2022

# End-of-Life Education for Long-Term Care Nurses

Naquita Altidor Jacques
*Walden University*

# Walden University

College of Nursing

This is to certify that the doctoral study by

Naquita Jacques

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. Lynda Crawford, Committee Chairperson, Nursing Faculty
Dr. Janine Everett, Committee Member, Nursing Faculty
Dr. Eric Anderson, University Reviewer, Nursing Faculty

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

Walden University
2022

Abstract

# End-of-Life Education for Long-Term Care Nurses

by

Naquita Jacques

MSN, Western Governor University, 2013

BSN, Long Island University, 2008

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2022

# Abstract

Long-term care (LTC) nurses play a crucial role in preserving the quality of life of terminally ill patients. However, many identify deficits in skills, education, and training for end-of-life (EOL) care. The objective of this project was to educate LTC nurses caring for individuals reaching the end of their lives on EOL care. The practice-oriented question concerned whether an evidence-based educational program improved nurses' knowledge related to EOL care and confidence in caring for EOL patients and families. The End-of-Life Nursing Education Consortium's evidence-based educational module was used to provide the content. Rosswurm and Larrabee's model for change to evidence-based practice was the conceptual framework supporting project development and dissemination. Twenty nurses at the project site participated in the educational program and performed a pre- and post-test to assess the impact, if any, of EOL care education on their knowledge, competence, and confidence in caring for patients and families with serious illness. Pre-PCQN group values were lower (Mdn = 9) than post-PCQN group values (Mdn = 18.5). The Wilcoxon test showed a statistically significant difference between the two groups, $p$ =.001. The project findings support the need for improvement in the EOL education of the facility's nurses, and it is recommended that the PowerPoint training be incorporated into the facility's orientation program for all new nurses and offered annually to current nurses. The staff education may bolster nursing staff's knowledge, attitudes, and application of EOL concepts to their practices. The potential implications for positive social change include enhancing EOL care for patients and increasing the confidence and job satisfaction of nurses.

# End-of-Life Education for Long-Term Care Nurses

by

Naquita Jacques

MSN, Western Governor University, 2013

BSN, Long Island University, 2008

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2022

# Dedication

This project is dedicated to my mother, who has been my greatest supporter. I began this adventure as a result of a diagnosis of an autoimmune illness that attacked my muscle cells. Consequently, I was unable to execute my duties as a nurse, such as hanging IV bags, and qualified for long-term disability. Throughout my acute period, I was bedridden and unable to walk. I believed my nursing career was over. Nonetheless, despite my challenging time, I was motivated to get a doctorate and become a professor. As the doctors discussed the potential of my death, everyone around me thought it was a bizarre idea that I wanted to pursue my doctorate.

During my time as a patient, I observed that the nurses were understaffed, overworked, task-focused, irritated, and rushed, and I felt neglected. My mother was responsible for my care when I was hospitalized. I got Stage 2 pressure ulcers because I was constantly in a supine position. The nurses were too busy to evaluate me from head to toe. No one changed my position every 2 hours. In fact, the majority of nurses were unaware of my medical condition, so I had to explain it to them.

As soon as I felt better, I applied for a position as a nursing instructor and began instructing the next generation of nurses. I intend to serve on the board of nursing as a nurse executive or legal nurse. I believe nurses operate in the healthcare industry without assistance or support. I intend to support nurses.

# Acknowledgments

I would like to thank several people, without whose patience and assistance this project would not have been completed. I wish to thank Dr. Lynda Crawford, my DNP advisor, whose encouragement and assistance I appreciate. I would not have obtained my degree without her direction and critique. She is an outstanding instructor with a wonderful spirit.

I would also like to thank my mother, who encouraged me to persevere throughout the process. In addition, I would like to thank the director of nursing for granting me permission to utilize the location for the project, which was my greatest obstacle.

Table of Contents

List of Tables ........................................................................................................ iv

Section 1: Nature of the Project ....................................................................1

Introduction ............................................................................................1

Problem Statement ..................................................................................2

Purpose ...................................................................................................5

Nature of the Doctoral Project ................................................................7

Significance ..........................................................................................10

Summary ...............................................................................................13

Section 2: Background and Context ...........................................................15

Introduction ..........................................................................................15

Concepts, Models, and Theories ..........................................................16

Relevance to Nursing Practice ..............................................................21

Local Background and Context ............................................................24

Role of I DNP Student ..........................................................................24

Role of the Project Team ......................................................................26

Summary ...............................................................................................27

Section 3: Collection and Analysis of Evidence ..........................................29

Introduction ..........................................................................................29

Practice-Focused Question ...................................................................29

Sources of Evidence .............................................................................30

Participants ...................................................................................... 31

Procedures .......... 32

Protections .......... 36

Analysis and Synthesis .......... 37

Summary .......... 38

Section 4: Findings and Recommendations .......... 40

Introduction .......... 40

Findings and Implications .......... 40

Pre- and Posttest Results for the Palliative Care Quiz for Nursing .......... 41

Pre- and Posttest Results for the Frommelt Attitude Toward the Care of the Dying Scale .......... 47

Recommendations .......... 50

Strengths and Limitations of the Project .......... 52

Section 5: Dissemination Plan .......... 54

Analysis of Self .......... 54

As a Scholar .......... 54

As a Practitioner .......... 55

As a Project Manager .......... 56

Summary .......... 57

References .......... 59

Appendix A: Permission to Use the Palliative Care Quiz for Nursing .......... 78

Appendix B: Permission to Use the Frommelt Attitude Toward the Care of the Dying Scale .......... 80

Appendix C: Palliative Care Quiz for Nursing ....81

Appendix D: Palliative Care Quiz for Nursing Answers ....84

Appendix E: Frommelt Attitudes Toward Care of the Dying Scale ....87

# List of Tables

Table 1. Demographics of Participants (*N* = 20) ..............................................................41

Table 2. Descriptive Statistics for Palliative Care Quiz for Nursing (PCQN)..................42

Table 3. Distribution of Nurses' Knowledge About Palliative Care on the Palliative Care Quiz for Nursing (PCQN) Scale..............................................44,45

Table 4. Wilcoxon Signed Rank Test for PCQN...............................................................46

Table 5. Wilcoxon Rank Test Statistics for PCQN...........................................................47

Table 6. Descriptive statistics for FATCOD-B..................................................................48

Table 7. Descriptive statistics for FATCOD-B..................................................................49

Table 8. Wilcoxon Signed Rank Test for FATCOD-B.....................................................50

Table 9. Wilcoxon Rank Test Statistics for FATCOD-B ..................................................50

# Section 1: Nature of the Project

## Introduction

Long-term care (LTC) facilities are becoming the final resting places for an increasing number of elderly individuals, who are generally the most vulnerable members of society. The number of people in the United States who are in need of long-term support services is estimated to be 14 million (Hado & Komisar , 2019). In the United States, about one-fourth of chronic illness-related fatalities occur in skilled nursing facilities, and this proportion is projected to rise to 40% by 2030 (Hado & Komisar , 2019). In LTC settings, nurses have a crucial role in preserving quality of life, including coordinating care with an uncertain prognosis, facilitating residents' preferences in end-of-life (EOL) care decisions, and controlling symptoms. In practice, however, LTC nurses regularly describe widespread gaps in EOL care skills, education, and training (Bergman et al., 2014; Chan et al., 2016; Gilissen et al., 2017; Ho et al., 2016; Karlsson et al., 2017). Barriers like a lack of education or experience still come into play, but they can be overcome when nurses start using palliative care (Gibbs et al., 2015).

The purpose of this Doctor of Nursing Practice (DNP) project was to educate nurses caring for individuals reaching the end of their lives in an LTC facility about EOL care. The potential positive social change implications of the project stem from improvements in the nursing staff's knowledge, attitudes, and application of EOL concepts to their practices. Research shows that staff education enhances EOL care for patients and boosts the confidence of nurses, research shows (Hodgkinson et al., 2018). This project established a framework for proactive patient and caregiver needs assessment by health professionals. Improving confidence to initiate discussions about EOL care is vital because patient satisfaction with care increases when health providers immediately initiate discussions about EOL care (Leung et al., 2012). Ultimately, the project could result in positive social change that improves the quality of patient care and makes nurses happier at work.

## Problem Statement

Patients in LTC might benefit from palliative care, which is a relatively new specialty, but these treatments are frequently not provided in LTC facilities (Frey et al., 2019). The goal of the palliative care approach is to improve the quality of life for people who are managing life-limiting illnesses by preventing and relieving suffering. This is accomplished through early identification, assessment, and treatment of pain, in addition to the treatment of other physical, psychosocial, and spiritual issues (World Health Organization, 2013). In the context of LTC facilities, EOL care plays an important part in enhancing both the quality of life and the quality of death for people who are battling degenerative illnesses that restrict their lifespan. In the past, those working in the healthcare industry have acknowledged the need for expanded educational opportunities related to EOL care and have expressed concern over their inability to provide patients with palliative care of the highest quality (Aboshaiqah, 2019; Achora & Labrague, 2019; Teno et al., 2018). Professionals in the healthcare industry are in agreement that there is an urgent requirement for additional training in palliative care (Kim, Lee, & Kim, 2020; Lupu et al., 2018). It has been demonstrated that providing education on EOL care to staff nurses can increase the knowledge base of healthcare workers. (Harasym et al., 2021).

Another issue is that Medicare does not provide reimbursement for palliative care treatments provided by LTC institutions (Mor & Teno, 2016). Medicare's coverage of LTC services is restricted to specific types of care under specific conditions. Pay-per-service (FFS) At present, Medicare Part A only provides facility-based LTC coverage for skilled nursing services and various types of therapy if the beneficiary: 1) has a hospital admission with an inpatient stay of at least three days; 2) is admitted to a Medicare-certified skilled nursing facility (SNF) within 30 days of that hospital admission; and 3) a doctor prescribes such services as necessary to treat an illness or injury. Medicare Part A also covers the cost of long-term care hospital services. However, some institutions are reserved for patients with serious health issues that require long-term hospitalization. They do not give the type of care typically referred to as "Long-Term Care," which is assistance with daily duties.

Even if patients require palliative care or hospice care, the facility is not allowed to bill them for those types of services. Patients who are admitted to a skilled nursing facility with an advanced illness are eligible for rehabilitative therapy under Medicare Part A, but they are not eligible for palliative care in this program (Harris-Kojetin et al., 2016). For instance, LTC facilities, for instance, receive more compensation for residents who are fed through tubes as opposed to those who are fed by hand (Mitchell et al., 2004). Additionally, laws that assist surveyors in evaluating the quality of treatment may also be a barrier to the administration of comfort care to patients who are nearing the end of their lives. A major component of palliative care is the management of domains, which can include weight loss, functional decline, and the use of antipsychotic medicine, which are the focus of surveyors. (Harris-Kojetin et al., 2016; Mitchell et al., 2004) For example, some nursing homes worry that if they let patients keep dieting until the end of their lives, they might get a bad review from surveyors.

In addition, Medicare does not provide any financing for palliative care, which means that patients in LTC institutions cannot receive palliative treatment (Mor & Teno, 2016). As a consequence of this, nurses working in LTC facilities have a tendency to transport patients to hospitals for emergency treatment whenever patients exhibit severe symptoms such as hypotension or shortness of breath (Laging et al., 2015). The unnecessary and preventable overuse of severe medical intervention and life-sustaining therapy is a problem that must be addressed (Ouslander, 2019). These treatments are frequently ineffective from a medical standpoint, which results in a waste of resources as well as money. On the other hand, this has resulted in patients experiencing poorer well-being quotients in the final stages of their lives (Teno et al., 2018). Palliative care or hospice care may be used instead of hospital treatment at the EOL if greater care planning is done in advance to avoid unneeded and uncomfortable hospital care at the EOL (Ouslander, 2019).

This doctoral project may yield insight that helps nursing staff and leaders to promote a painless, peaceful, and dignified passing for patients. Conversations that are part of EOL care are intended to assist individuals in making emotional and spiritual preparations for passing away, thereby facilitating a transition from what has been (life) to what will be death (Alftberg et al., 2018). People who are on their deathbeds should be given the opportunity to communicate their desires, needs, and emotions, as well as gain perspective on their impending passing. If instruction on EOL care was provided in LTC facilities themselves as opposed to being outsourced to emergency units, many patient issues might become less severe or more manageable. Greater knowledge about on the part of their caregivers may lead to an improvement in the patients' quality of life and death.

## Purpose

EOL education for nursing staff is becoming increasingly important in LTC institutions due to the lack of palliative and hospice care options available in these facilities (Mor & Teno, 2016). In addition, the Institute of Medicine (2014) highlighted the difficulty that exists for healthcare professionals across the continuum of care in terms of improving their understanding of palliative care. Therefore, giving EOL education to patients and their families is one option to remove the challenges to integrating palliative care into the management of the chronic and debilitating diseases that patients and their families encounter (Aldridge et al., 2016). This education trained nurses to become healthcare professionals and advocates for their patients, which may enable them to help their patients maximize their quality of life and have a peaceful death. Education about EOL care should be incorporated into LTC facilities so that patients and the family members or other caregivers can have a calm and painless passing (Spetz et al., 2016).

EOL care also has the goal of improving the quality of life for patients and their families who are managing advanced illness (World Health Organization, 2018). This is accomplished by providing relief from symptoms such as pain, shortness of breath, exhaustion, and depression. Palliative care offers patients and their families emotional and practical assistance as they make final preparations for death. It also makes it possible for decisions to be made in an open and honest manner, affirms the patient as a whole person, and provides opportunities to take stock of one's life and spend time with loved ones (Alftberg et al., 2018). Because of these factors, the Institute of Medicine (2015) suggested that EOL care be made available to all people living in the United States who were suffering from terminal illnesses.

This doctoral project addressed the meaningful gap in practice between the level of education regarding EOL care among nurses at the local long-term facility and the need for additional EOL knowledge, as identified during the need assessment. The gap was found to exist between these two factors. This project addressed that gap in practice, enhancing the knowledge level of nurses during the EOL, which may help to improve the quality of life and the process of dying for patients. This goal was accomplished by the development of an evaluation plan, the implementation of an evidence-based education program to increase nurses' knowledge level in providing care for terminally ill patients, and the implementation of a program to increase nurses' knowledge level in providing care for terminally ill patients. The practice-focused question for this project was, Does an evidence-based educational program for nurses working in an LTC facility improve nursing knowledge related to EOL care and confidence in caring for EOL patients and families?

