time and date to implement the program.
- Collaborated with me on the staff education program.
- Made sure the nursing staff is aware of the staff education program.

- Provided support during the implementation phase.

The nurse educator:

- Helped plan and design the curriculum and formulate questions. Provide input into the curriculum using the ADDIE model.
- Provided support during the analysis phase.
- Provided required evaluation.
- Attended DNP presentation.

Summary

Section 2, covered the background and context, described the concepts, model, and theories, the relevance to nursing practice, the local background and context, the role of the DNP student, and the role of the project team. In section 3, I discussed the collection and analysis of evidence, identified the sources of evidence, described the systems used for recording, tracking, organizing, and analyzing the evidence, outlined the procedures used, and described the analysis procedures used for this project to address the gap in practice.

Section 3: Collection and Analysis of Evidence

Introduction

The purpose of the project was to create a program to educate hospice and palliative care nurses in a local hospice facility located in the South Central United States on EoL protocols for terminally-ill patients or patients with chronic long-term conditions. The project goal was to improve nurses' knowledge of EoLC protocols, therefore improving patient QoL and family experiences. The practice problem was a lack of knowledge of EoLC protocol education amongst hospice and palliative care nurses. Nurses had not received formal training on EoL protocol for terminally ill patients.

Section 3 included the project design, using the Walden staff education manual as a guide for project development.

Practice-Focused Question(s)

I identified a gap in nursing practice in a hospice facility in South Central United States. The nurses at this facility did not use current end-of-life protocols. As a result, many hospice patients at this facility did not receive the most current, evidence-based, EoLC care. The purpose of this project was to address a gap in practice. The gap was linked to a gap in care delivery for patients receiving EoLC. The primary question that I addressed was: Does a nursing staff education program for hospice nurses increase knowledge related to end-of-life protocols? The purpose of this DNP project was to educate hospice and palliative care nurses on evidence-based EoLC protocols.

Sources of Evidence

A comprehensive literature review search was done using the following databases: MEDLINE, OVID, and PubMed, using the following search terms: *palliative*

care, hospice care, comfort care, end-of-life care, and *end-of-life protocols*. Inclusion criteria included full-text articles with abstract, publication date less than five years, systematic and other literature reviews, randomized controlled trials (RCT), and written in English. Exclusion criteria included cohort studies, case studies, observational studies, and non-experimental studies. The Boolean search strings were AND /OR. The keyword search included the terms*: comfort, end-of-life, palliative care,* and *hospice care*. Surrogate terms for comfort included *caring, ease, relief, satisfaction, support,* and *comfortable.*

Using the keywords, I identified 723 articles. There were 12 articles on comfort/end-of-life, 12 articles on palliative care/end-of-life, and 72 articles on hospice care/end-of-life. I identified (5) articles on comfort care/end-of-life; comfort/end-of-life (8); comfort/palliative care (12); palliative care/end-of-life (157), 437 articles on comfort/end-of-life, and eight articles for end-of-life protocols.

Experts on evidence-based practice recommended searching for the highest level of evidence to guide patient care and ensure the best possible patient outcomes (Maricopa, 2017). Levels of evidence appearing high within the pyramid, assure the researcher that the intervention will produce the target health effect (Stevens, 2015). Valid and reliable research provides the best evidence for clinical decisions (Stewart & Denisco, 2015). Evidence sources rank according to the strength of evidence they provide (Polit & Beck, 2018).

I generated evidence using the results of the demographics, pre-and post-test. I analyzed and evaluated the descriptive statistics to answer the question: Does a nursing staff education program for hospice nurses increase knowledge of end-of-life protocols?

Evidence Generated for the Doctoral Project

Participants

Evidence-based staff education on end-of-life protocols was done after receiving approval from the facility and Walden University IRB and consulting with experts for input concerning the education. Participation in the education program was voluntary and there was no patient involvement. Consent for an anonymous self-assessment questionnaire was provided to determine knowledge gained from the staff education program and to indicate which behaviors respondents were likely to adopt after the staff education program. Eighteen nurses had the opportunity to participate in the education. The ability to participate was voluntary and participants could withdraw from the project at any time. The participants signed a form that indicated their willingness to participate (Appendix A)

To ensure confidentiality I used a coding system to link the pre-and post-test scores in the place of names. The participants were given a pre-and post-test. The education was presented via a PowerPoint presentation. A paired *T*-test was used to analyze the data.

