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Nurses' Lived Experiences of Comfort Care Among Residents at the End of Life

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Walden University
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Abstract

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MSN, Wilmington University, 2013

BSN, Chamberlain College of Nursing, 2009

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
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Abstract

Nurses provide comfort care for individuals who are at the end of life and reside in the long-term care environment. However, how nurses provide comfort care to those who are dying and nurses' perceptions about providing comfort care are not known. The purpose of this phenomenological study, guided by Kolcaba's theory of comfort, was to examine nurses' lived experiences of comfort care among residents at the end of life in long-term care facilities. The research questions were designed to elicit rich data about the lived experiences of nurses in providing comfort care to dying residents to find out factors that help nurses determine what comfort measures to implement and what the concept of comfort means to nurses. Interviews were conducted with 13 nurses who provided care to patients at end of life. Date were transcribed each recorded interview into a Word document coding then used NVivo 12 to organize the codes. Study findings reflected that nurses' experiences included being emotionally drained, being part of a peaceful transition, feeling ambivalent regarding use of pain medication at the end of life, and being vigilant at recognizing which comfort measures to implement at the end of life. The findings may be used to inform nurses that their experiences with residents at the end of life are shared by other nurses and to help them design plans of care for end-of-life symptom management, which can effect positive social change. Further study is needed to gather lived experiences of other members of the healthcare team, such as the physicians, nurse practitioners, certified nursing assistants, and social workers, and to explore perspectives on endo of life care from nurses from different cultures.

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Dedication

This project is dedicated to my two beautiful daughters, Temitope Comfort Osundina and Anuoluwa Grace Osundina, for being so supportive and understanding.

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I am grateful to God for His grace and guidance throughout this study. Thanks to my beautiful daughters, Temitope and Anuoluwa Osundina, my spouse, Olamide Osundina, and my friends for their support and encouragement. My special thanks to my dissertation chairperson (Dr. Leslie Hussey) and committee member (Dr. Cynthia Fletcher) for their constructive criticism throughout this study. I would also like to extend my appreciation to Professor ‘Diji Aina, Adebusola Oyewole, and Professor Dayo Alao for their expression of confidence in my ability to do this.

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Chapter 1: Introduction to the Study

Introduction

End-of-life care is focused on relieving the distressing symptoms experienced by dying individuals and supporting their families (Sussman et al., 2017). However, there is no clear-cut end-of-life symptom management protocol to ensure that those who are dying experience comfort, especially when hospice care has not been instituted. Waldrop and Kirkendall (2009) observed that transition from routine care to end-of-life care among dying residents in long-term care who have needs for comfort can be delayed due to lack of awareness about what constitutes end-of-life symptoms, indecision, inaction, or inadequate communication between and among stakeholders including the dying residents. In this study, I explored nurses' lived experiences of comfort care among dying residents in long-term care using a qualitative phenomenological research approach. The results of this study have the potential for positive social change by generating a multidisciplinary individualized end-of-life symptoms management order protocol (ESMO) that can be utilized to enhance comfort and enhance peaceful death among residents at the end of life when a “comfort measures only” order is triggered. In this chapter, I identified the background, problem statement, the purpose of the study, research questions, theoretical framework of the study, significance, nature of the study, method of data analysis, assumptions, limitations, and scope of the study.

Background

Comfort care has been described as an essential part of care designed for people at the end of life as it helps to soothe dying patients who may be suffering from multiple end-of-life symptoms and to help improve quality of life. Siefert (2002) described comfort as “a basic core value of nursing care” (p. 16). The National Institute of Health (2004) described end of life as a process of multiple transitions, including physical, emotional, spiritual, and financial, but there is no one single definition of end of life. However, end of life has prerequisite components, such as the presence of chronic illnesses, persistent functional impairments, impairments resulting from irreversible diseases that can lead to death, and old age that may allow for life-threatening illnesses and comorbidity.

There are two identified pertinent decisions made during the terminal phases of illness: whether to send the resident to the hospital or to start end-of-life care in the nursing home. These decisions could be delayed because of lack of awareness of what constitutes end of life, not knowing what to do, and inaction. However, Waldrop and Kirkendall (2009) identified physical, behavioral, and social indicators of approaching death and that a good death in a nursing home entails individualized care involving interdisciplinary teamwork and an advanced plan of care to avoid resuscitation and hospitalization. The goal of care at the end of life is to enhance comfort using a holistic and person-centered care approach focusing on the interrelationship between physical, psychosocial, and spiritual domains (Waldrop & Kirkendall, 2009).

End-of-life care affirms life and considers death a normal process. However, end-of-life care is not to hasten death, nor to prolong suffering, but it should be initiated as soon as it becomes evident that death is imminent. End-of-life care is also described as whole-person care focused on relieving the physical, social, psychological, and spiritual suffering of the dying residents and their families (Sussman et al., 2017). Nurses in nursing homes need to be knowledgeable about end-of-life care and the skills required to provide the care, and this can be accomplished through training and in-services to improve competence in end-of-life care (Raudonis, Kyba, & Kinsey, 2002). Long-term care facilities are gradually becoming the place of death for residents at the end of life because of the increasing number of older adults living in nursing homes. The care paradigm in long-term care facilities needs to shift toward end-of-life care where optimal comfort and care are needed at end of life instead of cure being the goal of care (Krishnan et al., 2015). Comfort care at the end of life involves adequate control of the distressing end-of-life symptoms using skilled psychosocial and spiritual support to the residents and their supportive families to enhance comfort. Blinderman and Billings (2015) posited that instead of writing orders for comfort care, the physician needs to review the entire plan of care and write orders that will promote comfort and prevent unnecessary interventions.

The plan of care for residents when death is imminent is expected to be focused on comfort. Walling et al. (2011) found that ESMO protocols that included comfort measures were instituted late and sometimes not at all because the family or the resident was not ready for ESMO because the clinician had not discussed the option of comfort at the end of life with them. Walling et al. (2011) concluded that information about an ESMO protocol be disseminated throughout the facility to be used in the care of residents at the end of life.

Currently, there is no ESMO protocol to use when a “comfort measures only” order is written for residents at the end of life (Oliveira, 2013). A review of literature indicated that studies have been carried out about nurses' perceptions in relation to care at the end of life in acute care hospitals and emergency departments (Tse et al., 2016), but no studies have been found to address nurses' perceptions about comfort care in long-term care, which could identify factors to guide the development of ESMO protocol to provide comfort care for residents at the end of life.

Problem Statement

Most residents in long-term care facilities have advanced illnesses that present with complicated, significant cognitive and functional impairments (Krishnan et al., 2015). A significant number of long-term care residents are at the end of life. Cagle, Unroe, Bunting, Bernard, and Miller (2017) stated that 1.5 million people reside in nursing homes in the United States, and 30% of deaths among older adults (65+ years) occur in the nursing home setting. Providing quality care at the end of life for long-term care residents is becoming the norm as the number of older adults who reside in nursing homes continues to increase in the United States (Cagle et al., 2017).

Krishnan et al. (2015) supported the idea of a "dying in place strategy" where choices of a good death are offered to residents in long-term care facilities and where facilities will be able to fulfill their mission of caring for residents at the end of life. However, when residents in long-term care at the end of life are ordered comfort care measures only, nurses are left to make the determination as to what needs to be included in comfort care measures. Walling et al. (2011) stated that a prior study of one institution's ESMO protocol suggested that comfort measures were often instituted late and sometimes not at all. Comfort care measures may include pain management, reduction of respiratory secretion (often referred to as “death rattle”), and control of breathlessness (LeGrand & Walsh, 2010). But there is no accepted individualized ESMO protocol to provide comfort and care with. Using an unclear approach to providing comfort care measures for residents at the end of life not only leads to discomfort, but it also places residents at the end of life in a position where nurses may easily forget their priority need for comfort.

Purpose of the Study

In this qualitative phenomenological study, I sought to examine the nurses’ lived experiences of comfort care among residents at the end of life in long-term care facilities. Nurses were able to express their worldview about comfort and comfort measures, and the resulting themes may be utilized in collaboration with other healthcare professionals to formulate a meaningful ESMO protocol among residents in long-term care facilities.

Research Questions

In order to align my research topic, problem statement, and the purpose of the research study, I formulated the following overarching research question and sub questions to elicit information from the research participants:

RQ: What are the lived experiences of nurses who provide comfort care to residents at the end of life in long-term care facilities?

Sub questions

SQ1: What does the concept of comfort mean to nurses when providing care for long-term care residents at the end of life?

SQ2: What are the factors that help nurses determine what comfort measures to implement for the resident at the end of life?

SQ3: What are the challenges nurses experience when providing care to residents at the end of life?

Theoretical Framework for This Study

The complexity of needs at the end of life, including the need for comfort, required that I use a middle range nursing theory as the theoretical framework for this study. Comfort, as identified to be the focus of care at the end of life, aligns with the use of the theory of comfort, i.e., Kolcaba's theory of comfort. Kolcaba described the major concepts involved in the theory to include comfort, comfort care, comfort measures, comfort needs, health-seeking behaviors, institutional integrity, and intervening variables. The concept of comfort was defined to clarify its use in nursing practice, theory, and research (Kolcaba & Kolcaba, 1991). Comfort means a cause of relief from discomfort, a state of ease and peaceful contentment, whatever makes life easy or pleasurable, to strengthen, to encourage, to support, physical refreshment (Kolcaba & Kolcaba, 1991).

Assumptions from Kolcaba's (2001) theory of comfort include the following: (a) human beings have holistic responses to complex comfort needs in stressful health care situations such as the end of life, (b) comfort is a desirable outcome, (c) human beings make efforts to meet basic comfort needs, and (d) comfort promotes institutional integrity. Kolcaba also proposed that nurses are responsible for identifying the comfort needs of patients and can design interventions to address the identified comfort needs. Therefore, if comfort is enhanced, patients are encouraged to embark on health-seeking behaviors because of effective comfort measures that may lead to positive social change. Enhancing comfort in the contexts of physical, psychospiritual, environmental, and sociocultural aspects at the end of life among residents in long-term care requires the use of comfort measure interventions to address the accompanied multiple distressing end-of-life symptoms that cut across the four domains of care (Krinsky, Murillo, &Johnson, 2017). Therefore, I used Kolcaba's theoretical framework and a qualitative phenomenological study approach to solicit answers to the proposed research questions to elicit an understanding of what comfort meant to nurses providing comfort care to residents at the end of life in long-term care. My approach was well aligned with this study because of the holistic and person-centered nature of the theory of comfort. More detail about Kolcaba's theoretical framework is presented in Chapter 2.

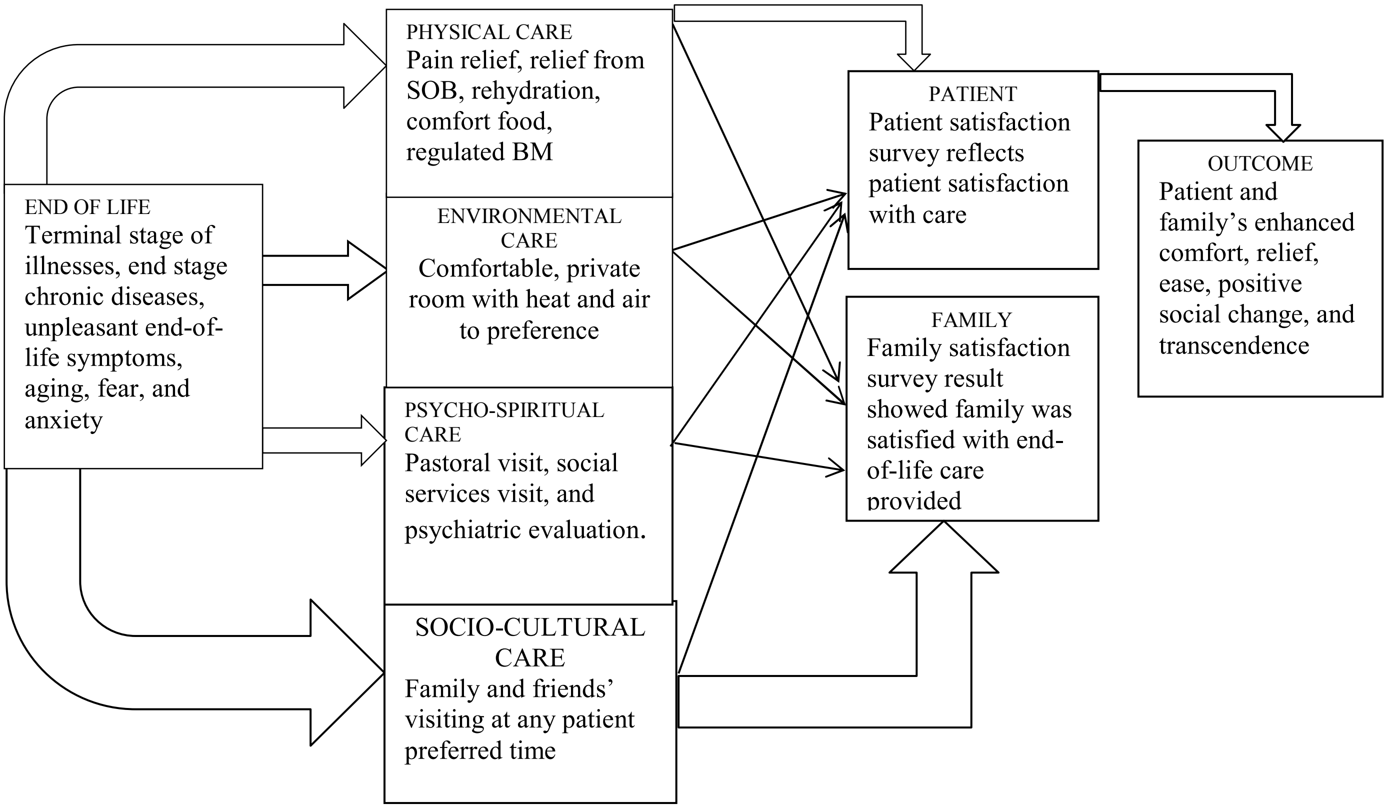

Figure 1. Comfort graphic model adapted from the theory of comfort.

