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Knowledge and Attitudes of Emergency Room Nurses Regarding Palliative Care Patients

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Dr. Janice Long, Committee Member, Nursing Faculty
Dr. Faisal Hassan Aboul-Enein, University Reviewer, Nursing Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2018

Abstract

Knowledge and Attitudes of Emergency Room Nurses Regarding Palliative Care Patients

by

Pearl Alethea Harrison

MSN, Walden University, 2012

BSN, Mercer University 2006

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

August 2018

Abstract

Palliative care (PC) is the comprehensive management of patients diagnosed with terminal illness. Care for PC patients focuses on relieving symptoms. The purpose of this study was to determine the difference between pretest and posttest scores on the Frommelt Attitude towards the Care of the Dying (FATCOD) and the Palliative Care Quiz for Nurses (PCQN) after an educational intervention to emergency department (ED) nurses. The framework for this project was Bandura's social cognitive theory. The FATCOD was used to assess ED nurses' attitudes toward PC, and the PCQN was used to assess ED nurses' knowledge about PC prior to the educational program. The educational intervention was developed using evidence obtained from the literature review and guided by the PCQN. The program presented to the ED nurses covered the essentials of palliative care and the information and skills needed by the ED nurse caring for the PC patient. The FATCOD and the PCQN were then administered as a posttest. A total of 70 nurses from two ED units volunteered to take part in the project. Results of the PCQN pre- and posttest showed a significant difference ($p < .05$), and the FATCOD pre- and posttest showed no significant difference ($p = .849$). The results revealed that education significantly improved knowledge of PC for the ED nurses participating in the project. Attitudes about PC were not significantly changed after the education program. The project promotes positive social change by raising awareness of the need for PC educational opportunities for ED nurses. By improving PC in the ED, patients and their families may experience increased satisfaction with end-of-life care and improved quality of life.

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Dedication

It with my sincere gratitude, I dedicate this project to Susan Baddi (deceased). Susan believed in the importance of giving excellent care to patients, who are terminally ill. My love for palliative care began with Susan introducing me to the concept. She was not a nurse, but she believed in the value of caring for the terminally ill. I also dedicate this project to my husband, Clifton Harrison, and my two children, Ashlyann and Blake. They are the catalysts of this DNP journey to higher learning, helping them to understand the importance of being resilient and never giving up, even when the road ahead seems bleak.

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My sincere thanks to Dr. Andrea Jennings-Sanders, Dr. Janice Long and Dr.

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been an easy task; many ups and downs with varied twists and turns. Yet your

understanding, professionalism and mentorship have helped me stay the course and

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believed in my passion on this topic, I thank you for your encouragement and support.

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Section 1. Nature of the Project

Introduction

Palliative Care (PC) is the comprehensive management of physical,

psychological, social, spiritual, and existential needs of patients with an incurable disease

(Clark, Drain, & Malone, 2003). Palliative care affirms life and regards dying as a natural

process that is a profoundly personal experience for the individual dying and his or her

family (Canadian Hospice Palliative Care Association Nursing Standards

Committee[CHPCA], 2009, p. 9). PC is specialized medical care focusing on relieving

patients' symptoms, such as pain, nausea, vomiting, emotional stressors, and

psychological problems. The goal is to improve the quality of life for patients and their

families while being sensitive to the cultural norms, values, and practices of patients

(CHPCA, 2013; World Health Organization [WHO], 2009). Palliative care, as defined by

the medical community, is care givento the ill within the aging population; however,

individuals of any age, and at any stage of acute, chronic, or terminal illness need PC,

which is traditionally provided by doctors, nurses, social workers, and other specialists

(Meier & Brawley, 2011).

According to the Centers for Disease Control and Prevention (CDC) (2009),

seven in ten Americans die due to chronic illness. The Center for AdvancePalliative Care

(2011) reported by the year 2020, the number of Americans living with a serious, life-

threatening illness would increase to approximately 157million. Additionally, the Merck

Institute of Aging and Health (MIAH) (2009) indicated by the year 2030, there would be

a surge in the number of individuals, aged 65 and older, accounting for higher than 20%

of the population impacting healthcare in the United States. These numbers indicate over

6 million residents of the United States were not significantly from PC (MIAH, 2009).

MIAH further stated more than 15% of the current U. S. elderly population are crippled

with chronic illnesses and take more than five prescription drugs daily. Chronic diseases

considered terminal are critical indicators for PC management (Pasman, Brandt, Deliens,

& Francke, 2009).

The ED is a complex environment providing care to patients with varying

symptoms. As the entry point for hospital admission, the ED offers access to health care

specialists 24 hours per day. Patients diagnosed with terminal diseases requiring PC often

utilize the ED as access for management of symptoms. The ED staff is equipped to

diagnose, treat, and make quick decisions to transition patients to a more appropriate

setting. Palliative care patients enter the ED with complex needs and are often discharged

without symptoms relief, which suggests ED staff is not equipped to appropriately attend

to the needs of these patients (Mierendorf & Gidvaniv, 2014). Thus, when confronted

with medically complex patients in the ED daily, the demands for PC training becomes

apparent. Lamb, Pound, Rella, and Compton (2012) argued the ED environment should

have staff trained to address PC issues.

Providing quality PC requires ED nurses possess the knowledge, skills, and

positive attitudes to care for these patients. White, McClelland, VanderWielen, and

Coyne (2013) concluded the evidence is clear on the efficacy of PC, across all settings,

but the providers in the ED have minimal knowledge on managing the care of patients

with terminal illness. Palliative intervention in the ED allows for the timely provision of

care, improve outcomes, improve patient and family satisfaction and cost savings (Rosenberg and Rosenberg, 2013).

Since the opening of the organization's ED in 2012, review of data reveals a total of 976 patients have been evaluated for symptom management due to terminal illness. Of that number over 50% were transferred out to the contracted hospital for symptom management due to inconsistencies in healthcare professionals' ability to provide quality PC. During the orientation process of the ED, a needs assessment was conducted on the eighty-five nurses in the department. The result of the evaluation revealed more than 80% of the nurses had minimal interaction with PC patients, thus requiring further assessment of their knowledge about PC. Additionally, the same nurses indicated they would not know how to provide palliative care in the ED. Chan (2006) posited "many ED nurses and staff are inadequately trained in PC, especially related to family grief needs" (p. 72). An understanding of PC is crucial to initiate the best care practices for patients and families with incurable illnesses.

Although experienced in emergency nursing and quick response to patients' need for care, there is a laissez-fair attitude when it comes to caring for terminally ill patients requiring PC among nurses in the facility. The issues stem from lack of understanding of PC and limited resources to educate nurses; therefore, improvement in training on PC to ED nurses is essential. It may mean implementing a palliative education program to enhance skills in clinical practice, teaching and program development in PC. An understanding of nurses' knowledge and attitudetoward PC is an essential step in enhancing care for patients diagnosed with a terminal illness in the ED (A. Skully,

personal communication, October 5, 2014). Incorporating PC not only addresses the needs of the patient, but the organization as well.

The Center for Medicare and Medicaid Services (2012) estimated Medicare expenditure for palliative and end of life care have grown by 6% from 2008 to 2012. This has contributed to a significant increase in the use of hospital inpatient and outpatient services for the relief of symptoms. Moreover, McCarthy, Robinson, Huq, Philastre, and Fine (2014) conducted a study on PC at five hospitals in Texas. The study sample consisted of 38,475 inpatient palliative patients, 18 years and older. The findings from this study revealed a total savings of $3,426 per inpatient stay. Also, PC significantly increased patient satisfaction while reducing the use of medical services and costs for medical care at the end of life.

Problem Statement

Patients diagnosed with a terminal illness needing PC deserve the right to uncompromised care in all areas of the healthcare setting. Patients with any form of illness should be treated with respect and compassion. But too often, their needs are unmet, and they are discharged home with the unresolved symptoms. Emergency department nurses must show a level of compassion when giving PC; they must understand the importance of their role and the benefits the patients receive from their interventions in the ED (Quest, Asplin, Cairns, Hwang, & Pines, 2011). An assessment of nurses' knowledge and attitude towards PC is therefore essential to improve practice processes within the stand-alone ED in the organization.