## Nature of the Doctoral Project

I acquired the evidence for this doctoral project by conducting a comprehensive, systematic literature review, which included the following search engines and databases: CINAHL, Medline, and PubMed through Walden University Library, ProQuest, and Cochrane Database. I reviewed the literature for background information on the topic and evidence to inform the construction of the content and the pre-and post questions. I used the Johns Hopkins (JHNEBP; Newhouse et al., 2007) model in this DNP project to organize and assess the evidence. This model provided a methodical strategy for identifying, evaluating, and synthesizing the evidence. Using a defined scoring system, I evaluated the evidence's strength and quality. The evidence was ranked from Level I, representing the strongest evidence, to Level V, representing the weakest, per the JHNEBP evidence rating scheme. The evaluated studies were evaluated based on their outcomes, sample size, controls, conclusions, recommendations, literature review, and scientific evidence. Using the JHNEBP approach, an evaluator classifies evidence as research or non-research and then ranks it accordingly. Articles at the I, II, and III levels are regarded as research articles. Nonresearched items are categorized as either Level IV or V.

After I had collected all of the data, I compiled the bibliographic sources and citations using a Microsoft Excel spreadsheet. This allowed me to easily arrange, record, and manage the sources. In the Excel spreadsheet, I noted the author, title, URL, level of evidence, and a synopsis of the best practices. I also kept all of the pertinent articles there.

In the resulting educational effort, I instructed facility nurses on the assessment and management of pain, the management of geriatric symptoms, and the importance of communication. The personnel attending the education received training on thorough pain assessment and the therapy of geriatric symptoms as a result of this project. Communication is complicated, but having difficult conversations about death and dying can be especially challenging (Dahlin & Wittenberg, 2019). This education project provided an overview of fundamental ethical concepts and principles in the context of determining care objectives for older adults. Furthermore, it provided information on the rationale for advance directives as well as the various types of advance directives that are most commonly used.It also discussed the application of ethical decision-making in relation to the aims of care and advance directives. It covered ethics, which is a subfield of philosophy that has many important implications for the work that nurses do. It is essential to It is consistent with the approaches that assist older adults on their path toward death. Providing care that is in line with an older person's values and objectives is the most important factor in ensuring that they will have a good death (Matey, 2018). Because of its importance in delivering beneficial EOL care to elderly people, I included discussion of cultural and spiritual themes in the project. In the end, there was a discussion of loss, grief, mourning, bereavement, as well as a variety of views regarding grief and different categories of grief.

Throughout the course of this project, the participants and I discussed numerous essential interventions that can be used to assist elderly mourners and their families. Grief is something that everyone goes through at some point in their lives, regardless of factors such as culture, age, economic standing, educational level, or belief system(Rosa 2019). It is essential to keep in mind, when providing care for older individuals, that the individuals, families, and staff members who provide care for them all suffer from sadness (Zheng et al., 2018). The people who worked on this project learned about how to deal with grief and why self-care is important.

I conducted the educational sessions in the auditorium on the third floor of the LTC facility. The auditorium can accommodate 50 people and is equipped with a projector for PowerPoint presentations and a podium for the speaker. Participants could work in groups or independently. The education included

a Microsoft PowerPoint presentation,

- a group discussion,
- handouts of fact sheets,
- a speaker,
- a content evaluation survey, and
- a pretest and posttest.

I delivered the education at a variety of times over the course of 7 days. It was split into two sessions that each lasted for four hours. The nurses gained information on the assessment and management of pain, as well as the management of geriatric symptoms, during the first session. In the second meeting, participants explored EOL care for older individuals, including topics such as communication, ethics, cultural and spiritual considerations, loss, grieving, and mourning. The sessions were planned in such a way as to accommodate everyone on staff. Due to the constraints imposed by social distance requirements amid the COVID-19 pandemic, several of the staff members were also given the opportunity to participate in the session by logging in remotely to their Zoom meetings. These people got their materials ahead of time, and their tests were given during normal business hours while I was there.

For the project, I used a one-group pretest and posttest design to evaluate participants' knowledge and attitudes both at the beginning of the education plan project and after it had been completed. The participants were given a pretest to complete prior to the educational project, which was then followed by the educational program. Afterwards, at the conclusion of the educational project, the participants were required to do a posttest that had the same test items as the pretest.

After collecting the test, I conducted Wilcoxon signed-rank tests to identify differences between pairs of replies before and after EOL education. Because of the ordinal distribution of responses, a nonparametric test statistic was selected. I also utilized Wilcoxon signed-rank tests to compare the median differences between baseline (pretest) and posttest responses. The level of significance was fixed to 0.05.

## Significance

The provision of high-quality palliative care depends on the commitment of institutional administrators to provide the necessary attention and resources (Shu-Wan et al., 2021). When stakeholders do not completely understand the concept of palliative care, they may be reluctant to ensure appropriate staffing and hospice team support to ensure a palliative approach to treatment (Shu-Wan et al., 2021). A lack of stakeholder involvement has led to a lack of advanced care planning, ineffective referral to hospice hospitals, and underuse of palliative care services in LTC institutions (Mor & Teno, 2016). Because of this, older adults who live in LTC facilities are more likely to get poor care at the EOL.

This doctoral project's potential contribution to nursing practice is that it has the ability to improve nurses' understanding of caring for patients during EOL care, which in turn has the potential to alter how patients at the facility experience their final days. Dying is the final phase of a human's existence; as a result, patients depend on their nurses to respect their preferences and intents and to urge them to cultivate their independence and dignity while simultaneously reducing their symptoms and maximizing their comfort. Therefore, in order to offer great care for patients who are nearing the end of their lives, nurses need to have the information, abilities, and attitudes necessary to deliver care that is both competent and compassionate (Shu-Wan et al., 2021). Yet, in the United States, the majority of nurses do not have any sort of professional training in hospice and palliative care (Ashley & Fasolino, 2016). Multiple studies discuss educational deficiencies, heavy staff workloads, and a lack of comfort levels in addressing EOL issues as barriers to providing appropriate nursing care (Aldridge et al., 2016; Ashley et al., 2016; Hodgkinson et al., 2018; Meie et al., 2017; Wiggins, 2016). Because nurses don't know enough, care isn't coordinated well (Harasym et al., 2021; Mor & Teno, 2016).

The lack of information and the amount of discomfort that nurses experience when caring for the dying, as evident from the literature, demonstrates the significance of designing an EOL educational program for nurses. Nurses have reported not feeling adequately equipped to give competent EOL care (Ashley et al., 2016; Holms et al., 2014). At the LTC facility, senior nurses reported that the majority of nurses did not have extensive expertise in this area, which is a practice issue identified by Ashley et al. (2016). The lack of expertise complicates the task of providing appropriate levels of EOL care for patients. In prior studies, nurses agreed that patients and families should be given truthful information about their sickness, but nurses lacked the competence to conduct these discussions (Ashley et al., 2016; Holms et al., 2014). Another important conclusion was that nurses had a lower level of confidence in their ability to alleviate patients’ pain through nonpharmacologic therapies (Aldridge et al., 2016; Ashley et al., 2016). The literature review highlighted the barriers to palliative care that have been cited in the nursing literature. Some of these barriers are that nurses don't have the education and training to meet the needs of this population, that they have a negative view of palliative care, and that there aren't enough people trained to give palliative care (Long, 2019).

The COVID-19 pandemic has revealed persisting obstacles to quality EOL care in LTC institutions for adults. In addition, there were 16,100 nursing facilities in the United States, with 1,7 million beds and an occupancy rate of 86% (Hado & Komisar , 2019). According to the Robert Wood Johnson Foundation (2014), by 2050 there will be 72.2 million senior citizens living in the United States. According to the Foundation, in 2011, $210 billion was spent on LTC, with Medicaid and out-of-pocket spending covering the majority. The aging population will require quality care. Highly educated and skilled nurses are necessary to offer superior EOL care for residents and their families. The poor education of nurses as the first-line caregivers of LTC facility residents facing EOL problems is a cause for worry. This project’s education program established the groundwork for nurses to provide more competent care to dying patients and their families. This project’s potential implications for positive social change include expanding the understanding of nurses caring for terminally ill patients. Educated nurses could provide better care to EOL patients, resulting in enhanced patient and family experiences (Hallman & Newton, 2019). Short-term goals could include making nurses more aware of end-of-life nursing practices and giving them more comfort and confidence so they can talk to terminally ill patients more directly.

## Summary

Some people pass their final years in an LTC facility. However, many nurses do not receive formal education in hospice and palliative care (Ashley & Fasolino, 2016) and frequently do not feel confident or equipped to provide necessary palliative or EOL care (Aldridge et al., 2016; Ashley, et al., 2016; Malloy, et al., 2010; Meie et al., 2017). When delivering palliative care in the LTC context, nurses have stated a need and desire to enhance their knowledge base in order to feel comfortable caring for these terminally ill patients, especially when there is no chance of recovery (Hodgkinson et al., 2018; Wiggins, 2016). To satisfy these needs and solve this care gap, I designed a curriculum centered on general palliative care information, symptom management, and care objectives meetings. Existing research demonstrates that educational programs boost nurses’ awareness of EOL care (American Association of Colleges of Nursing [AACN], 2010). This project enhanced the nursing profession’s understanding and awareness of EOL care. This project  equipped nurses to be healthcare providers and advocates, which may allow their patients to maximize their quality of life and die with dignity.

I describe the application of Rosswurm and Larrabee's model in Section 2. Use of this model was crucial in achieving the objectives and outcomes of the education initiative. This section contains a description of the project’s multidisciplinary team. I elaborate on my involvement in the education program’s implementation, as well as provide a brief summary of the local context. Finally, the relevance to nursing practice is addressed in detail.

# Section 2: Background and Context

## Introduction

The aim of this doctoral project was to address the absence of EOL care education among nurses in an LTC facility in the northeastern United States by developing and evaluating the effectiveness of an EOL care educational program. Numerous studies on the inadequacies of palliative care education in the health professions indicate that nurses are not well versed in palliative care and, as a result, require more adequate education to provide specialized care (Bergman et al., 2014; Chan et al., 2016; Ho et al., 2016; Hoseini & Memarian, 2018). According to the End-of-Life Nursing Education Consortium (ELNEC, 2018), a lack of palliative-care education for nurses and physicians is a significant barrier to providing good palliative and EOL care. In addition, the quality of the health professionals' education often does not match the skills necessary for palliative care (Ho et al., 2016). In palliative care, Patel and Masi (2015) found that people didn't have enough training and education.

Although there are specialists in palliative care, it is essential that all personnel working in these areas feel they have the necessary education to deliver high-quality care (Harris et al., 2016). The Institute of Medicine (2015) report, Dying in America, and Ferell (2018) strongly suggest that palliative and EOL care be accessible to all patients and families in all care settings, including the community environment. Additionally, according to Ferell, palliative care is the responsibility of all disciplines and physicians and is not exclusive to specialist care. Existing research indicates that educational programs increase nurses' knowledge of EOL care (AACN, 2010). Improving palliative care education in all fields can make people more aware of it and make it easier for doctors and nurses to talk to patients and their families about end-of-life care and practice.

I explored the gap between the amount of education on EOL care that nurses at the local LTC facility receive and the amount they perceive as needed. Enhancing nurses’ knowledge of EOL issues can enhance patients’ quality of life and the process of dying. To address the gap in practice, I developed an evidence-based education program to improve the knowledge of nurses who care for dying patients. I also developed an evaluation plan to measure whether the program had an impact on attendees’ knowledge and attitudes. The practice-based question for this project was, "Does an evidence-based educational program for nurses working in an LTC facility improve nurses' knowledge of EOL care and their confidence in caring for EOL patients and their families?"

I begin Section 2 by discussing Rosswurm and Larrabee’s model for change to evidence-based practice (EBP). This methodology was crucial in achieving the objectives and outcomes of the education initiative. This section includes a description of the diverse team that participated in the project. I will elaborate on my involvement in the education program’s implementation. I also offer a brief summary of the local context. At the end of this section, there is a detailed discussion of how this study relates to nursing practice.

## Concepts, Models, and Theories

The conceptual model developed by Rosswurm and Larrabee served as the framework for this effort to convert evidence into practice. I selected this paradigm because it supports clinical expertise and bridges knowledge gaps through theoretical and empirical literature relating to EBP (Rosswurm & Larrabee, 1999). EBP has been shown to improve patient care outcomes and eliminate potentially damaging variances in care delivery systems, which have an impact on quality and costs (Melnyk et al., 2014). The conceptual paradigm of Rosswurm and Larrabee is a viable option for adopting EBP. It gave a clear, easy-to-follow plan for putting the project into action and was made with the clinician in mind.

Furthermore, the Rosswurm and Larrabee models have had positive results in projects translating research into practice. Jones (2008), for instance, sought to determine whether men with known risk factors were being screened for osteoporosis; the researcher used Rosswurm and Larrabee's model for change to EBP. A retrospective chart review was conducted, comparing the screening rates in four categories: those with predisposing primary disease processes, those with previous fragility fractures, those with independent comorbidities, and those who fall into more than one of these categories. Based on the result, Jones determined that men were not screened.

In another project, Mack (2016) designed, implemented, and assessed a motivational interviewing methodology to improve diabetic outcomes and patient satisfaction. The Larrabee model for EBP change was selected as the change framework for the EBP project. Two thirds of the patients who completed the project improved their HA1c over the course of 3 months, and patient empowerment and confidence to make adjustments rose. From the doctor's point of view, the way the patient took care of his or her diabetes and solved problems seemed to have gotten better.

The last example is an EBP intervention to implement a targeted EBP program to increase human papillomavirus vaccination rates among male and female individuals ages 9 to 27 years in a large military family practice clinic (Throop, 2012). The Rosswurm and Larrabee (1999) model was selected as the framework to underpin this EBP project. A multipronged approach that included project and protocol development, a formal education program, and poster reminders was utilized to encourage immunization within the outpatient clinical setting. Throop found out that there was a slight increase in human papillomavirus immunizations at the end of the 3 months (increasing from 59 the month before the intervention to 70 for the 3 months following the intervention), and an increase from 25% to 38% in males receiving the vaccine.

The Rosswurm and Larrabee (1999) conceptual model incorporates EBP and change theory. It also parallels the sequential nursing process, which enhances the possibility that healthcare workers may develop a desire and readiness to alter their practice (Melnyk & Fineout-Overholt, 2005). I incorporated the model’s six steps into the original design of this education initiative. After evaluating the present practice and identifying the need for EOL care education, I was able to determine the need for EOL care education. Because of the COVID-19 pandemic, the number of people who have died at this nursing home has gone up by a lot.