Nature of the Study

I used a qualitative phenomenological research method to provide a framework for my study that researchers can use to describe the meanings of human experience. The philosophical underpinning of this study emerged from a naturalist paradigm referred to as *interpretive constructionism*, "that the core of understanding is learning what people make of the world around them" (Rubin & Rubin, 2012, p. 19). The meaning of a phenomenon is dictated by how people interpret what they encounter and assign value to the phenomenon. Interpretive constructionists believe that people see things through distinct lenses and arrive at different summations, so there can be many, conflicting versions of the same event that are true at the same time (Rubin & Rubin, 2012).

Rudestam and Newton (2015) stated that phenomenology explains how people describe their lived experiences. I used an interpretive phenomenological approach, which explained “how different individuals understand and give meaning to similar life events”; it is also referred to as the Heideggerian approach, which was developed with interest in the uniqueness of individuals (Rudestam &Newton, 2015, p. 43). I used this approach to examine how nurses perceive the concept of comfort care among residents at the end of life, and the uniqueness of individual nurses’ perceptions of comfort manifested and elicited information-rich results using interviewing and open-ended questions.

The first step in qualitative data analysis (QDA) was to read and reread the transcript several times to get a sense of the data. I numbered the lines for easy reference and made the determination of the different themes. As I reread the transcripts, I looked for themes which I inserted into a margin on the right side or in the text itself and provided a name for the theme. The next step was to look for connections between the themes in order to cluster them together, and I explored the connections within and between the conceptual groups and began to generate explanation (Fade, 2004).

I used a combination of manual coding and QDA software NVivo 12. Saldaña (2016) stated that it is important for any qualitative researcher who is willing to be proficient in QDA to learn the coding system and apply the skill to be excellent in qualitative research; Saldaña suggested practicing and learning basics of coding and

QDA manually before engaging in QDA software. Practicing the basics of coding gave me control over and ownership of my work. QDA software did not formulate codes but helped me to turn abstract information into concrete data; it helped to store, organize, manage, and reconfigure the data to allow me to make human analytic reflection (Saldaña, 2016)**.**

Definitions of Terms

Comfort: It is "the satisfaction (actively, passively, or co-operatively) of the basic human needs for relief, ease, or transcendence arising from healthcare situations that are stressful" (Kolcaba, 1994, p. 1178).

Comfort measures: These are "interventions or actions employed in a process to promote the comfort of patients, and they are described as active, decisive strategies or activities specifically designed to achieve an identified comfort goal" (Oliveira, 2013, p. 99).

Comfort care: Care that is "holistic and person-centered focusing on the interrelationship between physical, psychosocial, and spiritual issues" (Waldrop & Kirkendall, 2009, p. 719)

End of life: A process of multiple transitions including "physical, emotional, spiritual, and financial" areas of life, with components such as the presence of chronic diseases, functional impairments that persist but may also fluctuate, impairments resulting from underlying irreversible disease requiring care and can lead to death (NIH, 2004).

End-of-life symptoms management order (ESMO): A protocol for "evidence-based practices for the pharmacological management of the most commonly experienced symptoms at end of life, the elements of nursing comfort assessments of the dying patient every 2 hours; and patient and family education around the dying process" (Lau et al., 2017, p. 653).

Long-term care residents: Predominantly comprised of people who have reached advanced old age, usually 65+years, and have been afflicted by a number of often chronic illnesses, needing much assistance with activities of daily living and more intervention for difficult behaviors, and requiring long-term facility-based care; however, they can also be people who are under the age of 65 with higher care needs requiring long-term care (Wilson & Truman, 2004).

Assumptions

I assumed that all nurses in the study will express their perceptions truthfully based on their own experiences. I also assumed that nurses desired to provide high-quality end-of-life care to long-term care residents.

Scope and Delimitations

Understanding what the concept of comfort means to nurses was the goal of this study in an effort to contribute meaningfully as part of a multidisciplinary team to formulate a multidisciplinary, individualized ESMO protocol. ESMO protocol is a tool that could be used to implement comfort measures and is usually prescribed by physicians at the end of life when family and residents are unable to decide between withdrawing from aggressive medical treatment and accepting hospice care. I conducted this study in nursing homes using nurses with experience in caring for dying residents who have worked in the long-term care facility for about 2 years; nurses with fewer years of experience were not considered because they lacked the opportunity to provide comfort care to dying residents in the nursing home. The voices of other team members, like social services, physicians, nurse practitioners, housekeepers, activities directors, administrators, and certified nursing assistants, were not included because nurses provide the assessment and most of the bedside care at the end of life.

I considered using the Roy adaptation model (RAM),which is a theory based on nursing practice that provides guidance for nurses on physiologic and psychosocial adaptation in relation to the distressing symptoms and situational crisis involving last-minute decisions about care preferences, legal issues, role challenges, depression, and anxiety at the end of life (McEwen & Wills, 2014). However, I decided to adopt Kolcaba's theory of comfort because a basic tenet of the theory is that nurses identify residents with comfort needs at the end of life through assessment, and that understanding of comfort can aid in the implementation of holistic nursing care. However, implementation of holistic care to enhance comfort at the end of life involves not only the nurses, but also nurse practitioners, physicians, certified nursing assistants, and other healthcare professionals whose voices were missing in this study. As a result, the transferability of the study findings to other long-term care facilities is limited, and further study that includes all healthcare team members may be required to expand the scope and benefit to other long-term care facilities.

I used phenomenological qualitative research design, a method that allowed people to describe their experiences in relation to the phenomenon under study, because it helped to elicit how individual participants understand and give meaning to their experiences (Rudestam & Newton 2015). I could have used narrative qualitative research design, but the method is best suited for individuals' storied lives with the focus on one or two individuals telling their personal experiences. I used the interview as my data collection tool; I could have used participant observation, but I was seeking to understand the perceptions of individual nurses about comfort care at the end of life among dying residents in long-term care and not the perceptions of a group of nurses (Ravitch & Carl, 2016).

Limitations

I used key informants, key knowledgeable groups, and reputational purposive sampling method, where participants were purposefully chosen to take part in the qualitative research study and where the chosen sample have had certain experiences or knowledge of the phenomenon under study (Ravitch & Carl, 2016). As a result, there was an inherent bias in relation to the choice of participants because I chose a specific group of participants for my research study. Another limitation was the exclusion of other healthcare team members, like social services, administrators, certified nursing assistants, housekeepers, nurse practitioners, physician, and activity aides, from participating in the study, which may limit transferability of the study findings to other long-term care facilities, and the findings may not necessarily represent the experiences of other groups of nurses who work in long-term care facilities. According to Morse (2007) (as cited in

Rudestam & Newton, 2015), qualitative study is “inherently biased” (p. 123). Qualitative researchers select people who have in-depth knowledge about the phenomenon of interest to contribute meaningfully to the understanding of the phenomenon. However, it is inherent in my theoretical framework that comfort, comfort care, and comfort measures were the conceptual focus of nursing care of the dying residents at the end of life, so the analysis and findings at the end of this study are dependable and valid to the type of care that will enhance comfort for dying residents at the end of life in long-term care (Ravitch & Carl, 2016). I used email to disseminate requests for participation and to disseminate informed consent to participants.

Significance

Most residents in long-term care facilities at the end of life have advanced, chronic, and terminal illnesses that present with complicated, significant cognitive and functional impairments (Krishnan et al., 2015). These residents have different levels of disease burden and functional limitations that require formal care services in long-term care to provide needed care to enhance comfort, improve quality of life, and quality of dying instead of comfort measures only (Krishnan et al., 2015)

The stakeholders were the residents who need comfort at the end of life, family members who need to be satisfied with the care received by their loved ones, the nurses who need to be fulfilled that they have met the comfort needs of their residents, and other healthcare professionals who need to know that they have supported family members and contributed to the comfort of their residents (Garcia, 2018).Each of these stakeholders will benefit from having an ESMO protocol that is individualized and resident-centered; residents will experience enhanced comfort and improved quality of dying.

Krishnan et al. (2015) stated that “comfort care orders strongly and independently predicted death within long-term care in the current study” (p. 139). This study helped to reveal nurses’ perceptions about what *comfort* and *comfort measures* mean, and because nurses are set to implement “comfort measures only” orders to residents at the end of life, there was a need to understand what comfort means to them. Nurses may use study findings to design an individualized plan of care and ESMO to meet patients’ needs during their end-of-life transition. Tutton and Seers (2003) posited that knowledge of comfort by patients and nurses can help validate and understand patients’ responses to nurses’ actions and can help direct nurses’ interactions with patients toward outcomes that result in patient comfort. Patients will receive care tailored to their specific needs that will enhance their comfort and quality of life. Family members will have satisfaction when their loved ones’ end-of-life experience is peaceful and nontraumatic, and a facility’s increased referral of residents who might require end-of-life care which can create positive social change.

Summary

Comfort remains the central focus and essential part of nursing care at the end of life, especially with people experiencing multiple distressing dying-related symptoms, which could be emotional, physical, and psychospiritual in long-term care. ESMO protocols, which include do not resuscitate orders, are plans of care that are comfort-oriented in relation to patient prognosis and matched to documented distressing end-of-life symptoms (Walling et al., 2011); they have been implemented in acute care hospitals, but a similar approach to care at the end of life has not been implemented in nursing homes. I used a phenomenological research design approach to help elicit information-rich perceptions from nurses about comfort care at the end of life in a long-term care facility, and the resulting outcome may be used to formulate ESMO protocols and help create positive social change. I have presented an in-depth review of the literature in Chapter 2.

Chapter 2: Literature Review

Introduction

Many residents in long-term care facilities have advanced illnesses that present with multiple chronic symptoms of pain and difficulty breathing, especially at the end of life. These residents require special attention on protection of personal integrity and control of symptoms to enhance comfort and improve quality of life and quality of dying. In this study, I examined nurse perceptions of comfort care among residents at the end of life. Physicians traditionally write an order for “comfort measures only” for dying residents. This order often occurs when treatment decisions regarding end of life are difficult to make, especially when the resident is unable to communicate (Goodridge, Bond, Cameron, & McKean, 2005) and may not have a living will. Krishnan, Williams, and Maharaj (2015) posited that the use of comfort care orders alone strongly influences death in nursing homes. Because death and dying are becoming the central features of long-term care, the measure of quality in nursing homes is shifting to the measure of the quality of care provided to residents at the end of life (Krishnan, Williams, & Maharaj, 2015). A shift has occurred in the long-term care policies and practices from emphasizing cure to emphasizing care and ensuring optimal comfort at the end of life. The key variables in this study are comfort, comfort care measures, and end of life. In this study, I sought to examine nurses’ perceptions of the concept of comfort for long-term care residents at the end of life in long-term care facilities. Comfort care orders play a significant role at the end of life in long-term care. Dying residents should receive care tailored to their specific needs that will enhance comfort at the end of life (Krishnan et al., 2015).

Literature Search Strategy

I used multiple databases in Walden University's library to search for my study's literature. The keywords and search terms used were *comfort care at the end of life in nursing homes*; the search phrases were also broken down into *comfort care* + *end of life* + *nursing homes, comfort measures* + *end of life* + *nursing homes, nurses' perception* + *comfort* + *nursing homes, and comfort theory* + *Kolcaba*. I conducted searches in the following databases: (a) CNAHL & MEDLINE combine search, (b) CNAHL plus with full text, (c) MEDLINE with full text, (d) OVID Nursing Journals Full text, (e) ProQuest Nursing, (f) Allied Health source, and (g) Google Scholar. The literature search included peer-reviewed scholarly journals and extended beyond 5 years to obtain sufficient information for my study. There were few recent publications recovered in this area; most search results were older than 5 years, but despite their age, they were relevant to my study.

Framework

The complexity of needs at the end of life, including the need for comfort, required that I use a middle range nursing theory as the theoretical framework for this study. Comfort, as the focus of care at the end of life, aligns with the use of the theory of comfort, i.e., Kolcaba's theory of comfort. Kolcaba (Kolcaba & Kolcaba, 1991) described major concepts involved in the theory to include comfort, comfort care, comfort measures, comfort needs, health-seeking behaviors, institutional integrity, and intervening variables. The concept of comfort was defined by Kolcaba and Kolcaba (1991) to clarify its use in nursing practice, theory, and research. Comfort occurs when there is relief from discomfort, a state of ease and peaceful contentment, whatever makes life easy or pleasurable, to strengthen, to encourage, to support, physical refreshment (Kolcaba & Kolcaba, 1991).