Purpose

There is a large gap of care delivery in the ED for palliative patients. These gaps are linked to factors such as poor goal setting, inability to practice with an evidence-based approach, and the unsuitable environment for giving care (Grudzen, Stone and Morrison, 2011). Palliative care patients' main purpose to seek treatment in the ED is related to symptom management, which cannot be controlled at home, in a physicians' office, or a facility. Therefore, ED nurses must be prepared to manage PC symptoms. The purpose of this project is to decide the difference between pretest and posttest scores on the FATCOD and the PCQN after an educational intervention. The FATCOD assess ED nurses' attitude toward PC while the PCQN assess ED nurses' knowledge about PC.

The objectives of the study were to examine the collected data from the PCQN and FATCOD instruments to:

1. Assess knowledge of ED Nurses in caring for PC patients;

2. Assess attitude and practice patterns of ED nurses of PC patients; and

3. Compare the differences in pre- and posttest scores on the PCQN and FATCOD assessments.

It was expected the findings from this project would allow for a safe practice environment for PC patients, and improvement in ED nurses' competence level.

The Nature of the Doctoral Project

The nature of the doctoral project is to assess the knowledge and attitudes of ED nurses towards care for PC patients. Palliative care is the psychological and emotional care provided to patients diagnosed with terminal illness and their families (WHO, 2009).

Intertwined in this puzzle is the potential problem where patients on PC need relief from symptoms such as pain, anxiety, nausea, and vomiting. According to Norlandar (2008), lack of knowledge about PC is an obstacle to ED nurses, as they strive to give quality care to terminally ill patients. Weil, et al. (2015) reported healthcare professionals have a different understanding of the relevance of PC in the ED due to inconsistencies,beliefs, and practices in care delivery.

In the 1960s, there was minimal education on how care should be provided to patients. The American Association of Colleges of Nursing (AACN, 1997) proposed a national effort to discuss educational deficiencies relative to palliative/end-of-life care in the nursing curriculum with the principal goal of impacting undergraduate nurses regarding care of patients and families needing PC. The American Nurses Association's (ANA) revised position statement (2010) mentioned nurses' role in PC acrossany setting is to provide the highest quality care that is embellished with life-sustaining treatment to support patients and families. Additionally, educational opportunities should prepare nurses to give compassionate care while serving as advocates for patients and families. Guten and Ferrell (2014) mentioned a need exists for faculty training and rigorous educational models. The educational model and training will serve to prepare nurses to meet the needs of patients and families experiencing terminal illness and needing PC.

Significance

According to the National Hospice and Palliative Care Organization (NHPCO, 2013) in 2012, an estimated 1.5 to 1.61 million patients diagnosed with chronic disease received PC. Rooda, Clements, and Jordan (1999) noted daily experience in the ED

suggests patients suffering from chronic, life-limiting illnesses and with unmet PC needs are often caught in a revolving door of emergency care that wastes resources and fails to properly address their stage of disease and goal of care. The average length of stay in the ED for patients was 9.2 hours, which was considered avoidable if nurses understood how to manage symptoms. PC is proper at any stage of illness and is an approach that can begin in all settings, including the ED. Therefore, giving PC education to nurses early in their careers will affect practice delivery.

In 2009, the Agency for Healthcare Research and Quality looked at four key areas pertinent to nurses' role in providing best care to patients with terminal illness. Those areas were:

1. Education and training
2. Attitude towards the provision of care for palliative patients;
3. Beliefs on current care practices; and
4. Appropriateness of the emergency room as a venue for PC.

A key recommendation was providing quality educational opportunities to aide nurses in providing optimal care to palliative patients. The Emergency Nurses Association (ENA) (2013) echoed collaborating sentiments on the importance of educating nurses on how to meet the needs of patients seeking palliative treatment and have included, as part of their curriculum, training for nurses on knowledge and skills critical to care for palliative patients.

Summary

Emergency department nurses lack the knowledge and skills necessary to provide care to patients who present to the ED seeking PC. The requisite knowledge and skills must be developed through professional training activities designed to decrease the deficit in how healthcare providers deliver care to palliative patients. Stevens (2013) asserted that when the present levels of professionals can engage in knowledge-building activities, improvement in healthcare is transformed. Section 2 includes an overview of the background and context of concepts, relevance to practice and the role of the DNP student in achieving objectives of this project.

Section 2: Background and Context

Introduction

The purpose of this project is to determine the difference between pretest and posttest scores on the FATCOD and the PCQN, after an educational intervention. The FATCOD assesses ED nurses' attitude toward PC while the PCQN assesses ED nurses' knowledge about PC.

Conceptual Model and Theories

The conceptual model chosen for this study is Bandura's social cognitive theory, developed in 1995. A major part of this model is self-efficacy and was the focus of the study (Bandura, 1986; Chowhury et al., 2002; Malone, 2002). Lunenburg (2006) mentions an individual should think of self-efficacy as self-confidence or self-esteem. Additionally, self-efficacy is perceived as the central traits of understanding one's interaction with the environment as the mediator between knowledge and the environment. Harvey and McMurray (1994) found self-efficacy to be a predictor of behavior performance. Researchers have shown a significant relationship between patient outcomes, nursing practice, academic preparation, and professional practice to patient's outcomes (Aiken, Clarke, Cheung, Sloanne, & Silber, 2003). Callaghan (2003) used Bandura's self-efficacy theory to show the relationship among health-promoting behaviors, and self-efficacy in an adult population. Self-efficacy in this study was conceptualized as a transitional operation. Callaghan suggested there was no significant weakness in the relationship with self-efficacy.

Bandura's model is not specific to nursing rather; it is a borrowed model which is important in developing nursing discipline and fitted to enhance the perspective of nursing (Desbiens, Gagnon, & Fillion, 2011). Aish and Isenberg (1996) reviewed self-efficacy to determine if it motivated a change in behavior as relates to nutrition. One hundred participants were randomly selected and assigned to either treatment or control group. After the first six weeks, Aish and Isenberg found that nursing intervention was effective in supporting healthy behaviors, but while the care influenced self-care agency of patients, there was minimal impact on self-efficacy relative to healthy eating. The self-efficacy model was utilized with a medical student at Liverpool University in a two-week program to assess the impact education program had on PC through communication, teamwork, and patient management on PC (Mason & Ellershaw, 2004).

Defined as a function of an individual's internal characteristics (perceived self-efficacy), the environment (modeling) and reciprocal determination (person-environment interaction) (Bandura, 1977, 1986; Edberg, 2007) (see Figure 1). These three factors of social cognitive theory influence an individual's self-efficacy. Because self-efficacy is the foundation of human agency as mentioned by Bandura (1999), it is imperative there is understanding of its relevance in practice and how it can be impact behavior change to improve outcomes. Thus, it should not be thought of as confidence builder, but a belief in one's ability to perform a task. In light of ED nurses' ability to provide care to emergent patients, enhancing their skills through raising awareness of self-efficacy was vital in influencing their ability to provide PC.

Nurses in the ED may have reservations about their ability to provide quality care to palliative patients. Self-efficacy indicates "efficacy beliefs" play a large role in influencing how people think, feel, motivate them, and behave. Efficacy beliefs develop from four main resources: mastery experiences, vicarious experiences, social persuasion, and physiological and emotional states (Bandura, 1982). Further, self-efficacy influences all phases of personal change, which include the decision to increase learning, whether people have the motivation and determination necessary to succeed. There are three ways in which self-efficacy affects learning: (a) individual goal setting, (b) the effort one exerts on their job, and (c) the persistence in which the individual attempts new and difficult tasks (Bandura, 1982).