During this public health emergency, worldwide health care systems have witnessed an exponential increase in the demand for palliative care, with an urgent need for palliative care nurses (Etkind et al., 2020; Knaul et al., 2020; Radbruch et al., 2020). This facility has not provided adequate palliative care for the terminally sick and dying (with or without COVID-19) and their loved ones. Numerous nurses at the facility reported that residents did not always receive narcotic medications as prescribed because the nursing staff lacked confidence and comfort administering narcotics to this group. The majority of nurses have said that it was challenging to manage the symptoms of terminally ill patients. When faced with a circumstance requiring a painful dialogue with patients and their families about their deteriorating condition, they felt unprepared. As a result, there has been an undue reliance on invasive medical care and unnecessary hospital transfers for EOL patients. Nurses from various disciplines must learn a variety of skills that are typically reserved for palliative care practitioners (Rosa & Davidson, 2020).These include taking care of symptoms, making decisions and talking about them in important clinical situations, and end-of-life care.

The second step of the Rosswurm and Larrabee (1999) framework encompasses identifying interventions, activities, and outcomes. In this doctoral project, I explored the significant gap between the amount of education on EOL care among nurses at the local LTC facility and the indicated need for further EOL knowledge. This DNP project has the ability to address this gap in practice by increasing the level of knowledge of nurses caring for patients during the EOL, consequently enhancing patients' quality of life and dying process. ELNEC was one of the solutions and standard practices previously employed to overcome this practice gap. The ELNEC program began providing health care professionals with EOL instruction (Ferrell et al., 2015). Historically, the ELNEC project focused on providing primary palliative and end-of-life care education and was tailored to suit the educational requirements of advanced practice nurses. ELNEC-Core was the first curriculum implemented in 2000 to educate nursing educators at the undergraduate level (Ferrell et al., 2015). The ELNEC project's curriculum was created to satisfy the needs of undergraduate nursing instructors, licensed nurses, and nurses working in clinical settings (Ferrell et al., 2018).

Third, I collected and synthesized the results of a literature review. The following databases and search engines were used to perform a comprehensive literature review: MEDLINE, PubMed, Cumulative Index to Nursing and Allied Health, and Google Scholar. I accessed the databases from Walden University Library. The most recent accessible information was selected. The findings were peer-reviewed research articles and systematic reviews published within the last five years and located in the United States. To identify relevant material, however, I conducted an additional evaluation of the titles and abstracts based on the inclusion and exclusion criteria. Research reports that had been conducted by a third party, articles that had not been written in English, articles that had been published in a country other than the United States, and articles that had been published before 2015 were not considered. Then, the studies were evaluated based on the JHNEBP for strength of evidence and quality (Dang et al., 2022).

The fourth phase of the model was to design the project by outlining the implementation process and defining the potential results. I reviewed the literature on interventions to improve EOL care in LTC facilities and identified the most important intervention components for enhancing EOL care quality. The curriculum was determined by the ELNEC-Geriatric Training Program (AACN, 2016b). The ELNEC addressed pain management, symptom management, as well as ethical and legal concerns. In addition, cultural and theological aspects of EOL care, communication, loss, grieving, bereavement, death preparation, and care at the time of death were addressed. This educational program may assist nurses in reaching their ultimate objective of implementing an EBP change in the form of a policy, protocol, or standard (see Rosswurm & Larrabee, 1999). This educational program enhanced the nurses' knowledge, fostered their competence, and gave them the authority to administer primary palliative care. The American Nurses Association and Hospice and Palliative Nurses Association (2017) concurred that the ELNEC curriculum should be implemented as the standard palliative care nursing curriculum for undergraduate, graduate, and three doctoral levels.

I implemented and evaluated the educational activity as the fifth step. I conducted the educational activity and examined the outcomes of the pre- and posttests. The administration team was provided with my findings to determine whether to adopt, adjust, or reject the change. The final step, putting the change into effect and maintaining it (Step 6), is not included in this project. I plan to implement this step following my graduation from Walden University.

## Relevance to Nursing Practice

In all settings, nurses care for patients who are dying. The number of Americans who are older adults is growing, necessitating an increase in the number of health care professionals who can assess and manage the needs of the chronically ill and the dying. The Population Reference Bureau (2016) anticipated that there would be 98 million persons aged 65 and older living in the United States by 2060. This forecast is a significant increase from the current estimate of 46 million Americans over 65 (Mark, 2016). According to the World Health Organization (2018), over 40 million individuals globally require palliative care annually, yet only 14% of these patients receive this form of assistance. Caring for the dying entails attending to the patient's medical, psychological, social, and spiritual needs, as well as enhancing the quality of life of those with life-limiting conditions. It is the obligation of all health care practitioners to satisfy the palliative care needs of terminally ill patients and create meaningful relationships with them. According to research, EOL patients frequently face fragmented care and many avoidable hospitalizations (Harasym et al., 2021; Mor & Teno, 2016;). The Centers for Disease Control and Prevention (2018) reported that approximately 2.5 million people die annually in the United States, with one third of these deaths occurring in hospitals under the care of nurses. Despite an increase in specialist palliative care and hospice services over the past 15 years, approximately two thirds of all dying patients are hospitalized in their final 90 days, with one third receiving intensive care and 40 % of cancer patients receiving chemotherapy in their final 6 months of life (Teno et al., 2018). The need for specialized palliative care skills greatly exceeds the available resources (Lupu et al., 2018). In certain rural and underserved regions of the United States, certain services do not exist (Lalani & Cai, 2022; Lupu et al., 2018). Other studies have demonstrated that patients and their families require palliative care in the final phases of life. However, the majority of nurses are not fully equipped to give this type of care, making its delivery increasingly challenging for nurses (Negarandeh et al., 2015).

Understanding EOL care is crucial for nurses to give appropriate care to terminally ill patients (Gillan et al., 2014). The AACN’s (2016a) position statement addressed the nurse’s roles and obligations when caring for the terminally ill and made recommendations to enhance nursing practice, education, research, and administration. The statement highlights the nurse’s responsibilities to the terminally ill patient and caregiver, including the ability to diagnose symptoms, provide medications, and implement extra treatments to fulfill the patient’s requirements, as well as provide holistic support to all parties involved. Principles of primary palliative care, pain and symptom management, communication, spirituality, and grieving were the 32 constructs found for the study. Each construct was discussed in the AACN position statement, and suggestions were provided for improving each in clinical practice.

To care for the patient and family during EOL, nurses must be educated. The current DNP project enhances nursing practice by expanding knowledge and promoting best practices among nursing home personnel. It has been demonstrated that education and training improve the performance of nurses and reduces their attrition (Raco et al., 2019).The EOL education helped reduce the anxiety of nurses offering specialist EOL care and enhance their care practices. Teno et al. (2018) demonstrated that EOL education can enhance the quality of care, support the dignity of dying residents, and empower nurses to feel confident in their duties as caregivers. This project taught nurses to be health care providers and advocates in order to help their patients maximize their quality of life and die in peace (Teno et al., 2018).

## Local Background and Context

This initiative involved 33 Rehistered Nurses (RNs) and Licensed Practical Nurses (LPNs) working in an LTC institution with 190 beds. Their aim is to provide care based on love, compassion, service, and excellence to residents and their families. This facility provides LTC as well as EOL care. The LTC facility supports and cares for individuals throughout a spectrum of living environments, based on their daily lives and health care requirements, around the clock. The patient population is diverse in terms of color, age, and gender. Frequently, patient diagnoses and comorbidities are multiple and complex. The facility also specializes in short-term rehabilitation to expedite the return of individuals to the community. Residents can move between settings with different levels of care as needed. Providers in this local facility are committed to providing exceptional caring in a patient-centered environment.

The facility administrators were quite supportive of our effort. This education activity could be used as continuing education unit hours for the staff. To better prepare for the expanding older population, the administrative team feels that all nurses should be educated on EOL care. Therefore, credentialed health care professionals will receive annual continuing education in palliative care.

## Role of I DNP Student

I was responsible for leadership and teamwork on this project. After multiple discussions with the nursing director and assistant director regarding my observations and findings, the facility granted me permission to implement EOL education. I promoted staff participation in this annual EOL education under the guidance of the nurse educator.

They were not compelled to take part. This research served as a solution to a practice issue I had observed in a long-term clinical setting. I conducted a brief literature search to determine how to fill the gap. I performed a comprehensive review of the literature by searching the Walden University Library databases MEDLINE and PubMed. Then, the studies that match the inclusion criteria were evaluated using the JHNEBP paradigm (Newhouse et al., 2007) to determine the quality of the evidence. I constructed Microsoft Excel spreadsheets for data storage, tracking, and recording. As more proof for this project, I also looked at the work of the National Association for Home Care and Hospice-Palliative Care and the ELNEC.

It was my role to manage, create, and implement all components of this project in collaboration with the project team, which consisted of the nursing director, the assistant nurse director, the nurse educator, and the scheduler. I designed the target learning outcomes, the content outlines, the PowerPoint presentations, the posters, and the case studies. For the pretest and posttest, I used the Palliative Care Quiz for Nursing (PCQN) to assess nurses' knowledge of EOL care (see Appendix A for permission documentation). The substance of the posttest was identical to that of the pretest. The overall score ranges from 0 to 20 and is based on the number of accurate responses. The scores were then calculated as a percentage of correct PCQN responses. Each participant received one point for a correct response and no points for incorrect or "don't know" responses, for a maximum score of 20 points.

In addition, with the author's permission (see Appendix B), I utilized the pretest and posttest based on the Frommelt Attitudes Toward Care of the Dying (FATCOD) to assess changes in attitudes. The content of the posttest and the pretest were identical. FATCOD contains 30 items for which participants indicate their level of agreement on a scale ranging from strongly disagreeing to strongly agreeing. The 30 statements are measured on a 5-point Likert scale: 1 (strongly disagree), 2 (disagree), 3 (unsure), 4 (agree), and 5 (strongly agree). Half of the statements are negative, and the other half are optimistic. Thus, negative attributes are given a low score. Higher ratings imply more positive than negative attitudes. I used the Wilcoxon signed-rank test to compare data from before and after the test. This test enabled me to examine any score variations between two time points. Appendices C-E contain the PCQN and FATCOD instruments. Appendix C contains the unmarked PCQN instrument; Appendix D has the correct responses highlighted. Appendix E contains the FATCOD.

In addition, I was responsible for maintaining the confidentiality of all survey responses, the pretest, and the posttest, and no personal information was required. After analyzing the data using version 25 of IBM SPSS Statistics, I shredded and destroyed the copies. Last, I set up a meeting to show everyone involved in the project a PowerPoint presentation of the project's results and suggestions.

## Role of the Project Team

My role is that of a prominent leader of the diverse group that conceived and directed the project. However, it is preferable to have a conceptual framework that places stakeholder involvement within the context of a plan for encouraging the practical application of research. The model proposed by Rosswurm and Larrabee (1999) fosters the participation of stakeholders in all phases of implementing research into practice. I included the project team to ensure the information was relevant, accurate, and suited the facility's requirements. The team gathered to share feedback and recommendations and to address obstacles. The director of nursing, the assistant director of nursing, the nurse educator, and the scheduler were all part of the project team.

The scheduler had a crucial role in scheduling the staff education session. I relied on the scheduler to relay the implementation dates for the education project. The scheduler's main job was to make sure that all of the patients were seen during the instruction session.

At the conclusion of the education plan, the employees had the opportunity to review the education project and the instructor, as well as provide any suggestions or comments. One strategy to successfully implement a change of this size (Rosswurm & Larrabee, 1999) is to allow people most affected by the practice change, such as nurses, to be the reform's driving force. The nurses will have the chance to share their knowledge.

I planned a meeting with the advisory panel to discuss the conclusion and recommendations. Using Rosswurm and Larrabee's (1999) conceptual framework model for this EBP project, participant and administrator input were considered throughout project development and implementation. After this project is done, Rosswurm and Larrabee's (1999) model will help stakeholders put EBP into practice in their work.

## Summary

Rosswurm and Larrabee's (1999) methodology involves stakeholders to promote EBP, develop buy-in for the change in practice, and increase stakeholder satisfaction. In

Section 3, I examine the methods I used to search the literature as well as analyze and synthesize the evidence I collected. I will describe how I conducted the literature search, implemented the project's procedures, and assessed the findings.

## Section 3: Collection and Analysis of Evidence

### Introduction

The LTC facility supports and offers care for residents over a continuum of living settings, based on the residents' daily lives and health care needs. As necessary, residents can travel between care settings with varying levels of care. Many residents die in these LTC institutions, where they frequently reside for years (Tanuseputro, 2015). There are numerous obstacles to successful EOL care communication for nurses in LTC, including the treatment of complex patients with multiple comorbidities and diminished functionality (Tanuseputro, 2015). In addition, inconsistent patient-provider communication, a lack of nursing education, and workflow constraints exacerbate the problem (Bernacki & Block, 2014; Karlsson et al., 2017; Lund et al., 2015; Towsley et al., 2015). The objective of this education project was to address the shortage of EOL care education among nurses in an LTC facility by developing an EOL care educational program and measuring improvements in knowledge and attitude among nurses. In this section, I discuss the literature search strategy that I used to find evidence and the processes and methods that I used to analyze the data.

### Practice-Focused Question

I investigated the significant gap in practice between the level of education about EOL care among nurses at the local LTC facility and the stated need for further EOL knowledge. This evidence-based education program for nurses who care for terminally ill patients involves the development of an evaluation strategy to see how their knowledge and attitudes have changed as a result of the program. The practice-based question for this study was, "Does an evidence-based educational program for nurses working in an LTC facility improve nurses' knowledge of EOL care and their confidence in caring for EOL patients and their families?"

## Sources of Evidence

I used the following search engines and databases to perform a comprehensive literature review: MEDLINE, PubMed, Cumulative Index to Nursing and Allied Health, and Google Scholar. I accessed the databases from Walden University Library. The review was limited to primary sources only. Reports containing secondary research were omitted. I did a truncated search to identify the search term's variants. I employed adjacency searching to obtain more precise results, such as "nursing home ADJ3 end of life." This strategy improves the relevance of the search result; in general, the closer two terms appear, the tighter their link. In the search technique, both subject headings and keywords were utilized (Ecker & Skelly, 2010). AND, OR, while NOT were applied, and parenthesis and truncation (*) boosted the search's efficiency and allowed users to experiment with various combinations of search words or subject headings (Ecker & Skelly, 2010). The original key search phrases end-of-life care, terminal care, nurse education, educational programs on end-of-life care, palliative care, and long-term care facilities were included using the combined Boolean search terms "and" and "or." Death, dying, death experience, nursing, palliative care, attitudes, attitudes toward care of the dying, attitude change, education, research, longitudinal, and end-of-life were used for all database searches.