Procedures

Developing the program content was the first step of the project with input from the nursing supervisor. The content of the program was presented through a 30-minute PowerPoint on EoLC protocols. The ELNEC Module 8 was used as a guide to developing the education program. I focused on Kolcaba's three forms of comfort. A 10-question multiple-choice questionnaire was administered as a pre-and post-test to assess the nurse's attitudes and knowledge before the EoLC protocol education training.

Thirty-minute educational sessions were offered at different times to accommodate the nursing staff. Participation was voluntary. The multiple-choice questionnaire was administered to assess knowledge gained from the staff education content and presentation and to indicate which behaviors respondents are likely to adopt after the staff education program.

Protections

Human subjects were protected. A coding system was used instead of names to link the assessment scores to prevent potential ethical issues that may present problems for the completion of this project. No proprietary, sensitive, or confidential information was disclosed in the doctoral project document. The staff education program consisted of no patient involvement, participation is voluntary, and the name and/or location of the organization will be changed so that it is not identifiable. Approval (12-07-21-0667262) of this project was obtained from Walden University's IRB. The signed site agreement form A was submitted to the Walden IRB.

Analysis and Synthesis

The literature review demonstrated the need for this project. I received IRB approval from the facility and Walden. A staff education program was designed and developed. A knowledge gap existed concerning EoL protocols in a hospice agency in the South Central United States. The nurses at a hospice facility in the South Central United States did not use current evidence-based EoL protocols. Palliative care and EoLC are global health issues. The ELNEC is nationally and internationally recognized for its education on palliative care. The education program was implemented using ELNEC guidelines and input from the nursing supervisor. The staff education program took place

at a local hospice agency in the South Central United States. The staff education program consisted of no patient involvement.

Participation was voluntary, and the name and/or location of the organization was changed so that it was not identifiable. The Walden Staff Education Manual was the guide for this project. The ADDIE model was used to design and develop the curriculum. Training programs that use ELNEC as a guideline provide knowledge and skills required for evidence-based, EoLC protocols to improve palliative care. ELNEC guidelines focus on competencies and recommendations for EoLC and palliative care.

The educational project provided the current evidence-based interventions for EoLC protocols. Education was done via PowerPoint. Education topics included symptom management, communication, comfort, palliative care, pain relief, spirituality, planning, symptom management, lifestyle interventions, and decision support. A 15-item questionnaire was generated from ELNEC. Five of the 15 questions covered demographics. The results of the questionnaire determined knowledge gained from the staff education.

Data collected from the results of the pre and post-tests were analyzed using a paired *T-test* to access knowledge before and after the staff education program.

Summary

In section 3 I reintroduced the practice focus question. A literature review was provided that supported the project. The methodology for this project was described as well as the process for data collection and analysis. In section 4 I present the findings and the recommendations.

Section 4: Findings and Recommendations

Introduction

The fourth section of this project report includes the results and recommendations established from the analysis of the data collected from the hospice/palliative care nurses who participated. My objective for this project is to develop an evidence-based staff education program on EoLC protocols. Educating nurses on EoLC protocols is imperative to make sure that nurses can care for end-of-life patients and to improve nurses' knowledge regarding evidence-based practices of EoLC protocols. The problem is nurses' failure to use evidence-based EoLC practices when providing care to EoL patients. Hospice/palliative care nurses at the site express a lack of knowledge in providing EoLC for their patients. The sources of evidence for this project are results from a literature review and the pre-and post-test used to assess the knowledge of the participants. The pre-education questionnaire is given to the participants before the education program to determine a baseline of knowledge, and the post-education questionnaire is given following the education program to determine if knowledge increased. All information collected on the questionnaires is anonymous.

Findings and Implications

Nine nurses were willing to participate in the education program. Initially, 12 nurses agreed to participate; however, the day before the program started, three of the 12 were unable to participate. The average age of the study participants was 23.5 years. Participants were 33% male and 67% female. Among the participating nurses, 55.56% had an associate degree, 44% had a bachelor's degree, 11% had previous education on EoLC protocols, 89 % had not, 11% had no previous experience with EoL clients and 89

% previously provided EoLC. The demographic details of the study participants are indicated in Tables 1 through 4. Table 5 shows the results of the pre, and post-test questionnaire, and Table 6 reflects the *T-tes*t results.

