2020

Evidence-Based End-of-Life Care Education for Intensive Care Nurses

Kimberly Ann Hare
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Kimberly Hare

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

Review Committee
Dr. Cheryl McGinnis, Committee Chairperson, Nursing Faculty
Dr. Diane Whitehead, Committee Member, Nursing Faculty
Dr. Dana Leach, University Reviewer, Nursing Faculty

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

Walden University
2020

Abstract

Evidenced-Based End-of-Life Care Education for Intensive Care Nurses

by

Kimberly A Hare

MSN, University of Phoenix, 2007

BSN, University of Alabama, Birmingham, 1988

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2020

Abstract

Most nurses have limited education on end-of-life care (EoLC), which can affect their ability to provide care to meet the needs of the dying patient. Nurses in a critical care unit in a hospital in the Southeastern United States lacked education on EoLC for their patients. The purpose of this study was to develop a project guided by Kolcaba's theory on caring. The staff education project addressed the attitudes and knowledge of 36 nurses before and after an educational presentation on EoLC. Data were analyzed descriptively. Results indicated that 56% of the staff nurses had never received prior education on EoLC. In addition, 92% stated they had been providing care to dying patients. After receiving the educational program on EoLC, 35 participants strongly agreed, and 1 participant agreed that the program content extended their knowledge of EoLC. All participants reported that the content was applicable to their job in caring for patients. This project has the potential to promote positive social change through EoLC education to improve the knowledge and confidence of nurses working with dying patients and their families, thereby improving the patient and family experience with EoLC.

Evidence-Based End-of-Life Care Education for Intensive Care Nurses

by

Kimberly A. Hare

MSN, University of Phoenix, 2007

BSN, University of Alabama, Birmingham, 1988

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2020

Dedication

I would like to dedicate this project and any acclaim to almighty God. It is my faith in God that has brought me through this incredible journey. I truly believe all things are possible with God by my side. I want to thank the support of my family and friends because there were times I wanted to give up, but their support helped me see this to the end. To my one and only son, Bradley R. Johnson, you are always the light and the end of the tunnel. You are the reason I made it to my goal.

Acknowledgments

I would like to acknowledge Dr. Cheryl McGinnis for her unrelenting patience in the process of this project. Her guidance has been immeasurable, and I will be forever in her debt. Her guidance helped me to understand the writing process, and this help has been greatly appreciated. I would also like to thank Dr. Linda O'Sullivan for her excellent guidance as a preceptor and mentor. Not only did you help me learn, but you also gave me positive motivation that I could get to the finish line. To my family and friends for listening to me through hours of venting of frustration, you have made me laugh and see the lighter side of life. I also want to thank Dr. Diane K. Whitehead and my project committee for the constructive comments and encouragement to help me through this project.

Table of Contents

.

List of Tables

.

Section 1: Nature of the Project

Introduction

End-of-life care (EoLC) is an approach that health care practitioners use to relieve the suffering of dying patients. According to a recent report, out of all the deaths that occurred within the hospital, 14.7% occurred in the critical care units (Boone et al., 2018). EoLC needs are projected to increase by 42% by 2040, out of proportion to deaths (Boone et al., 2018). However, many organizations are not prepared to offer evidence based, high-quality EoLC to their patients (White & Coyne, 2011). Hospitals invest numerous resources in the development of nurses in the intensive care unit (ICU), but research showed that few nurses receive EoLC education before or after they become professional nurses (Barrere & Durkin, 2014). The purpose of this study was to develop an evidence-based staff education program for the ICU nurses derived from the eight core modules of the End-of-Life Nursing Education Consortium (ELNEC) material. Identifying knowledge gaps among health care providers is one strategy to determine what type of continuing education is needed (Schulman-Green et al., 2011), The implications for social change with this project include ensuring that end-of-life needs are met to ensure a peaceful death for the patient, and advancing nursing practice at the project site.

Problem Statement

Quality and skilled EoLC is important for every patient who may be entering the last stages of life, and adequate pain and symptom management is an essential component within this specialty care (Willkie & Ezenva, 2012). Nurses spend more time with

patients than members of any discipline in the hospital setting (Barrere & Durkin, 2014). The patient and family are going to expect more from the nurse as it relates to their care and comfort. When patients are dying, the emphasis of their care is on symptom assessment and treatment (Barrere & Durkin, 2014). The five most common symptoms experienced by critically ill patients who are dying include pain, dyspnea, anxiety, delirium, and death rattle (Campbell, 2015). These physiologic changes occur within the last hours and days of life and can be alarming if not understood by the nurse and distressing to the patient as well as the family if not treated appropriately (Campbell, 2015). EoLC is addressed briefly within the nursing schools as a short lecture or not offered in nursing curricula; therefore, new nurses are less knowledgeable and skilled to provide EoLC after graduation (Barerre & Dunkin, 2014).

The problem at the practice site was nurses' failure to use evidence based EoLC practice when providing care to dying patients. ICU nurses at the project site expressed discomfort in providing EoLC for their patients. This is consistent with what researchers found in the EoLC literature (Anderson et al. 2016). Researchers have shown that ICU nurses could be trained to facilitate goals-of-care conversations and provide primary interventions to reduce discomfort from symptoms such as pain, dyspnea, anxiety, delirium, and the death rattle (Grossman, 2013). Therefore, an evidence-based ICU staff education program focusing on EoLC may fill the knowledge gap on EoLC guidelines at the project site. The nurses at this facility get a brief training video on EoLC as part of their initial nursing orientation and annual competency. There is minimal education provided in nursing schools related to caring for dying patients, especially in recognizing

the symptoms that the patient may have when dying (Pulsford et al. (2013), This educational program for EoLC will be incorporated into existing educational materials on EOL care and standards of care at the project site. According to Pulsford et al. (2013), many scholars recognized the need to address knowledge deficits and limited self-confidence related to delivery of EoLC concluded that nurses' needs are multidimensional.

Despite the shift in the approach to preparing nurses to care for dying patients, many challenges exist for nurse educators. Effective, evidence-based methods to infuse palliative and EoLC education into the undergraduate nursing curriculum are needed (Glover, Garvan, Nealis, Citty, & Derrico, 2017). Another problem is the lack of consistency in how EoLC is taught (Glover et al., 2017). About 1 8% of nursing programs offer EoLC as a separate course (D'Antonio, 2017). Training programs such as the ELNEC have helped educate the nursing workforce in palliative and EoLC concepts; however, as of 2016, only 615,000 of the nearly 3 million registered nurses in the United States had participated in ELNEC courses (Glover et al., 2017). The number of hospital-based palliative care programs has nearly tripled since 2000, but health care systems have a long way to go in ensuring access to patient-centered care at the end of life (Glover et al., 2017). The focus of the current study was to develop a nursing staff education program that could bridge the gap with EoLC dilemmas and barriers, which are common in nursing practice.