I limited the search parameters to nurses working in nursing homes or LTC facilities between 2015 and 2021. The search did not include other contexts, such as hospital or school nursing environments. Consideration was given to studies that included nurses who work in LTC facilities for older individuals and care for residents at EOL. Consideration was given to those that address any part of the nurse's role and responsibilities, education, and experience in caring for EOL patients. The titles of unrelated papers were eliminated by scanning the titles, and the abstracts were analyzed to further restrict the evidence. In addition, the search was restricted to adult practice, articles authored in or translated into English, and articles reviewed by other specialists. Then, I evaluated the studies based on the JHNEBP (Newhouse et al., 2007) for their level of evidence and quality. According to the JHNEBP research evidence grading scheme, the level of the evidence will be ranked from Level I, representing the strongest evidence, to Level V, representing the lowest evidence. The analyzed studies were evaluated based on their outcomes, sample size, controls, conclusions, recommendations, literature review, and scientific evidence. Additionally, I consulted the National Association for Home Care and Hospice-Palliative Care and the ELNEC to support the evidence for this research.

## Participants

This project involved 33 RNs and LPNs working in an LTC facility with 190 beds. Attendance was not mandatory. Participants could potentially earn up to 8 hours of continuing education credit towards their required annual hours. After discussing the schedule with the director of nursing and the scheduler, I established that nurses would need to attend two sessions lasting four hours each to receive the eight hours of continuing education credit. Moreover, some employees had the option to participate remotely via Zoom sessions. The participants were required to complete a pretest prior to the educational project and a posttest with the same test tasks as the pretest after the educational program. Those who went to the Zoom meeting got their materials and pre-test ahead of time, and I made them take the post-test at work while I was there.

## Procedures

The ELNEC educational modules offer a framework for educating nurses on palliative and end-of-life care based on empirical research. The ELNEC was established in February 2000 to enhance nursing education in palliative and EOL care (AACN, 2016b ). The ELNEC-Geriatric Training Program educates nurses to become educators and leaders in order to enhance the quality of EOL care in geriatric care facilities. Education provided by ELNEC focuses on pain management, symptom management, and ethical and legal issues and is specifically developed for nurses and other health care professionals. It also discusses cultural and spiritual aspects of EOL care, communication, loss, grieving, bereavement, death preparation, and EOL care. (O'Shea et al., 2015). The ELNEC education has increased the confidence and knowledge of nurses providing EOL care (O'Shea et al., 2015). Other studies (Bishop et al., 2019; Harden et al., 2017; Lippe et al., 2017) have shown that nurses' knowledge, confidence, and sense of competence in palliative care grew after taking ELNEC courses.

Throughout the course's six lecture modules, participants gain an understanding of the following topics: what end-of-life care is; cultural and ethical issues; communication, loss, grieving, and bereavement; pain management; symptom management; care in the dying phase and death; and how to utilize structured records. The ELNEC geriatric course is what I used as the foundation for the education of the staff. This course instructs nurses on pain evaluation and management, geriatric symptom management, communication, ethics, cultural and spiritual considerations, loss, grieving, and bereavement in end-of-life care for older people. It is imperative that those in leadership positions within nursing give careful attention to the prospect of establishing a curriculum that is compliant with the standards of the ELNEC. Registered nurses can learn to feel more at ease and build confidence while working with terminally ill patients. They can also offer support and information to palliative care patients to help them through their last days.

I offered the education at various times throughout the course of 7 days, separated into two 4-hour sessions. The first session taught participating nurses about pain assessment and treatment, as well as geriatric symptom management. The second session focused on communication, ethics, cultural and spiritual considerations, loss, grieving, and mourning in older individuals' EOL care. Sessions were planned to accommodate the entire workforce. Due to the limitation of social distance, several employees also had the option to attend the workshop remotely through Zoom meetings. I saw that these people got their materials ahead of time and took their exams on time while they were at work.

I used a one-group pretest and posttest approach to evaluate knowledge and attitudes at the outset and after the education plan project was implemented. The participants were required to complete a pretest prior to the educational project, which was followed by the educational program; at the conclusion of the educational project, the participants performed a posttest with the same test items as the pretest. After collecting the test, I applied the Wilcoxon signed-rank test to analyze any scores pertaining to nurses' knowledge and attitude towards EOL care.

I used the PCQN to measure participating nurses’ knowledge of EOL care. The PCQN was developed by Ross et al. (1996). Ross and colleagues used the Canadian Palliative Care Curriculum as a conceptual framework to guide the development of the PCQN. The preliminary version of the quiz consisted of 60 true/false/do not know questions. A committee of palliative care coordinators reviewed the questions for accuracy, relevance, and clarity. Ross et al. retained 20 questions for the final version of the PCQN. Sample items included: "Adjuvant therapies are important in managing pain," "Suffering and physical pain are synonymous," and "The pain threshold is lowered by anxiety or fatigue." The responses are "true," "false," and "I do not know."

Ross and colleagues (1996) administered the PCQN to a sample of 200 students and 196 nurses working in hospital and community practice settings in Ontario, Canada. In analyzing test item-by-item difficulty, the developers found that the PCQN is reliable, user-friendly, and capable of assessing the educational needs of nurses in a range of settings and programs. When it was first made, the original English version of the PCQN was reliable and valid enough.

Multiple PCQN studies have been undertaken in various countries (Brajtman et al., 2009; Carroll et al., 2005; Knapp et al., 2009; Raudonis et al., 2002). The overall score ranges from 0 to 20 and is determined by the number of accurate responses. Ross et al. (1996) assigned 1 point for a correct response and 0 points for incorrect or "don't know" responses, for a maximum score of 20 points. The PCQN includes questions in three areas: (a) palliative care philosophy and concepts (Items 1, 9, 12, 17), (b) pain and symptom management (Items 2-4, 6-8, 10, 13-16, 18, 20), and (c) psychosocial and spiritual care (Items 5,11,19). This proportion was then determined as the accurate PCQN response percentage. For instance, if a participant correctly answers 10 out of 20 questions, their score will be 50%. Scores might range between 0% and 100%. The higher the score, the greater the percentage of accurate answers and the greater the degree of expertise of the nurse. The responses "I do not know" were rated as incorrect.

I used Frommelt’s (1988) FATCOD measure to evaluate participating nurses' attitudes toward care of the dying. FATCOD comprises 30 items for which participants are asked to indicate their level of agreement on a scale from strongly disagreeing to strongly agreeing. Two thirds of the statements pertain to nurses' attitudes toward the dying patient, while the remaining third pertains to nurses' sentiments about the patient's family (Frommelt, 1991). The 30 statements are scored on a 5-point Likert scale: 1 (strongly disagree), 2 (disagree), 3 (uncertain), 4 (agree), and 5 (strongly agree). Half of the statements are worded negatively, while the other half are worded optimistically. Thus, the negative things are scored negatively. Higher ratings indicate attitudes that are more favorable than negative. 150 is the greatest possible score (Frommelt, 1991). If a person's FATCOD score is high, it means that they are more willing to help care for terminally ill patients and their families.

Frommelt (1988) used a test-retest technique to assess reliability in the original FATCOD. The reliability was evaluated three times. The first two instances that reliability was tested, in 1988, were related to earlier studies. The sample was comprised of 18 nurses from an oncology unit who were initially assessed with the instrument and then retested three weeks later using the same instrument. The Pearson product-moment correlation coefficient (r) between the first and second tests was 94 and 90, respectively (Frommelt, 1991). Rooda et al. (1999) discovered a substantial correlation between the FATCOD and attitudes toward mortality. On the Death Anxiety Profile-Revised, they discovered a negative correlation between FATCOD scores and fear of death and avoidance of death. It was positively connected with neutral acceptance of death and approach acceptance, suggesting that nurses who perceive death as a doorway to a joyful afterlife had more favorable views toward care for the dying. The FATCOD is a viable and reliable instrument for measuring nurses' attitudes regarding EOL care. Frommelt demonstrated reliability by completing a test-retest cycle twice. The obtained Pearson product-moment correlation coefficients were 0.94 and 0.90, which demonstrate that FATCOD is legitimate and trustworthy. According to Barrere et al. (2008), FATCOD has been implemented in 16 other nations and nine different languages, in addition to its use in 79 U.S. schools and institutions and health care systems.

## Protections

Before beginning the education program, I obtained approval from the director of the LTC facility and the Institutional Review Board of Walden . The confidentiality of all survey responses, the pretest, and the posttest was maintained. This project did not collect any participant identification information. A two-digit code was assigned to each participant. This method was used to find matched couples solely for the purpose of comparing pre- and post-test scores.Only I had access to the hard copies of the quizzes, the list of code assignments, and the results when they were stored in a secured filing cabinet. After data analysis, the copies were shredded and discarded. The information on a computer's hard disk was erased using commercial software programs that are made to erase all information from a storage device.

## Analysis and Synthesis

This program for education uses the Wilcoxon signed-rank test to compare differences between the pre- and posttests. The Wilcoxon signed-rank sum test is used for ordered categorical data when a numerical scale is inappropriate, but it is possible to rank the observations and test the null hypothesis that the median of a distribution is equal to a certain value. In addition, the Wilcoxon signed-rank test is recommended for matched pairs with non-normally distributed data of ordinal or higher level. The Wilcoxon signed-rank test was used to conduct a paired difference test of repeated measurements on a single sample to determine if their population mean ranks were distinct.

Wilcoxon rank tests are frequently employed non-parametric sample dissimilarities based on ranking differences (Feltovic, 2003). Their advantages include a small number of assumptions and the comparability of subjects at two periods in time, hence enabling the comparison of comparable samples (Hollander &Wolfe, 1999). Tanizaki (1997) evaluates and compares the power features of the Wilcoxon rank-sum test and other rank-based tests to the t-test under various distributional assumptions based on Monte Carlo simulations. The results reveal that the Wilcoxon test has the greatest overall power in small samples, outperforms other rank-based tests, and is superior to the t-test.

Version 25 of IBM's Statistical Package for the Social Sciences (SPSS) was used to analyze the data. A non-parametric test statistic, the Wilcoxon signed-rank test, was selected to examine changes between baseline (pretest) and posttest median responses. The level of significance was set at 0.05.

In addition, the data was summarized by descriptive statistics, and tables. In addition to the PCQN's total score, descriptive statistics for each PCQN question will be determined. The FATCOD study also utilized descriptive statistics to indicate a change in opinion. The FATCOD questionnaire included 30 Likert-type statements assessed on a 5-point scale: 1 (*strongly disagree*), 2 (*disagree*), 3 (*uncertain*), 4 (*agree*), and 5 (*strongly agree*). Half of the statements are worded negatively, while the other half are worded optimistically.

## Summary

This program's findings expanded what was previously known regarding the preparation of nurses for EOL care. This project trained nurses to be health care providers and advocates in order to help their patients maximize their quality of life and die peacefully. This initiative finally found opportunities for enhancing educational settings for LTC. The effectiveness of the educational program was measured by comparing pre- and posttests. This education strategy uses a descriptive statistic and the Wilcoxon signed-rank test to determine the impact of EOL care education on nurses’ understanding of EOL care. This methodology illustrated how this project impacted the selected participants and summarized the findings and recommendations in section four.

# Section 4: Findings and Recommendations

## Introduction

In developing an EOL care educational program, I aimed to address the lack of EOL care education among nurses working in LTC facilities, in particular the local LTC facility. This evidence-based education program taught nurses more about caring for terminally ill patients, and a strategy was developed to monitor how their knowledge and attitudes have evolved as a result. I used the PCQN to evaluate nurses' EOL care knowledge. The FATCOD was used to evaluate nurses' perspectives on EOL care. The findings of pre-and post-FATCOD and PCQN evaluations were compared to evaluate whether there were statistically significant differences in scores following intervention. Before and after an educational intervention, FATCOD and PCQN results were compared using the Wilcoxon signed rank test. The evidence-based project question that underpinned this project was, "Does an evidence-based educational program for nurses working in an LTC facility improve nursing knowledge related to EOL care and confidence in caring for EOL patients and families?"

## Findings and Implications

In this project, I investigated the levels of knowledge, attitudes, and confidence in palliative care among nurses caring for nurses in LTC facilities. I invited 33 nurses to participate. The per diem and agency nurses declined the invitation because they would not be rewarded for their participation in the educational activity. Twenty nurses took part in the study. The demographics of the nurses who completed both the FACTOD and PCQN evaluation surveys are summarized in Table 1. According to a descriptive analysis of background data, 80% of participating nurses were female, and 20% were male. Seventy percent of participants were LPNs with less than 5 years of experience. Eighty percent of individuals questioned reported having no formal instruction in palliative care.

**Table 1**

*Demographics of Participants (*N *= 20)*

| Variables | *n* | % |
|---|---|---|
| Gender | | |
| Male | 2 | 20 |
| Female | 18 | 80 |
| Educational level | | |
| LPN | 14 | 70 |
| AAS-BSN | 5 | 25 |
| MSN-DNP | 1 | 5 |
| Work experience (years) | | |
| 1-5 | 14 | 70 |
| 6-10 | 4 | 20 |
| 11-20 | 1 | 5 |
| 21+ | 1 | 5 |
| Palliative care experience | | |
| Yes | 4 | 20 |
| No | 16 | 80 |

## Pre- and Posttest Results for the Palliative Care Quiz for Nursing

The PQCN assesses three aspects of palliative care: philosophy and principles (four items), control of pain and other symptoms (13 items) and psychosocial aspects (three items). A descriptive analysis for PCQN (see Table 2) revealed that the mean score for the pretest was 9.5 (*SD* = 3.46), and the mean score for the posttest was 18.5 (*SD* = 3.25). The pretest scores ranged from 4 to 16, and the posttest ranged from 7 to 20.