There are four sources mentioned by Bandura (1997) vital to achieving self-efficacy that were beneficial to improving ER nurses' performance in providing PC: mastery experiences, vicarious experiences, verbal, social persuasion, and emotional cues (see Figure 1). Self-efficacy is crucial at all levels of personal change influencing the decision to change a behavior. To impact PC practices in the ED, nurses will need to capitalize on resources to build their self-efficacy level by obtaining knowledge relative PC to improve practice processes. Additionally, they will need to show motivation and determination to achieve success when change is accepted and maintaining the change, which can lead to high performance and productivity (Bandura, 1986). Self-efficacy, according to Cherian and Jacob (2013), is a useful measurement in predicting behavioral outcomes which can be beneficial to the organization.

There is a strong linkage between experience and outcomes of care. Nurses working in the ED have the experience to provide care to patients with varying complaints. Because this experience exists, and past experiences are the building block used to guide care, mastery experience can help to strengthen self-efficacy among ED nurses through professional development, goal setting, and supportive leadership. Building on this domain is essential for ED nurses to improve outcomes of PC through structured symptom management protocols.

Vicarious experience knowledge gained through observing or copying the behaviors of others. Self-efficacy through vicarious experience requires ED nurses to have an understanding of direct clinical experience relative to PC. However, it is important ED nurses engage in the experiences of others or copying behaviors, which can lead to the acquisition of the same skill. Verbal persuasion deals with providing feedback in an effort to accomplish a task. When recognition is not given, nurses will lose confidence, which will affect their skills in PC. Emotional cues occur when an individual finds a task to be demanding to result in a flight or fight response. Emotional cues in ED nurses as it relates to PC practices can be mitigated with a well-structured training program increasing their comfort level and decreasing unwanted stressors or fears helping in goal achievement.

The self-efficacy model is a useful guide that can help in understanding how the behavior of nurses in the ED guides their action when providing PC. Further, self-efficacy influences all phases of personal change, which includes the decision to change a health habit, whether people have the motivation and determination necessary to succeed

if they decide to make a change, and the degree in which a person maintains any changes he or she has made (Bandura, 1986). This change can be achieved through well-developed educational programs embodied with practice guidelines/protocols. Therefore, it is imperative healthcare professionals understand the importance of self-efficacy to develop the motivation necessary to change practice through educational training, behavior modification and the utilization of the best practice in PC.

Definitions of Terms

The following definition and terms will be utilized for this project.

Attitude: A relatively enduring organization of beliefs, feelings, and behavioral tendencies towards socially significant objects, groups, events or symbols (Hogg & Vaughan, 2005, p. 150).

Educational intervention: A process aimed at changing one's knowledge and attitude regarding a particular subject that is measured by primary outcome with an end result (Gustafsson & Borglin, 2013).

Emergency department nurse: A registered nurse who provides care to patients in emergency situations experiencing life-threatening trauma or illness (Johnson & Johnson, 2018).

Palliative care: A healthcare approach used to improve patient's quality of life and provides support for families facing problems associated with life-threatening illness (WHO, 2009).

Knowledge: A factual body of information that provides a foundation for correct principles and concepts (Drisdom, 2013).

Protocols: Guidelines designed to support the decision-making processes in patient care (Wollersheim, Burgers, & Grol, 2005).

Social cognitive theory: A theoretical framework where the functions of personality are explained by cognitive contents and processes acquired through social interactions (Bandura, 2001).

Self-Efficacy: A person's belief about his or her ability and capacity to be successful in certain situations. Self-efficacy motivates how one behaves and influences personal change (Cherry, 2011).

Symptom management: Care given to patients diagnosed with a life-threatening illness; the goal is to prevent or treat the symptoms of the disease (Bookbinder, & McHugh, 2010).

Terminal illness: A progressive disease where death can reasonably be expected within 6 months (Cox, Doorenbos, Shannon, Scott, & Curtis, 2013).

Relevance to Nursing Practice

As a treatment process for individuals who are terminally ill, PC is critical in the overall well-being of patients. Thus, ED nurses, who are at the frontline of patient access and care, are instrumental in providing the highest level of care to these patients. PC is specialized medical care focusing on providing patients diagnosed with severe illnesses at any stage of life with relief from symptoms, pain, and stress of such illnesses. Therefore, assessing the knowledge of nurses in providing care to palliative patients is essential in minimizing low quality and unhealthy care practices. There is an increased emphasis on education of nurses to update and improve their skills to

meet the ever-changing healthcare environment (Institute of Medicine [IOM], 2010). The challenge seems insurmountable but increasing the knowledgebase on all fronts is tantamount to allowing for critical thinking and improving the processes in response to the needs of patients.

Grant, Elk, Ferrell, Morrison, and Von Gunten (2009) asserted PC knowledge and an integrated multidisciplinary approach to research is vital to impacting change within healthcare organizations. To significantly improve PC practices in the emergency department, change is needed. However, change does not occur in a vacuum; educational programs will provide the essential tools needed to impact care practice must be designed and implemented. The implemented PC educational programs will allow nurses to gain a better-understanding PC diagnosis and build their knowledge base on how to apply appropriate PC to patients and families.

Local Background and Context

The pattern where PC patients was once left to be treated by their primary care physician, oncologist, or other specialist has exceeded the threshold and has now ballooned into other spheres of healthcare. Klein (2014) asserted "healthcare professionals must understand the medical history of palliative patients and build a strong knowledge base to help them reach the next phase of life" (p. 3).To provide the best care for palliative patients, the implications arecontingent on (a) the improvement in educational programs geared towards care practices in the ED,(b) the fluidity of program to meet patients' individual needs, (c) integration of families into care practices, and (d) collaboration with all members of the interdisciplinary team in practice protocols.

The changes to the delivery of healthcare services resulting from the Affordable Care Act (ACA), have presented new opportunities beneficial to the delivery of PC. According to Meier (2011), optimal delivery of PC medical care is threatened by the shortage of medical and non-medical personnel with the requisite knowledge and skills to deliver care to patients, who are terminally ill.

Role of the DNP Student

As the Primary Investigator (PI) for this project, I had the responsibility and privilege to coordinate and implement all aspects of this project with guided assistance from my mentor professor**.** In the role of the PI, my responsibilities brought me into constant contact with coworkers, departmental directors for all areas of the ED, and the PC department. All documents submitted were reviewed to ensure all standards set forth by Walden University Institutional Review Board (IRB) and the project site's Institutional Review Department were met. I also, researched and reviewed literature to find proper data collection instrument relevant to my project. Once the instrument was found, I contacted the developers for approval to use the instruments for my project. Prior to moving forward with this project, I completed the Collaborative Institutional Training certification relating to research with human subjects.

Summary

The Doctor of Nursing Practice (DNP) project is designed to determine if there is a difference in ED nurses' knowledge and attitude towards PC following an educational invention. Bandura's Social Cognitive Theory Conceptual Model was helpful to provide insight into the evaluation of training for nurses to improve outcomes for patients with

PC issues. This study will help to fill gaps related to lack of knowledge, and nurse's

attitude in providing PC in the ED. The intent of the study is to extend knowledge by

incorporating the experiences of nurses and their attitude toward PC patients with chronic

illnesses emphasizing a collaborative approach. Section Three will provide a

comprehensive overview on collection and analysis of evidence for the project.

Section 3: Collection and Analysis of Evidence

Introduction

The purpose of this project is to determine the difference between pretest and posttest scores on the FATCOD and the PCQN after an educational intervention. The FATCOD assess ED nurses' attitude toward PC while the PCQN assess ED nurses' knowledge about PC. Improving the knowledge, attitudes, and skills of ED nurses, who interact with PC patients, is essential to giving optimal care to individuals who are terminally ill. The results from this project can be used to design and implement professional development programs meeting the needs of ED nurses about PC.

Practice-Focused Question

Palliative care treatment is necessary to relieve the burden of symptoms patients experience as their disease progresses. While it is clear the ED is the first line environment for patients with varying ailments, health care organizations must provide the tools for them to provide quality care. The question for the project was: Is there a significant difference in the pretest and posttest scores of ED nurses related to their attitude and knowledge towards the delivery of PC following an educational intervention?