This project holds significance for the field of nursing practice as it may support the educational needs of the nursing staff within the ICU and other areas within the acute

care settings. The provision of EoLC by critical care nurses with a focus on goals may allow nurses to concentrate efforts on the patient's and family's needs and values. By learning the evidence-based management of end of life, nurses may implement medicinal and nonmedicinal interventions to improve comfort for their patients and for themselves when providing care.

Purpose

There is a large gap of care delivery in the ICU for patients experiencing end of life. This gap is linked to poor recognition of symptoms of the dying patient, treating these symptoms appropriately, and inability to practice with an evidence-based approach (Glover et al., 2017).The purpose of this project was to address the lack of EoLC education among the ICU nurses by implementing and testing the efficacy of an evidence-based staff education project. This educational project has the potential to increase nurses' knowledge, skills, and confidence in providing EoLC in the ICU setting. The patient and family experience may be impacted if the nurses lack the knowledge regarding how to apply the necessary comfort measures at the end of life. The gap in practice at this site is that ICU nurses are not providing EoLC based on current evidence. A formal program designed for ICU nurses may provide EoLC education focused on the physical, emotional, and spiritual needs of dying patients. Through the introduction and implementation of evidence-based education, nurses may be encouraged to become engaged in effective symptom management and communication with their patients and families. The project question was the following: Will evidence-based practice education on EoLC increase the ICU nurse's knowledge, skills, and confidence in caring for end-of-

life patients? The staff education project may promote a safer practice environment for EoLC for the dying patient within the ICU and improvement in the ICU nurses' competence level.

Nature of the Project

The sources of evidence for this project included the training programs using the guidelines from the ELNEC. A comprehensive literature review was completed using electronic databases in the Walden library. Databases included Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), National Library of Medicine's collection database (PubMed), and Cochrane Database of Systematic Reviews (CDSR). I reviewed professional organization nursing websites for position statements and published standards for development content. Within my research, I included resources related to training of nurses working in the ICU. I reviewed the National Association for Home Care and Hospice-Palliative Care, and the Palliative Care Guidelines to support the evidence for this project. Peer-reviewed journals included the past 5 years of research.

For this doctoral project, the approach that I used to address the practice problem was to review the literature for evidence to support the development of the nursing education program. I looked at primary and secondary resources related to my practice question. The literature indicated that there is enough evidence to address the gap in nursing practice to contribute to the development of an EoLC education program for nurses in the ICU. This education project followed the Walden staff education manual. An Excel spreadsheet was used to organize and summarize evidence pertinent to this

project. This method was used to identify the quality, strengths, and weaknesses of the evidence, as well as commonalities and gaps in the evidence. This provided an efficient strategy to review sources for content and synthesize the literature.

I developed an evidence-based staff education program for the ICU nurses derived from the eight core modules of the ELNEC material with a focus on providing EoLC to fill the gap with the recommendations of ENLEC and current palliative care guidelines. The educational component included areas of (a) pain management; (b) palliative nursing care; (c) symptom management; (d) ethical, cultural, and communication issues; and (e) the final hours experienced by the dying patient and the bereavement process of the family (ELNEC, n.d.). I conducted a pretest and a posttest to the ICU nurses by using a 5-point Likert scale questionnaire. This education project served to prepare nurses to meet the needs of patients and families experiencing terminal illness or a traumatic injury requiring EoLC.

Significance

Numerous stakeholders may be impacted by this project. Initially I will give the project to an expert panel of educators and the director of nursing education. The panel of experts will include educators from Surgical Intensive Care, Neurological Intensive Care, Cardiac Intensive Care, Burn Intensive Care, and the Intermediate Care Unit. These ICU educators hold Master's in Nursing degrees and have at least 5 years of experience in the ICU setting. The director is a DNP-prepared nurse with over 30 years of experience in nursing.

The primary stakeholders who may benefit from this project are ICU nurses, patients, their families, the nursing education department, nursing leadership, and other nurses within this facility who also caring for dying patients. This facility does not have a dedicated hospice unit; therefore, an evidence based EoLC education program may benefit nurses and patients outside of the ICU and the emergency department. The implementation of an EoLC education program may change the way care is provided to the dying patient within the ICU. This project has the potential to change practice standards through the incorporation of evidence-based practice guidelines using the ELNEC and current palliative care guidelines. Managing discomfort in patients who are critically ill and nearing the end of life is a significant part of the nurse's role. Nurses who learn the evidence-based supporting symptoms management may be able to implement medicinal and nonmedicinal interventions to improve comfort for their patients and for themselves when providing care. The nursing leadership, including the chief nursing officer and the director of education, will support the nurses in the ICU with the appropriate education to ensure that the care provided to patients is evidence based, current, and able to achieve positive outcomes for the patient and their family.

This project has significance to nursing practice because of its support for the educational needs of nurses in the ICU and other areas of the acute care setting. Researchers have shown that discomfort and lack of empowerment are barriers to ICU nurses providing evidence based EoLC (Holms, Milligan, & Kydd, 2014). Educating nurses on the evidence based EoLC may provide nurses with the knowledge to implement medicinal and nonmedicinal interventions to enhance patient comfort.

Researchers have identified that nurses who receive a course of EoLC have a more positive perception and attitude about caring for dying patients (Whitaker, 2016). In a recent call to action, the American Nurses Association (ANA, 2016) in conjunction with the Hospice and Palliative Nursing Association recommended that primary palliative and hospice care components be adopted from the ENLEC and taught in all nursing curricula.

This doctoral project has the potential to contribute to nursing practice by providing the education and support needed for the nursing staff who will be caring for patients requiring EoLC. According to the ANA (2016), nurses need to attain the competence required for current practices. Nursing staff education and specific orientation will lay the groundwork for the competencies needed for a change in care delivery and will contribute to nursing practice because it will improve practice and lead to better care outcomes for patients (Goebel, Guo &Wood 2016).

The patient experience can be impacted through nurses' knowledge and application of comfort measures at end of life. Increasing nurses' knowledge and the potential for improving EoLC for patients will provide a positive social change for both ICU staff and their patients. Evidence has shown that the integration of EoLC into critical care units is effective for nurse as well as patients (Aslakson et al., 2012). Specialized education in EoLC may create social change by helping nurses to enhance their confidence in caring for the dying patient.

Summary

Nurses adequately trained in EoLC can properly respond and meet the needs of the dying patient (Aslakson et al., 2012). The requisite knowledge and skills can be

developed through educational activities designed to increase knowledge in how nurses deliver care to dying patients (Aslakson et al., 2012). In Section 2, I describe the background and context of the practice problem. Topics in Section 2 include concepts, models, theories, project relevance to nursing practice, and my role as the DNP student.