The theory of comfort was originally postulated by Kolcaba in the 1990s, and she stated that “in stressful healthcare situations, unmet needs for comfort are met by nurses” (Kolcaba, 2001, p. 86). The theory of comfort is a middle range nursing theory that has logical interrelationships between the concepts and is easily adaptable to practice and research. The philosophic underpinnings of the theory of comfort were drawn from human needs, adaptation, and the health-illness continuum. Human beings possess basic needs that must be met to maintain optimum physical health, and they have desires and aspirations that go beyond physical needs that must be met to avoid undesirable consequences. The sum of these needs makes up the construct of holistic comfort as it entails the physical, the psychospiritual, the sociocultural, and the environmental components of human needs (Kolcaba, 2001). The concept of *holism* is at the core of the theory of comfort as Kolcaba posited that when residents’ comfort needs are attended to correctly, comfort is enhanced with positive institutional outcomes (Kolcaba, 2001).

Assumptions of Kolcaba’s (2001) theory of comfort include the following: (a) human beings have holistic responses to complex comfort needs in stressful healthcare situations such as the end of life, (b) comfort is a desirable outcome, (c) human beings make efforts to meet basic comfort needs, and (d) comfort promotes institutional integrity. Kolcaba also proposed that nurses are responsible for identifying the comfort needs of patients and can design interventions to address the identified comfort needs. If comfort is enhanced, patients are encouraged to embark on health-seeking behaviors because of effective comfort measures that lead to positive social change.

The theory of comfort was derived from the relationship between patient needs, nursing interventions, comfort, and outcomes. For instance, adverse stimuli and thoughts cause discomfort, which precedes a need for comfort. A need for comfort calls for comfort measure interventions to bring about a state of ease, relief, or transcendence (Kolcaba, 1994). Comfort existed in three dimensions (as illustrated in Figure 1): (a) relief that is the experience exhibited when a specific need is met to return to a prior state or to a peaceful death, (b) ease that is a condition necessary for optimum performance, and (c) transcendence, a state where ordinary powers are enhanced (Kolcaba, 1994). Comfort is a desirable outcome of nursing care and is essential for a peaceful death because a dying person requires psychological balance to deal with and accept the stressful situation that accompanies dying and death (Kolcaba, 1994). Kolcaba (1994) cited the American Nurses Association's position statement on the promotion of comfort in dying patients, stating that "the main goal in the dying patients should be maximizing comfort as it is consistent with the desires of the patient" (p. 1181).

The use of the theory of comfort is evident in clinical practice, as complex nursing interventions have shown to enhance comfort. The theory of comfort provides direction for nursing practice, theory, and research because the outcome of comfort can be measured, is holistic, and is nurse-sensitive (Kolcaba, 1994). Researchers used Kolcaba's theory of comfort to test several formats of end-of-life comfort instruments for patients and closely involved caregivers in two hospice agencies in Northeastern Ohio (Novak, Kolcaba, Steiner, & Dowd, 2001). They found that the instruments provided these agencies the ability to assess and document ongoing efforts at providing comfort at the end of life to the patients and caregiving family members (Novak, Kolcaba, Steiner, & Dowd, 2001). Wilson and Kolcaba (2004) used the theory of comfort to address the comfort needs of patients in a perianesthesia unit, and such comfort interventions included monitoring vital signs, laboratory results, pain control, and repositioning, which may indicate homeostatic compromise. They found that proactive comfort care not only minimized negative aspects of surgery and illness, but enhanced positive indicators of daily function, which included comfort, mobility, and healing (Wilson & Kolcaba, 2004). Kolcaba and DiMarco (2005) applied the theory of comfort in pediatric nursing where comforting strategies such as positioning, thumb-sucking, blanket-holding, rocking, and presence of family members were implemented to enhance comfort. They found that comfort was a positive outcome that empowered children and their families to engage in health-seeking behaviors and that enhancing comfort of children and their families in clinical settings was altruistic, practical, and satisfying (Kolcaba & DiMarco, 2005). A hospital in New England used the theory of comfort as a unifying framework to enhance the practice environment to achieve Magnet status. Researchers found that integration of the theory of comfort within the hospital was exemplar and had a positive impact on the organizational climate (Kolcaba, Tilton, & Drouin, 2006). Krinsky, Murillo, and Johnson

(2017) tested the theory of comfort in cardiac care where the use of quiet time intervention promoted comfort. Their results showed that nothing was more germane to nursing than comfort, which was evidenced by the use of quiet time that improved standard of care and outcomes for the cardiac patients (Krinsky, Murillo, &Johnson, 2017). Figure 1 depicts the theory of comfort and the subsequent outcome of relief, ease, and transcendence after effective comfort measures have been utilized.

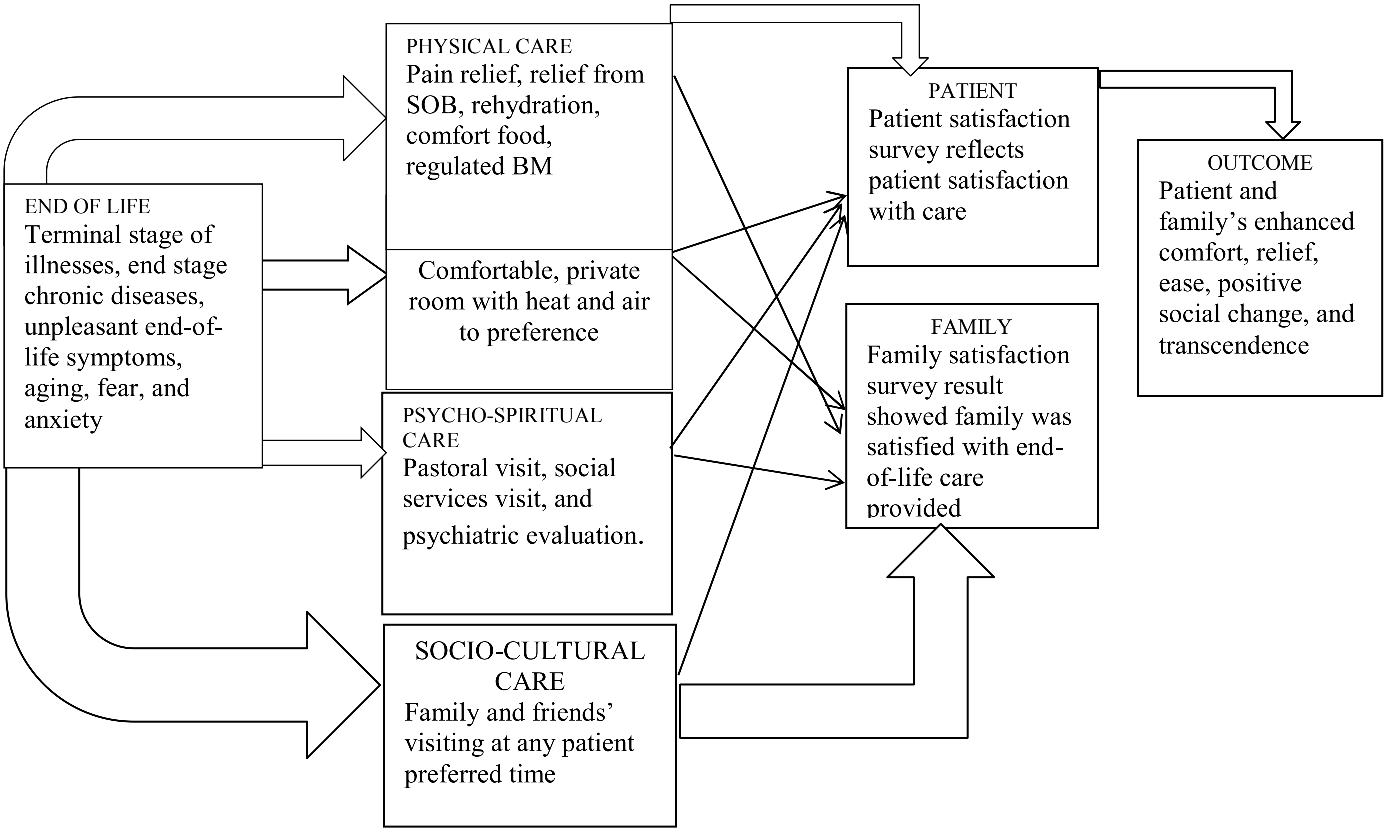

Figure 1. Comfort graphic model adapted from the theory of comfort.

Enhancing comfort in the contexts of physical, psychospiritual, environmental, and sociocultural aspects at the end of life among residents in long-term care requires the use of comfort measure interventions to address the accompanied multiple distressing end-of-life symptoms that cut across the four domains of care (Krinsky, Murillo, & Johnson, 2017). Therefore, the use of Kolcaba's theoretical framework helps to reveal the importance of applying the theory of comfort at the end of life in long-term care, and the theory of comfort is well aligned with this study in relation to its holistic and person-centered nature.

Literature Review Related to Key Variables and/or Concepts

End of Life

End of life is a difficult concept to define because nobody knows for sure when life will end. Hui et al. (2014) defined end of life as a "progressive life-limiting disease with a prognosis of months or less" (p. 87). Long-term care residents may not want to accept the life-limiting diagnosis or may not be ready to die, and sometimes because beliefs about death and dying are culturally and religiously influenced, divergent cultural beliefs and personal preferences have also prevented death from being viewed as a normative process (Sussman et al., 2017). McLeod-Sordjan (2013) posited that how people view death is influenced by relationships with caregivers, prognosis, culture, morality, society, and law. The National Institute of Health (NIH;2004) State-of-the-Science conference statement posited that end of life has additional dimensions, such as impaired function and elevated end-of-life symptoms that require higher levels of care.

The end-of-life process involves multiple transitions in the areas of physical, emotional, spiritual, and financial aspect (NIH, 2004). End of life has also been attributed based on accompanying unique distressing symptoms, such as difficulty breathing, loss of appetite, social isolation or withdrawal from friends and family, constipation, pain, nausea, and vomiting. LeGrand and Walsh (2010) identified the key symptoms of impending death as “pain, dyspnea, respiratory tract secretions, and restlessness” (p. 488). Lau et al., (2017) also described the commonly experienced end-of-life symptoms as “pain, dyspnea, restlessness, upper airway secretions, fever, and seizures” (p. 653). Nevertheless, commonly experienced end-of-life symptoms do not specifically define the concept of end of life, but these distressing end-of-life symptoms require comfort care measures.

End-of-Life Care

End-of-life care is treatment and emotional and psychosocial support provided to those who are close to death. It is care that is provided which is not designed to hasten or postpone death and should be instituted as soon as life-limiting illness diagnosis is made (WHO, 2011) as cited by Sussman et al. (2017). End-of-life care has also been described as “whole person care” that brings relief in the areas of physical, social, psychological, and spiritual suffering for the dying residents and their families starting from the time of diagnosis into bereavement (Canadian Hospice Palliative Care Association, 2002) as cited by Sussman et al. (2017); end-of-life care centered on enhancing comfort to the dying residents and their families with emphasis on physical, social, emotional, spiritual, and environmental care. Sussman et al. (2017) advocated for the integration of end-of-life care into long-term care environment in relation to the prevalence of death occurring in nursing homes.

Deaths of nursing home residents are becoming a common occurrence, especially among older adults over the age of 65. These deaths can have devastating effects on families and the staff, so nurses must be adequately equipped to provide quality end-of-life care to residents (Goodridge et al., 2005). Last Acts (2002) (as cited in Goodridge et al., 2005) projected that half of all deaths in the United States will occur in nursing homes by 2020. Prompt and adequate symptoms management are critical factors in providing quality end-of-life care, including emotional and psychosocial support for the residents (Goodridge et al., 2005). Singer et al. (1999) identified five domains of quality end-of-life care from patients' perspectives: (a) adequate pain control and symptoms management, (b) avoiding undue prolongation of dying process, (c) empowering resident to have a sense of control, (d) relieving burden on loved ones, and (e) strengthening relationships with loved ones.

Residents, staff, and family members viewed comfort as central to quality end-of-life care in actively dying residents in long-term care facilities. Enhancing comfort at the end of life is multidimensional and involves pain control and symptom management, providing food and drink, attention to the needs of families of the dying residents, and maintaining a quiet and calming environment for residents and their families (Sussman et al., 2017). End-of-life care is highly individualized and person-centered, based on interrelationship between physical, psychosocial, spiritual, and cultural issues (Waldrop & Kirkendall, 2009). End-of-life care involves interrelationships among symptom management, family care, interpersonal relationships, and teamwork (Sussman et al., 2017; Waldrop & Kirkendall, 2009).