Sources of Evidence

The literature presented here was drawn from CINAHL, Medline, and PubMed through Walden University Library, Ovid, ProQuest, and Cochrane Database. total of 20 articles were retrieved ranging from randomized trials and systematic review all being deemed relevant to the DNP project. The keywords and terms used to extract the

literature were palliative care, attitudes, knowledge, care practices in the emergency department, practice patterns, and nurse's knowledge on caring for patients. Of the 20 articles retrieved, 15 which were published between 2000 and 2013 were selected for inclusion in the literature review. These articles suggested knowledge deficit, negative attitudes, and inadequate practice patterns are issues related to ED nurses' inability in providing care to palliative patients in the ED.

General Literature Review

A general review of the literature supports the idea ED nurses lack the requisite knowledge and skills to provide PC. In addition to the lack of knowledge and skills, the literature also indicates ED nurses' attitude towards PC is a function of their knowledge and belief about patients who are terminally ill. The literature underscores the importance of further research on PC to provide evidence-based practice to improve ED nursing competence (Engstrom, Bruno, Holm, & Hellen, 2007). According to Kumar, Anand, and Sisodia (2012), evidence-based information on nurses' attitudes toward PC should be uncovered because attitudes are products of an individual's social culture.

One of the pervading themes in the literature is the lack of available educational opportunities and resources for ED nurses to acquire the knowledge and skills for providing PC care, which could result in a more positive attitude toward PC. Dunn, Otten, and Stephens (2005) were of the opinion some ED nurses project a positive attitude towards caring for patients who are terminally ill, but nurses expressed a need for educational programs to aid in effective strategies, for coping, removing barriers to care, and developing competency in PC. ED nurses' attitudes towards and about the delivery of

palliative care to terminally ill patients can be accomplished through sound education programs that aid nurses in developing needed competencies.

Specific Literature Review

Knowledge Deficit Among ED Nurses

The reviewed literature indicated a secure connection between ED nurses' knowledge and skills relative to PC and the provision of quality PC in the ED. However, there is a considerable gap in the knowledge and skills of ED nurses relative to PC. As such, there is substantial support to provide ED nurses with the education and skills needed to deliver quality PC in the ED. McKeown et al. (2010) used a grounded theory approach to examine the delivery of PC in the ED. Among the 25 participants in this study, 10 were nurse volunteers, five nurse consultants, and ten medical staff. The researchers found nurses and physicians expressed a genuine lack of understanding of PC. The nurses suggested the ED was not conducive to the care, management, and decisions required for palliative patients. They argued palliative patients need to be in an environment where their symptoms can be properly managed. Additionally, lack of knowledge and practice protocols were reported as major barriers when caring for the palliative patient. The recommendation from the study was ED nurses receive PC education to bolster their confidence when caring for palliative patients.

Dalgaard, Thorsell, and Delma, (2010) posited that nurses' inability to provide care and to treat symptoms were due to the lack of training on the specific ailment and the organization's inability to provide the knowledge and skills necessary to palliate patients' symptoms. A phenomenology study conducted to assess the different aspects of

care for palliative patients requiring symptom management indicated nurses lacked the knowledge and skills required to make care decisions for palliative patients. The overall recommendation from this study was that PC education should be provided for nurses, so they can provide credible input into on how to care for palliative patients (Walker & Reid, 1996). According to the study by Jack, Gambles, Murphy and Eller-Shaw (2003), ED nurses who receive PC training reported a significant boost in their confidence level, relative to providing PC.

The lack of proper educational resources and opportunities place ED nurses in an uncomfortable position relative to the provision of PC (Quest et al., 2011). ED nurses believe PC intersects with other practice areas, and the need for the implementation of a PC curriculum and professional development opportunities remains a major challenge.

Factors That Prevent the Delivery of PC

Limited understanding and knowledge of PC. Among the many barriers to the provision of palliative care by ED nurses, the lack of knowledge and understanding of PC is foremost. The textbooks used in nursing education programs do not cater towards the treatment of palliative patients. An analysis of the textbooks by researchers revealed that only 2% of the top selling books included content related to PC. Furthermore, the quality of the included PC information was deemed to be very poor (Giles, 2011). Davies et al. (2014) conducted a study to explore the apparent barriers to the provision of high-quality PC using a semi structured interview format. Sixteen participants representing individuals with PC background, dementia services, and PC research and policymakers were included in this study. The analysis of the collected data revealed four factors that

prevented healthcare workers from providing high-quality PC. There were: (a) ambivalence towards systematization of PC, (b) disconnection between services, (c) different assumptions about training needs, and (d) negotiation risk.

Ambivalence towards systematization of PC. The age of accountability has affected the flexibility with which healthcare professionals can provide high-quality services due to the increased guidelines, standards, rules and regulations that encumber the healthcare professional. The standardization of PC has obliterated professional autonomy. Lawrence et al. (2011) argued all healthcare professionals must become actively involved in this systemization practice such they can seek to preserve as much flexibility as possible.

The disconnection between services. The provision of PC is perceived as patchy and disorganized by the study's participants. This fragmented approach to palliative is often excluded professionals (General Practitioners and PC specialists) from the decision-making process, which leaves professionals pointing fingers at each other. Pastrana et al. (2008) conducted a discourse analysis (qualitative approach) of the different definitions of PC. The researchers concluded the fragmentation observed in the treatment of palliative patients could be attributed to the lack of a multidisciplinary approach with healthcare professionals working together for the single benefit of the patient.

Different assumptions about training needs. While knowledge deficit is the primary barrier towards the provision of high-quality PC, healthcare professionals have different ideas as to what training is or should be (Davies et al., 2011). For some professionals, training means the acquisition of skills to provide needed services. Others

view training has the avenue through which they can increase their self-efficacy to use their knowledge and skills to provide services. Sachs, Shega, & Cox, (2004), in their discussion of barriers to end of life care for patients, stated more training is needed for professionals working in the area of PC. However, the researchers' definition of training is multifaceted: acquisition of skills and development of confidence. An interesting aspect of the idea of training is the fact some providers may be uncomfortable working with dying patients, and may relinquish their responsibility to others, citing lack of training (Giles, 2011).

Negotiation risk. Healthcare professionals working with palliative patients perceive risk differently. The perception of risk and the manner in which the risk is negotiated determines the level of PC provided. The presence of trust between providers, patients, and families, risk is positively negotiated. However, the absence of trust and communication leads to negative feelings of uncertainty, litigation, and blame. In this situation, the practice of defensive medicine is invoked. This idea is supported by Harrison-Deng, Cavers, and Murray, 2012, who suggested healthcare professionals often feel fearful when dealing with the difficulties associated with providing PC.

According to Giles (2011), there are three barriers inhibiting ED nurses from providing PC to patients. The first barrier is the false impression about outcomes by patients and family members. These misconceptions are often nurtured and promoted by media sources that portray miraculous outcomes of emergency care to dying patients. Secondly, the ED environment is not designed to provide quality PC because of the high patient turnover, space availability, and the frantic and raucous environment. The final

barrier is the lack of resources needed to educate ED nurses about PC. The lack of educational resources leaves ED nurses ill-prepared to provide PC.

Grudzen et al. (2011) conducted a focus group, a semi-structured study, in which they explored the attitudes and beliefs of ED providers regarding PC. The participants in this study acknowledged the benefits of PC in the ED, which should include specialized skill set, communication among staff regarding the goals of provided services, and occasion to mediate for seriously ill or dying patients. However, providers expressed concerns about medical and legal issues interfere with their desire to provide treatment. Another issue of concern for these providers was the culture of the ED, which is to stabilize medical emergencies. This cultural aspect of the ED is incongruent with the needs of palliative patients.