Section 2 Background and Context

Introduction

EoLC and treatment are best provided in an appropriate setting with staff who are educated on the needs of the population. The purpose of this project was to educate ICU nurses in an acute care hospital in the Southeast region regarding how to care for dying patients, with the goal of improving nurses' knowledge of EoLC to improve patient and family experiences. The project question was the following: Will evidence-based practice education on EoLC increase the ICU nurse's knowledge, skills, and confidence in caring for end-of-life patients? ICU nurses at the project site have not received enough training on caring for dying patients. Section 2 includes an overview of the background and context of concepts, relevance of the project to practice, and the role of the DNP student and project team in achieving objectives of this project relevant to nursing practice.

Concepts, Models, and Theories

Comfort care theory was developed by Katharine Kolcaba in 1990 and published in 1994. The middle range theory by Kolcaba (1994) provides support to encourage EoLC and treatment to patients. Within this theory, there are three forms of comfort: ease, relief, and transcendence (Kolcaba (1994). The education program developed for this project involved educating nurses on the three stages of comfort and why symptom management is important during the dying phase. Nurses need to know that when a patient is closer to death, the patient may need comfort by means of medication, repositioning, emotional support, spiritual support, and holistic care (Pattison et al, 2013).

Kolcaba (1994) defined *comfort* to satisfy basic human needs. I chose this theory because EoLC encompasses this fundamental need for comfort.

Comfort is a primary goal for the dying patient and can be an outcome for the family if the patient is unable to express their needs. Comfort theory was applied to the education program that will be provided to the nurses in this training. The care the nurses provide to the dying patient should be based on the identified needs, and the care should be holistic with outcomes that can be measured and that are nurse driven (Kolcaba, 1994). Clear communication addressing the expectations and comfort helps improve the dying experience during end of life (Moir, Roberts, Marts, Perry, & Tivis, 2015). When the nurse has clear communication, this will help meet the patient's physical, psychosocial, environmental, and social needs. Physical needs are related to the symptoms of the illness and sensations during the dying phase. What is going on inside the patient and their awareness is the psychosocial element. A pleasant environment, which includes a quiet room, dim lights, and a comfortable temperature, is also needed (Moir et al., 2015). Social needs of the patient are to have the family present with supportive relationships (Moir et al., 2015). Through an understanding of Kolcaba's theory of comfort, nurses can better provide EoLC to meet the multiple needs of the dying patient. Kolcaba's theory of comfort provided the framework necessary to guide this staff education project, promoting staff knowledge and confidence in providing symptom management for the dying patient. When nurses can recognize and treat end-of-life patient systems, they are providing comfort to both the patient and the family (Barello, 2015).

Definitions of Terms

The following definitions of terms were used for this project:

Anticipatory grief: Mourning and preparing for loss or death before a loved one has died (Kondo & Nagata, 2015).

Bereavement: Deprivation from someone or something (Walter et al., 2013).

Caring: Demonstrating concerns or displaying kindness to others (Kolcaba, 1994).

Death: The termination of all functions from a living being (Kinoshita et al., 2015).

Dying: Approaching death, expiring (Walter, et al, 2013.)

End of life care (EoLC): Care delivered to patients by health care providers during the final hours of their lives (Adams, 2010).

Intensive care unit: A specialty department within the hospital where staff take care of patients with the most severe or life-threatening injuries or illnesses (Johansson & Lindahl, 2012).

Intensive care nurse: Registered nurses, sometimes called critical care nurses, who have received additional training and education that equipped them to work in the ICU to care for patients needing many life sustaining care modalities (Noome et.al, 2016)

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

Relevance to Nursing Practice

The literature review revealed that there is a lack of knowledge and training for nurses when it comes to caring for the dying patient. This lack of knowledge could lead to negativity in the workplace, burnout, turnover, stress, and anxiety for the nursing staff (Choi, Lee, Kim, Kim, & Kim, 2012). Nurses at the project site have expressed being uncomfortable when caring for the dying patient, and they may be unprepared because of lack of education. Nurses face the situation of caring for dying patients and may be unprepared from an education standpoint. It is important for nursing staff to receive the necessary training so that they will have the knowledge to care for the patient during the end of life (Estathiou & Walker, 2014). Nurses who have had more education are better able to address patients' concerns than nurses who have not had training in EoLC (Tan & Manca, 2013). The practice problem was the lack of knowledge among nurses related to the best practices in EoLC and the resulting inconsistency in care provided to dying patients.

Studies have shown that formalized training programs have been successful in improving the knowledge level of the nursing staff regarding EoLC. It is important for nurses to receive adequate training so that they will develop the knowledge to care for the dying patient (Efstathiou & Walker, 2014). Nurses who have received adequate training in EoLC will better understand the stages of death and will know how to care for the dying patient with more comfort and ease (Griffiths, Ewing, Wilson, Connolly, & Grande, 2015). Nurses who have not received the appropriate training lack the ability to ensure competent care for patients who are dying (Fernandez et al., 2012).According to

Lange, Thom, and Kline (2008), it was identified that nurses who have had specific training to care for the dying patient are more comfortable providing that care. Raphael et al. (2014) showed that the more educational opportunities need to be made available for the nurses to be competent in caring for the dying patients.

The U.S. population is aging, and nurses must have the skills to care for the dying patient (Jeffers & Ferry, 2014). In most developed countries, the number of older adults is projected to increase substantially in the next decade, indicating the need for nurses who are skilled in the provision of EoLC (Jeffers & Ferry, 2014). Melvin (2015) posted that EoLC requires extensive management of complex patient symptoms. However, nurses are not receiving appropriate training to ensure competent care for patients during end of life, and lack of training causes anxiety and doubt in their knowledge and skill (Fernandez et al., 2012). For nurses to be competent in caring for the dying patient, educational opportunities need to be available (Raphael et al., 2014). The comfort level of the nurses will improve when they have received adequate education on caring for patients experiencing death (Fernandez et al., 2012).

To significantly improve EoLC in the ICU at the practice site, a change was needed. However, change does not occur in a vacuum; educational programs that will provide the essential tools needed to impact care practice must be designed and implemented (Raphael et al., 2014).The implementation of an education program may allow nurses to gain a better understanding of EoLC that is needed, and may allow them to increase their knowledge on how to apply EoLC to patients and families.