Comfort

Defining comfort as a concept has not been easy, as comfort has been identified as a noun, a verb, an adjective, a process, a product, a cause, and an effect (Kolcaba, 2003, as cited by Bland, 2007). Bland (2007) described comfort as being more than just the absence of discomfort, and comfort and discomfort are not mutually exclusive, in that one can experience comfort in one area and experience discomfort in other areas. The concept of comfort was explained to delineate its use in nursing practice, theory, and research. Comfort means a cause of relief from discomfort, a state of ease and peaceful contentment, whatever makes life easy or pleasurable, to strengthen, to encourage, to support, physical refreshment (Kolcaba & Kolcaba, 1991). The multidimensional nature of comfort requires an individualized, yet multidisciplinary, team approach to ensure enhanced comfort, especially among residents at the end of life in long-term care facilities. Harmer (1926) (as cited in Kolcaba & Kolcaba, 1991) stated that nurses are responsible for providing environmental comfort as well as relief from pain and discomfort. Goodnow (1935) (as cited by Kolcaba &Kolcaba, 1991) described comfort as both physical and mental, and nurses' responsibilities do not end with physical care.

Comfort is the outcome and central focus of nursing care. Comfort, when experienced, produces a change in human experience in physical, psychospiritual, sociocultural, and environmental contexts to exhibit feelings of relief, ease, and transcendence (Kolcaba, Tilton, & Drouin, 2006). Kolcaba (1994) (as cited by McEwen & Wills, 2014) defined comfort as "the satisfaction of the basic human needs for relief, ease, or transcendence arising from health care situations that are stressful" (p. 244), and understanding of comfort can promote nursing care in a holistic fashion; the outcome of comfort can be measured, positive, and nurse-sensitive.

Comfort is one of the elements of nursing care with different perspectives, and the exact meaning of comfort as a concept remains unclear. Tutton and Seers (2003) defined comfort as a state that can be linked to ease, well-being, and satisfaction and also stated that comfort is concerned with relief from discomfort. Tutton and Seers (2003) concluded that the patients' feeling and experience are revealing in trying to find a unique definition for the concept of comfort, to some extent, so it will be helpful to define comfort as whatever the experiencing person says it is. Like the concept of pain, comfort exists whenever and however people say it does. Comfort, therefore, has a great potential for nursing but needs to be explored further to identify its true potential. Comfort is used to describe nursing actions undertaken to demonstrate that caring has taken place, so comfort is perceived as part of caring, but not as an outcome of caring actions. The use of the term comfort has evolved over time and has been used in different contexts. Comfort has been an outcome sought by patients when sick, so comfort is not just soothing activities (Tutton & Seers, 2003).

Kolcaba (1994) supported the idea that understanding what comfort is helps to guide nursing care that is holistic, inclusive of physical, psychospiritual, sociocultural, and environmental care. Kolcaba (1994) defined comfort "as the satisfaction actively, passively or cooperatively of basic human needs for relief, ease or transcendence arising from healthcare situations that are stressful" (p. 1178). Therefore, it is necessary to understand what comfort care means to nurses who are charged with providing comfort care to residents at the end of life in long-term care facilities. The findings can be used to formulate interdisciplinary symptoms management order protocols that will be useful in enhancing comfort for residents at the end of life in long-term care facilities. The general goal of nursing care has been to help patients be comfortable or maintain a state of comfort (Kolcaba & Kolcaba, 1991). However, the American Nurses' Association (1987) (as cited by Kolcaba &Kolcaba, 1991) stated that "emphasis is placed on maintaining life in dignity and comfort until death" (p. 1304).

Comfort Measures

Comfort measures are defined as the clinical management of the dying person using specific measures that is implemented solely for comfort in the last hours of life (LeGrand & Walsh, 2010). Cagle et al. (2017) stated there is need for increased high-quality end-of-life care in nursing homes which includes comfort measures in relation to fast-growing number of older adults in the United States, and that these efforts are dependent on frontline nursing home staff to provide the needed care. Provision of comfort care to dying residents becomes the central focus of care in nursing homes (Kavanaugh, 2001). There are more comfort care measures to implement to enhance comfort among dying residents in nursing homes other than pain management, and there is a need for care paradigm shift from rehabilitative and health promotion to enhancing comfort at the end of life. Some nursing homes are partnering with hospice services to provide comfort care to residents of nursing homes that are terminally ill, so services of social work, pastoral visit, use of home health aide, and sometimes around the clock comfort care, depending on the severity of the end of life distress (Kavanaugh, 2001).

Comfort measures go beyond providing physical comfort and administration of pain-relieving medications. For instance, Oliveira (2013, p. 96) (as cited by Hodnett (1996)) stating that comfort measures involve physical actions to relieve physical discomfort, but also include critical comfort needs, such as holistic and supportive care (LeGrand & Walsh, 2010). Comfort measures may also include a combination of psychological, sociocultural, spiritual, and environmental interventions that enhance comfort at the end of life. Comfort measures require the skill to control pain and maintain physiologic functioning, to allay residents' fear and anxiety such as reassurance, active listening, sitting quietly, and rubbing residents' hands if culturally permitted, and providing opportunity for soul food. For instance, Oliveira (2013) cited Kolcaba (2003) stating that comfort measures evolve in three forms such as technical comfort measures, which involve any intervention that helps to maintain body's homeostasis, coaching comfort measures such as reassurance, and comfort food measures where residents are offered their food preferences.

Comfort needs, end-of-life symptoms, and stages of dying (except sudden and unexpected death), seems similar regardless of the cause of imminent death. End-of-life symptoms may include pain, shortness of breath, lack of appetite, constipation, vomiting, and social isolation, LeGrand and Walsh (2010) found that end-of-life symptoms are similar regardless of the illness which include pain, dyspnea, increased respiratory secretions, and restlessness. LeGrand and Walsh (2010) also advocated for stopping medications and treatments that are not contributing actively to patient's comfort at the end of life and stressed that medications to control the symptoms of dying should take priority as the goal of care at this time is excellent symptom control. Many nurses are not comfortable administering certain medications that will enhance comfort at the end of life, not because they do not want to, but because they believe that certain pain control, such as opioid medications, suppress the respiratory center and help to speed up the dying process and so tend to hold such medications under the pretense that the dying residents are too sedated or are lethargic. LeGrand and Walsh (2010) suggested that nurses not refuse to administer medications that will result in comfort because they may cause a change in cognition and breathing. Use of opioids, especially morphine in adjusted doses, adequately helps to relieve distress and control symptoms of dyspnea without causing sedation. Repositioning, avoidance of humidified oxygen, and use of anticholinergic medications also helps to reduce respiratory secretions referred to as “death rattle” was described as a usual practice (LeGrand & Walsh, 2010, p. 490).

Diagnosis of the end of life entails a lot of emotional turmoil for families and patients who must experience the distressing symptoms and situational crisis that may accompany last-minute decisions about care preferences, legal issues, role challenges, depression, fear, and anxiety. Dying residents are expected to make some adjustment and be able to cope with all these demanding current internal and external environmental changes that are negatively affecting the quality of life and peaceful dying. Lau et al., (2017) identified ability of a resident to resolve any existing psychological and existential distress at the phase of imminent death as a sign of improved quality of dying and death because inability to resolve these issues denote emotional and psychological discomfort for the dying residents. There is need for adequate and timely reevaluation of patients’ plan of care in acute care to reflect a need for a switch from aggressive medical treatments in imminently dying patients to end-of-life care. Lau et al. (2017) also identified psychosocial care and spiritual support for emotionally distressed dying patients and advocated for development and implementation of a standard approach to the end of life such as ESMO protocol for dying patients. ESMO includes appropriate interventions to address commonly experienced symptoms of dying such as increased airway secretions, pain, dyspnea, restlessness, and fever to be assessed every 2 hours. Lau et al. (2017) also proposed that ESMO include family education about the dying process, and a multidisciplinary team to include social services and preferred spiritual leaders to "support the psychological, emotional, and spiritual needs of grieving patients and families" (Lau et al., 2017).

End-of-Life Care Experiences of Nurses in Acute Care

Care of the dying is not limited to nursing homes. Other specialized units like oncology, the intensive care unit, and the emergency room also must deal with the care of the dying. Though the expectation is that nurses will do whatever it takes to save lives especially in acute care settings, but the prognosis may change so that patients may need end-of-life care. Powazki et al. (2014) assessed how nurses perceive their capability and their comfort level in the care of the dying patients, the authors posited that nurses have a great deal of positive influence on the health and general well-being of patients especially when death is imminent. Powazki et al. (2014) found a correlation between clinical experience of experienced nurses and training in end-of-life care as factors that enabled older nurses to be able to meet the needs of the actively dying patients. The authors develop and implement an “End-of-life” toolkit to increase nurses’ confidence in taking care of dying patients, and the toolkit included how to handle symptom control, how to communicate, postmortem care, bereavement, and counseling opportunities that nurses may utilize in educating patients and families.

It is ironic to see nurses in emergency department providing end-of-life care for dying patients. Emergency department is that unit part of the hospital where the nurses and the physicians are expected to do whatever it takes to save people’s lives. Regardless of the issues of ambiguity, people still die in the emergency department. Wolf et al., (2015) explored the “nurses’ perceptions of possible challenges and facilitators in the provision of end-of-life care in the emergency department”; the authors described two types of death that can occur in the ED to include the “spectacular” or sudden, unexpected death, and where the goal of care was life-saving, and the “subtacular” or expected death due to terminal illnesses which received less aggressive care. Nurses are expected to have special skills in managing emotions, developing interpersonal and therapeutic skills that are needed to enhance quality death and dying in patients at the end of life in the ED. Tse et al., (2016) examined the perception of nurses in providing end-of-life care in the emergency department, and the authors posited that provision of end-of-life care in ED allow patients the opportunity to fulfill last wishes, and enhance grief and bereavement opportunity for families, and also allow for professional staff development in ED; these findings have greatly

Becker, Wright, and Schmit (2017) explored experiences of nurses that worked various units such as medical, surgical, oncology, intensive and progressive care units about dying well for patients; though nobody expects that death will be the result of hospital admission for acute care illnesses. However, sudden death may result; the authors stated that the majority of end-of-life care in America occurs in acute care settings (National Institute on Aging, 2012). Becker, Wright, and Schmit (2017) also posited that nurses believed that dying well involved resolution of emotional conflicts and spiritual support for patients and families, allowed patients' and families' input into the end-of-life care, and maintaining a calm and quiet environment. Nurses also identified comfort measures as communication, provision of optimal physical care, showing compassion, maintaining dignity in death, education of patient and family to enhance quality death and dying, emotional stability of the patient and family, and advocacy for a quality death and dying to be important part of dying well. Nurses also believed that maintaining physical comfort, adequate pain management, the presence of a loved one at the patient's bedside, and maintaining dignity and respect for patient's wishes are among the qualities of dying well.

End-of-Life Care Experiences of Nurses in Nursing Homes

Enhancing comfort and provision of quality end-of-life care to dying patients is not only a challenge to acute care settings, long-term care also has challenges, though long-term care facilities are expected to be a haven for dying residents where comfort care orders are set to strongly predict death (Krishnan, Williams, & Maharaj, 2015). Raudonis, Kyba, and Kinsey (2002) explored palliative care knowledge level among licensed nurses, physicians, and certified nursing assistants involved in providing end-of-life care for terminally ill residents, and found that lack of education in palliative care posed challenges to integrating hospice care services into long-term care services. However, most of the nurses acknowledged that hospice services are a resource agency in pain management and support for families and dying residents. Results showed that nurses in long-term care facilities need education about pain management, symptoms management, principles of end-of-life care, and psychosocial components of end-of-life care.

Bükki, Neuhaus, and Paal (2016) explored the views, attitudes, and concerns among staff and implemented a process that enhanced end-of-life care in nursing homes. There is an increasing number of aged people live and die in nursing homes but there may not be adequate end-of-life care available due to the nursing staff's lack of knowledge about the end-of-life care. The authors stated that nurses and nursing assistants had a more skeptical attitude about care for the dying compared to others and that nurses, sometimes unintentionally triggered a referral to acute care settings without justification instead of discussing end of life preferences. The results of the study by Bükki, Neuhaus, and Paal (2016) are consistent with findings from a previous study (Raudonis, Kyba, & Kinsey, 2002) in relation to knowledge gaps, attitudes, and self-perception about the end-of-life care in nursing homes.

Relative to increased numbers of older adults that reside in nursing homes in the United States, approximately 30% of deaths among the elderly that occur within the nursing homes, so there is need for care paradigm shift from restoration and rehabilitation to a model consistent with provision of quality end-of-life care that will result in comfort (Cagle et al. 2017). Cagle et al. (2017) suggested that understanding nursing home staff perceptions about death and dying is important in addressing the challenges of providing quality end-of-life care. The results revealed that many nursing home staff were happy providing end-of-life care to dying residents and that their actions positively impacted the residents. However, lack of help in relation to inadequate staffing when needed, not knowing what to do, communication problems, and lack of support from co-workers and management contributed to staff distress. The study findings of Cagle et al. (2017) was consistent with the other previous study findings of Raudonis, Kyba, and Kinsey (2002) and Bükki, Neuhaus, and Paal (2016), which recommended staff education and training in end-of-life care, consistent working with hospice providers, and increased social support for residents as ways to improve end-of-life care in long-term care facilities. In contrast, McLeod-Sordjan (2013, p. 1009) stated that "education does not sufficiently prepare health professionals to recognize the final phases of illnesses, understand and manage their own emotional reactions to death and dying, construct effective strategies for care and communicate sensitively with patients and those close to them"; fears about dying continues to have profound impact on end of life in spite of the advances in palliative care. The perceptions of nurses about comfort among residents at the end of life will help to develop individualized ESMO protocol. Goodridge et al. (2005) stated that a caring attitude of nursing home staff at the end of life is a critical element in timely managing distressing symptoms as the dying experience of a nursing home resident can be affected by the interventions of nurses.