Attitudes of ED Nurses towards PC

Shearer, Rogers, Moterosso, Ross-Adjie, and Rogers (2013) conducted a study in which they investigated ED nurses' perspective and attitude regarding PC and appropriate care modules. A total of 52 Likert-scale surveys with open-ended questions were distributed to the nurses. A descriptive statistics and intergroup comparisons were made for all variables. A total of 44 nurses returned the surveys with a majority reported working with palliative patients but expressed lack of knowledge in treating symptoms. The key findings from this study indicated ED nurses were confident in their ability to manage symptoms related to PC. Additionally, nurses often misjudge the important role of PC in non-cancer diagnoses. However, these nurses reported more educational

opportunities on end-of-life communication and ethical issues would help improve their attitudes towards the provision of PC.

A qualitative study conducted by Gourdji, McVey, and Purden (2009) to explore the meaning of quality of life of palliative patients and their perceptions of nursing care. The authors utilized the theoretical framework of McGill's Model of Nursing King's concept of "good death." Population sampling included five women and five men with a mean age of 57.9 and was diagnosed with terminal illness. The patients were interviewed in a semi-structured format. Three variables were addressed: symptom management, the perception of care from nurses, and the ability of nurses to provide information on symptom control. A total of three patients had follow-up interviews, two patients expired. The findings indicated patients perceived some of the nurses had a positive approach to care, as evident in their expressions of humor, and hope. Some nurses did not seem to understand how to treat symptoms evidenced by no relief from symptoms. From the study, the authors concluded that PC patients are at a disadvantage in care management.

Participants

The proposed population for the project was a convenience sampling of nurses that work in the ED at two healthcare facilities in a large metropolitan area in the Southeast. A convenience sampling technique applies to this project because it allows for the choice of participants, who are available and willing to take part in the proposed study (Creswell, 2005). Criteria for inclusion in the sample are full and part-time nurses working in either of the two EDs and must have one or more years of experience in emergency nursing.

Procedures

Recruitment was in the form of a letter personally delivered to all ED nurses working in both EDs; providing opportunities for an answer to any questions (Appendix C). Individuals were advised to return the letter indicating their intent to or not participate in the box located on the left lower corner of the letter. They were instructed to return the letter in the confidential locked survey box located in the nurses' lounge. After the receipt of intent to participate form nurses, the consent and personal demographics forms (Appendix D) were packaged and hand-delivered to eligible participants. Once the consent forms and demographic data were returned, the PCQN and FATCOD pre-test were made available to participants with an initial response deadline date. After the initial deadline, staff that agreed, but did not return the PCQN and FATCOD scale, was personally contacted.

Questionnaires, as mentioned by Parahoo (2006) are designed to identify facts and opinions from specific groups and are an attractive and more precise alternative method than interviewing or observing. According to Jones and Rattray (2010) questionnaires are quick, easy, convenient, and inexpensive. The FATCOD questionnaire was structured to meet project's purpose. All participants who have completed the demographic data sheet and elected to participate in the study received the questionnaire once approval was obtained. Pretest designs provide an opportunity for measurement of the outcome in a study prior to administering treatment, then followed by a posttest using the same measure of treatment (Salkind, 2010).

Protection

As mentioned by Polit and Beck (2010) ethical issues are important in research when human beings are involved. Approval was requested from the Director of Nursing for the unit and from the organization's ethics committee (Appendix G). This approval was requested in writing. Prior to data collection, permission was obtained from the Institutional Review Board (IRB) at Walden University. Once IRB approval is obtained, all ED nurses from both facilities with full or part-time status, and one or more years of ED experience; with or without PC experience were included in the study.

A confidential list of nurses was obtained from management. Informed consent was then obtained from nurses. This is important as participants had the right to know the extent of their participation in the project. The informed consent addressed participants' right to be involved in the study and included details and nature of the study. Upon assessment of nurses and inclusion criteria met, questionnaires were hand delivered to subjects, in a sealed envelope. Each participant was assigned a confidential number to ensure the privacy of subjects. A self-reported method was used in which subjects responded to the test questionnaire. Polit and Beck (2010) assert the use of a self-report method allows for response in writing and provides the researcher with retrospective data gathering relevant to the individual's behavior and potential future on a topic. After collection of the pretests, the educational program was presented. The program covered the essentials of palliative care and the information needed by the ED nurse for care of the PC patient in the ED.

Analysis and Synthesis

Parahoo (2006) noted data analysis is essential to research and careful

consideration must be given to ensure clarity prior to presentation. To establish if

significant differences existed on the PCQN and FATCOD pre-and posttest, SPSS was

used to conduct inferential data analysis. The inferential test conducted was the Wilcoxon

Signed Rank test because it allowed for the comparison of before and after scores from

the participants without the assumption of data normality. Gray, Mills, and Airasian

(2011) asserted non-independent sample compares groups or single group's performance

on a pre-and posttest or two different treatments to conclude if there is a significant

change once treatment was completed.

Nurses attitude towards caring for the terminally ill patient was measured using

the FATCOD scale. The questions on the scale was a 5-point Likert scale ranging from 1

strongly disagree to 5 strongly agree. Nurses' knowledge was measured using the PCQN

true or false test questionnaire. Additionally, descriptive statistical analysis was

calculated, using SPSS for the demographic variables (age, gender, ethnicity, education,

etc.).

Summary

This section discussed data collection and analysis, inclusive of the literature

researched and reviewed. From the review of literature there is limited evidence supporting

ED nurses with strong knowledge on caring for PC patients. The participants were selected

with considerations given to ethical responsibilities inherent in the project plan, which

included certain demographic information. Data collection was through two test

questionnaire the PCQN and FATCOD which were hand delivered. A quantitative analysis of the data was used to determine any significant difference between both tests which were administered over a two-week period. The following section will focus on the actual findings, implications, strengths recommendations and limitations of the project.

Section 4: Findings and Recommendations

Introduction

The purpose of this project is to determine the difference between pretest and posttest scores on the FATCOD and the Palliative Care Quiz for Nurses after an educational intervention. The FATCOD assess ED nurses' attitude toward PC while the PCQN assess ED nurses' knowledge about PC. The objectives of this research project were to analyze the data for the PCQN and FATCOD pre- and posttest questionnaires to assess:

1. Assess knowledge of ED Nurses in caring for PC patients;

2. Assess attitude and practice patterns of ED nurses of PC patients; and

3. Compare the differences in pretest and posttest scores on the PCQN and FATCOD assessments.

The findings presented in this chapter include the quantitative analysis of both pre-and post-survey data gathered from nurses using the FATCOD and PCQN instruments. The evidence-based project question, which guided this project was: Is there a difference in the pretest and posttest scores of ED nurses related to their attitude and knowledge towards the delivery of PC following an educational intervention? To evaluate the project's question, the Wilcoxon Signed Rank (WSR) test was used with the help of SPSS. The WSR test was proper for this project design because it allowed for the comparison of pre- and posttest scores without the assumption of normality.

Findings and Implications

One hundred ED nurses, at the project site, received invitation letters requesting their participation in the project. Of the 100 letters sent, 82(82%) of the invited nurses responded showing their interest and desire to participate in the project. Table 1 gives the demographic profile of the project's participants who agreed to take part and fully complete both the FACTOID and PCQN assessment surveys. Twelve of the 82 respondents (14%) did not return or returned incomplete surveys. Incomplete surveys were eliminated from the data analysis process. More than 50 of the participants were females (74%) while males accounted for 26% (n=18) of the project's participants. Additionally, Caucasians and African American (80%) were the majority ethnic groups that participated in this study. The other participants (20%) identified as Asian American, American Indian, Latino or some other ethnic group. Seventy-four percent of the participants reported achieving the AAS-BSN degree. All other participants (26%) had degrees beyond the BSN. Additionally, 71% of the participants have worked in the nursing profession for more than six years. More than 50% of the participants reported no experience with the delivery of palliative care to patients.