The goal of this project was to address the need for staff education on EoLC of patients in the ICU setting. The problem at the practice site was nurses' failure to use evidence based EoLC practice when providing care to dying patients. Literature on nursing knowledge related to EoLC indicated that nurses are not comfortable caring for a patient who is experiencing the final stage of dying (Choi et al., 2012).Nurses are confused about how to treat the symptoms and do not understand what the dying process looks like in a patient (Choi et al., 2012). Van der Werff, Paans, and Newegg (2012) stated that hospital nurses need to be able to recognize the signs and symptoms of the onset of the dying phase of a patient. By recognizing these symptoms in a timely manner, the nurse can better provide a plan of care for the patient to decrease or minimize some of the complications of the dying process. Symptom management can promote patient comfort at end of life (Van der Werff, Paans, and Newegg, 2012)

Most nurses do not receive formal education on the stages of death and the support that is needed by the dying patient (Tan & Manca, 2013). Symptoms that are experienced by the dying patient include pain, anxiety, difficulty breathing, gastrointestinal issues, temperature fluctuations, and altered mental status (Tan & Manca, 2013). The ELNEC guidelines will be used to train nurses in the education program.

End-of-Life Nursing Education Consortium

The ELNEC education began in 2000 to improve palliative nurse education. This education focuses on nursing care at the end of life including pain management, symptom management; ethical and legal issues, cultural and spiritual considerations on EoLC, communication, loss, grief, bereavement, and preparation for and care at the time of

death (Dahlon et al., n.d.). Lack of palliative care education for nurses and physicians is a major barrier in providing effective palliative and EoLC for nurses and physicians as well as patients and families who noted lack of education to make appropriate decisions as a barrier to their own best care (Dahlon et al., n.d.).

The ELNEC has eight modules that identify the basis of care needed for the dying patient. The modules cover all aspects of the dying patient, and these modules provided the framework for the education program for the nurses in the ICU at the practice site. The educational component included areas of (a) pain management; (b) palliative nursing care; (c) symptom management; (d) ethical, cultural, and communications issues; and (e) the final hours experienced by the dying patient and the bereavement process of the family (ELNEC, n.d.).

The purpose of the ELNEC is to develop and implement a comprehensive national effort to improve palliative care and EoLC by nurses across all practice specialties. The ELNEC's train-the-trainer model has been successful in increasing palliative care and EoLC knowledge for nurses working across multiple practice settings. After receiving ELNEC education, which consisted of 4 hours of education, nurses reported an improvement in the effectiveness of their work in teaching end-of-life content and increased comfort with the topic of end of life (Marian et al., 2013). The ELNEC also focuses on the family as the unit of care, the important role of the critical care nurse as advocate, the importance of culture as an influence at the end of life, and the relevance of end-of-life issues in all systems of care across all settings (Matzo et al., 2003).

Within the dying phases, the major focus is symptom management while considering the patient and family experience. One symptom that can be quite distressing for the patient, nurse, and family is the noisy, rattling respiration that often occurs when the patient approaches the last hours of life. This is also known as the death rattle. This noise is due to a buildup of secretions within the oropharynx, hypopharynx, and trachea; these secretions coincide with the inspiratory and expiratory phases of respiration (Owens, 2006). This symptom occurs in 40-90% of dying patients (Emmanuel, Bennett & Richardson, 2007). Studies showed that the death rattle predicts death within 48 hours for 75% of patients who develop this symptom (Emmanuel, Bennett & Richardson, 2007).

To improve the EoLC practices in the project site ICU, change was needed. An educational program needed to be designed and implemented to improve care practice. The implementation of this program may allow nurses within the ICU to gain a better understanding of EoLC and be able to increase their knowledge on how to apply appropriate EoLC to patients and families.

According to Tan and Manca (2013), when the patient is going into the dying stage, a certain standardization of care should take place. However, this does not occur in the project site facility because of nurses' lack of knowledge of care for the dying patient. Some nurses may try to avoid an assignment that has a patient who is dying due to their lack of skill and comfort with taking care of the dying patient. Research showed that nurses who are educated on EoLC can better handle the care of the dying patient and better address the patient's and family's needs (Pattison, Carr, Turncock, & Dolan, 2013).

The health care team, which includes the nurse, should discuss the patient's EoLC with the family and the patient to ensure they follow the wishes of the patient. When a patient is dying, the type of care received is different from the care given to other patients within the ICU who are acutely ill. If nurses are knowledgeable, they will have the ability to provide support to the family by providing them education on the steps of the dying process and the grieving process.

Local Background and Context

Terminally ill patients admitted to the ICU are dependent on nurses' knowledge and skills for their care. The aging population is increasing, and the need to provide a comfortable death is important in the hospital setting (Johansson & Lindahl, 2012). Providing the best care for patients experiencing end of life is contingent on educational programs promoting EoLC practices within the ICU. Research shows that the end-of-life care that nurses provide to patients and their grieving families throughout the dying process requires skill, empathy, and compassion (Melvin, 2015). Improving the nurses' knowledge regarding care for patients during the end of life could change the experience for the patient and their families at the project site. Even though nurses have formal training in nursing, most lack the ability to care for dying patients because EoLC was not offered or was limited in their nursing curriculum (Harris, Gaudet, & O'Reardon, 2014). The families of the dying patient also need the support of the nurses when their loved ones are going through the dying phase; however, research has shown that nurses not properly trained in EoLC cannot provide the support that is needed to the family, leading to a decrease in the patient and family experience (Johansson & Lindahl, 2012).

The problem at the practice site was nurses' failure to use evidence based EoLC practice when providing care to dying patients. ICU nurses at this project site have expressed discomfort in providing EoLC for their patients. The nurses have stated to the educators on the ICU units how difficult it is to go from aggressively trying to save a life to caring for a patient who is dying. Most have stated it is hard to know what to say to the family and how to manage the symptoms that the patients may display during their end of life.

This site is the region's premier level one trauma center and receives patients from all over the southeast region with the most critical life-threatening illnesses and injuries for example: poly-trauma, severe pulmonary injuries, burns, and central nervous system problems that involve the brain and the spine. Some of these patients do not survive their injuries or their illnesses, thus supporting the need for staff education on EOL. Education will help enhance the current practice to provide the best care for patients and their families needing end of life care. Nurse educators for the ICUs assist the nurses with their educational needs. The educators at this site along with all licensed nursing staff take the same 15 minutes computer-based learning management exam each year and therefore it was be beneficial to have them as my experts address this nursing gap in practice related to education on EoLC.

Role of the DNP Student

My role in this project was the one of leadership and collaboration. My relationship to the project site was one of a DNP student, but also as an employee in the nursing education department. My employment at the project site was not connected to

this project. My project will serve as an intervention for a practice problem that I observed, first-hand, in the clinical setting. I will seek permission from the facility where would like to implement this staff development project, communicate to the ICU nurses what the program is all about and get them to participate in the training. I would also like to introduce this program to the nursing education department so that is may expand to other units within the facility. My responsibility will be to coordinate and implement all aspects of this project as a DNP student.