Table 1

Demographic Information for Hospice/Palliative Care Nurses

N=9	Frequency	Percentage
Gender		
Male	3	33 %
Female	6	67 %
Age		
18- 22 years		
23-27 years	3	33 %
28- 35 years	6	67 %
36- 45 years		
46- 55 years		
56- 65 years		

Table 2

Current Educational Level

	Column A	Column B
Associate degree	5	56 %
Bachelor's degree	4	44 %
Master's degree		
Education beyond master's		
Other (please specify)		

Table 3

Previous Education on EoLC

	Column A	Column B
6 Previous education on end-of-life protocols?		
a) I took a course on end-of-life protocols ___	1	11 %
b) I have not taken a specific course on end-of-life protocols ___	8	89 %

Table 4

Previous Experience with EoLC

	Column A	Column B
3. Previous experience with end-of-life clients?		
a) I have previously provided care for end-of-life/terminally ill clients and their family members ___	8	89 %
b) I have NO experience providing care for end-of-life/terminally ill clients and their family members ___	11	11 %

Table 5

Pre- and Posttest Results of Knowledge Assessment

Item	Pretest		Post-test	
	N	%	N	%
1. Recognize early predictive signs of death	8	88.9	9	100.0
2. Aware of late signs that increase the likelihood of death within 3 days	9	100.0	9	100.0
3. Use Prognostic tools	6	66.67	9	100.0
4. Perform End-of-life assessment	9	100.0	9	100.0
5. Signs of bereavement needs	7	77.78	9	100.0
6. Provide caregiver support	6	66.67	9	100.0
7. Signs of spiritual distress	4	44.44	9	100.0
8. Provide resources and services to the family	7	77.78	9	100.0
9. Rationalize treatments	9	100.0	9	100.0
10. Nursing role in EoLC	8	88.89	9	100.0

The descriptive statistics on the pre and post-test results indicate an improved level of knowledge in the hospice/palliative care nurses on EoLC protocols.

Table 6

T-test Results

Item	Pretest Correct	Posttest Correct	
1	88.89	100	
2	100	100	*t-test* paired 0.003773063
3	66.67	88.89	
4	100	100	
5	77.78	100	
6	66.67	100	
7	44.44	100	
8	77.78	100	
9	55.56	100	
10	88.89	100	
n=9			
M	76.668	98.889	*t-test* (unpaired) 0.001514994

The result of the student *T-test* showed a *p*-value of 0.0038. This is smaller than 0.05 and is therefore statistically significant. The specific questions that demonstrated the significance of the nursing education program were the questions that evaluated the nurse's knowledge concerning prognostic tools, bereavement needs, caregiver support, and signs of spiritual distress, providing resources and services to the client's family. These data indicate that a nursing staff education program improved nurses' knowledge of EoLC protocols.

A potential and unanticipated drawback is the small number of nursing staff, which reduced the generalizability and transferability of the findings. Another potential constraint was low participation in nursing staff education programs aimed at increasing knowledge about EoLC protocols. Additionally, data on the nursing staff's knowledge and skills were obtained via questionnaires, which presented a potential constraint in terms of misinterpretation of the questions and the chance of dishonest answers impairing the project's validity. Despite the study's low participant turnout, potential social ramifications of the findings include greater knowledge about EoLC protocols. These are critical because they will potentially result in an improvement in patient outcomes and QoL.

Recommendations

This DNP project findings support a recommendation for continued education of hospice/palliative care nurses in EoLC protocols. Measures to provide EoLC protocols can be individualized. These measures are patient-related and healthcare-related. This project also supports a recommendation to use EoLC protocols.

Contribution of the Doctoral Project Team

The medical director, the nursing supervisor, and the nurse educator were all members of the project team. They aided in the planning and implementation of the EoLC staff education program. The hospice agency's nursing team was involved in expressing their familiarity with patient problems and complaints. Their responsibility was to attend the scheduled education program and contribute to the project's evaluation. The medical director, nursing supervisor, and nurse educator were involved in determining the project's acceptability for the hospice service. Additionally, they

established the project's times, and the director of nursing assisted with scheduling and arranging staff attendance. The entire doctoral project team was involved in determining the effectiveness of the nursing staff education program, and their primary goal was to improve EoLC at the hospice agency. The medical director, nursing supervisor, and nursing educator will be involved in future approval of recommended policies or practices, such as continuing education of nursing staff to enhance their knowledge and abilities in EoLC protocols.