Table 1

Demographic information for Participants

Variables	N=Total (n=70	Percentages
Gender		
Male	18	26
Female	52	74
Ethnicity		
White/Caucasian	28	40
African American	28	40
Asian American	5	7
American Indian	1	1
Hispanic/Latino	6	9
Other	2	3
Educational Level		
AAS-BSN	52	74
MSN-DNP	18	26
Work Experience		
1-5 years	20	29
6-10 years	50	71
Palliative Care Experience		
Yes	34	49
No	36	51

Project Question

The overarching question needed to be answered from the collected data was: Is there a significant difference in the pretest and posttest scores of ED nurses related to their attitude and knowledge towards the delivery of PC following an educational

intervention? The project participants completed a pre-and post FATCOD and PCQN

assessment; the results were compared to see if there were significant differences

between scores after intervention.

Table 2

Descriptive statistics for PCQN

Variable	N	Mean	Std. Deviation	Minimum	Maximum
Pretest-PCQN	70	35.7571	4.65766	26.00	52.00
Posttest-PCQN	70	46.1429	48.65623	32.00	445.00

Table 3

Wilcoxon Signed Rank Test for PCQN

Posttest-PCQN	N	Ranks	
		Mean Rank	Sum of Ranks
Negative Ranks	7[a]	19.07	133.50
Positive Ranks	56[b]	33.62	1882.50
Ties	7[c]		
Total	70		

a. posttest < pretest pcqn
b. posttest > pretest pcqn
c. posttest= pretest pcqn

Table 4

Wilcoxon Rank Test Statistics for PCQN

	Pretest-Posttest
Z	-5.994[b]
Asymp.sig(2-tailed)	.000

a. Wilcoxon Signed Ranks Test
b. Based on negative ranks

The Wilcoxon signed ranks test was used to compare the pretest and posttest scores to

decide if there exists a statistically significant difference between the attitude and

knowledge of the 70 ED nurses who took part in this project. Tables 2, 3, and 4 present

the results of descriptive statistics, Wilcoxon Signed Ranks, and test statistics of the

pretest and posttest results for the PCQN. As indicated in Table 4, the result of the

Wilcoxon test indicated no significant difference, $z=-5.99$, $p=.000$ ($p<.05$ between the

pretest and posttest scores of the PCQN. The mean for the posttest PCQN score was

19.07, while the mean for the pretest score was 33.62 (see table 3).

Table 5

Descriptive statistics for FATCOD

Variable	N	Mean	Std. Deviation	Minimum	Maximum
Posttest-FATCOD	70	73.1000	4.76749	62.00	89.00
Pretest-FATCOD	70	78.6429	5.48261	67.00	95.00

Table 6

Wilcoxson Signed Rank Test for FATCOD

	N	Ranks Mean Rank	Sum of Ranks
Negative ranks	0ª	.00	.00
Positive Ranks	65ᵇ	33.00	2145.00
Ties	5ᶜ		
Total	70		

a. posttest<pretest fatcod
b. posttest> pretest fatcod
c. posttest=pretest fatcod

Table 7

Wilcoxson Rank Test Statistics for FATCOD

	Posttest-Pretest
Z	-7.033
Asymp. Sig. (2-tailed)	.000

a. Wilcoxon Signed Ranks Test

The Wilcoxon signed ranks test was conducted to compare the pretest and posttest scores for 70 ED nurses, who took part in the project, on the FATCOD assessment. Table 5, 6, and 7 presents the descriptive, Wilcoxon rank and test statistics of the FATCOD pretest and posttest scores. As indicated in table 7, the result of the Wilcoxon test indicated a significant difference in nurses' attitude, z=-7.033, p=.000 (p<.05 between the pretest and posttest scores on the FATCOD. The mean of the posttest FATCOD score was .00, while the mean for the pretest score was 33.00 (see table 6).

Implications

The decision to change behavior to affect performance is not sought after in most cases. The availability of resources is a much-needed commodity especially when dealing with specialized areas of care. The overarching goals of this project was to assess ED nurses' knowledge, and attitude towards caring for palliative patients using the PCQN and FATCOD questionnaire. The PCQN test provided an overall assessment of nurses' knowledge on palliative care. The FATCOD scale looked at the nurses' attitude to care of the dying patient. The results of the test show clear indication for increase awareness of PC among ED nurses through education and the possibility of utilizing clinical pathways to enhance care.

There is a strong need for continuing education. As mentioned by Grudzen, Stone, and Morrison (2011), there is unmet need in the ED of PC patients, and more complex skill sets are required to help patients meet optimal management of symptoms. Although there were no statistical significant differences between the pre- and posttest of both instruments there is a need for behavior modification in the global healthcare

environment due observation of behavior. Level of comfort in providing care identified as a strong deterrent. Thus, engaging stakeholders at all levels of the organization is a pivotal factor in aiding ED nurses to develop a comfort level in behavior and improved skills in caring for palliative patients.

Recommendations

Palliative care, when rendered appropriately, will significantly improve patients' and families' quality of life. There is a need for strengthening the knowledge attitude and skills of ED nurses to improve the way palliative care is provided. Recommendations should be geared towards open discussions, to identify factors affecting care delivery in the ED for PC patients. Initiate early start programs from an interdisciplinary approach to include consultation with ED providers of care to improve effectiveness in care. Incorporate PC training in the orientation process of nurses hired in the ACC. Engage nurses in the development of PC policy to guide practice. Another recommendation is the integration of practice protocols on PC to guide in managing symptoms. Finally, additional work is necessary to assist nurses in recognizing their own believes that can hinder giving PC.

Strengths and Limitations of the Project

Strengths

The instruments used in this project PCQN and FATCOD were both valid and reliable. According to Creswell (2014) and Polit (2013), reliability deals with the consistency and accuracy with which an instrument measures what its designed to measure. The data collection instrument used were appropriately tested to ensure their

ability to measure the content. Other strengths of this project included the engagement

and interest showed by staff in gaining knowledge about palliative care. Throughout the

entirety of this project staff stayed engaged and committed to the improving the level of

knowledge and skills about PC. Because of this educational intervention, staff's ability to

work with PC patients and their families showed signs of improvement. The results of

this project can be used by hospitals and other patient care facilities to develop

educational strategies focused on elevating the knowledge and skills of nurses throughout

the organization to improve the PC delivered to terminally ill patients.

Limitations

The information garnered was limited to a sample from a specific practice setting

of ED nurses which limited the generalizability of findings to other populations. An

important limitation of this study was all data was self-reported and some participants did

not answer all the questions. Although over 100 samples were administered, only a small

number of participants returned the surveys. Additionally, one of the site was undergoing

transition into their new space which prevented quite of number of participants. Some

staff showed an electronic approach would have yielded more participation as loss of

instrumentation prevented return of the questionnaire.

Section 5: Dissemination Plan

Organizational Dissemination

This project was done in a nontraditional nursing department providing care to acute patients in an ED-like setting. The organization has a robust PC program; however, the Acute Care Center employs ED nurses who give care to PC patients. There continues to be an interest for high level PC education for these nurses. The organization has an effective wellness program across all continuum of the interdisciplinary team, and the value in finding gaps for these nurses' rests on effective planning for education.

To disseminate the results of this project throughout the organization and beyond, I plan to present the results to stakeholders at the research site to include physicians, program directors, nursing care teams and nursing directors. This will be done through poster presentations and webinars.As a member of the National Research Committee at my place of employment, I have access to a broad audience that could benefit from the project findings.Thus, I will be contacting the Director for the National Research committee for a platform to present. There is a call within the region for poster presentations topic of choice for nurses' week; I will be working with the committee to present. Finally, I plan to publish in the Journal of Palliative Care. This project can serve as means to inform nursing leadership of gaps in care for PC patients and offer simple steps to improve practice.

Analysis of Self

As a Scholar

Scholarship, according to Zaccagnini and White (2011) is the dissemination of research finding through credible peer-reviewed publications, conference presentations and in institutions of learning.The American Association of Colleges of Nursing (2004) offered that DNP prepared nurses have in-depth knowledge in evidence-based practice and population health, are leaders, prepared to influence change in practice, policy, and are clinical scholars. Enrolling in the DNP program has helped me use what I have learned to transform systems of care in my organization. As a scholar, I can collaborate on various planned change opportunities while managing cost effectively. A major project undertaken was the opening of a new Urgent Care center in Atlanta, Georgia. There, I handle staff initiation, training, development, and closing of the project. This project allowed me to collaborate with stakeholders from the administration, facilities, staffing and human resources.