Stakeholders

The panel included six experts that are the educators from the Surgical Intensive Care ICU), the Neurological Intensive Care (NICU), Cardiac Intensive Care (CVICU), Burn Intensive Care (BURNS) and the Medical Intensive Care Unit (MICU). These ICU educators each hold a master's in nursing degree (MSN) and have at least 5 years of experience in the ICU setting. The panel also included the Director of Staff Development who approves all nursing educational projects for the health system. The Director holds a DNP degree and has been in her role for approximately 20 years. I chose the panel of experts based on level of education, experience and their stake in advancing staff education on EoLC. By using my expert panel, it helped to validate my project because the use of organizational and systems leadership are critical for DNP graduates to improve patient and healthcare outcomes. Furthermore, after the approval of this staff educational project for nursing can lead to a positive change in care of patient experiencing EoLC at this facility within the guidelines of the DNP essentials one and two (American Association of Critical Care Nurses, 2016).

As project leader, I contacted all six of my experts, to review this project. The expert panel was given the pretest before the education and posttest right after and they provided me the feedback and agreed with me the need to improve EoLC recognition and management of symptoms furthermore increasing nurses' knowledge using EB. I reported and will follow up with nursing leadership and the education department on a regular basis on the progress of the project. I made sure all required documents were submitted to the Walden University Institutional Review Board (IRB) and reviewed the literature to find the proper data collection instrument that is relevant to my project.

Summary

The Doctor of Nursing Practice (DNP) project was designed to review if there is a difference in ICU nurses' knowledge towards EOL following an educational intervention. Kolcaba's theory was used to identify and provide support a valuable framework for the project purpose and goals. Improving nurses' knowledge of EOL care can transfer to improving patient care during the dying process. Providing education on EOL care may help fill the nursing gap in practice to provide education on caring for the dying patient. It is imperative that nurses receive the education that they need to care for the patient and family during EOL. The intent of this study was to extend the knowledge for the nursing staff by incorporating evidenced-based education. Section 3 will provide a comprehensive overview on collection and analysis of evidence for this project

Section 3: Collection and Analysis of Evidence

Introduction

The purpose of the project was to create a program to educate ICU nurses in a Level 1 trauma center located in the Southeastern United States on how to care for dying patients. The project goal was to improve nurses' knowledge of EoLC, thereby improving patient and family experiences. The practice problem was a lack of EoLC education among ICU nurses. Nurses had not received formal training on caring for dying patients. Section 3 includes the project design, which was developed using the Walden staff education manual as guidance for project development.

Practice-Focused Question

EoLC is necessary to relieve the burden of symptoms patients experience as their disease progresses when they are dying. The project question was the following: Will evidence-based practice education on EoLC increase the ICU nurse's knowledge, skills, and confidence in caring for end-of-life patients? The purpose of this DNP project was to address the lack of EoLC education among the ICU nurses.

Sources of Evidence

A comprehensive literature review was completed using the following databases to conduct the literature search: CINAHL, MEDLINE, PUBMED, and CDSR. Key words used for the search included *end of life care, nurses caring for the dying in the ICU, educational programs on end of life care*, and *symptom management during the dying phases*. I reviewed the National Association for Home Care and Hospice-Palliative Care, and the ELNEC to support the evidence for this project.

Over 70 articles on EoLC were identified. Of these articles, 50 that were published between 2010 and 2019 were selected for inclusion in the literature review. These articles suggested knowledge deficit, negative attitudes, and inadequate practice patterns are issues related to ICU nurses' inability to provide EoLC to patients. Observations of staff practice and review of current staff education for ICU nurses at the facility indicated that EoLC education was lacking after nursing orientation. These problems indicated a gap in nursing practice and supported the need for this educational program. By reviewing these articles, I was able to identify nursing practices for EoLC that helped me develop an educational program for this project. The peer-reviewed articles were English only, published in professional journals, and contained best practices related to education for nursing staff involving EoLC within an ICU setting and within nursing curricula.

Participants

As a DNP student, I developed this staff education program for the staff nurses in a medical ICU. This is a 33 bed ICU with a total of 45 registered nurses. The nurses were given the same pretest and posttest as my expert panel. Participation in this education program was voluntary, and the nurses were provided the Consent for Anonymous Questionnaire prior to participating in the program. All data collected was anonymous to ensure confidentiality. The education was delivered with the use of a PowerPoint presentation. The pretest and posttest included a 5-point Likert scale response for each question. The pretest and posttest questionnaires are located in Appendices A, B and C

Procedures

The first step in this project was to develop the program content. I used the ELNEC # 8 module to guide the development of the education program on EoLC. The program content was presented through a 45-minute PowerPoint on care at the time of death, including best care practices during end of life. Kolcaba's comfort theory was also included in the program, focusing on three forms of comfort (ease, relief, and transcendence) and the symptoms of a dying patient (see Appendix D. This theory was chosen because within nursing, comfort is defined as one of the basic human needs for relief, ease, or transcendence arising from health care situations that are stressful (Kolcaba, 1994).

The program was provided to the nurses, and they completed the education required. Ninety minutes of classroom time and educational sessions were offered at a variety of times to accommodate staff's schedules. Participation was voluntary for the nurses in the ICU. Immediately after the education was completed, I administered the End of Life Care Education Questionnaire, which was the same education evaluation given to the expert reviewers to evaluate the educational program content (Appendix C).

The nurses were given the Frommelt Attitudes Toward Care of the Dying (FATCOD) scale before the educational program. The FATCO scale was structured to meet the project's purpose for assessing the current knowledge and attitudes of the nurses prior to receiving the EoLC education. A 5-point Likert evaluation form was used post education to assess the program content and presentation.

The identified panel of six experts reviewed the program content and provided a review of the content and effectiveness of the program. The FATCOD scale was provided pre-education to the panel of experts. They were also provided the End of Life Care Questionnaire as the posttest to evaluate the program after completion (Appendix C). The expert panel did not recommend program modification. The education program followed the guidelines of Walden's staff education manual for an education program. The staff education program included a well-developed framework for effective comfort care for the dying patient within the ICU. Key stakeholders were included in all phases of this project.

Protections

Approval of this project was obtained from Walden University's Institutional Review Board (IRB) prior to initiating the project. The IRB number for this project was 10-01-19-0460699. The signed site agreement form was submitted to the Walden IRB with Form A. A site agreement form was part of the approval process to verify site administrative support and approved. All participation in this project was voluntary. All data collected will remain deidentified. Data from project results will be kept for 5 years in a locked cabinet per IRB requirements.

Summary

In Section 3 I summarized the project design, including collection and analysis of data. The staff education manual provided the project structure and implementation after Walden IRB approval. The practice-focused question, sources of evidence, participants,

and procedures were also discussed in Section 3. Section 4 presents the data analysis, project strengths and limitations, and recommendations.