**Table2**

*Descriptive Statistics for Palliative Care Quiz for Nursing (PCQN)*

| Statistic | Pre-PCQN | Post-PCQN |
|---|---|---|
| *M* | 9.5 | 17.3 |
| *SD* | 3.46 | 3.25 |
| Minimum | 4 | 7 |
| Maximum | 16 | 20 |

The outcome exposed the nurses' fundamental misconceptions. The PCQN question with the highest percentage (95%) of incorrect responses was item 3: "The extent of the disease dictates the method of pain treatment." The PCQN question with the second-highest percentage of erroneous responses (90%) was item 7: "Drug addiction is a significant problem when morphine is used long-term for pain management.". Fear of respiratory arrest could be the reason. Third, many participants (85%) gave an incorrect response to item 5: "it is critical for family members to remain at the bedside until death occurs." Fourth, items 1 and 6 had a high percentage (80%) of incorrect responses. Item 1 stated, "Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration," and item 6 was; "During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation." Fifth, item 11 was incorrect: "Men generally reconcile their grief faster than women (70%)." Sixth, Questions 10 and 12 were incorrect. Item 10 was "Drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnea" (65%), and item 12 stated, "Palliative care philosophy is compatible with aggressive treatment" (65%). Seventh, item 13 was incorrect: "The use of placebos is appropriate in the treatment of some types of pain" (55%). Eighth, item 15 was wrong and stated, "Suffering and physical pain are synonymous" (40%). Ninth, item 16 was wrong and stated, "Pethidine is not an effective analgesic in the control of chronic pain" (35%). The PCQN questions with the highest percentage of correct responses were 2 and 8. Item 2 said, "Morphine is the standard used to compare the analgesic effects of other opioids" (80%). Item 6 said "Individuals who are taking opioids should also follow a bowel regime" (80%). The PCQN questions with the second highest number of incorrect responses were 4, 17, 18, and 19. Item 4 said: "Adjuvant therapies are important in managing pain" (75%). Item 17 said "The accumulation of losses renders burnout inevitable for those who seek work in palliative care." Item 18 said "Manifestations of chronic pain are different from those of acute pain" (75%). Item 19 said "The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate" (75%). Third, item 14 was correct: "In high doses, codeine causes more nausea and vomiting than morphine" (70%).

**Table 3**

*Distribution of Nurses' Knowledge About Palliative Care on the Palliative Care Quiz for Nursing (PCQN) Scale*

| No. | PCQN item | Correct *n* (%) Pre-Post | | Incorrect *n* (%) Pre-Post | | Don't know *n* (%) Pre-Post | |
|---|---|---|---|---|---|---|---|
| Theme 1: Philosophy and Principle of Palliative Care | | | | | | | |
| | | Pre | Post | Pre | Post | Pro | Post |
| Q1 | Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration. (F) | 20 | 100 | 80 | 0 | 0 | 0 |
| Q9 | The provision of palliative care requires emotional detachment. (F) | 10 | 60 | 90 | 40 | 0 | 0 |
| Q12 | The philosophy of palliative care is compatible with that of aggressive treatment. (T) | 35 | 85 | 65 | 15 | 0 | 0 |
| Q17 | The accumulation of losses renders burnout inevitable for those who seek work in palliative care. (F) | 75 | 90 | 25 | 10 | 0 | 0 |
| Theme 2: Psychosocial and Spiritual Care | | | | | | | |
| Q5 | It is crucial for family members to remain at the bedside until death occurs. (F) | 15 | 95 | 85 | 5 | 0 | 0 |
| Q11 | Men generally reconcile their grief more quickly than women. (F) | 30 | 80 | 70 | 20 | 0 | 0 |
| Q19 | The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate. (F) | 75 | 100 | 25 | 0 | 0 | 0 |
| Theme 3: Management of Pain and Other Symptoms | | | | | | | |
| Q2 | Morphine is the standard used to compare the analgesic effect of other opioids. (T) | 80 | 95 | 20 | 5 | 0 | 0 |
| Q3 | The extent of the disease determines the method of pain treatment.(F) | 5 | 95 | 95 | 5 | 0 | 0 |

(*table continues*)

| No. | PCQN item | Correct *n* (%) Pre-Post | | Incorrect *n* (%) Pre-Post | | Don't know *n* (%) Pre-Post | |
|---|---|---|---|---|---|---|---|
| Q4 | Adjuvant therapies are important in managing pain. (T) | 75 | 65 | 25 | 35 | 0 | 0 |
| Q6 | During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation. (T) | 20 | 70 | 80 | 30 | 0 | 0 |
| Q7 | Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain. (F) | 10 | 80 | 90 | 20 | 0 | 0 |
| Q8 | Individuals who are taking opioids should also follow a bowel regime. (T) | 80 | 75 | 20 | 25 | 0 | 0 |
| Q10 | During the terminal stages of illness, drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnea. (T) | 35 | 85 | 65 | 15 | 0 | 0 |
| Q13 | The use of placebos is appropriate in the treatment of some types of pain. (F) | 45 | 85 | 55 | 15 | 0 | 0 |
| Q14 | In high doses, codeine causes more nausea and vomiting than morphine. (T) | 70 | 95 | 30 | 5 | 0 | 0 |
| Q15 | Suffering and physical pain are synonymous. (F) | 60 | 100 | 40 | 0 | 0 | 0 |
| Q16 | Pethidine is not an effective analgesic in the control of chronic pain. (T) | 65 | 100 | 35 | 0 | 0 | 0 |
| Q18 | Manifestations of chronic pain are different from those of acute pain. (T) | 75 | 100 | 25 | 0 | 0 | 0 |
| Q20 | The pain threshold is lowered by anxiety or fatigue. (T) | 70 | 100 | 30 | 0 | 0 | 0 |

The majority of correct responses fell under the category of pain and symptom management. Participants had received academic and continuing education in the management of pain and other symptoms, although not in a palliative care setting. Typically, nurses have experience educating medical-surgical and critically ill patients on pain and symptom management (Mario, et al., 2022).

The least accurate responses fell under the category of psychosocial and spiritual care. Due to the nursing shortage in the United States, nurses are required to work much longer than their shifts require (Carayon, et al., 2008). This was expected because being overworked and underpaid as a result of the system's nurse shortage has a detrimental effect on their interactions with dying patients (Carayon, et al., 2008).

**Table 4**

*Wilcoxon Signed Rank Test for the Palliative Care Quiz for Nursing (PCQN) Scale*

| | | N | Mean Rank | Sum of Ranks |
|---|---|---|---|---|
| post-PCQN – pre-PCQN | Negative Ranks | 0 | 0 | 0 |
| | Positive Ranks | 19 | 10 | 190 |
| | Ties | 1 | | |
| | Total | 20 | | |

- Negative Ranks: post-PCQN < pre- PCQN
- Positive Ranks: post-PCQN > pre- PCQN
- Ties: post-PCQN = pre- PCQN

The pre-PCQN group had lower values (*Mdn* = 9) than the post-PCQN group (*Mdn* = 18.5). The Wilcoxon Test revealed that there was a statistically significant difference, p =.001. This results in a p-value of.001, which is less than the specified threshold of 0.05. As indicated by the Wilcoxon test, the differences in the pre and post test present data were significant. And knowledge increase with education.

**Table 5**

*Wilcoxon Rank Test Statistics for the Palliative Care Quiz for Nursing (PCQN) Scale*

| | post-PCQN – pre- PCQN |
|---|---|
| Z | -3.83 |
| p (2-seitig) | <.001 |

## Pre- and Posttest Results for the Frommelt Attitude Toward the Care of the Dying Scale

The Frommelt Attitude Toward the Care of the Dying Scale form B (FATCOD-B) was used to assess nurses’ attitude toward dying patients’ care. This self-report questionnaire in paper and pencil format contains 30 randomly ordered items that are assessed on a five-point Likert-type scale. Half of the statements are favorable in tone, while the other half are negative. The statements express beliefs and feelings about EOL care, including the patient’s autonomy in making decisions, the doctor’s emotional participation with the patient’s experience, family care, and pain management. The following are the positive items scored: 1 indicates significant disagreement, 2 indicates disagreement, 3 indicates uncertainty, 4 indicates agreement, and 5 indicates strong agreement. For negative items, the scores are inverted. The total score is between 30 and 150; higher values imply more favorable attitudes.

A descriptive analysis for FATCOD-B (Table 5) revealed that the mean score for the pretest was 94.25 (*SD* = 3.46), and the mean score for the posttest was 139.55 (*SD* = 3.25). The pretest scores ranged from 66 to 138, and the posttest ranged from 100 to 148.

**Table 6**

*Descriptive statistics for the Frommelt Attitude Toward the Care Of the Dying Scale (FATCOD-B)*

| | Post- | Pre- |
|---|---|---|
| Mean | 139.55 | 94.25 |
| Std. Deviation | 10.13 | 19.94 |
| Minimum | 100 | 66 |
| Maximum | 148 | 138 |

This project's participants were significantly less knowledgeable about palliative care. Participants' attitudes toward palliative care range from moderately negative to neutral, according to the findings. Low levels of knowledge and negative attitudes toward palliative care among nurses may be attributable to cultural and organizational factors. The absence of palliative care education and specific training in the nursing curriculum may be one of these factors.  In this study, nurses with prior education and/or personal experience with palliative care, as well as those with a higher level of education, were more likely to have positive attitudes toward it than those without such training.

**Table 7**

*Descriptive statistics for the Frommelt Attitude Toward the Care Of the Dying Scale (FATCOD-B)*

| | N | Mean | Median | Standard deviation |
|---|---|---|---|---|
| Pre- | 20 | 94.25 | 90.5 | 19.94 |
| Post- | 20 | 139.55 | 140 | 10.13 |

The Wilcoxon signed-rank test was used to compare the pretest and posttest scores of the 20 LTC nurses who participated in this study to determine if there is a statistically significant difference in their attitude and knowledge. The pretest group had lower values (*Mdn* = 90.5) than the posttest group (*Mdn* = 140). A Wilcoxon Test showed that this difference was statistically significant, p = < .001. This results in a p-value of < .001, which is below the specified significance level of 0.05. The result of the Wilcoxon test is therefore significant for the present data and the null hypothesis is rejected. Therefore, it is assumed that both samples are from different populations.

**Table 8**

*Wilcoxon Signed Rank Test for the Frommelt Attitude Toward the Care Of the Dying Scale (FATCOD-B)*

| | | N | Mean Rank | Sum of Ranks |
|---|---|---|---|---|
| Post- - Pre- | Negative Ranks | 1 | 1 | 1 |
| | Positive Ranks | 19 | 11 | 209 |
| | Ties | 0 | | |
| | Total | 20 | | |

- Negative Ranks: Post- < Pre-
- Positive Ranks: Post- > Pre-
- Ties: Post- = Pre-

**Table 9**

*Wilcoxon Rank Test Statistics for the Frommelt Attitude Toward the Care Of the Dying Scale (FATCOD-B)*

| | Post- - Pre- |
|---|---|
| Z | -3.88 |
| p (2-tailed) | <.001 |

## Recommendations

It is imperative that nurses be educated to fill the void in services created by the growing number of people living with serious illness and the lack of specialized palliative care providers available to help them manage the associated pain, symptoms, and distress. Primary palliative care-trained nurses can provide care for patients with uncomplicated issues throughout the progression of serious illness and at the EOL. Unfortunately, many nurses do not receive this training in their nursing programs and are unable to provide this type of care competently. Add primary palliative care education to nurse residency programs, which are devoted to educating and supporting novice nurses with limited clinical experience from undergraduate and prelicensure programs. The online ELNEC-Undergraduate Curriculum is a good way for nurses to improve their knowledge, skills, and confidence when caring for seriously ill patients and their families. It is designed for nurses who are new to clinical practice.

To improve knowledge and attitude toward palliative care, novice nurses and nursing students must gain experience in palliative care under the supervision of an experienced preceptor during their training. In this study, the participants' negative attitudes and lack of knowledge about palliative care may have been influenced by a lack of education, experience, and cultural and professional constraints. To enhance the quality of EOL care, it may be necessary to incorporate palliative care education into the nursing curriculum. The organizational context, specifically nurse managers, is also responsible for fostering an environment that enables nurses to enhance the quality of their care. Since there are many different ways to feel about palliative care, it is suggested that qualitative studies be done to create useful tools for figuring out what the most important issues are. Based on the scores of the nurses, this project supports the need for improvement in the EOL education of the facility's nurses. They suggested that all new nurses get this PowerPoint training as part of the facility's orientation program and that all current nurses get it once a year.

## Strengths and Limitations of the Project

This study has several limitations that must be discussed. The first limitation is that the project was conducted in a single LTC facility and used convenience sampling techniques, thereby limiting the project's applicability to other patient populations. The project was restricted to nurses who cared for adult and older adult patients; per diem staff and agency nurses were not encouraged to participate in the educational program. Due to its limited scope, the PCQN may not test all of the knowledge that nurses need to know to give EOL care.

The data collection instrument was adapted from the PCQN. This scale demonstrated a high level of content validity and acceptable reliability (test–retest = 0.56 and Kuder-Richardson 20 = 0.78). In addition, the validity and reliability of the PCQN have been examined in prior research (Iranmanesh et al., 2014; Kim et al., 2024). These authors determined that the validity and reliability of PCQN were satisfactory. Both the PCQN and FATCOD instruments utilized in this study were valid and reliable (Frommelt, 1991; Ross et al., 1996). Several studies have been conducted with the PCQN in different countries (Brajtman, Fothergill-Bourbonnais, Fiset, & Alain, 2009; Carroll, Brisson, Ross, & Labbe, 2005; Knapp et al., 2009; Raudonis, Kyba, & Kinsey, 2002). According to Barrere et al. (2008), FATCOD has been used in 16 other countries, in 9 different languages, in addition to its use in 79 colleges and universities and health care systems in the United States. The equipment used for data collection was properly evaluated to verify its ability to measure the content. Creswell (2014) and Polit (2013) define instrument dependability as the consistency and accuracy with which an instrument evaluates the target variable.

# Section 5: Dissemination Plan

After completing this DNP project, I shared the findings within the organization. I communicated the findings to facility stakeholders, such as physicians, program directors, nursing care teams, and nursing directors. This was accomplished via poster displays and conferences. As a professor of nursing, I have access to a large audience that could benefit from the outcomes of this investigation. I will therefore call the various nursing program directors and request a meeting to discuss EOL care with the nursing students. Last but not least, I want to publish in the *Journal of Palliative Care*.