Strengths and Limitations of the Project

The project's strength is that it established that the nursing education program increased nurses' knowledge of EoLC protocols. The study population consisted of hospice/palliative care nurses employed by a hospice agency in the South Central United States. As a result, the findings of this study contribute to the existing body of knowledge regarding EoLC protocols. An unexpected disadvantage was the study's limited sample size of only nine nurses. This resulted in a severe loss in generalizability and transferability. The data collecting questionnaires took the nurses roughly five minutes to complete. The low enrollment rate in the study population was unforeseen. Unpredictably, the study was limited by the absence of three nurses who were unexpectedly unable to participate. The missing data were omitted from the data analysis. Another drawback of the study was that the questionnaires were self-administered, and consideration was not given to the participants' trustworthiness, proposing a potential bias that could impair the validity of the data.

Section 5: Dissemination Plan

The results of the project are disseminated to the medical director, nursing supervisor, and nurse educator of the hospice agency. The project team included the stakeholders of the project and they were involved from its start to completion. They were therefore informed of the developments, progression, and results of the project. The presentations to the stakeholders on the project results and recommendations that can be implemented to improve EoLC were at a staff meeting. All participants are allowed to ask questions and voice their concerns and recommendations. The recommendation included implementing EoLC protocols. The dissemination of the project results is important for the quality of care for EoL. These results were disseminated to the nurses as well using a PowerPoint presentation. I plan to publish a report on selected websites and peer-reviewed journals to indicate that a nursing staff education program increased knowledge of EoLC protocols among hospice/palliative care nurses. These publications will follow the outlines given by the selected websites and journals to reach a wider audience in the nursing profession. I plan to present the project findings in local and state conferences and workshops and BSN level programs.

Analysis of Self

EoLC protocols are a worldwide healthcare concern, as it results in clients receiving evidence-based quality care. The focus of the DNP project is on educating hospice/palliative care nurses on evidence-based EoLC protocols within a hospice agency in South Central United States. This DNP project was guided by the following question: Does a nursing staff education program for hospice nurses increase knowledge related to end-of-life protocols? My role in this project involved educating the nursing staff at the

hospice agency on the importance of current evidence-based EoLC protocols. I used my formal pedagogy along with contributions from experts to prepare and deliver the educational content. As a doctoral-level nurse, I executed a review of literature from peer-reviewed journals and publications and synthesized and analyzed it. I facilitated the planning, implementation, and evaluation of the staff education program. Findings suggest that increased knowledge can improve EoLC for chronic and terminally ill clients. I will disseminate results to ensure other nurses remain up to date with the latest EoLC protocols.

Summary

The number of people who are seriously ill is increasing. EoLC will always be required in hospice/palliative care facilities. Some nurses were not using EoLC protocols. The focus of my DNP project is on a local hospice/palliative care agency in South Central United States. The nursing staff at this agency were not using current evidence-based EoLC protocols. This contributed to a lack of quality care. The results of the project data were used to evaluate whether a nursing staff education program would increase the staff's knowledge of EoLC protocols. The findings indicated that a nursing staff education program effectively increases the knowledge of the nursing staff in EoLC protocols. Therefore, staff education on EoLC protocols can improve the quality of care for clients who are chronically or terminally ill; however, further studies are needed to determine specific improvements.

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Appendix A: ELNEC Guidelines