Section 4: Findings and Recommendations

Introduction

The fourth section of this project report contains the findings and recommendation established from the analysis of the data collected from the expert team and the nurses who participated. The purpose of this project was to develop an evidence-based staff education program on EoLC for the dying patient within the ICU. Educating nurses in EoLC is important to ensure that nurses are comfortable caring for dying patients and to improve nurses' knowledge regarding best practices of EoLC. The problem at the practice site was nurses' failure to use evidence based EoLC practices when providing care to dying patients. ICU nurses at the project site expressed discomfort in providing EoLC for their patients. The sources of evidence for this project were the pretest and posttest used to assess the knowledge of the participants. The pre education exam was given to the participants prior to the education program to determine a baseline of knowledge, and the post education exam was given following the education program. All information collected on the exams was anonymous. The exam scores were documented in an Excel spreadsheet and analyzed based on the scoring of the FATCOD for the pretest and a 5-point Likert questionnaire for the posttest. Section 4 includes the following topics: findings and implications, recommendations, and strengths and limitations of the DNP project.

Findings and Implications

Education Phase1

I conducted a comprehensive review of evidence using computerized databases, including CINAHL, NEDLINE, PubMed, and CDSR, to identify articles published from 2000 to 2019 to help me understand the needs of patients and their families experiencing end of life. Walden University's IRB approved the project, and approval was also obtained from the project site research committee. The staff development project was conducted over a 3-week period with multiple classes offered to the staff to allow participation on various shifts.

Throughout the development of the educational curriculum plan, my focus was on increasing ICU nurses' knowledge of the current EoLC guidelines. A PowerPoint education program was developed to deliver the program content. The FATCOD was used as the pretest for all participants. The FATCOD is a 30-item tool designed to measure participants' attitudes toward providing care to dying patients, and it is scored on a 5-point Likert scale. Some of the statements address nurses' attitudes toward the dying patient, and others address nurses' attitudes toward the patient's family (Frommelt, 1991). I received written permission to use the FATCOD from the author in an email (see Appendix E). The FATCOD demographics is included in Appendix A. The FATCOD is made up of an equal number of positively and negatively worded items. Positive items are scored from 1 (strongly disagree) to 5 (strongly agree). For a negative item, the scoring is reversed. The FATCOD questionnaire scale is (Appendix B) was a 5-point

Likert questionnaire that consisted of five questions scored from 1 (strongly disagree) to 5 (strongly agree). The posttest is in Appendix C.

Education Training Phase 2

Six experts from the educational department were invited to participate. Five of the six invited experts participated. The five experts included two clinical nurse specialists and three advanced clinical nurse educators. They were given the FATCOD before the education to assess their beliefs regarding EoLC. The FATCOD is divided into two sections. The first section includes questions about demographics, including age, gender, and education, and two questions on attitudes and knowledge on death and dying. Question 1 addresses previous education on death and dying. Question 2 addresses previous experience in dealing with terminally ill patients. Results of the expert panel demographics questions and the two questions on dying that are presented in Table 1.

Table 1

FATCOD Demographic Information for Expert Panel

N = 5	Column B
Gender	
Male	1 (20%)
Female	4 (80%)
18- 22 years	0
23-27 years	1 (20%)
28- 35 years	1 (20%)
36- 45 years	2 (40%)
46- 55 years	1 (20%)
56- 65 years	0
66 years and over	0
Educational level	
High school equivalency (GED)	0
Associate degree	0
Bachelor's degree	0
Master's degree	4 (80%)
Education beyond master's	1 (20%)
Other (please specify)	
Previous education on dying	
a. I took a course in death and dying previously.	0
b. I did not take a specific course on death and dying, but material on the subject was included in other courses	5 (100%)
c. No information dealing with death and dying was previously presented to me	
Previous experience in dealing with terminally ill persons	0
a. I have cared for terminally ill person and their family members previously	
b. I have NO experiences caring for terminally ill persons and their family members previously.	5 (100%)

All participants had a master's degree or higher. They all stated they never had any formal education on caring for the dying, but they had cared for terminally ill patients throughout their nursing career. After the demographic assessment was completed, the experts completed the FATCOD scale with 30 questions to assess their knowledge and attitudes on death and dying. The purpose of the FATCOD was to learn how nurses feel about certain situations involving the dying person and caring for them. The questionnaire states that where there is a reference to a dying patient, that patient should be considered terminally ill with 6 months or fewer to live. Questions were answered on a 5-point scale of strongly disagree to strongly agree. This questionnaire was completed before participants were given the education program. Table 2 presents the participants' responses to the FATCOD.

Table 2

*FATCOD Scores for the Expert Nurses (*N = 5)

	SD	D	U	A	SA
Q. 1					5 (100%)
Q. 2				1(20%)	4 (80%)
Q. 3	5 (100%)				
Q. 4					5 (100%)
Q. 5	5 (100%)				
Q. 6	4(80%)	1 (20%)			
Q. 7	4(80%)	1 (20%)			
Q. 8			4(80%)	1 (20%)	
Q. 9		5 (100%)			
Q. 10					5 (100%)
Q. 11		5 (100%)			
Q. 12					5 (100%)
Q. 13	5 (100%)				
Q. 14	5 (100%)				
Q. 15	5 (100%)				
Q. 16					5 (100%)
Q. 17	5 (100%)				
Q. 18					5 (100%)
Q. 19	5 (100%)				
Q. 20					5(100%)
Q. 21					5(100%)
Q. 22					5(100%)
Q. 23					5(100%)
Q. 24					5(100%)
Q. 25					5(100%)
Q. 26		5(100%)			
Q. 27					5(100%)
Q, 28	5(100%)				
Q. 29	5(100%)				
Q. 30				5(100%)	

Note. In the Frommelt Attitude Toward Care of the Dying (FATCOD), scoring is Strongly Disagree (SD), Disagree (D), Uncertain (U), Agree (A), or Strongly Agree (SA). Reprinted with permission from Katherine Frommelt.

In the FATCOD, positive items are scored from 1 (strongly disagree) to 5 (strongly agree). Negative items are scored in reverse (1 for strongly agree to 5 for strongly disagree.). Items 1, 2, 4, 10, 12, 16, 18, 20, 21, 22, 23, 24, 25, 27, and 30 are positively worded statements. The rest of the items are negatively worded. Higher score on the results reflects as positive attitude toward caring for the terminally ill patient. Immediately after the training, all experts were provided the End of Life Care Education questionnaire (Appendix C). Results of the post program evaluation are presented in Table 3.