Comfort is a multidimensional concept that has not been clearly defined, but the word comfort is used frequently to describe the attributes and outcomes of other nursing concepts. Pain relief is often used as a proxy for comfort, and pain as discomfort. Comfort is used as an intervention in the form of comfort measures to produce a state of comfort. Overall, comfort is considered a core value of nursing care (Siefert, 2002). Comfort has also been described as inherent part of basic human needs and has also be described as an outcome, as a process that covers not only the physiological dimension but also emotional and psychological dimensions (Malinowski & Stamler, 2002). Comfort has been used in relation to other nursing concepts like therapy, where comfort is identified within the nurse-patient relationship and nurses are viewed as therapeutic, and caring, where comfort is viewed as a part of caring (Tutton & Seers, 2003). Tutton and Seers (2003) posited that there is need to explore the concept of comfort further because there is limited knowledge of how patients and staff view the concept of comfort and how comfort is applied in practice by the patients and the nurses. Therefore, knowledge of comfort by the patients and the nurses can help validate and understand patients' responses to nurses' actions and can help to direct nurses' interactions with patients towards outcomes that result in patients' comfort (Tutton & Seers, 2003).

There are commonly experienced end-of-life symptoms that are distressing but do not necessarily provide definition of the concept of end of life. These distressing end-of-life symptoms require comfort measures that is expected to result in good death which is described as individualized and interdisciplinary with care focused on holistic and person-centered approach. However, comfort measures are used widely in nursing homes, but the definitions and mode of delivery varies. Comfort measures do not involve rigid set of orders, but it is individualized, person-centered and reflects interrelationship among symptoms management, family care, interpersonal relationships, and interdisciplinary teamwork (Waldrop & Kirkendall, 2009).

In order to understand the view of nurses about comfort therefore, the approach in this study will be phenomenological qualitative research method, an approach that will enable the participants to describe their worldview and what they make out of the world around them (Rubin & Rubin, 2012) to reveal the uniqueness of their perception of comfort especially in long-term care among the residents at the end of life.

Summary and Conclusions

The traditional nursing home focus of care has been based upon restoration and rehabilitation. However, when the end-of-life symptoms are imminent and unavoidable, nursing home nursing staff are required to make a shift from the traditional focus of care to end-of-life care focus (Cagle et al., 2017). Comfort remains the central focus of care at the end of life among residents no matter where death occurs, whether in the acute care settings or the nursing homes. There are no known unique ways of reaching the utmost goal of care for the residents at the end of life since comfort measures can vary and be individualized. Relief from pain, emotional disturbances, psychosocial care, spiritual care, and some resident-specific needs constitute measures that can enhance comfort at the end of life. However, in an effort to achieve comfort at the end of life in nursing homes among residents, it is paramount to understand the perceptions of nurses about comfort care at the end of life. Using phenomenological qualitative study approach, this study utilized interview as a means to obtain information-rich data from participants to understand nurses’ worldview about comfort among residents at the end of life, and this understanding helped nurses play an active role in interdisciplinary care team to formulate suitable and appropriate ESMO protocol that is individualized and resident-centered to enhance comfort at the end of life.

I provided detail on the research method, data collection process I used, and reviewed the issues of trustworthiness and ethical procedures for my study in Chapter 3.

Chapter 3: Research Method

Introduction

In this study, I sought to examine nurses' lived experiences of comfort care among residents at the end of life, using a phenomenological approach to elicit information-rich data. The study findings may be used to formulate individualized ESMO protocols that can be used while awaiting resident's and family's decisions to stop aggressive medical treatments and adopt hospice care to enhance comfort and enhance peaceful death among residents at the end of life. In this chapter, I provided detail about the research method, the role of the researcher, procedure for recruitment, and my sampling design, how my data were analyzed, and reviewed the issues of trustworthiness and ethical procedures.

Research Design

Research Questions

In order to align my research topic, problem statement and the purpose of the research study, I formulated the following overarching research question and sub questions to elicit information from the research participants:

RQ: What are the lived experiences of nurses who provide comfort care to residents at the end of life in long-term care facilities?

SQ1: What does the concept of comfort mean to nurses when providing care for long-term care residents at the end of life?

SQ2: What are the factors that help nurses determine what comfort measures to implement for the resident at the end of life?

SQ3: What are challenges nurses experience when providing care to residents at the end of life?

Central Concepts and Phenomenon

The major concept of this study phenomenon was comfort, a multidimensional concept used frequently in nursing to denote the attributes and outcomes of other nursing concepts (Siefert, 2002). Kolcaba (1994) defined comfort as “the satisfaction actively, passively, or cooperatively of the basic human needs for relief, ease, or transcendence arising from health care situations that are stressful” (p. 1178). Understanding what comfort means to nurses can promote nursing care in a holistic fashion, and the outcome can be measured through resident and family satisfaction with care received (McEwen & Wills, 2014).

Rationale for the Selected Tradition

I used a phenomenological approach to explore the experiences of nurses who strive to provide comfort care to long-term care residents at the end of life. The philosophical underpinning of this study emerged from a naturalist paradigm, referred to as *interpretive constructionism*, that the best way to understand a phenomenon is to learn how people view the world around them (Rubin & Rubin, 2012). The meaning of a phenomenon is dictated by how people interpret what they encounter and assign values to the phenomenon. Interpretive constructionists believe that people see things through distinct lenses and arrive at different summations, so there can be many, conflicting versions of the same event true at the same time (Rubin & Rubin, 2012). Phenomenology explains how people describe their lived experiences (Rudestam & Newton, 2015).

I used an interpretive phenomenological approach to explore how nurses describe their experiences when providing comfort measures to individuals in nursing homes. This approach is also referred to as Heideggerian, that reality is that which is perceived and reported by the individual (Rudestam & Newton, 2015). I used this research design to elicit information-rich data from nurses about their unique perceptions of comfort among residents at the end of life using interviewing with open-ended questions. The results of this study have the potential for positive social change by helping nurses to better understand the comfort measures to implement while managing end-of-life symptoms.

Role of Researcher

In qualitative research, a researcher plays different roles, ranging from the recorder to interviewer to obtain in-depth data from participants. In-depth interviewing is the tool of choice for exploring participants' worldviews in personal and sensitive phenomena. Researchers could also assume roles of participant observers where they watch others perform an everyday activity, or they might participate in the activity and later stand outside of the activity to take notes for later analysis of the pattern of behavior and action (Rubin & Rubin, 2012). Researchers can also be moderate focus groups where a few questions are given to the group for discussion and the researcher facilitates the discussion so that the group stays on topic (Rubin & Rubin, 2012).

My role in this research study was that of observer, interviewer, listener, and recorder, as the participants constructed meaning from their experiences. I interviewed nurses on their experiences of comfort care among residents at the end of life.I observed them for any facial or other expressions and made notes during the interview. Having a good rapport with people will make them share more of their story with the researcher and that, in turn, will elicit better data (Jacob & Furgerson, 2012). Good connections include active listening without being distracted to avoid the risk of not getting the real story (Jacob & Furgerson, 2012). I tape-recorded the interviews, so that I could focus my full attention on the participants. Additionally, I used open-ended questions, as this approach helps elicit information from participants (Jacob & Furgerson, 2012).

To ensure that participants feel free to express their worldview about comfort care at the end of life, they were assured that information shared would be kept confidential, that participating in this study would not negatively impact their employment, that participation in this study was voluntary, there were no right or wrong answers, and that information obtained would not to be used against them in any form. I obtained informed consent from participants. During the informed consent process, I assured participants the information they shared would be kept confidential, and I showed respect, honored promises, avoided using pressure to obtain information, and did no harm while diligently seeking to elicit information that was helpful in the research study (Rubin &Rubin, 2012). To avoid researcher biases, such as power over the participants, I did not conduct this study within my place of work. I used other long-term care facilities, and I did not use any incentives for participants.

Methodology

Participant Selection Logic

Nurses working with patients during the end of life who required comfort care were knowledgeable about this phenomenon. The target population for my study were the

RNs and LPNs. Individuals with at least 2 years' experience working in long-term care facilities and who have provided care for residents during the dying process qualified for selection to participate in the study.

Sampling Design

I used a purposeful sampling technique to select a sample of nurses who work with residents experiencing end-of-life symptoms. Purposeful sampling helps to ensure that participant selection aligns with the research purpose, research questions, and data collection (Patton, 2015). Participants were selected who are knowledgeable about the phenomenon being studied (Patton, 2015). Nurses working with residents in long-term care at the end of life are information-rich in relation to their experiences with providing comfort in this environment. I used purposeful sampling as my method to select participants with great knowledge of the phenomenon and who can shed light on the phenomenon being studied. My goal was to use a minimum of 10 and a maximum of 15 participants. My interviews lasted approximately 30 minutes, and because I needed in-depth knowledge of the phenomenon, I followed up to clarify issues with participants who agreed to do so.

There were no set rules stipulating a certain number of participants in qualitative research, but the participants were able to provide a multiperspectival understanding of the phenomenon being studied and provided answers to my research questions (Ravitch & Carl, 2016). A small number of participants can be valuable in a phenomenological research study because it is in-depth information-seeking process where meaningfulness is embedded in the information-richness of the participants selected as opposed to a larger sample size (Patton, 2015). I planned to interview 10–15 participants, and I used data saturation as a guiding principle to determine the number of participants. Data saturation occurs when more data does not necessarily provide new information and does not shed any further light on the phenomenon being studied (Patton, 2015). I selected long-term care facilities close to my neighborhood due to ease of access (Ravitch & Carl, 2016).

Instrumentation

I used the naturalistic-interpretive-constructionist paradigm approach, which included an interviewing technique, especially a responsive interviewing model, which was appropriate for this study. Responsive interviewing emphasizes the importance of building a trusting relationship between the researcher or the interviewer and the participants. I used open-ended questions for the interviews (Appendix A). The pattern of questioning was flexible and nonconfrontational, and the questions revolved around an interviewee's responses; in addition, I designed the questions around obtaining information about experience and knowledge of the phenomenon (Rubin & Rubin, 2012).

Nurses were the source of data in this study. Qualitative data were collected using responsive interviewing to elicit in-depth responses to a phenomenon. I treated participants as experts, and the interpretations of the participants' responses were not interpreted as right or wrong but as different perspectives on the phenomenon. I was attentive when listening to participants, so I obtained information-rich data from the participants that helped answer the research questions, while I kept the participants in their comfort zone asking questions in a nonconfrontational and nonjudgmental manner. The questions I used for my interview are listed in the interview guide in Appendix A.

Procedures for Recruitment, Participation, and Data Collection

I created a recruitment flyer that explained my study (see Appendix A). I attended a conference organized by the American Health Care Association for the nursing home administrators, the directors of nursing, and the assistant directors of nursing in the State of Delaware where I met with some directors of nursing and shared my dissertation topic with them and requested to post my flyer in their facilities to recruit interested nurses to participate in the study. I obtained their email addresses and telephone numbers and sent emails to the directors of nursing to officially request permission to post my flyer in their facilities. I also sent a follow up email message to the directors of nursing when I did not receive any response from the previous email message. I received three responses from the directors of nursing giving me approval to post my flyer in their facilities.

The flyer included my email and telephone number through which the nurses who were interested in learning more about the study contacted me. I described the purpose of the study and the requirement for participation using a screening guide (Appendix B), and what they were to be asked to do when they contacted me. I emailed the consent (Appendix D) to those who met the criteria and agreed to participate in the study for them to review. I scheduled an appointment to meet after they returned an email indicating their agreement to participate in the study. I planned to meet with each participant in a private, quiet, and comfortable area of their choice to ensure that our conversation was not overheard. I followed up by sending an email to those who did not return the email agreeing to participate in one week, reminding them of the purpose of the study and inquired if they were still interested in participating in the study. I reminded them that I will schedule a time for me to meet with them after I had received their agreement to participate and after reading the consent. Participants were asked to sign a copy of the consent indicating their agreement to participate in the study when we met for the interview. I provided each participant with a copy of the consent. I followed up with another email reminder when I did not obtain the sample needed for my study. I also used snowball recruiting from individuals who had been interviewed to ensure that I obtained the number of participants needed.

When I met with the participant, I reviewed the introductory information contained in an interview guide (Appendix C), such as the purpose of the study, that the interview will last approximately 30 minutes, and that the discussion would be tape recorded.. I utilized the interview guide template from Walden University to develop my interview guide (Appendix C). I reminded the participant that the conversation would be tape-recorded so that I could listen attentively and not rely on my memory. However, during the interview, I took a few notes. Immediately after the interview, I made notes of my initial reaction to the interview. At the end of the interview, participants were able to read their interview transcript for accuracy.

Data Analysis

Data analysis in qualitative research study is the method employed to transform the information-rich data obtained from the participants during interview process into findings (Patton, 2015). The first step in phenomenological data analysis is to read and reread the transcript several times to get the sense of the data. I numbered the lines for easy reference and coding, and made the determination of the different themes. Saldaña (2016) suggested that the interview text can be divided into separate units for easy coding, and to keep a wide right-hand margin for writing codes. I reread the transcripts, I looked for themes which I inserted into a margin on the right side or in the text itself, and provided a name for the theme as it was found in the transcript. Next, I looked for connections between the themes to cluster them together, and began to explore the connections within and between the conceptual groups and began to generate explanation (Fade, 2004). There were no discrepant cases that were contrary to emerging patterns.