## Analysis of Self

### As a Scholar

In its 2015 Task Force Report on the Implementation of the DNP, the AACN defined scholarship as a form of translation of new knowledge and research into the dissemination and integration of new knowledge to meet the needs of humans. DNP nurses are irreplaceable members of the healthcare system because of their expertise, clinical experience, and ability to give a dynamic perspective on patient care (May et al., 2020). DNP nurses are trained to identify gaps in evidence for practice (AACN, 2006). Undertaking the DNP program equipped me to devise and implement innovative patient care models and assess cost-effectiveness. As a scholar, I am able to design and implement an evidence-based process and then evaluate its outcome of practice within a practice setting or organization or against established national benchmarks to evaluate trends. I can translate evidence to bedside practice utilizing quality improvement practices. I completed my practicum in a pediatric clinic where my public health problem was the increase in childhood obesity during the COVID-19 pandemic. There was a need for a clinical strategy during the pandemic, a time when most children at the clinic were doing virtual learning. I needed to identify students at more significant risk for obesity and provide supportive services that allowed them to derive greater benefit from broader environmental and educational strategies, such as virtual physical education opportunities. The result was encouraging; there was a decrease in body weight in 87% of the children during the 12 weeks. One of my personal goals is to contribute to nursing knowledge through empirically based studies of the effectiveness of practice approaches that ultimately benefit patients and health care systems.

DNP nurses can positively impact health care systems, clinical practice, health policy, academic settings, and many other areas like health economics, health insurance, and administration and information technology. According to AACN (2018), it is imperative for DNP-prepared nurses to work at the highest level of their license and use their skills and knowledge to translate evidence into practice. DNP-prepared nurses also have a mandate to further disseminate that knowledge to promote positive patient outcomes, whether that be by leading interprofessional teams to advance health care or disseminating peer-reviewed papers to influence practice and policy (AACN, 2018).

## As a Practitioner

I chose to continue my education because I felt compelled to comprehend the nursing profession. It did not satisfy me to follow doctors' orders without knowing why. I was curious as to why I was performing specific tasks, such as the Braden scale and the fall risk. I had many questions about the manual policy book and was curious about the policy-making process. Due to their advanced education and training, DNP-prepared nurses are well-positioned to lead change and influence health care policies at multiple levels in the current health care setting. The DNP is a recommended practice degree that prepares nurse practitioners to assume full leadership roles in clinical practice, clinical teaching, and research applications, with the capacity to provide exceptional, high-quality care and leadership in increasingly complex health care delivery systems (McCauley, 2020). According to Benner's (1982) novice to expert theory, a novice is a beginner who lacks experience in the situations where they are expected to perform tasks. As a practitioner at the beginner level. I am acutely aware that I am in the process of acquiring discretionary judgment and that I heavily rely on context-free rules to guide my clinical performance (see Benner, 1982). This DNP project taught me how to apply and implement policies in the real world. This DNP project highlighted the significance of collaboration with peers and other health care system members. I am now prepared to ensure the management of patients in a variety of complex health delivery settings by utilizing EBP resources and staying informed of and current with changes.

## As a Project Manager

As a project manager, I was excited to embark on the journey. I gained a great deal of knowledge along the way. The clinical interventions for this project were based on findings from the relevant literature, which were used to address the significant gap between the level of education regarding EOL care among nurses at the local LTC facility and the need for additional EOL knowledge, as identified during the need assessment. Using Rosswurm and Larrabee's (1999) model for change to EBP, I was able to outline a systematic process for EBP change. This model was essential for communicating the need for change to key stakeholders, monitoring progress, and conducting an evaluation. I was the prominent leader of the multidisciplinary group that conceived and directed the project. The presence of a structured EBP education program, protected time, supportive leadership, and easy access to EBP literature facilitates implementation of EBP (Wallin et al., 2003). I had the full support of the administrator team, who assisted with participant recruitment. The educational intervention was successful despite the social distance.

The most difficult aspect was writing the capstone, but my mentor provided me with numerous resources throughout the process. With my mentor's encouragement, I was required to rewrite each section numerous times. I cannot count the number of times I wanted to quit after receiving the capstone for revision. My mentor kept me grounded and provided constructive criticism. I am more confident in my writing and have mastered the American Psychological Association style.

## Summary

Many patients spend their final years at an LTC institution. Many nurses do not have official training in hospice and palliative care (Ashley & Fasolino, 2016), and they frequently do not feel confident or equipped to provide basic palliative or EOL care (Meie et al., 2017; Malloy, Ashley et al., 2016; Aldridge et al., 2016). In order to feel comfortable caring for these terminally ill patients, particularly when there is no chance of recovery, nurses have stated a need and desire to expand their knowledge base on palliative care in the LTC setting (Hodgkinson et al., 2018; Wiggins, 2016). To satisfy these needs and solve this care gap, I designed a curriculum focused on general palliative care information, symptom management, and care objective meetings. Existing research demonstrates that educational programs increase nurses' knowledge of EOL care (AACN, 2010). This effort enhanced the nursing profession's understanding and awareness of EOL care. This project educated nurses to be health care providers and advocates so they can assist their patients in maximizing their quality of life and passing away peacefully. This experiment yielded useful information that can be used to build instructional programs for palliative care despite these limitations. To provide patients and their families with high-quality palliative care, it is essential to establish continuous and comprehensive palliative care education programs based on nurses' palliative care knowledge, attitude, confidence, and educational needs.

# References

Aboshaiqah, A. E. (2019). Assessing palliative care knowledge among nurses in 2 hospitals in Saudi Arabia. *Journal of Hospice & Palliative Nursing*, *21*(3), E1–E6. https://doi.org/10.1097/NJH.0000000000000521

Achora, S., & Labrague, L. J. (2019). An integrative review on knowledge and attitudes of nurses toward palliative care: Implications for practice. *Journal of Hospice & Palliative Nursing*, *21*(1), 29–37. https://doi.org/10.1097/NJH.0000000000000481

Alftberg, Å., Ahlström, G., Nilsen, P., Behm, L., Sandgren, A., Benzein, E., Wallerstedt, B., & Rasmussen, B. H. (2018). Conversations about death and dying with older people: An ethnographic study in nursing homes. *Healthcare, 6*(2), Article 63. https://doi.org/10.3390/healthcare6020063

American Association of Colleges of Nursing. (2000). *Peaceful death: Recommended competencies and curricular guidelines for end-of-life nursing care*. Retrieved on January 2022.

American Association of Colleges of Nursing. (2006, October). *The essentials of doctoral education for advanced nursing practice*. https://www.aacnnursing.org/Portals/42/Publications/DNPEssentials.pdf

American Association of Colleges of Nursing. (2010, September). *Recommended baccalaureate competencies and curricular guidelines for the nursing care of older adults: A supplement to the* Essentials of Baccalaureate Education for Professional Nursing Practice.

https://www.aacnnursing.org/Portals/42/AcademicNursing/CurriculumGuidelines/AACN-Gero-Competencies-2010.pdf

American Association of Colleges of Nursing. (2015, August). *The Doctor of Nursing Practice: Current issues and clarifying recommendations: Report from the Task Force on the implementation of the DNP*. https://www.aacnnursing.org/Portals/42/DNP/DNP-Implementation.pdf

American Association of Colleges of Nursing. (2016a). *CARES: Competencies and recommendations for educating undergraduate nursing students: Preparing nurses to care for the seriously ill and their families*. https://www.aacnnursing.org/Portals/42/ELNEC/PDF/New-Palliative-Care-Competencies.pdf

American Association of Colleges of Nursing. (2016b). *End-of-Life Nursing Education Consortium (ELNEC) FACT SHEET*. http://www.aacn.nche.edu/elnec/about/fact-sheet

American Association of Colleges of Nursing. (2018). *Defining scholarship for academic nursing* [Position paper]. https://www.aacnnursing.org/News-Information/Position-Statements-White-Papers/Defining-Scholarship-Nursing

American Nurses Association & Hospice and Palliative Nurses Association. (2017, March 13). *Call for action: Nurses lead and transform palliative care*. https://www.nursingworld.org/~497158/globalassets/practiceandpolicy/health-policy/palliativecareprofessionalissuespanelcallforaction.pdf

Ashley, Jennifer L., Fasolino, Tracy K. (2016). Palliative and hospice care: Educational needs of inpatient registered nurses. *Creative Nursing, 22*(2), 114-120. doi:http://dx.doi.org/10.1891/1078-4535.22.2.114

Barrere, C.C., Durkin, A., and LaCoursiere, S. (2008). The influence of end-of-life education on attitudes of nursing students. *International Journal of Nursing Education, 5*(1), 1-18.

Benner, P. (1982). From novice to expert. *The American Journal of Nursing, 82*(3): 402-407. Retrieved on January 2022.

Bennett, M. P., Lovan, S., Hager, K., Canonica, L., & Taylor, B. (2018). A one hour teaching intervention can improve end-of-life care. Nurse Education Today. http://dx.doi.org/https://doi.org/10.1016/j.nedt.2018.05.010

Bergenholtz H, Timm HU, Missel M. (2019)Talking about end of life in general palliative care – what's going on? A qualitative study on end-of-life conversations in an acute care hospital in Denmark. *BMC Palliative Care;18*(1):62.

Bergman, J., Ballon-Landa, E., Lorenz, K., Saucedo, J., Saigal, C., Bennett, C. and Litwin, M. (2014), "Community-partnered collaboration to build an integrated palliative care clinic: the view from urology", *American Journal of Hospice and Palliative Care, Vol*. 33 No. 2, pp. 164-170.

Bernacki R. E., Block S. D. the American College of Physicians High Value Care Task Force. (2014). Communication about serious illness care goals:Areview and synthesis of best practices. *JAMA Internal Medicine, 174*(12), 1994–2003 10.1001/jamainternmed.2014.5271 PMID: 25330167

Bishop, C. T., Mazanec, P., Bullington, J., Craven, H., Dunkerley, M., Pritchett, J., & Coyne, P. J. (2019). Online end-of-life nursing education consortium core curriculum for staff nurses: An education strategy to improve clinical practice. *Journal of Hospice and Palliative Nursing, 21*(6), 531–539. 10.1097/NJH.0000000000000593

Brajtman S , Fothergill-Bourbonnais F , Fiset V , Alain D , (2009). Survey of educators' end-of-life care learning needs in a Canadian baccalaureate nursing programme. *International Journal of Palliative Nursing, 15*(5), 233--241.

Brouns, S. H., Brüggemann, R., Linkens, A., Magdelijns, F. J., Joosten, H., Heijnen, R., Ten Cate-Hoek, A. J., Schols, J., Ten Cate, H., & Spaetgens, B. (2020). Mortality and the Use of Antithrombotic Therapies Among Nursing Home Residents with COVID-19. *Journal of the American Geriatrics Society, 68*(8), 1647–1652. https://doi.org/10.1111/jgs.16664

Carayon P, Gurses AP. (2008). Nursing Workload and Patient Safety—A Human Factors Engineering Perspective. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US). Chapter 30. https://www.ncbi.nlm.nih.gov/books/NBK2657/

Carroll G , Brisson D P , Ross M M , Labbe R , (2005). The French version of the Palliative Care Quiz for Nursing (PCQN-F): Development and evaluation. *Journal of Palliative Care, 21*(1), 27--34.

Chan, R., Webster, J. and Bowers, A. (2016), "End-of-life care pathways for improving outcomes in caring for the dying", *Cochrane Database of Systematic Reviews, Vol*. 2, pp. 1-31.

Conlen M. More than 40% of US coronavirus deaths are linked to nursing homes. New York Times. Retrieved from https://www.nytimes.com/interactive/2020/us/coronavirusnursing-homes.html. Accessed August 13, 2020.

Dahlin, C. M., & Wittenberg, E. (2019). An Essential Competency for Nurses. Oxford Textbook of Palliative Nursing, 55.

Dang, D., Dearholt, S., Bissett, K., Ascenzi, J., & Whalen, M. (2022). Johns Hopkins evidence-based practice for nurses and healthcare professionals: Model and guidelines. 4th ed. Sigma Theta Tau International

DiCenso A , Guyatt G , Ciliska D , (2005). Evidence-based nursing: A guide to clinical practice. St. Louis, MO: Mosby.

Ecker, E. D., & Skelly, A. C. (2010). Conducting a winning literature search. *Evidence-based spine-care journal, 1*(1), 9–14. https://doi.org/10.1055/s-0028-1100887

End-of-Life Nursing Education Consortium. (2018, April). End-of-life nursing education consortium (ELNEC) fact sheet. Retrieved from http://www.aacnnursing.org/Portals/42/ ELNEC/PDF/FactSheet.pdf

Etkind, S. N., Bone, A. E., Lovell, N., Cripps, R. L., Harding, R., Higginson, I. J., & Sleeman, K. E. (2020). The role and response of palliative care and hospice services in epidemics and pandemics: A rapid review to inform practice during the COVID-19 pandemic. *Journal of Pain and Symptom Management, 60*(1), E31–E40. 10.1016/j.jpainsymman.2020.03.029

Feltovich, N. (2003), Nonparametric Tests of Differences in Medians: Comparison of the Wilcoxon-Mann-Whitney and Robust Rank-Order Tests. *Experimental Economics, vol*. 6, pp. 273-297.

Ferrell, B., Malloy, P., & Virani, R. (2015). The end of life nursing education consortium project. *Annals of Palliative Medicine, 4*(2), 61-66. doi: 10.3978/j.issn.2224-5820.2015.04.05

Ferrell, B. R., Twaddle, M. L., Melnick, A., & Meier, D. E. (2018). National Consensus Project Clinical Practice Guidelines for Quality Palliative Care Guidelines, 4th Edition. *Journal of palliative medicine, 21*(12), 1684–1689. https://doi.org/10.1089/jpm.2018.0431

Ferrell, B., Mazanec, P., Malloy, P., & Virani, R. (2018). An innovative end-of-life nursing education consortium curriculum that prepares nursing students to provide primary palliative care. *Nurse Educator*, *43*(5), 242-246. doi: 10.1097/NNE.0000000000000497

Frey, R., Balmer, D., Boyd, M., Robinson, J., & Gott, M. (2019). Palliative care nurse specialists' reflections on a palliative care educational intervention in long-term care: an inductive content analysis. *BMC palliative care, 18*(1), 103. https://doi.org/10.1186/s12904-019-0488-4

Frommelt, K. H. M. (1991). The effects of death education on nurses’ attitudes toward caring for terminally ill persons and their families. *American Journal of Hospice*

*& Palliative Care, 8*(5), 37-43. https://doi.org/10.1177/104990919100800509

Gilissen, J., Pivodic, L., Smets, T., Gastmans, C., Vander Stichele, R., Deliens, L., & Van den Block, L. (2017). Preconditions for successful advance care planning in nursing homes: A systematic review. *International journal of nursing studies, 66,* 47–59. https://doi.org/10.1016/j.ijnurstu.2016.12.003

Gillan, P. C., Jeong, S. & van der Riet, P. (2014). End of life care simulation: A review of the literature. *Nurse Educator Today, 34*(5).766-774. https://doi.org/10.1016/j.nedt.2013. 10.005

Goodman C, Sharpe R, Russell C, Meyer J, Gordon AL, Dening T, Corazzini K, Lynch J and Bunn F (2017) Care home readiness: a rapid review and consensus workshops on how organizational context affects care home engagement with health care innovation. https://doi.org/10.18745/pb.18200

Hado , E., & Komisar , H. (2019, August 0). AARP® Official Site -Long-Term Services and Supports. AARP; www.aarp.org. Retrieved from https://www.aarp.org/content/dam/aarp/ppi/2019/08/long-term-services-and-supports.