As a scholar, I engaged in writing workflows to support the benefit of nursing care and to lead change effectively and advance the process to improve health for patients. As a scholar, my confidence level has grown, especially in literature research, to find the best evidence for care. I am prepared to analyze data and to draw a conclusion to metrics that support results within the organization. Finding the best practice through research is by far a learned behavior gained throughout this program. It is clear the role of the DNP is significant to the nursing profession integrating best practices for positive outcomes. As mentioned by Bell (2003), clinical scholarship is important yet complex

requiring a greater understanding of the value of nursing. Thus, as a scholar, I am equipped to take risks that are embedded in research, using my heart and mind to serve the needs of patients and society.

As a Practitioner

I have often second guessed myself as to why I ventured on this journey; the answer took some time to reveal itself. But when it did, I realize that this DNP journey, which began five years ago, was the correct path for my academic and professional development. The journey was lonely, tiresome, arduous, yet rewarding. In many ways, I have grown and well-prepared to meet the challenges presented by 21stcentury, dynamic healthcare environment. An environment that requires depth of understanding of evidence-based nursing care delivery to help prevent and cure diseases.

As a practitioner, I have learned the importance of delving into research to find solutions helping to change practices within my organization. In changing practices, my listening skills have been thoroughly enhanced, which have further helped in my professional development where I am being sought for assistance on major projects. I am viewed by much of my colleagues and leaders as a source for information gathering and have been asked to be an active member of the research committee on a Regional as well as a National level in the organization. Thus, I see myself as value added to the organization making a difference in the life of each employee and patient being cared for. Additionally, the DNP role has opened the door to boundless professional opportunities.

As I reflect on the past five years, I am deeply humbled to know I began this journey, and I have embraced the struggles encountered on the road, and task completed.

While I am not sure how the next chapter of my professional life will begin, I see myself as a learner. More importantly, as a leader, I want to continue to make a positive difference in the organization I work and to engage staff in utilizing the best evidence to care for patients.

As a Project Developer

As a developer, this was the most challenging aspect of the journey. The various stakeholders that were involved coupled with the forms that needed to be completed with accuracy complicated the project. Additionally, the reviewing of the details required by Walden's IRB and working with project site for appropriate documents and feedback were additional stressors. My time management was in full gear, as it would have been difficult to manage work and project if I was not organized. Waiting for the various stakeholders to give permission for the project was an arduous task as office time with them was sparse. Numerous calls went unanswered, but I had to be patient and exercise good problem-solving skills. A big positive during the development stage was the time spent with the Director of the Palliative Care program, who could provide me with key stakeholders aided with moving the project along.

The rewriting of the chapters to satisfy project chairpersons was also challenging. It is not a good feeling when you have done your best to write and to have it returned dissected. I felt like a fish without water, who needed help but could not get it although it was there. However, positive mentoring throughout the various stages of the project set my mind at ease. I remember one of my mentors said, "I told you it would not be easy, but you will get it done".

Disseminating the project was an easy road to travel. At this juncture, I feel confident as I am almost at the end of the journey. Planning has been my foundation as a developer. Although I have experienced some gaps and frustration with the process, I have always had the confidence the project would close, and here I am. The DNP project has boosted my confidence, and I consider myself an accomplished individual. I can tackle any task placed in my hands, but more importantly, I have learned the value in collaboration with all disciplines to be an effective project developer. I am more confident, than five years ago, to take on any project and deliver a well-thought-out project for the organization.

As a Professional

Professional development is achieved with learning experiences through processes and products. In reflecting on this thought, my initial journey to enroll in the DNP program at Walden was due to my desire to grow professionally. As a masters prepared nurse, I felt accomplished and knew I was on the path to professional growth. My skills were enhanced because of my role as a clinical supervisor, educator, and quickly a manager. However, with the global evolution of healthcare, nurses are needed to help in leading patient care in the 21st century and beyond. While enrolled in the DNP program, I have become a professional entrepreneur as the co-owner of a small hospice. I am also a mentor for nurses who have enrolled in BSN as well as Master's nursing program. As a professional, I have been able to use my skills to bring out changes in my work environment, engage staff in change process which has led to innovation and

successful outcomes. I am seeking adjunct professorship in an online nursing BSN program after graduation.

Summary

The overarching goal of this project was to assess the knowledge and attitude of ED caring for PC patients and determine if there was significant difference between pre- and posttest scores in administration of the PCQN and FATCOD. The testing results revealed there was no significant difference in nurses' knowledge (PCQN), but a significant difference nurses' attitude (FATCOD). Thus, there is a need for education. The delivery of PC care is pivotal to how ED nurses administer care. PC education should be important to emergency nursing. Academia and healthcare organizations have the responsibility to assess workplace needs and support training programs to provide a balance between patient care needs and appropriate quality service delivery.

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    Learning.

Appendix A: Palliative Care Quiz for Nursing

Created by Margaret M. Ross, Beth McDonald, and Joan McGuinness

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

<div align="center">True   False Don't Know</div>

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

<div align="center">True   False Don't Know</div>

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

<div align="center">True   False Don't Know</div>

4. Adjuvant therapies are important in managing pain.

<div align="center">True   False Don't Know</div>

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

<div align="center">True   False Don't Know</div>

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

<div align="center">True   False Don't Know</div>

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

<div align="center">True   False Don't Know</div>

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

<div align="center">True   False Don't Know</div>

9. The provision of palliative care requires emotional detachment.

<div align="center">True   False Don't Know</div>

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

<div align="center">True   False Don't Know</div>

11. Men generally reconcile their grief more quickly than women.

<div align="center">True   False Don't Know</div>

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

True False Don't Know

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

True False Don't Know

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

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 chronic pain.

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 acute pain.

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 B: Form B—Frommelt Attitudes Toward Care of the Dying Scale

       In these items, the purpose is to learn how caregivers feel about certain situations in which they are involved with patients. All statements concern the giving of care to the dying person and/or, his/her family.Where there is a reference to a dying patient, assume it to refer to a person who is terminally ill and to have six months or less to live.

       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 meaning of the letters is:

SD = Strongly Disagree
D = Disagree
U = Uncertain
A = Agree
SA = Strongly Agree

1.   Giving care to the dying person is a worthwhile 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.   Caring 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 care for a dying person.
                                      SD   D   U   A   SA

6.   The non-family caregivers 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 give 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 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, "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 if they want to.
                                        SD   D   U   A   SA

13. I would hope the person I'm caring for dies when I am <u>not</u> 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 non-family caregiver 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 <u>not</u> 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. Care should extend to the family of the dying person.
                                        SD   D   U   A   SA

23. Caregivers 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

25. Addiction to pain relieving medication should <u>not</u> be a concern when dealing with a dying person.

SD   D   U   A   SA

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

SD   D   U   A   SA

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

SD   D   U   A   SA

28. Educating families about death and dying is <u>not</u> a non-family caregivers responsibility.

SD   D   U   A   SA

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

a job with the patient.

SD   D   U   A   SA

30. It is possible for non-family caregivers to help patients prepare for death.

SD   D   U   A   SA

Non-family caregiver is defined as anyone who is giving care to the dying person, professional or non-professional, who is not a member of the patient's family.

Last 4 digits of your Social Security No.

Completion and Return of This Questionnaire Was Construed as Your Consent to be a Research subject in this Study. Your Anonymity is guaranteed

Appendix C: Letter of Invite to the Participants

Date:XXXXXX

AddressXXXXXXX

Re: Research Study: Knowledge and attitudes of emergency room nurses in Palliative Care

Dear Mr./Ms. XXXXX

I am currently pursuing a Doctor of Nursing Degree (DNP) at Walden University in Minneapolis, Minnesota and a research proposal is required as a fulfillment of my degree. I have chosen to focus my study on assessing the knowledge, attitudes and practice patterns of emergency room nurses providing care to the palliative patient.