Table 3

*End of Life Care Education Questionnaire on Expert Post Test Scores (*N = *5)*

	1	2	3	4	5
Content					
1 The content was interesting to me				(0%)	5 (100)%
2. The content extended my knowledge of the topic	0%	0%	0%	0%	5(100%)
3 The content was conductive to learning	0%	0%	0%	0%	5(100%)
4. The content was related to my job.	0%	0%	0%	0%	5(100%)
5. Objectives were consistent with purpose/goals of activity	0%	0%	0%	0%	5(100%)
Setting					
1. The room was conducive to learning	0%	0%	0%	0%	5(100%)
2. The learning environment stimulated idea exchange	0%	0%	0%	0%	5(100%)
3. Facility was appropriate for the activity	0%	0%	0%	0%	5(100%)
4. The presentation was clear and to the point	0%	0%	0%	0%	5(100%)
Presenter effectiveness					
1.The presenter demonstrated mastery of the topic	0%	0%	0%	0%	5(100%)
2, The method used to present the material held my attention	0%	0%	0%	1 (20%)	4(80%)
3.The presenter was responsive to participant concerns.	0%	0%	0%	0%	5(100%)
Instructional material					
1.The instructional material was clear and to the point	0%	0%	0%	0%	5(100%)
2.The instructional methods illustrated the concepts well	0%	0%	0%	0%	5(100%)
4.The teaching strategies were appropriate for the activity	0%	0%	0%	0%	5(100%)
By the end of this presentation I will be able to Define some of the signs and symptoms	0%	0%	0%	0%	5(100%)
2. Understands the various procedures and their uses that are involved when caring for the dying patient and family.	0%	0%	0%	0%	5 (100%)

Note. Strongly (SD) 1, Disagree (D) 2, Uncertain (U) 3, Agree (A), 4, Strongly Agree (SA) 5.

My expert panel did not recommend any changes to the educational training. Based on the results of their post program evaluation, the expert team agreed that this education is needed. When evaluating the content of the education program, all participants gave a score of 5, which indicated that the content of this education was needed.

Education Training Phase 3

The second phase of this project was to offer this training to the nursing staff within the ICU. A total of 41 participates were invited to attend the training. At the completion of the training, 36 staff participated and completed the program. Table 4 presents the FATCOD demographic data.

Table 4

FATCOD Demographic Information for ICU Nurse Participants

	Column B
Gender	
Male	9 (25%)
Female	27 (75%)
18- 22 years	2 (6%)
23-27 years	7 (19%)
28- 35 years	11 (31%)
36- 45 years	10 (28%)
46- 55 years	5 (14%)
56- 65 years	1)3%)
66 years and over	0
Educational level	
High school equivalency (GED)	0
Associate degree	6 (17%)
Bachelor's degree	23 (64%)
Master's degree	7 (19%)
Education beyond master's	0
Other (please specify)	
Previous education on dying	
d. I took a course in death and dying previously.	15 (42%)
e. I did not take a specific course on death and dying, but material on the subject was included in other courses	
f. No information dealing with death and dying was previously presented to me	20 (56%)
Previous experience in dealing with terminally ill persons	
c. I have cared for terminally ill person and their family members previously	1 (3%)
d. I have NO experiences caring for terminally ill persons and their family members previously.	33(92%)
	3 (8%)

Based on my data, collected from the demographics from the FATCOD, Scale 56 % of the staff have never had any formal education on EoCL. And within the overall group 92% state that they have been provide care to dying patients. This data shows that nurses are providing care to dying patients without the needed skills to understand the dying process

Table 5 is the ICU Nurses answers to the 30 questions of the FATCOD Scale which measured their attitude towards caring for a terminally ill patient. Positive items (1, 7, 8, 9, 15, 16, 18, 19, 20, 24, 25, 28, 29, and 30) are scored from 1 (strongly disagree) to 5 (strongly agree), and scores are reversed for negative items. I followed the scoring guidelines of the FATCOD survey, which indicated that the negative items needed to be reversed to a positive scoring (Frommelt, 2003). A higher score indicates a more positive attitude toward caring for a dying patient. I used the FATCOD because the nurses had voiced a concern about lack of knowledge and fear about care for the dying patient. I wanted to know what their attitude was and the FATCOD is a tool that has been validated to capture this information.

Table 5

*FATCOD Scores for the ICU Nurses (*N = *36)*

	SD	D	U	A	SA
Q. 1	1 (3%)	1 (3%)	11 (31%)	23 (64%)	1 (3%)
Q. 2	2 (6%)	2 (6%)	7 (19%)	15 (42%)	10 (28%)
Q. 3	5 (14%)	8 (22%)	15 (42%)	6 (17%)	2 (6%)
Q. 4		1 (3%)	1 (3%)	10(28%)	24 (67%)
Q. 5	14(39%)	13(36%)	6 (17%)	3 (8%)	
Q. 6	7 (19%)	15(42%)	7 (19%)	6 (17%)	1 (3%)
Q. 7	1 (14%)	1 (13%)	7 (19%)	6 (17%)	1 (3%)
Q. 8	7 (19%)	10(28%)	12 (33%)	5 (14%)	2 (6%)
Q. 9	14(39%)	18(50%)	1 (3%)	3 (8%)	
Q. 10			4 (11%)	16(44%)	16 (44%)
Q. 11	7 (19%)	19(53%)	8 (22%)	2 (6%)	
Q. 12			2 (6%)	15 (42%)	19 (53%)
Q. 13	5 (14%)	10(28%)	13 (36%)	6 (17%)	
Q. 14	9 (25%)	21 (59%	3 (8%)	3 (8%)	
Q. 15	10(28%)	20(56%)	4(11%)	2 (2%)	
Q. 16	7 (19%)	15(42%)	7 (19%)	6 (17%)	1 (3%)
Q. 17	1 (14%)	1 (13%)	7 (19%)	6 (17%)	1 (3%)
Q. 18	7 (19%)	10(28%)	12 (33%)	5 (14%)	2 (6%)
Q. 19	14(39%)	18(50%)	1 (3%)	3 (8%)	
Q. 20	1 (3%)	6 (17%)	13(36%)	16 44%)	1 (3%)
Q. 21		1 (3%)	10(28%)	25(69%)	
Q. 22	1 (3%)	1 (3%)	1 (38%)	21(58%)	1 (3%)
Q. 23		2 (6%)	9 (25%)	25(69%)	
Q. 24			4 (11%)	19 (53%)	13 (36%
Q. 25			2 (6%)	9 (25%)	25 (69%)
Q. 26	6 (17%)	17(47%)	5 (14%)	8 (22%)	
Q. 27			4 (11%)	13(36%)	19 (39%)
Q, 28	12(33%)	15(42%)	5 (14%)	4 (11%)	
Q. 29	7 (19%)	13(36%)	9 (25%)	7 (19%)	
Q. 30		1 (3%)	4(11%)	21(38%)	10 (28%)

Note. From the Frommelt Attitude Toward Care of the Dying (FATCOD) Scale scoring is Strongly Disagree (SD), Disagree (D), Uncertain (U) Agree (A) Strongly Agree (SA) Reprinted with permission from author Dr. Katherine Frommelt.