Table 1 ELNEC modules

Module	Curriculum topics	Overview
Module 1	Introduction to palliative nursing	This module creates the foundation for the ELNEC-International curriculum. It is an overview of the need to improve palliative care and the role of the nurse as a member of an interdisciplinary team in providing quality care. Basic definitions and principles of hospice and palliative care are presented within a quality of life (QOL) framework, assessing not only physical needs, but psychological, social, and spiritual domains, too
Module 2	Pain management	This module reviews basic principles of pain assessment and management with a focus on pain at the end of life
Module 3	Symptom management	This module builds on the pain management module, by addressing other symptoms common in advanced disease and the role of the nurse in managing these symptoms
Module 4	Ethical issues	This module discusses some of the key ethical issues and legal concerns in end-of-life/ palliative care and resources to address these in practice.
Module 5	Cultural and spiritual considerations	This module reviews dimensions of culture, which influence care in advanced disease. Cultural and spiritual assessments are emphasized as essential to adequate communication and in providing culturally competent care
Module 6	Communication	This module emphasizes the importance of good communication in end-of-life care. The complexities of communicating with patients and families at this critical time are described along with suggestions for care
Module 7	Loss, grief, and bereavement	This module addresses loss, grief, and bereavement issues for patients, their families, and the nurses who provide this care.
Module 8	Final hours	This module focuses on care at the actual time of death, emphasizing the preparation necessary to insure the best care at this critical event in the trajectory of illness

ELNEC, End-of-Life Nursing Education Consortium.

Appendix B: Demographics Questionnaire

Pretest and Post Questionnaire for End-of-Life Protocol Education

1. What is your gender?

   Male ____ female ____ other _____ prefer not to respond _____

2. What is your age?

   18- 22 years ___

   23-27 years ___

   28- 35 years ___

   36- 45 years ___

   46- 55 years ___

   56- 65 years ___

   66 years and over ___

3. What is your educational level?

   High school equivalency (GED) ___

   Associate degree ___

   Bachelor's degree ___

   Master's degree ___

   Education beyond master's ___

   Other (please specify) ___

4. Previous education on end-of-life protocols?

a. I took a course on end-of-life protocols ___

b. b. I have not taken a specific course on end-of-life protocols ___

5. Previous experience with end-of-life clients?

a. I have previously provided care for end-of-life/terminally ill clients and their family members ___
b. I have NO experience providing care for end-of-life/terminally ill clients and their family members ___

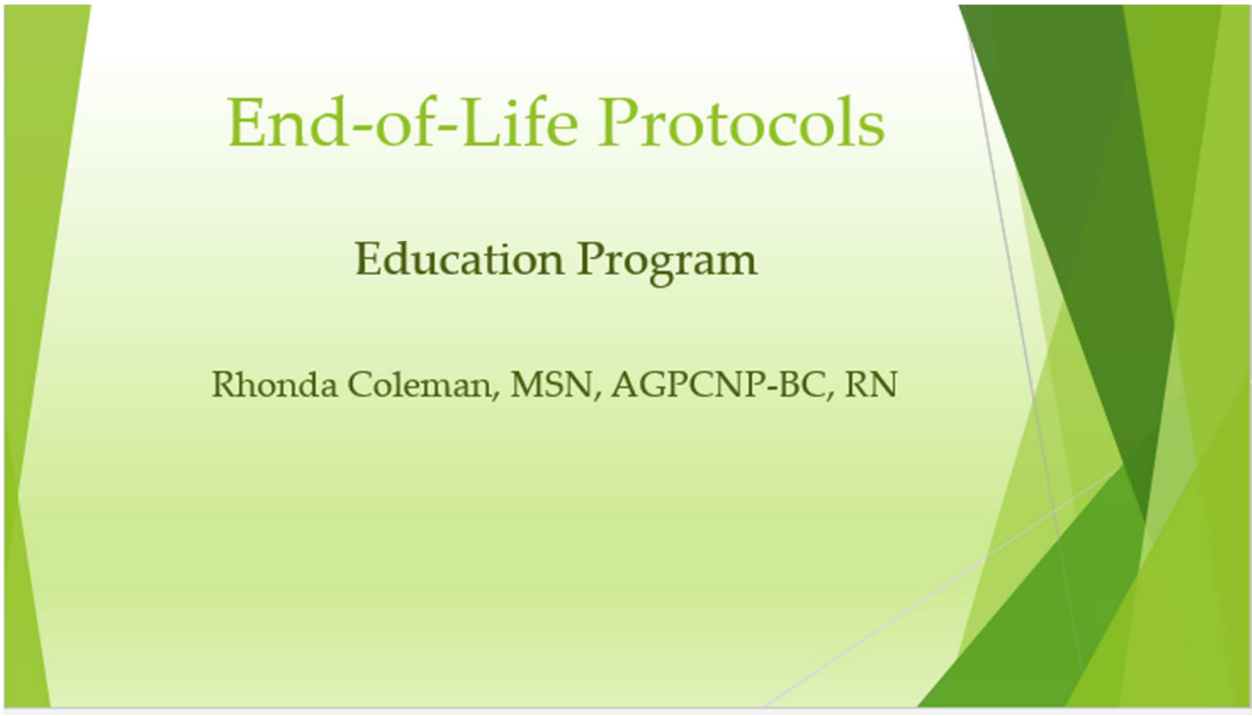
Appendix C: Pre- and Posttest Questionnaire