I have worked as an emergency room for over 20 years, in addition to hospice nursing for 10 years. During my tenure as an emergency room nurse, I along with my colleagues have provided care to palliative patients. The question that is asked by many of my colleagues is, "why are physicians sending palliative patients to the emergency room"? It is, in fact, a very important question because there has been no training of emergency room nurses on this important topic; lending to less than quality care. This is a situation that requires immediate attention as the number of patients with chronic illness-terminal illness is increasing. The nursing profession must be prepared to meet this demand in all setting. It is expected that the results of the study will provide useful information for the implementation of a structured program to assist emergency room nurses in being equipped to providing quality care to palliative patients.

This letter serves as an invitation for your participation in this study. The participation requires your completion of a 20-item true and false test on your knowledge of palliative care and a 30-item questionnaire addressing attitude towards palliative care. The test and attitude questionnaire should take approximately 20 to 30 minutes each to complete. Please answer the questions to the best of your ability at your convenience without collegial discussion to allow for accuracy in the results. Because confidentially and anonymity is important, be assured your name is not necessary on the test/questionnaire. Access to the results was the privilege of the researcher. Upon completion, all information relevant to the study was destroyed. Please note you are not obligated to participate, and you will not be affected if you choose not to take part in this study.

I thank you for your time in reading this letter. If you so choose to or not participate in this study, please place a checkmark below indicating your decision.

I choose not to participate in the study at this time: _____
I would like to participate in the study: _____

Appendix D: Demographic Information

1. Write in Age:

2. Gender: ___ Male___ Female

3. Race/Ethnicity: White African American Hispanic Asian American Indian Other:

4. Level of Education: AS____   BSN____   MSN____   DNP_____

5. Years of Experience: 1-2 years3-5 years6-9 years   10+ years

6. Do you have any personal or professional experience with palliative care?

Yes__No___

Appendix E: Director of Nursing Approval Letter

AddressXXXXXXX   DateXXXXXXXX
                                                        Phone #XXXXXX
Re: Research Study: Knowledge and attitudes of emergency room nurses in palliative
care.

Dear Mr./Ms. XXXXX

  I am currently pursuing a Doctor of Nursing Degree (DNP) at Walden University
in Minneapolis, Minnesota. a research proposal is required as a fulfillment of my degree.
I have chosen to focus my study on assessing the knowledge, attitudes and practice
patterns of emergency room nurses providing care to the palliative patient.

  For over 30 years, I have worked as an emergency care and hospice care. And
during this period, I, along with my colleagues, have provided care to palliative patients.
Many of my colleagues have asked, "why are physicians sending palliative patients to the
emergency room"? It is, in fact, a very important question because there has been no
training of emergency room nurses on this important topic; lending to less than quality
care. The nursing profession must be prepared to meet this demand in all setting. It is
anticipated that the results of this study will provide useful information for the
implementation of a structured program to equip emergency room nurses to provide
quality care to palliative patients.

I am requesting your permission to invite staff nurses, currently employed in your
emergency room, to participate in this study. It is my hope that the results of the study,
addressing the knowledge, attitudes and practice patterns of nurses in your emergency
room, will produce useful information that will improve care practices for palliative
patients, not only in your organization but in other emergency rooms

  Information for the study was obtained using a test questionnaire sent via
employees' department email, a sample is enclosed. This is a true and false questionnaire
designed to measure knowledge, practice, and attitude of nurses providing care to
palliative patients.

  Should you agree to this request, please provide me with a list of all staff nurses
employed in both emergency rooms in your organization. A cover letter was sent to each
staff (enclosed) and consent was implied on completion of the questionnaires.
Confidentiality was maintained throughout the study.

  Thank you for reading this letter. Should you have any questions or would like to
discuss the project plan in detail, please contact me.

Figure 1: Bandura's Self-Efficacy Source
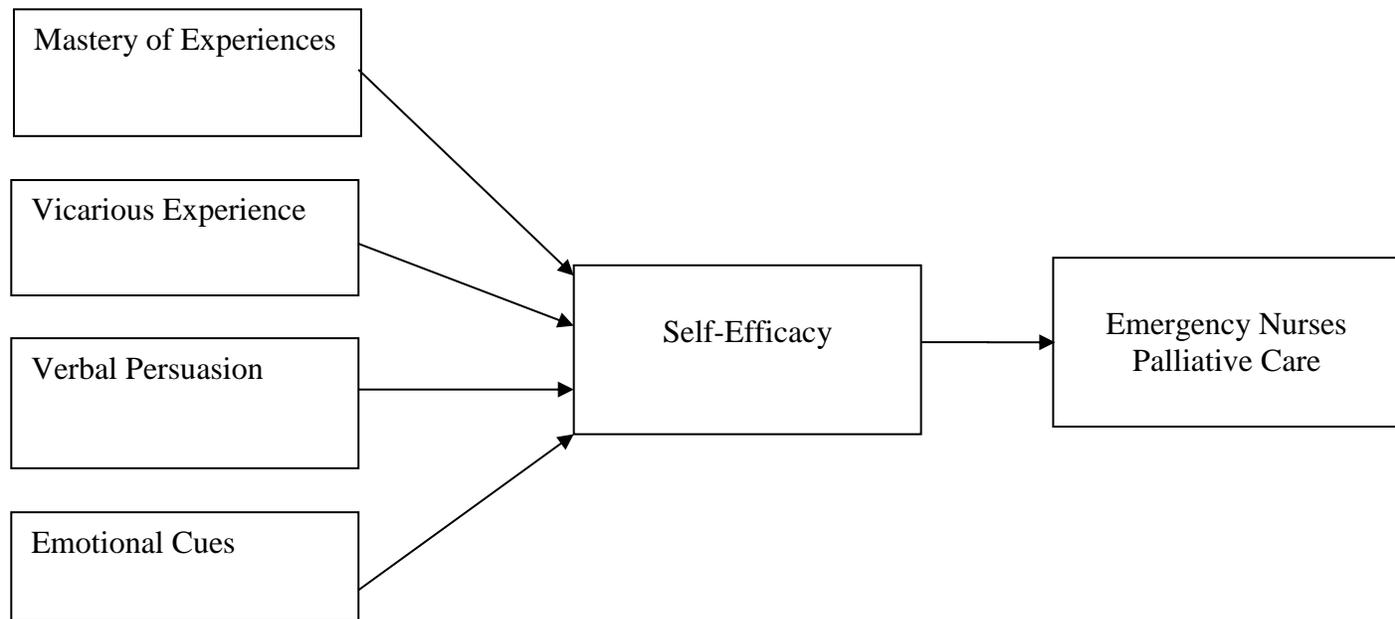
(No permission required)

Figure 2: Logic Model

INPUTS	OUTPUTS		OUTCOMES
	ACTIVITIES	AUDIENCE	SHORT-TERM INTERMEDIATE LONG-TERM
Inputs are the resources used by the program. Examples: program staff, funding, time, external partners, volunteers, materials, equipment, technology	*Activities* are what the program does with its inputs to fulfill its mission. Examples: events, informational materials, products, workshops, trainings, conferences, exhibits, curricula	*Audience* refers to the participants, clients, or customers reached by the program. Examples: number of people attending an event, workshop, and/or training; type of participants (grade levels, ages, ethnicities, etc. of participants)	*Outcomes* are the results of your program. They are the changes that take place during or after the program for individuals, groups, communities, or organizations. These changes can take place over the short, intermediate, or long-term. Long-term outcomes are sometimes referred to as *Impacts*. Examples of short/intermediate-term *Outcomes*: knowledge, attitudes, awareness, opinions, skills, behavior Examples of *Impacts*: educational, environmental quality, or human health improvements

Satisfaction refers to participants' satisfaction with their experience in the program and how it was implemented