I used a combination of manual coding and QDA (QDA) software, Nvivo 12. Saldaña (2016) stated that it is important for any qualitative researcher, who is willing to be proficient in QDA to learn the coding system and apply the skill to be excellent in qualitative research, and suggested to practice and learn basics of coding and QDA manually before engaging in QDA (QDA) software. Practicing the basics of coding gave me control over and ownership of my work. QDA software does not formulate codes, but helped me to turn abstract information to concrete data. In addition, I used it to store, organize, manage, and reconfigure the data to allow me to make analytic reflections (Saldaña, 2016).

I used Nvivo 12 software to gain richer insights from qualitative methods data. It stores and sorts all data in one platform from quantifiable demographic information to qualitative open-ended questions and interviews. It helped me to categorize and classify data, sort sentiments, themes, and attributes. It saved me time and I used it to back up my findings since NVivo supports data from any source.

Issues of Trustworthiness

Honesty of the data collected from the participants is what trustworthiness is all about. This stemmed from the meaningful relationship between the researcher and the participants, respecting and trusting relationships between the researcher and the participants as reflected in credibility, transferability, confirmability, and reliability (Rebar et al., 2010). Openness and thorough step by step process of recruiting and collecting data from the participants will help ensure trustworthiness in this study.

Credibility

Credibility is a way to explain the confidence expressed in the findings of the study by the researcher and the user of the research which can be achieved by appropriate follow-up and use of probing questions as necessary during data collection to elicit information-rich data from the participants (Rebar et al., 2010). Patton (2015) identified a systematic, in-depth fieldwork as key to obtaining high-quality data using skillful interviewing as a way to show credibility in qualitative research, and also suggested verifying data sources for consistency by means of triangulation. I engaged with the participants to gain their trust and allowed them to feel comfortable with me before I began my in-depth questioning. I allowed the participants' access to the transcript of the interview to ensure accuracy and allow for clarification (Rudestam & Newton, 2015).

Transferability

Transferability is defined as the extent with which the findings of this study can be applied to a different group in a different setting where data were collected (Rebar et al., 2010). The ability to confirm that what was meaningful in this study's setting with this study's group will also be meaningful and accurate if applied in other setting or group (Rebar et al., 2010). I provided a thick description of the data collected and setting during my study so that readers of my study findings can make comparisons to other contexts, and can transfer aspects of my study design to another study. I ensured that the data collected were consistent in answering my research questions by using phenomenological research method and interviewing as my data collection plan (Ravitch & Carl, 2016).

Dependability

Dependability refers to the extent to which the reader can be assured of the quality of the findings (Anney, 2014). Cross-checking and cross-validating data sources during interviewing process is a way to show dependability (Patton, 2015). I ensured data saturation, a situation where more data does not necessarily provide more information, and as the study goes on, new data collected does not shed any further light on the issue being studied (Patton, 2015). I also provided an audit trail of the step-by-step process engaged throughout the study, keeping diary and journal to document supplementary information and events that ensued during the interview process.

Confirmability

Confirmability refers to the extent to which the results can be confirmed (Anney, 2014) Use of audit-trail by keeping documentation of the process of decision making about data collection and data analysis, such as the field notes, helped me to demonstrate confirmability in this study (Rebar et al., 2010). I also implemented a self-reflection approach to illuminate my potential biases, as this may influence the analysis process (Rudestam & Newton, 2015).

Ethical Procedures

I sought permission to post my flyer from the long-term care facilities that I intended to use. I also obtained Walden Institutional Review Board approval with IRB approval number (2019.03.1414:15:25-05’00’). In addition, I emailed an informed consent to potential nurse participants stating that participation was voluntary, and participants may opt out of the study at any time without penalty. Assurance that information collected from participants were kept confidential. No identifiable information about participants was used in the study, and I assigned each participant a code to conceal their identity. Taking part in this study had no direct benefit to the participants, however, the information provided helped nurses to have a better understanding of comfort measures to implement while managing end-of-life symptoms. Being in this type of study did not pose any risks beyond those of typical daily life such as fatigue, nor was there risk to safety or wellbeing of participants.

Findings from this study did not include any information that could identify participants personally. Interview recordings and full transcripts were shared with the participants upon request. Data will be kept for a period of at least 5 years as required by the university and then shredded in my personal shredder.

Summary

In phenomenological qualitative research where participants’ lived experiences and perceptions about a chosen phenomenon are desired, interviewing is one of the data collection methods to elicit information-rich knowledge from participants about the phenomenon under study. I arranged to have interview sessions with each participant for approximately 30 minutes to allow them to give information-rich data about their experiences. Jacob and Furgerson (2012) posited that having a good rapport with people allow them to share more of their story and elicit information-rich data. This study was approved by the Institutional Review Board (IRB) of the Walden University because the study involved use of human subjects Consent of participants was obtained after they have been assured of safety and protection of identity and confidentiality. Chapter 4 addresses the findings of my study.

Chapter 4: Results

Introduction

In this qualitative phenomenological study, I sought to examine nurses' lived experiences of comfort care among residents at the end of life in a long-term care facility. To align my research topic, problem statement, and research purpose, I formulated the following overarching research question and sub questions to elicit information from the research participants:

RQ: What are lived experiences of nurses who provide comfort care to residents at the end of life in long-term care facilities?

SQ1: What does the concept of comfort mean to nurses when providing care for long-term care residents at the end of life?

SQ2: What factors help nurses determine what comfort measures to implement for the resident at the end of life?

SQ3: What are challenges nurses experience when providing care to residents at the end of life?

This study was carried out in three long-term care facilities, and interested nurses with appropriate years of long-term care and end-of-life care experience were recruited to participate. I conducted interviews with 13 participants to elicit information-rich data about their lived experiences of comfort care among residents at the end of life in long-term care facilities. I obtained approval from Walden University's Institutional Review Board (IRB).

Setting

I attended a conference organized by the American Health Care Association for nursing home administrators, directors of nursing, and assistant directors of nursing in the State of Delaware, where I met with some directors of nursing and shared my dissertation topic with them and requested to post my flyer in their facilities to recruit interested nurses to participate in the study. I obtained their email addresses and telephone numbers. I sent emails to the directors of nursing to officially request permission to post my flyer in their facilities. I also sent a follow-up email message to the directors of nursing when I did not receive a response from the previous email message. I received three responses from the directors of nursing giving me approval to post my flyer in their facilities. I followed up by visiting the nursing homes to post my flyer after I received the Walden Institutional Review Board (IRB) approval to proceed with data collection. I recruited participants by posting flyers in strategic places, such as the nurses' station and notice boards where information is shared with staff, at the facilities. Interested participants reached out to me through my telephone number that was written on the flyer, and some participants gave me their phone numbers while I was posting my flyer in their facility. I called some of the participants on the phone to discuss the purpose of my study and to see if they were interested in participating. To those who were willing to participate in the study, I emailed the consent after I explained the content of it. Each of the participants signed the consent and returned it back to me by email or in-person. I made follow-up telephone calls to the participants to schedule the interviews. I also reviewed the consent with each participant and handed them a copy of the signed consent before the interview.

The choice to participate in this study was voluntary. Participation in this study did not cause any changes in any organizational budget or changes in personnel that may influence interpretation of the study results.

Demographics

I had a total of 13 participants in my study. Nine of the participants were registered nurses consisting of three Caucasian women, four African American women, and two African American men. I also had licensed practical nurses: two were Caucasian women, one African American man, and one Native American woman. Five of the registered nurses had bachelor's degrees in nursing and two of the LPNs held degrees in another field different from nursing; four RNs had associate degrees, and two LPNs had no other degrees. I used NVivo, a qualitative data software program, to generate case classification for my data. The case classifications included gender, level of education, race, and years of experience.

The figures and the table represent the output from NVivo software, which I used to help organize my data. Figure 2 below represents the participants by gender. Figure 3 below represents the participants by level of education. Figure 4 below represents the participants' race. I used NVivo QDS to produce the output.

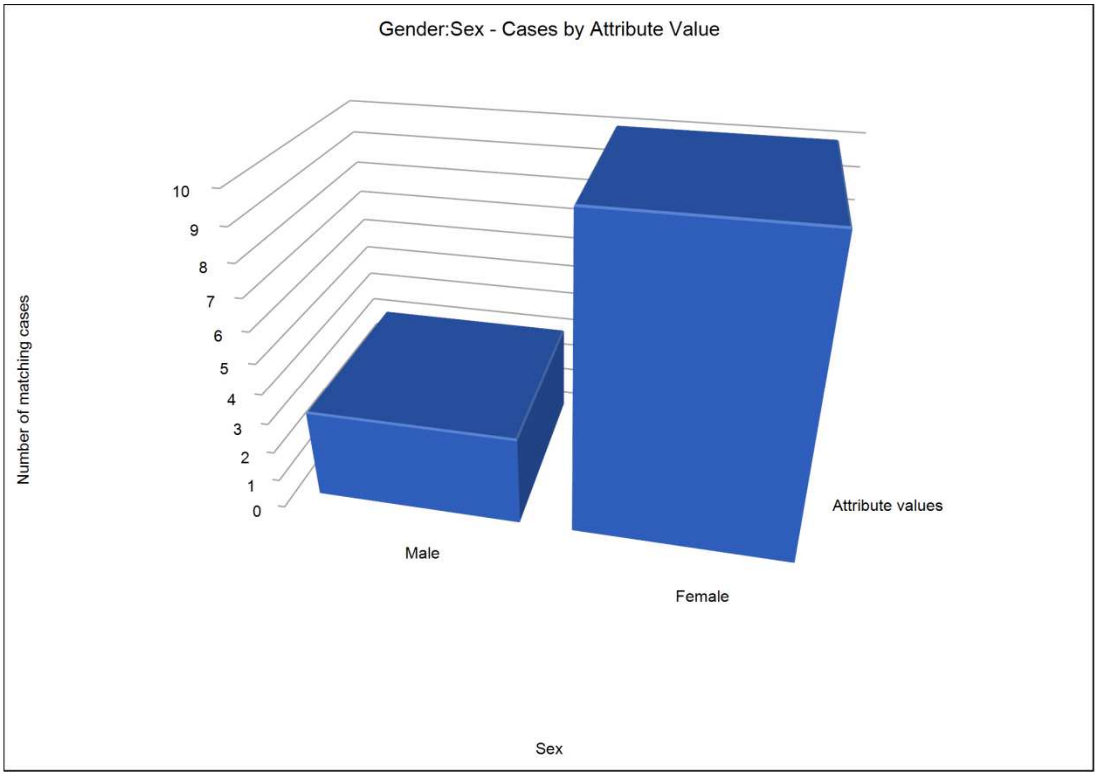

Figure 2. Participants by gender.

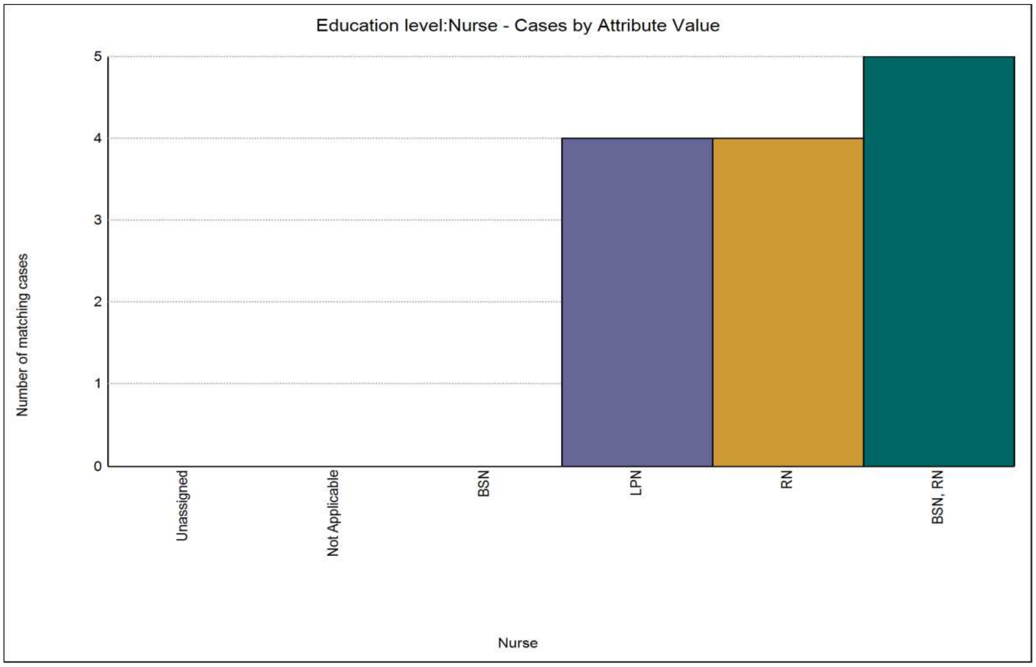

Figure 3. Participants by level of education.