Multiple Choice

6. An early predictive sign of death is a) Cheyne-Stokes respirations; b) vocal fold grunting; c) Palliative Performance Scale 20%?
7. Late signs increasing the likelihood of death within 3 days include: a) urine output < 100ml in 12 hours; b) reduced conscious state; c) food intake minimal-to-none?
8. Prognostic tools include a) Palliative Performance Scale; b) Glasgow Coma Scale; c) Karnofsky Performance Status?
9. End-of-life assessment includes a) spiritual distress; b) drug dependence; c) socioeconomic status?
10. Signs of bereavement needs include: a) death; b) lack of spirituality; c) factors influencing vulnerability to poor outcomes?
11. Providing caregiver support includes a) use of prognostic tools; b) screening for psychosocial distress; c) financial support?
12. Signs of spiritual distress include a) normal feelings of vulnerability; b) lack of support; c) grieving?
13. Providing resources and services to the family includes a) being aware of culture; b) financial support; c) assessing social factors?
14. Rationalized treatments include a) oxygen administration; b) pain medication; c) discontinuation of treatments?

    Nursing end-of-life care includes a) shared decision making; b) patient prognosis and risk-benefit assessment; c) managing spirituality

Appendix D: End-of-Life Protocol PowerPoint



Learning Objectives

- After taking this course you should be able to:

- Assess and diagnose impending death or dying
- Set goals of care following MDT holistic assessment
- Rationalize treatments
- Manage symptoms
- Provide care
- Re-assess and respond
- Care of family in bereavement (spiritual, psychological, and social

End-of-Life Protocols

- Provide physical comfort
- Manage symptoms
- Manage mental and emotional needs
- Assess spiritual needs
- Assess psychological issues
- Assess bereavement needs
- Provide support for caregiver
- Communicate with family
- Provide resources and services for family
- Get a Legal Pronouncement of Death
- Make Arrangements for After Death

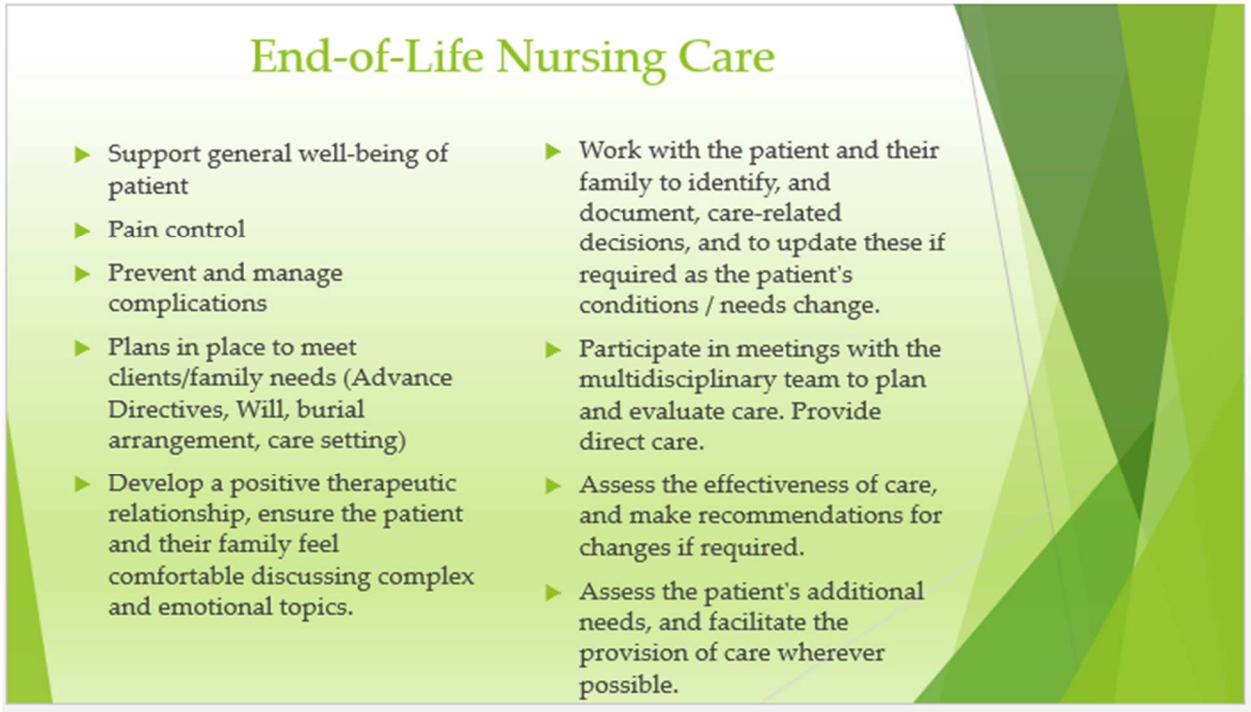
Why End-of-Life Protocols?