Hallman, Kathryn, & Newton, Susie. (2019). Outpatient palliative care. *Clinical Journal of Oncology Nursing, 23*(2), 203-208. doi:http://dx.doi.org/10.1188/19.CJON.203-208

Harasym, P. M., Afzaal, M., Brisbin, S., Sinnarajah, A., Venturato, L., Quail, P., . . . Holroyd-Leduc, J. (2021). Multi-disciplinary supportive end of life care in long-term care: An integrative approach to improving end of life. *BMC Geriatrics, 21,* 1-10. doi:http://dx.doi.org/10.1186/s12877-021-02271-1

Harden, K., Price, D., Duffy, E., Galunas, L., & Rodgers, C. (2017). Palliative care: Improving nursing knowledge, attitudes, and behaviors. Clinical Journal of *Oncology Nursing, 21*(5), E232-E238. doi:http://dx.doi.org/10.1188/17.CJON.E232-E238

Harris-Kojetin L, Sengupta M, Park-Lee E, et al. Long-term care providers and services users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014. National Center for Health Statistics. *Vital Health Stat 3(*38). 2016.

Harris, J.A., Herrel, L.A., Healy, M.A., Wancata, L.M. and Perumalswami, C.R. (2016), “Milestones for the final mile: interspecialty distinctions in primary palliative care skills training”, *Pain and Symptom Management, Vol.* 52 No. 3, pp. 345-352.

Ho, A., Luk, J., Chan, F., Chun Ng, W., Kwok, C., Yuen, J., Tam, M., Kan, W. and Chan, C. (2016), “Dignified palliative long-term care: an interpretive systematic framework of end-of-life integrated care pathway for terminally ill Chinese older adults”, *American Journal of Hospice and Palliative Medicine, Vol.* 33 No. 5, pp. 439-447.

Hodges, B. C., & Videto, D. M. (2011). Assessment and planning in health programs (2nd ed.). Sudbury, MA: Jones & Bartlett Learning. Homler, H. (2015). Hospice revocation with pleasure. *Journal of Palliative Medicine, 18* (1),84-85. doi:10.1089/jpm.2014.0080

Hodgkinson, I., Vince, C., Aylott, C., Pamphilon, J., Chandler, J., & Chumbley, K. (2018). P-243 End of life care education within the nursing and residential home setting. *BMJ Supportive & Palliative Care, 8* doi:http://dx.doi.org/10.1136/bmjspcare-2018-hospiceabs.268

Hollander, M., Wolfe, D.A. (1999), Nonparametric Statistical Methods, 2nd ed., New York: Wiley.

Hoseini A-S, Memarian R. (2009). The effect of employing Synectic model in teaching palliative Care in Children on nursing Students' writing creativity and academic performance. *Iranian Journal of Medical Education*. *9*(3):239–48 (in Persian).

Institute of Medicine. Dying in America: improving quality and honoring individual preferences near the end of life. 2015. Retrieved from http://iom.nationalacademies.org/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx/, . Accessed January 19, 2016.

Iranmanesh S, Razban F, Tirgari B, Zahra G. (2014). Nurses' knowledge about palliative care in Southeast Iran. *Palliative Support Care. 12*(3):203–210. https://doi.org/10.1017/S1478951512001058 PMID:23905678

Jones, N. (2008). Osteoporosis screening rates in men with risk factors (Order No. 1453243). Available from Nursing & Allied Health Premium. (304821223). Retrieved from https://www.proquest.com/dissertations-theses/osteoporosis-screening-rates-men-with-risk/docview/304821223/se-2?accountid=150060

Karlsson M., Kasén A., Wärnå-Furu C. (2017). Reflecting on one's own death: The existential questions that nurses face during end-of-life care. *Palliative & Supportive Care*, *15*(2), 158–167 10.1017/S1478951516000468 PMID: 27346543

Knapp C A , Madden V , Wang H , Kassing K , Curtis C , Sloyer P , (2009). Paediatric nurses' knowledge of palliative care in Florida: A quantitative study. *International Journal of Palliative Nursing*, *15*(9), 432--439.

Kim S, Hwang WJ. Palliative care for those with heart failure: nurses' knowledge, attitude, and preparedness to practice. Eur J Cardiovasc

Laging B, Ford R, Bauer M, Nay R. (2015). A meta-synthesis of factors influencing nursing home staff decisions to transfer residents to hospital. *Journal of Advance Nursing;71*(10):2224e36. https://doi.org/10.1111/jan.12652 10.

Lalani, N., & Cai, Y. (2022). Palliative care for rural growth and wellbeing: identifying perceived barriers and facilitators in access to palliative care in rural Indiana, USA. *BMC palliative care, 21*(1), 25. https://doi.org/10.1186/s12904-022-00913-8

Leung, J. M., Udris, E. M., Uman, J., & Au, D. H. (2012). The effect of end-of-life discussions on perceived quality of care and health status among patients with COPD. *Chest, 142*(1), 128–133. https://doi.org/10.1378/chest.11-2222

Lippe, M., Volker, D., Jones, T., & Carter, P. (2017). Evaluating end-of-life care education within nursing programs: A method for targeted curriculum evaluation. *Journal of Hospice and Palliative Nursing, 19*, 266-274. https://doi.org/10.1097/NJH.0000000000000341

Lund, S., Richardson, A., & May, C. (2015). Barriers to advance care planning at the end of life: an explanatory systematic review of implementation studies. *PloS one*, *10*(2), e0116629. https://doi.org/10.1371/journal.pone.0116629

Lupu, D., Quigley, L., Mehfoud, N., & Salsberg, E. S. (2018). The Growing Demand for Hospice and Palliative Medicine Physicians: Will the Supply Keep Up?. *Journal of pain and symptom management*, *55*(4), 1216–1223. https://doi.org/10.1016/j.jpainsymman.2018.01.011

Mack, K. T. (2016). Motivational interviewing to promote improvement in diabetic glycemic control and improve patient satisfaction (Order No. 10103083). Available from Nursing & Allied Health Premium. (1786969587). Retrieved from https://www.proquest.com/dissertations-theses/motivational-interviewing-promote-improvement/docview/1786969587/se-2?accountid=150060

Majid, U., Kim, C., Cako, A., & Gagliardi, A. R. (2018). Engaging stakeholders in the co-development of programs or interventions using Intervention Mapping: A scoping review. *PloS one, 13*(12), e0209826. https://doi.org/10.1371/journal.pone.0209826

Malloy, P., Virani, R., Kelly, K., & Munvevar, C. (2010). Beyond bad news. Journal of Hospice and Palliative Care, 12(3), 166- 174. Retrievef from https://nursing.ceconnection.com/ovidfiles/00129191-201005000-00007.pdf

Mark, M. (2019). What the 2020 Census will tell us about a changing America. *Population Bulleti*n *74, no.* 1. Retrieved from https://www.prb.org/news/what-the-2020-u-s-census-will-tell-us-about-a-changing-america/

Matey L. (2018). When Advocacy Extends Life: Age and Diagnosis Discrimination in Patients With Serious Illness. Journal of hospice and palliative nursing : *The Official Journal of the Hospice and Palliative Nurses Association, 20*(2), 114–117. https://doi.org/10.1097/NJH.0000000000000408

May, J. T., Littzen, C., Morrison, H. W., & Loescher, L. J. (2020). Experiences of dual PHD-DNP nursing students during doctoral education. *Journal of professional nursing : official journal of the American Association of Colleges of Nursing, 36*(5), 348–355. https://doi.org/10.1016/j.profnurs.2020.02.004

Mazanec, P., Ferrell, B., Virani, R., Alayu, J., & Ruel, N. H. (2020). Preparing new graduate RNs to provide primary palliative care. *The Journal of Continuing Education in Nursing, 51*(6), 280-286. doi:http://dx.doi.org/10.3928/00220124-20200514-08

McCauley, L. A., Broome, M. E., Frazier, L., Hayes, R., Kurth, A., Musil, C. M., Norman, L. D., Rideout, K. H., & Villarruel, A. M. (2020). Doctor of nursing practice (DNP) degree in the United States: Reflecting, readjusting, and getting back on track. *Nursing outlook, 68*(4), 494–503. https://doi.org/10.1016/j.outlook.2020.03.008

McMichael, T. M., Currie, D. W., Clark, S., Pogosjans, S., Kay, M., Schwartz, N. G., Lewis, J., Baer, A., Kawakami, V., Lukoff, M. D., Ferro, J., Brostrom-Smith, C., Rea, T. D., Sayre, M. R., Riedo, F. X., Russell, D., Hiatt, B., Montgomery, P., Rao, A. K., Chow, E. J., … Public Health–Seattle and King County, EvergreenHealth, and CDC COVID-19 Investigation Team (2020). Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington. *The New England journal of medicine, 382*(21), 2005–2011. https://doi.org/10.1056/NEJMoa2005412

Meier, D. E., Back, A. L., Berman, A., Block, S. D., Corrigan, J. M., & Morrison, R. S. (2017). *A national strategy for palliative care. Health Affairs, 36*(7), 1265-1273. doi:http://dx.doi.org/10.1377/hlthaff.2017.0164

Melnyk B M , (2012). Achieving a high-reliability organization through implementation of the ARCC model for systemwide sustainability of evidence-based practice. *Nursing Administration Quarterly, 36*(2), 127--135 10.1097/NAQ.0b013e318249fb6a.

Mitchell, S. L., Buchanan, J. L., Littlehale, S., & Hamel, M. B. (2004). Tube-feeding versus hand-feeding nursing home residents with advanced dementia: a cost comparison. *Journal of the American Medical Directors Association, 5*(2 Suppl), S22–S29. https://doi.org/10.1097/01.JAM.0000043421.46230.0E

Mor, V., & Teno, J. M. (2016). Regulating and Paying for Hospice and Palliative Care: Reflections on the Medicare Hospice Benefit. *Journal of health politics, policy and law, 41*(4), 697–716. https://doi.org/10.1215/03616878-3620893

Nambayan A. G. (2018). Palliative Care: Opportunities for Nursing. *Asia-Pacific journal of oncology nursing, 5*(1), 1–3. https://doi.org/10.4103/apjon.apjon_77_17

Negarandeh R, Mardani Hamooleh M, Rezaee N. (2015). Concept Analysis of Palliative Care in Nursing: Introducing a Hybrid Model. J Mazandaran. *Univ Med Sci. 25* (130) :40-51 URL: http://jmums.mazums.ac.ir/article-1-6392-en.html

Newhouse, R., Dearholt, S., Poe, S., Pugh, L. C., & White, K. M. (2005). Evidence-based practice: a practical approach to implementation. *The Journal of nursing administration, 35*(1), 35–40. https://doi.org/10.1097/00005110-200501000-00013

Ouslander, J. (2019). Strategies to reduce potentially avoidable hospitalisations among long-term care facility residents. *BMJ Quality & Safety, 28*(7), 515. doi:http://dx.doi.org/10.1136/bmjqs-2019-009384

Patel, K. and Masi, D. (2015), “Palliative care in the era of health care reform”, Clinics in Geriatric Medicine, Vol. 31 No. 2, pp. 265-270. Retrieved from https://eprints.bournemouth.ac.uk/31551/3/Main%20paper%2018%2010%2018.pdf

Prince-Paul M, Daly BJ. (2015). Ethical considerations in palliative care. In: Ferrell BR, Coyle N, Paice JA, eds. Oxford Textbook of Palliative Nursing. 4th ed. New York, NY: Oxford University Press; 987-1000. https://doi.org/10.1093/med/9780199332342.003.0065

Raco, M., Burdett, T., & Heaslip, V. (2019). Exploring an integrated palliative care model for older people: An integrative review: Managing community care. *Journal of Integrated Care, 27*(2), 111-122. doi:http://dx.doi.org/10.1108/JICA-10-2018-0065

Radbruch, L., Knaul, F. M., de Lima, L., de Joncheere, C., & Bhadelia, A. (2020). The key role of palliative care in response to the COVID-19 tsunami of suffering. *Lancet (London, England), 395*(10235), 1467–1469. https://doi.org/10.1016/S0140-6736(20)30964-8

Raudonis, B. M., Kyba, F. C., & Kinsey, T. A. (2002). Long-term care nurses' knowledge of end-of-life care. *Geriatric nursing (New York, N.Y.), 23*(6), 296–301. https://doi.org/10.1067/mgn.2002.130270

Reinke, L. F., Shannon, S. E., Engelberg, R., Dotolo, D., Silvestri, G. A., & Curtis, J. R. (2010). Nurses' identification of important yet under-utilized end-of-life care skills for patients with life-limiting or terminal illnesses. *Journal of palliative medicine, 13*(6), 753–759. https://doi.org/10.1089/jpm.2009.0423

Rooda, L. A., Clements, R., & Jordan, M. L. (1999). Nursesí attitudes toward death and caring for dying patients. *Oncology Nursing Forum, 26*(10), 1683-1687.

Rosa, W. (2019). Spiritual care intervention.  In B. R. Ferell & J. A. Paice (Eds.) Oxford textbook of palliative nursing (5th ed., pp. 447-455). Oxford University Press. https://doi.org/10.1093/med/9780190862374.003.0035

Rosa, W. E., & Davidson, P. M. (2020). Coronavirus disease 2019 (COVID-19): strengthening our resolve to achieve universal palliative care. *International nursing review, 67*(2), 160–163. https://doi.org/10.1111/inr.12592

Ross, M., McDonald, B., & McGuinnes, J. (1996). The Palliative Care Quiz for Nursing (PCQN): The development of an instrument to measure nurses’ knowledge of palliative care. *Journal of Advanced Nursing 23*(1), 126-137. https://doi.org/10.1111/j.1365-2648.1996.tb03106.x

Rosswurm, M.A., & Larrabee, J. (1999). A model for change to evidence- based practice. Image: *Journal of Nursing Scholarship, 31*(4), 317-322. http://dx.doi.org/10.1111/j.1547-5069.1999.tb00510.x

Shariff, A., Olson, J., Salas, A. S., & Cranley, L. (2017). Nurses' experiences of providing care to bereaved families who experience unexpected death in intensive care units: A narrative overview. *The Canadian journal of critical care nursing*, *28*(1), 21–29.