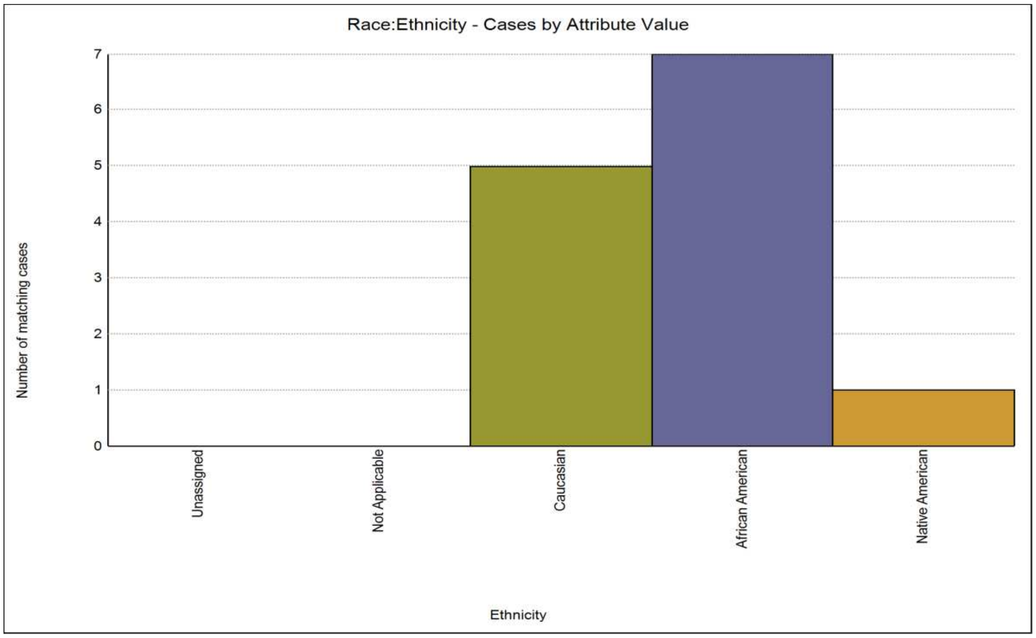

Figure 4. Participants by ethnicity and race.

Data Collection

After I received approval from Walden University's IRB to carry out my study, I recruited participants by visiting the facilities and posting flyers in strategic places, such as the nurses' station and notice boards where information is shared with staff at the facilities. Interested participants reached out to me through my telephone number that was listed on the flyer and some participants gave me their phone numbers while I was posting my flyer in their facility. I called some of the participants on the phone to remind them of the purpose of my study and to see if they were still interested in participating. To the participants who were willing to participate in the study, I emailed the consent after I explained the content of it. I also explained to them what they were expected to do and the estimated time commitment of the interview. Each of the participants signed the consent and returned it back to me through email. I made a follow-up telephone call to the participants to schedule the interviews at their preferred location and time. I also reached out to other participants who had not returned their signed consent. I reviewed the consent with each participant and handed them a copy of the signed consent before the interview. I interviewed 13 participants in different facility locations, and the average interview time was 30 minutes. I conducted each interview in the participants' preferred convenient locations, ranging from home offices to nearby libraries. The data were recorded on a digital recorder after the participants had signed the consent form and agreed to participate in the study knowing that the interview would be recorded. There were no unusual circumstances encountered or variations in the data collection plan during this study. I reviewed the introductory information contained in the interview guide after they agreed to participate in the study (Appendix C); each participant stated the purpose of the study, that the interview would be audio-recorded, and that the information provided would only be shared with the faculty involved in my study if needed. I took notes of my initial reactions to the interviews because I did not want to rely on my memory alone.

Data Analysis

I manually transcribed each recorded interview into a Word document to make it easy for me to code. I read and reread each transcript several times to gain an understanding of the participants' experiences. As I read the transcripts, I reviewed the data and identified codes (names given to sentences or quotes) and developed clusters of meaning that formed themes (significant statements). Each participant's transcript was uploaded into NVivo 12, a qualitative data software (QSR International, 2018). I used

QDS to organize the codes that emerged from the interview transcripts and each code had the participants' supporting statements as reference.

Codes

Participants described the concept of comfort as ensuring a peaceful death by making a dying resident restful, without distress, pain-free, meeting basic needs, relaxed, no worries, hydration, moist mouth, anxiety-free, emotional comfort, peaceful, no suffering, resting, and calm. Participant 13 stated that "comfort, to me, means going into the room seeing the dying person restful; that's what I consider to be comfort." Participant 10 stated that facilitating a peaceful transition means comfort.

Being vigilant was described as the key to identifying which comfort measures to implement at the end of life to enhance comfort and ensure a peaceful death. Participants described comfort measures as interventions to enhance comfort, which may include stopping aggressive medical treatments and procedures, meeting basic needs, use of medications, family support, meeting spiritual needs of the residents, implementing treatment based on specific needs, reassuring significant family members, and interventions to facilitate comfort. Participant 1 described comfort measure interventions as "medications that will relieve them of pain, medications that will relieve their anxiety, at times we introduce oxygen to at least enable them to breathe," and eventually facilitate a peaceful death. Participants identified being vigilant with the presenting symptoms as the means of knowing which comfort measure interventions to implement. Some of the participants stated that the needs of the dying residents dictate which comfort measure interventions to use. Participant 1stated that individualized care is provided as "the needs will now trigger what and what to do for them at that level." There were two discrepant cases identified among the participants' responses which will be discussed in the results.

Evidence of Trustworthiness

The data collected represents the worldview of the participants in relation to providing comfort care to residents at the end of life in a long-term care facility as well as helping to address the research questions of this study. Credibility explains the confidence expressed in the findings of the study and this was achieved by appropriate follow-up and use of probing questions as necessary during data collection to elicit information-rich data from participants (Rebar et al., 2010). I asked probing questions to elicit information-rich data from participants. For instance, one of the participants stated, "I have seen family who wants to just have this medication given, in spite the fact that you've really seeing that this person is not in any form of distress and that's been a bone of contention that I have had to deal with in my many years as a nurse." I asked the participant, "so, how do you deal with that, when the family was asking you to give the medication and you felt reluctant?" the participant responded, "I try to explain to them, I try to tell them that this person is not in any distress, and that if the medication was ordered routinely, there is really nothing you can do, you just have to give it." The participant had also stated that medication will be given only "on the extreme end." I asked for a definition of "extreme end," and the participant stated "The extreme is when I really feel that this person needs this, then I consider that's good use of medication to calm them down."

I scheduled appointments to meet with each participant to review responses on the interview transcripts to ensure the transcripts were correct. Patton (2015) identified systematic, in-depth fieldwork as key to obtaining high-quality data using high-quality, skillful interviewing to show credibility in qualitative research and also suggested verifying data sources for consistency by means of triangulation. All the transcripts were correctly transcribed. I provided thick descriptions of my data collection method and the settings under which the study was conducted so my study findings can be compared to other studies in similar settings. This is important so aspects of my study design can be transferred to another study with a different group in another setting. The ability to confirm that what was meaningful in my study's setting is also meaningful and accurate if applied in another setting or with a different group is referred to as transferability (Rebar et al., 2010). The data collected were consistent in answering my research questions using the phenomenological research method.

Data collected were cross-validated with the participants by allowing them to review the interview transcripts to ensure that information recorded was accurate and represented the experiences of participants, and that nothing was missing nor added that they did not share with me. I experienced data saturation during this study which occurred after I interviewed about eight (8) participants. More data were not necessarily providing me with more information, and as the study went on, new data collected did not shed any new information on the issue being studied (Patton, 2015). I heard the same concepts and themes from each participant. I did take some notes during the interview that I combined as memos to help me with decisions about coding during data analysis. I implemented a self-reflection approach to help illuminate my potential biases which may influence the data analysis process (Rudestam & Newton, 2015). However, the data analysis of this study was based on the data collected from the participants' experiences that they shared with me.

Results

The interview transcripts were manually transcribed and the data were imported into the Nvivo 12. Nodes were also created and the participants' responses that matched these nodes were assigned as matches occurred. References were representative of participants' lived experiences of comfort care among residents at the end of life in long-term care facility.

Participants expressed their experiences as emotionally draining, and there were three sub-themes that characterized this experience. Participants had a hard time dealing with the process of dying and death, they had to substitute themselves for the family, and they had been personally involved and attached to the resident. One participant stated "Um, I mean of course, it can be sad, I mean you get attached to certain people, sometimes they're here for a long time and not doing well, and sometimes it is fairly quick; I guess, that's part of what we have to deal with as a nurse." Another participant stated that caring for the dying resident can be "gratifying and sad, emotional when a lot of people don't have family and you become their family, and to make the experience better is my job." Overall, 69% (N=9) expressed that providing comfort care for the dying resident can be difficult, hard, sad, touching, and 7.69% (N=1) expressed feeling of ambivalence in that the experience can be sad and gratifying at the same time (see Table 1).

Table 1

Theme 1: Emotionally draining

Subthemes	Participants
Dealing with death and dying situation	6, 5, 12
Substituting self for the family	7, 8, 9
Because of their personal involvement and attachment	4, 9, 13

Participants expressed their experiences as emotionally draining, and there were three subthemes that characterized this experience. Participants had a hard time dealing with the process of dying and death, they had to substitute themselves for the family, and they had been personally involved and attached to the resident. One participant (12) stated "Um, I mean of course, it can be sad, I mean you get attached to certain people, sometimes they're here for a long time and not doing well, and sometimes it is fairly quick; I guess, that's part of what we have to deal with as a nurse." Another participant (8) stated that caring for the dying resident can be "gratifying and sad, emotional when a lot of people don't have family and you become their family, and to make the experience better is my job." Overall, 69% (N=9) expressed that providing comfort care for the dying resident can be difficult, hard, sad, touching, and 7.69% (N=1) expressed feeling of ambivalence in that the experience can be sad and gratifying at the same time.

Participants described the concept of comfort as ensuring a peaceful death, and this experience was also characterized under four subthemes. Participants identified reducing stress for the dying, creating a peaceful environment, meeting residents' basic needs, and meeting residents' spiritual needs as key contributors to making the transition peaceful. A participant (10) described comfort as "when somebody is not in pain, having somewhere to stay, clothes, food, and air to breathe." Another participant (9) described comfort as "Comfort, meaning that, to me comfort will be an area where a person can be and are pain-free" and a participant (8) also stated that comfort means "keeping someone out of pain, ah, depending on what they can tolerate, water for hydration, keeping their mouth moist, keeping the room temperature comfortable, touching them" (see Table 2).

Table 2

Ensuring peaceful death

Subthemes	Participants
Reducing stress for the dying resident	13, 5, 11
Creating peaceful environment	7, 8
Meeting basic needs	12, 11, 4, 10
Meeting spiritual needs	5, 9, 10

The majority of the participants identified being vigilant through nursing assessment, presenting symptoms, person-centered approach, and diagnosis as the major factors that helped determine what comfort measure interventions to implement for the residents at the end of life. This experience was characterized by five subthemes which were recognizing the needs of the individual, recognizing signs of comfort, implementing treatments based on specific needs, recognizing the needs of family members, and acknowledging a peaceful transition. One of the participants (8) stated that "it's going be personal to each resident, their needs will be based on likes and dislikes"; participant 7 stated that "It all depends on the resident. It's different for everybody," participant 6 stated "It's all about looking and assessment," and participant 5 stated "Hmm, so you know, a lot depends on the, the symptoms, you're, you're really treating the symptoms of the patient." (See Table 3)

Table 3

Being vigilant

Subthemes	Participants
Recognizing the needs of the individual	3, 6, 9, 10, 5
Recognizing signs of comfort	3, 2, 1
Implementing treatments based on specific needs	7, 8, 11, 12, 5
Recognizing the needs of family members	5, 4
Acknowledging a peaceful transition	7, 8

Two (N=2) of the participants presented as discrepant cases as they expressed this by experiencing ambivalence making decisions about the need for pain medication, about being part of the dying process, and feeling guilty about the use of pain medication. A participant stated that "we are quite aware of most of these medications, that what they will do actually is suppress breathing. To me, it's like pushing the person along, like yes, you know this person is dying, you're hastening the process. Definitely part of what the medication will do is suppress respiration," and participant 10 stated that "It was difficult giving pain medication, I felt like I have a hand to make somebody pass away" (See Table 4).

Table 4

Theme: Experiencing Ambivalence

Subthemes	Participants
• Making decisions about the need for medication	13, 10
• About being a part of the dying process	10
• Feeling guilty about use of pain medication	10

Summary

The information-rich responses from the participants helped to answer the research questions, as the participants expressed their lived experiences with taking care of dying residents to include emotionally draining, difficult, hard, sad, touching, and gratifying. The participants described the concept of comfort as restful, without distress, pain-free, meeting basic needs, relaxed, no worries, hydration, moist mouth, anxiety-free, emotional comfort, peaceful, no suffering, resting, and calm. The participants also described the factors that helped them determine comfort care measure interventions as result of nursing assessment, presenting symptoms, person-centered approach, and diagnosis. The interpretation of findings will be discussed in Chapter 5.