- Improve care and safety for patients and families
- Sets expectations for providers
- Guides clinical decision making
- Promotes standardization
- Creates a foundation for accountability
- Provide the essential elements for standards, policies and best practices

The goal of care at EoL is comfort and offering a personalized and individualized management of quality.

Legal and Ethical Issues

- Confidentiality
- Right to refuse
- The provision of artificial nutrition and hydration
- Withholding or withdrawing other life-prolonging treatments
- Organ and / or body donation.


End-of-Life Nursing Care
Support general well-being of patient
Pain control
Prevent and manage complications
Plans in place to meet clients/family needs (Advance Directives, Will, burial arrangement, care setting)
Develop a positive therapeutic relationship, ensure the patient and their family feel comfortable discussing complex and emotional topics.
Work with the patient and their family to identify, and document, care-related decisions, and to update these if required as the patient's conditions / needs change.
Participate in meetings with the multidisciplinary team to plan and evaluate care. Provide direct care.
Assess the effectiveness of care, and make recommendations for changes if required.
Assess the patient's additional needs, and facilitate the provision of care wherever possible.


End-of-Life Nursing Care cont'd
Research and recommend standards and alternative care options for the patient.
Work collaboratively with the multidisciplinary team to facilitate the patient's preferred options for care, where available and to the greatest extent possible.
Advocate for the patient to be cared for in the place of their choice, receiving care of their choice.
Educate the patient and their family about the condition, its prognosis, the goals of treatment, the intended outcomes and the likely progression to death, etc.
Anticipate the patient's future care needs
Ensure the patient is appropriately positioned, to ease their discomfort
Mouth and eye care
Bladder and bowel care
Withhold and withdraw life-sustaining treatments guided by the patient's wishes.
Ongoing management of symptoms

Signs that death has occurred

- ❑ The pupils become fixed and dilated.
- ❑ There is an absence of heart sounds.
- ❑ There is an absence of respiratory effort.
- ❑ There is no pulse.

Early Predictive Signs of Death

>1 week before death, may include

- ➢ Reduced conscious state
- ➢ Palliative Performance Scale 20%
- ➢ Dysphagia for liquids.

Late signs

Late signs increasing likelihood of death within 3 days include

- Non-reactive pupils
- Pulselessness of the radial artery
- Urine output

Prognostic Tools

- Palliative Performance Scale
- Palliative Prognostic Score
- Palliative Prognostic Index
- Glasgow Prognostic Score.

End-of-life Assessment

- Vital Signs
- Intake and output
- Pain level
- Patient wishes
- Spiritual needs
- Psychosocial support to the family/caregiver
- Signs of bereavement
- Nutrition
- Hydration

Signs of Bereavement

- Nausea
- Loss of appetite
- Trouble sleeping
- Anger
- Guilt
- Anxiety
- Sadness
- Despair
- Sleeping problems
- Changes in appetite
- Physical problems or illness

Providing Caregiver Support

- Evidence-informed information on grief
- Written material including braille
- Websites
- Telephone help lines
- Information events or
- Face-to-face contact with members of the PC team and being aware of culture, faith and language

Signs of Spiritual Distress

- Normal feelings of vulnerability
- Sadness and fear
- Depression
- Anxiety
- Panic
- Social isolation
- Existential spiritual crises

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