Shu-Wan, C., Shu-Chen, W., & Tai-Chu, P. (2021). The experience to implement palliative care in long-term care facilities: A grounded theory study of caregivers. *Asian Nursing Research*, *15*(1), 15-22. doi:http://dx.doi.org/10.1016/j.anr.2020.10.006

Spetz, J., Dudley, N., Trupin, L., Rogers, M., Meier, D. E., & Dumanovsky, T. (2016). Few Hospital Palliative Care Programs Meet National Staffing Recommendations. *Health Affairs, 35*(9), 1690-1697,1-6. http://dx.doi.org/10.1377/hlthaff.2016.0113

Tanizaki, H. (1997), Power Comparison of Non-Parametric Tests: Small-Sample Properties from Monte Carlo Experiments, *Journal of Applied Statistics, vol*. 24, pp. 603-632. https://doi.org/10.1080/02664769723576

Tanuseputro, P., Chalifoux, M., Bennett, C., Gruneir, A., Bronskill, S. E., Walker, P., & Manuel, D. (2015). Hospitalization and Mortality Rates in Long-Term Care Facilities: Does For-Profit Status Matter?. *Journal of the American Medical*

*Directors Association, 16*(10), 874–883. https://doi.org/10.1016/j.jamda.2015.06.004

Teno, J. M., Gozalo, P., Trivedi, A. N., Bunker, J., Lima, J., Ogarek, J., & Mor, V. (2018). Site of Death, Place of Care, and Health Care Transitions Among US Medicare Beneficiaries, 2000-2015. *JAMA*, *320*(3), 264–271. https://doi.org/10.1001/jama.2018.8981

Throop, M. D. (2012). Getting to the point: Promoting the HPV vaccine in a primary care clinic (Order No. 3508808). Available from Nursing & Allied Health Premium. (1018549896). Retrieved from https://www.proquest.com/dissertations-theses/getting-point-promoting-hpv-vaccine-primary-care/docview/1018549896/se-2?accountid=150060

Towsley, G. L., Hirschman, K. B., & Madden, C. (2015). Conversations about End of Life: Perspectives of Nursing Home Residents, Family, and Staff. *Journal of palliative medicine, 18*(5), 421–428. https://doi.org/10.1089/jpm.2014.0316

Trautman, D. E., Idzik, S., Hammersla, M., & Rosseter, R. (2018). Advancing Scholarship through Translational Research: The Role of PhD and DNP Prepared Nurses. *Online Journal of Issues in Nursing*, *23*(2), 1. https://doi-org.ezp.waldenulibrary.org/10.3912/OJIN.Vol23No02Man02

Travers, A., & Taylor, V. (2016). What are the barriers to initiating end-of-life conversations with patients in the last year of life?. *International journal of palliative nursing*, *22(*9), 454–462. https://doi.org/10.12968/ijpn.2016.22.9.454

Wallin, L., Bostrom, A. M., Wikblad, K., & Ewald, U. (2003). Sustainability in changing clinical practice promotes evidence-based nursing care. *Journal of Advanced Nursing, 41*(5), 509-518. doi:10.1046/j.1365-2648.2003.02574x

Wen, A., M.D., Gatchell, G., D.O., Tachibana, Y., M.D., Tin, M. M., M.D., Bell, C., M.D., Koijane, J., M.P.H., Zeri, Kenneth, RN,M.S., N.H.A., & Masaki, K., M.D. (2012). A Palliative Care Educational Intervention for Frontline Nursing Home Staff: The IMPRESS Project. *Journal of Gerontological Nursing*, *38*(10), 20-25. http://dx.doi.org/10.3928/00989134-20120906-96

Wiggins, H. D. (2016). Assessment of rural nurses' educational needs in providing evidence-based end-of-life care (Order No. 10113265). Available from Nursing & Allied Health Premium. (1794656269). Retrieved from https://www.proquest.com/dissertations-theses/assessment-rural-nurses-educational-needs/docview/1794656269/se-2?accountid=150060

White, K. M., Dudley-Brown, S., & Terharr, M. F. (2016). Translation of evidence into nursing and health care practice (2nd ed.). New York, NY: Springer.

Wittenberg-Lyles, E., Goldsmith, J., & Ragan, S. (2011). The shift to early palliative care: a typology of illness journeys and the role of nursing. *Clinical journal of oncology nursing*, *15*(3), 304–310. https://doi.org/10.1188/11.CJON.304-310

World Health Organization. (2013). WHO definition of palliative care. Available at: http://www.who.int.myaccess.library.utoronto.ca/cancer/ palliative/definition/en/ (accessed 23 July 2021).

World Health Organization. Palliative Care. [cited 2020 October 19]. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/palliative-care.

Zheng, R., Lee, S. F., & Bloomer, M. J. (2018). How nurses cope with patient death: A systematic review and qualitative meta-synthesis. Journal of clinical nursing, 27(1-2), e39–e49. https://doi.org/10.1111/jocn.13975

# Appendix A: Permission to Use the Palliative Care Quiz for Nursing

## Re: Requesting PERMISSION

Yahoo/Inbox

- 

**Frances Fothergill Bourbonnais** <email address redacted>

To:Naquita altidor

Fri, Dec 17 at 8:52 AM

Naquita, you are welcome to use the PCQN in your doctoral project. I have looked after Dr. Ross correspondence for many years. Dr. Ross is deceased. Please cite the article where the tool is located, namely Journal of Advanced Nursing, 1996, 23, 126-137. Best wishes on your future work. Frances

Frances Fothergill Bourbonnais, PhD, RN

Emeritus Professor

School of Nursing,

University of Ottawa,

[email address redacted]

[telephone number redacted]

---

**From:** Naquita altidor <email address redacted>
**Sent:** Thursday, December 16, 2021 8:36 PM
**To:** Frances Fothergill Bourbonnais <email address redacted>
**Subject:** Requesting PERMISSION

Dear Dr. Fothergill-Bourbonnais,

My name is Naquita Jacques and I am a Doctor of Nursing Practice student at Walden University in Minneapolis. I am in the process of preparing my evidence-based practice project on integrating end-of-life care in Long-Term Care facilities, I would like to use the Palliative Care Quiz for Nursing by Dr. Margaret Ross to measure the nurses' knowledge. However, I do not have any contact information for her. I would like to request her permission to use the instrument. If you have any information, could you please forward her my letter requesting permission? I would greatly appreciate your assistance.

Thank you.

Sincerely, Naquita Jacques, MSN, RN

# Appendix B: Permission to Use the Frommelt Attitude Toward the Care of the Dying Scale

## Re: Requesting PERMISSION

Yahoo/Inbox

**Katherine Frommelt** <email address redacted>

To:Naquita altidor

Tue, Jan 18 at 11:07 AM

I got my PhD from Walden. I am happy to give you permission to use this tool. Best of luck with your studies

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

Sent from my iPhone

On Jan 17, 2022, at 5:00 PM, Naquita altidor <email address redacted> wrote:

Dear Dt. Frommelt,

My name is Naquita Jacques and I am a Doctor Nurse Practice student at Walden University. I am currently working on my Capstone proposing to integrate End of life education in a Long-Term Care facility. Respectfully, I would like permission to utilize the Frommelt attitude toward the care of dying scale form A to measure the nurses' attitude pre and post the education. In addition, I will also use the demographic data sheet that you had created in your 2003 journal of hospice and palliative care article on attitude toward the care of the terminally ill.

Thank you in advance.

Naquita Altidor

# Appendix C: Palliative Care Quiz for Nursing

Ross, M., McDonald, B., & McGuinnes, J. (1996). The Palliative Care Quiz for Nursing (PCQN): The development of an instrument to measure nurses’ knowledge of palliative care. *Journal of Advanced Nursing 23*(1), 126-137. https://doi.org/10.1111/j.1365-2648.1996.tb03106.x

1. Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration.

   True False Don’t Know

2. Morphine is the standard used to compare the analgesic effect of other opioids

   True False Don’t Know

3. The extent of the disease determines the method of pain treatment

   True False Don’t Know

4. Adjuvant therapies are important in managing pain

   True False Don’t Know

5. It is crucial for family members to remain at the bedside until death occurs.

   True False Don’t Know

6. During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation.

   True False Don’t Know

7. Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain

   True False Don’t Know

9. Individuals who are taking opioids should also follow a bowel regime.

True False Don’t Know

10. The provision of palliative care requires emotional detachment

True False Don’t Know

11. During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment for severe dyspnea.

True False Don’t Know

12. Men generally reconcile their grief more quickly than women

True False Don’t Know

13. The philosophy of palliative care is compatible with that of aggressive

True False Don’t Know

14. The use of placebos is appropriate in the treatment of some types

True False Don’t Know

15. In high doses, codeine causes more nausea and vomiting than

True False Don’t Know

16. Suffering and physical pain are synonymous.

True False Don’t Know

17. Demerol is not an effective analgesic in the control of

True False Don’t Know

18. The accumulation of losses renders burnout inevitable for those who seek work in palliative care.

True False Don’t Know

20. Manifestations of chronic pain are different from those of

True False Don’t Know

21. The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate.

True False Don’t Know

22. The pain threshold is lowered by anxiety or fatigue.

True False Don’t Know

# Appendix D: Palliative Care Quiz for Nursing Answers

Ross, M., McDonald, B., & McGuinnes, J. (1996). The Palliative Care Quiz for Nursing (PCQN): The development of an instrument to measure nurses' knowledge of palliative care. *Journal of Advanced Nursing 23*(1), 126-137. https://doi.org/10.1111/j.1365-2648.1996.tb03106.x

Correct answers are highlighted in yellow.

1. Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration.

   True **False** Don't Know

2. Morphine is the standard used to compare the analgesic effect of other opioids

   **True** False Don't Know

3. The extent of the disease determines the method of pain treatment

   True **False** Don't Know

4. Adjuvant therapies are important in managing pain

   **True** False Don't Know

5. It is crucial for family members to remain at the bedside until death occurs.

   True **False** Don't Know

6. During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation.

   **True** False Don't Know

7. Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain

   True **False** Don't Know

8. Individuals who are taking opioids should also follow a bowel regime.

**True** False Don’t Know

9. The provision of palliative care requires emotional detachment

True **False** Don’t Know

10. During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment for severe dyspnea.

**True** False Don’t Know

11. Men generally reconcile their grief more quickly than women

True **False** Don’t Know

12. The philosophy of palliative care is compatible with that of aggressive

**True** False Don’t Know

13. The use of placebos is appropriate in the treatment of some types

True **False** Don’t Know

14. In high doses, codeine causes more nausea and vomiting than

**True** False Don’t Know

15. Suffering and physical pain are synonymous.

True **False** Don’t Know

16. Demerol is not an effective analgesic in the control of

**True** False Don’t Know

17. The accumulation of losses renders burnout inevitable for those who seek work in palliative care.

True **False** Don’t Know

18. Manifestations of chronic pain are different from those of

| | | |
|---|---|---|
| **True** | False | Don’t Know |

19. The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate.

| | | |
|---|---|---|
| True | **False** | Don’t Know |

20. The pain threshold is lowered by anxiety or fatigue.

| | | |
|---|---|---|
| **True** | False | Don’t Know |

# Appendix E: Frommelt Attitudes Toward Care of the Dying Scale

Frommelt, K. H. M. (1991). The effects of death education on nurses' attitudes toward caring for terminally ill persons and their families. *American Journal of Hospice & Palliative Care*, *8*(5), 37-43. https://doi.org/10.1177/104990919100800509

Instructions: Please circle the letter following each statement which corresponds to your own personal feelings about the attitude or situation presented. Please respond to all 30 statements on the scale. The meanings of the letters are:

SD = Strongly Disagree

D = Disagree

U = Uncertain

A = Agree

SA = Strongly Agree

1. Giving nursing care to the dying person is a worthwhile learning experience.

   SD D U A SA

2. Death is not the worst thing that can happen to a person

   SD D U A SA

3. I would be uncomfortable talking about impending death with the dying person.

   SD D U A SA

4. Nursing care for the patient's family should continue throughout the period of grief and bereavement.

   SD D U A SA

5. I would not want to be assigned to care for a dying person.

   SD D U A SA

6. The nurse should not be the one to talk about death with the dying person.

   SD D U A SA

7. The length of time required to given nursing care to a dying person would frustrate me.

   SD D U A SA

8. I would be upset when the dying person I was caring for gave up hope of getting better.

   SD D U A SA

9. It is difficult to form a close relationship with the family of the dying person.

   SD D U A SA

10. There are times when death is welcomed by the dying person.

    SD D U A SA

11. When a patient asks, “Nurse am I dying?,” I think it is best to change the subject to something cheerful.

    SD D U A SA

12. The family should be involved in the physical care of the dying person.

    SD D U A SA

13. I would hope the person I’m caring for dies when I am not present.

    SD D U A SA

14. I am afraid to become friends with a dying person.

    SD D U A SA

15. I would feel like running away when the person actually died

    SD D U A SA

16. Families need emotional support to accept the behavior changes of the dying person.

SD D U A SA

17. As a patient nears death, the nurse should withdraw from his/her involvement with the patient.

SD D U A SA

18. Families should be concerned about helping their dying member make the best of his/her remaining life.

SD D U A SA

19. The dying person should not be allowed to make decisions about his/her physical care.

SD D U A SA

20. Families should maintain as normal an environment as possible for their dying member.

SD D U A SA

21. It is beneficial for the dying person to verbalize his/her feelings.

SD D U A SA

22. Nursing care should extend to the family of the dying person

SD D U A SA

23. Nurses should permit dying persons to have flexible visiting schedules.

SD D U A SA

24. The dying person and his/her family should be the in-charge decision makers.

SD D U A SA

26. Addiction to pain relieving medication should not be a concern when dealing with a dying person.

    SD D U A SA

27. I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.

    SD D U A SA

28. Dying persons should be given honest answers about their condition.

    SD D U A SA

29. Educating families about death and dying is not a nursing responsibility.

    SD D U A SA

30. Family members who stay close to a dying person often interfere with the professionals' job with the patient.

    SD D U A SA

31. It is possible for nurses to help patients prepare for death.

    SD D U A SA