Chapter 5

Introduction

In this qualitative phenomenological study, I sought to examine nurses' lived experiences of comfort care among residents at the end of life in a long-term care facility. I conducted the study using a qualitative phenomenological research method as a framework to describe the meanings of human experience. Most residents in long-term care facilities at the end of life have advanced, chronic, and terminal illnesses that present with complicated, significant cognitive and functional impairments (Krishnan et al., 2015). These residents with different levels of disease burden and functional limitations require formal services in long-term care facilities to provide needed care to enhance comfort, improve quality of life, and quality of dying instead of only comfort measures (Krishnan et al., 2015). This study was conducted to elicit information-rich data to increase nurses' knowledge about comfort care at the end of life and assist in formulating individualized and resident-centered ESMO protocols. The information-rich data obtained from the participants indicated that nurses have some knowledge of comfort care at the end of life and were able to figure out that comfort measures interventions at the end of life are personal and individualized.

Interpretation of the Findings

The participants described ensuring a peaceful death as a state of being restful, living without distress, pain-free, meeting basic human needs, no worries, emotional comfort, no suffering, being relaxed, peaceful environment for the dying resident, and no stress. These phrases resonate with Kolcaba and Kolcaba (1991) who stated that comfort occurs when one is in a state of ease and peaceful contentment, when one has whatever makes life easy or pleasurable, when one has support and physical refreshment. Participant 9 stated that comfort meant an area where a person can be and is pain-free; Participant 12 saw comfort as meeting basic needs, but also stated that comfort meant keeping somebody as pain-free as you can. These perceptions are consistent with Kolcaba's (1994) definition of comfort as the satisfaction of basic human needs.

Being vigilant was the key to identifying which comfort measures to implement at the end of life to enhance comfort and ensure a peaceful death. Participants identified presence of family at bedside, sharing good memories of the past, food of choice, pain medications, medication for anxiety, mouth care, turning and repositioning when appropriate, reducing invasive procedures, reassurance, holding their hands, playing music of choice, and spiritual visits as comfort measures. The comfort measures mentioned by the participants resonate with Oliveira (2013) and LeGrand and Walsh (2010) who shared that comfort measures may include a combination of psychological, sociocultural, spiritual, and environmental interventions to enhance comfort at the end of life. Becker, Wright, and Schmit (2017) believed that dying well involved allowing families' input into the end-of-life care and maintaining a calm and quiet environment as described in Chapter 2. Participant5 stated that there are lots of things for comfort measures, which include use of medications, especially when the medications work, though they do not always take away all the pain; it could be just positional change for someone with difficulty breathing, propping them up, it could be a warm blanket, rubbing their hands, talking to them to enhance comfort.

Participants shared their experiences as being sad, emotionally draining, touching, hard, gratifying, and difficult, especially when nurses have been emotionally attached to their residents. Participant 8 stated that there is a feeling of ambivalence where nurses were sad and gratified at the same time because they were part of the dying residents' life for a length of time and have become like family, but also shared that the experience could be gratifying because you know that the resident was not dying feeling alone, and that making the dying experience better becomes the nurses' job. These nurses' experiences are consistent with Cagle et al.'s (2017) suggestion that understanding nursing home staff perceptions about death and dying is important in addressing the challenges of providing quality end-of-life care; many nursing home staff are happy providing end-of-life care to dying residents and their actions positively impact the residents. Participant 10 shared her experience stating that it was difficult to administer pain medication to a dying patient the first time; she felt she contributed to making someone die. However, with time and some training with hospice, she realized that she was actually helping keep residents comfortable so they could die peacefully without being in pain. This participant also wished for more training about administering comfort care to residents at the end of life. The experience was consistent with the study findings of Raudonis, Kyba, and Kinsey (2002) and Bükki, Neuhaus, and Paal (2016), who recommended staff education and training in end-of-life care.

Two of the participants presented as discrepant cases because they believed that use of pain medication, especially morphine, may help speed up the dying process of residents at the end of life. One participant considered use of pain medication at the extreme end of dying and only uses pain medication when the resident needs it. Participant 10 shared that her cultural background influenced her approach to care provided to dying residents and the grieving process. She was from a country outside of the United Stated and stated:

> When someone or a loved one passes, and I am not saying it is not painful in this country, but we see it in a different way. In America, somebody will pass and they'll be like it is prepaid, funeral home can just come and pick the body up. Where I came from, you are crying, people are coming and going, people are coming to stay with you, because they feel like if they leave you, you'll be alone and they don't want you to go through all that by yourself.

These feelings are consistent with Sussman et al. (2017) who described death and dying as being culturally and religiously influenced and that divergent cultural beliefs and personal preferences have prevented death from being viewed as a normative process.

Participants agreed that their expectations after comfort measure interventions have been implemented are that residents at end of life in nursing homes will have a peaceful transition, a state of calmness, comfort, relieve from anxiety, hope for a peaceful death, and reduced stress. These expectations are consistent with my findings in the literature review where Kolcaba, Tilton, and Drouin (2006) described comfort as the outcome and the central focus of nursing care, and when experienced, produces a change in human experience in four contexts as physical, psychospiritual, sociocultural, and environmental to exhibit a feeling of relief, ease, and transcendence.

It was evident by the shared experiences of the participants that residents at the end of life are faced with multiple chronic and sometimes distressing end-of-life symptoms such as pain, anxiety, loneliness, and other bio-psychosocial needs that require nursing interventions to enhance comfort and quality of dying. The participants also shared that efforts were made by nurses to relief residents' suffering by instituting interventions that will enhance comfort such as use of medications, holding hands, family involvement in the care of residents, spiritual visits, visit from friends, soft music, soul food, turning and repositioning, ensuring that residents are clean and dry, and oxygen administration. The participants' shared experiences of residents' needs and required nursing interventions are consistent with the assumptions of Kolcaba's theory of comfort (Kolcaba, 2001) which stated that: human beings have holistic responses to complex comfort needs in stressful health care situations such as the end of life, comfort is a desirable outcome, human beings make efforts to meet basic comfort needs, and comfort promotes institutional integrity. Kolcaba also proposed that nurses are responsible for identifying the comfort needs of patients and can design interventions to address the identified comfort needs. Therefore, the use of the theory of comfort was well aligned with this study because enhanced comfort or peaceful death of the residents at the end of life is the central focus of care.

Limitations of the Study

There was inherent bias in the choice of participants involving a certain group of nurses that work in long-term care facilities. This study did not include other valuable healthcare professionals like social services, physicians, nurse practitioners, administrators, nursing assistants, and others. The findings from this study may not represent the experiences of other healthcare professionals, therefore, the study findings may not be applicable to other long-term care facilities. Due to the qualitative nature of this study, causal relationships cannot be obtained from the data collected from the participants.

Recommendations

Further study is needed in long-term care to gather lived experiences of other valuable members of the healthcare team such as the physician, nurse practitioners, certified nursing assistants, and social workers, and to explore perspectives of other nurses from different cultures. This study findings revealed perceptual differences in the culture of death and dying among the participants. Therefore, further education may be needed for the nurses to instill the required confidence and knowledge in the care of the dying residents in long-term care facilities as some participants are also skeptical about using pain medications at the end of life because they feel as if they were helping to hasten the death of dying residents. This recommendation is consistent with the study findings of Raudonis, Kyba, and Kinsey (2002), and Bükki, Neuhaus, and Paal (2016) in which they recommended staff education and training in end-of-life care. Powazki et al. (2014) also found a correlation between clinical experience of experienced nurses and training in end-of-life care as factors that enabled nurses with experience to be able to meet the needs of the actively dying patients.

Implications

This study identified comfort, comfort care, and comfort care measures at the end of life as the key concepts. The findings from my study may be used by nurses to inform them that their own personal experiences with residents at the end of life are not unique but shared by other nurses which can provide positive impact leading to positive social change. Findings may also be used by nurses who care for residents at the end of life to help them design an individualized plan of care and ESMO protocol to meet the needs of residents during their end of life transition. Residents will receive care tailored to their specific needs that will enhance their comfort and quality of life (Krishnan et al., 2015). Family members will have satisfaction when their loved one's end of life experience is peaceful and non-traumatic which can create positive social change. Death and dying are becoming the central features of long-term care, the measure of quality in nursing home is shifting to the measure of the quality of care provided to residents at the end of life; therefore, use of comfort care orders strongly influence death within nursing homes (Krishnan, Williams, & Maharaj, 2015).

Conclusion

Death and dying are inevitable and the process may present with multiple distressing symptoms. However, the central focus and essential part of nursing care at the end of life is comfort, and the goal of care at this critical time in residents' life is to provide care that will enhance comfort and ensure quality of dying. I conducted this study to examine the lived experiences of nurses about comfort care among residents at the end of life in long-term care facilities using a phenomenological qualitative approach. The participants reported that their experiences were ambivalent, were sad, emotionally draining, touching, hard, gratifying, difficult, especially when nurses became emotionally attached to their residents. However, nurses also shared that implementing comfort measures such as turning and repositioning, when appropriate, reducing invasive procedures, reassurance, holding their hands, playing music of choice, spiritual visits, providing medication to reduce secretions, substituting self for family, touching, use of oxygen, hydration, care based on needs and emerging symptoms, staying with the resident, suctioning, and supporting the family, helped to ensure comfort of the dying residents. Nurses who work in long-term care facilities reported that adequate assessment and the presenting symptoms helped to determine which comfort measures to implement to achieve comfort of the dying. As measures shift to focus on the quality of care provided by nurses to residents at the end of life, use of comfort care orders strongly influence quality of end of life experiences within nursing homes.

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Appendix A: Study Invitation

YOU ARE INVITED TO PARTICIPATE IN A STUDY ON NURSES' LIVED EXPERIENCES OF COMFORT CARE AMONG RESIDENTS AT THE END OF LIFE

This study is academic research in support of a doctoral degree, and it is not connected with or part of any organizational initiative or program.

You are eligible if have 2 years of long-term care experience as an RN or LPN

The results of this study will help nurses to have a better understanding of comfort measures to implement while managing end of life symptoms. If you are interested in participating in the study or have questions, please contact by email or phone:
EZEKIEL OSUNDINA MSN RN at:
ezekiel.osundina@waldenu.edu
Phone number: 302-353-8277.

NURSES INSTITUTE COMFORT MEASURES
NURSES DETERMINE WHAT CONSTITUTE COMFORT MEASURES
THIS IS AN OPPORTUNITY TO EXPRESS WHAT COMFORT MEANS TO YOU
This study involves an interview lasting approximately 45 to 60 minutes

ezekiel.osundina@waldenu.edu
SHARE YOUR COMFORT CARE EXPERIENCES.

Appendix B: Screening Guide

Date___________ Participant Identification # ________________

Hello, my name is Ezekiel O. Osundina. I am a doctoral student at Walden University. I am pleased that you are interested in learning more about the study. The purpose of the study is to examine the nurses' lived experiences of comfort care among residents at the end of life in long-term care facility. To be sure that you qualify, I will ask you the following questions:

Are you 18 years or older	Yes	No
Have you worked for 2 years or more in LTC	Yes	No
Have you taking care of dying residents at the end of life?	Yes	No
Do you speak English?	Yes	No
Can you read English?	Yes	No
Will you be willing to be tape-recorded during the interview?	Yes	No

Appendix C: Interview Protocol and Questions

Participant Name:	**ID#**
Date of Interview:	
Date of Follow-up Interview:	
Hi, ____________. My name is **Ezekiel O. Osundina**, and I am going to ask you some questions today. Before we get started, there are a few things to review. I am going to review the consent with you. I have a copy for you to keep and another copy that you will sign if you agree to participate in the study. I will keep the signed copy for my record. Do you have any questions about the information on the consent? I will be asking you to answer questions regarding your experiences with the provision of comfort care among residents at the end of life in nursing home. I would like to ask questions about your experience in relation to comfort care, which is why I asked you to participate, and I am interested in your personal experiences. Therefore, there is no wrong answer, and all your responses are valuable to the success of this study. I will record the interview using digital audio-recorder. The information you provide will be kept confidential. Therefore, your identity will be known only to me. The interview will be tape-recorded and I will ask you not to identify yourself by name or the name of the facility or any information that will specifically identify you during this interview. Any information that is recorded that can identify you will not appear in any report of this study. I want to assure you that participating in this study is voluntary and you may decide not to proceed with the interview or stop participating at any time during the interview. If you have other answers or thoughts as we are moving along, feel free to express them. If you agree, I will leave my contact information in case you have additional information to give me or if there is a need for me to contact you to clarify information. What questions do you have for me before we proceed?	

Interview Questions

1. Tell me about your background (expecting information about education, nursing experience especially years in long term care, and working with dying residents), further questions will be developed if certain part of the information are missing as follows:

    (a) What is your experience like working with dying residents?
    (b) Tell me about your long term care experiences

2. Tell me about care of dying resident in nursing home based on your experience (expecting information to include comfort, comfort measures interventions, characteristics of comfort as care outcome, care characteristics of nurses that produce comfort as outcome); further questions will be generated if responses did not cover area of interest as follows:

    (a) What does comfort mean to you?
    (b) Tell me about your experiences of comfort
    (c) Tell me about interventions you consider as comfort measures
    (d) Tell me about your expectations after comfort measures interventions have been implemented
    (e) Tell me about the factors that help you determine what comfort measures to implement for the resident at the end of life