Education Training Phase 4

The final phase of this project was the review of the End of Life Care Education Questionnaire from the ICU nurses. An education survey was provided to all the participants once the education programs was completed. All surveys from each participant were collected. The scoring of the posttest was from 1 Strongly Disagree to 5

Strongly Agree. Table 6 reflect the End of Life Care Education Questionnaire scores of the ICU nurses.

Table 6

*End of Life Care Education Questionnaire ICU Nurse Post Test Scores (*N = *36)*

	1	2	3	4	5
Content					
1 The content was interesting to me				1 (3%))	35 (97%)
2. The content extended my knowledge of the topic				1 (3%))	35 (97%)
3 The content was conductive to learning	0%	0%	0%	0%	36(100%)
4. The content was related to my job.	0%	0%	0%	0%	36(100%)
5. Objectives were consistent with purpose/goals of activity	0%	0%	0%	1 (3%))	35 (97%)
Setting					
1. The room was conducive to learning	0%	0%	0%	0%	36(100%)
2. The learning environment stimulated idea exchange	0%	0%	0%	4 (11%)	32 (89%)
3. Facility was appropriate for the activity	0%	0%	0%	4 (11%)	32 (89%)
4. The presentation was clear and to the point	0%	0%	0%	0%	36(100%)
Presenter effectiveness					
1.The presenter demonstrated mastery of the topic	0%	0%	0%	0%	36(100%)
2, The method used to present the material held my attention	0%	0%	0%	1 (20%)	4(80%)
3.The presenter was responsive to participant concerns.	0%	0%	0%	1 (3%))	35 (97%)
Instructional material					
1.The instructional material was clear and to the point	0%	0%	0%	0%	36(100%)
2.The instructional methods illustrated the concepts well	0%	0%	0%	0%	36(100%)
4.The teaching strategies were appropriate for the activity	0%	0%	0%	0%	36(100%)
By the end of this presentation I will be able to: Define some of the signs and symptoms	0%	0%	0%	(0%)	36(100%)
2. Understands the various procedures and their uses that are involved when caring for the dying patient and family.	0%	0%	0%	0%	36 (100%_

Note: Strongly (SD) 1, Disagree (D) 2, , Uncertain (U) 3, , Agree (A), 4 Strongly Agree (SA) 5.

The ICU nurses scored the education with 4s and 5s, indicating they agreed or strongly agreed with the content and this education was helpful to them to understand how to care for the dying patient and their family. This project supports the need for improvement to the EOL education for the nurses within the ICU based on the scores of the nurses. They recommended to add this PowerPoint training to the onboarding education to all new hire nurses within the ICU and annual to all the nurses who are current employees. I did not use the FATCOD as the posttest because I wanted to see if the nurses felt that this staff development education was helpful in improving their care with patients who are dying. They also confirmed that they will use this knowledge in their everyday practice with their patients experiencing EoLC. The problem at this practice site was the nurses' failure to use evidence based EOLC practices when providing care to dying patients. As reported from the FATCOD demographics, 56% that reported that they were taking care of patients with no formal training proves that this education is needed.

Implications for Positive Social Change

A positive social change from this doctoral project may increase retention and job satisfaction among nurses working in the ICU. Providing care to the dying patient and the family can be difficult and this project. The social change that this education could provide is that family and patients would receive the better care from the nursing during the dying process because of increase knowledge. This project may also affect social change by increasing nurses' knowledge and skill leading to improved patient and family satisfaction with EoLC provided at this project site. The project may also influence social

change that may affect patient outcomes from the provision of care from experienced EoLC nurses with higher levels of knowledge.

Recommendations

This recommendation could ensure that the nurses within the ICU have increase knowledge on how to care for the dying patient within this environment. This training could also be beneficial to new nurses in other nursing inpatient units within the hospital with patients who are experiencing EOL. This increase in EOL education can lead to knowledge that may cause better outcomes for the patients and their families.

Project Strengths and Limitations

The strengths of this project include having the full support of the director of nursing education and the educators from the ICUs that were part of the expert team at the project site. The ICU nurses were enthusiastic and supportive. Another strength includes the dual role I served as a DNP student and as an employee of this hospital system. This dual relationship allowed for time outside regular work hours to continue to build relationships with ICU staff and further explain the DNP project goals.

Another strength that was noted was the methodology and structure. The project was well developed to meet its objectives. The project materials included a pretest, education plan, and posttest and program evaluation. The sample size was 36 ICU nurse participants and based on the test scores the educational program reflects a positive response from the clinical staff that this evidenced based education is needed.

A study limitation was that the pretest was administered right before the education and the posttest after the education was completed. There is no way to be sure if retention

of the education will be remembered over a long period of time This education was done over three weeks; therefore, the limitations of testing existed due to the short time of data collection and no retest completed within a few weeks to see if the nurses retained the knowledge and used it in their care of the dying patient. Currently, there is not a mechanism to evaluate the program outcome over time for both patients and staff. A future recommendation is to evaluate staff on the use of program content when caring for their patients who are experiencing EoLC.

Section 5 of the project will elaborate on the dissemination plan following the completion of the project as well as provide an analysis of self and final summary.

Section 5: Dissemination Plan

After completion of this doctoral education project, I reviewed the results of the pre- and posttests with the director of the education department. We discussed how education pertinent to EoLC remains an unmet need for staff. The results of this study are relevant to this institution because results provided a measure of nurses' baseline of knowledge of EoLC.

Analysis of Self

My role was that of a nurse and scholar in each phase of the doctoral project. Both roles were significant at different phases of this doctoral project. My self-analysis of the two roles in this doctoral project is provided in the following subsections.

Nurse

As a nurse, I was able to see the role of the DNP within this project site and how evidence-based practice makes a difference in the care of patients and improving the knowledge of nurses. I now feel that I am better prepared to implement new, evidence-based nursing practices because of this doctoral project experience.

Scholar

In the role of the scholar, I was able to learn how to identify a nursing practice problem; develop a literature review matrix; and search for supportive, evidence-based literature to plan, implement, and evaluate an educational program. This role helped me to learn how to search for, discover, and present the evidence related to EoLC and nursing practice in the hospital setting.

I plan to disseminate this education to the Chief Nursing Council called the Professional Development and Practice Council. This group meets monthly, and my presentation will recommend a practice change on EoLC education. I will create a poster presentation to display the project's purpose and results.

I would like to take this knowledge that I have learned and use it to expand my career within the next 5 years. I would like to move up the ladder from unit director to executive director of a health care system by Year 5. I would also like to become the chief nursing officer.

Summary

EoLC and treatment are best provided in an appropriate setting with staff who are educated on the needs of the population. The purpose of this project was to educate ICU nurses in an acute care hospital in the Southeast region of the United States regarding how to care for dying patients, with a goal of improving nurses' knowledge of EoLC. The data collected showed that nurses were providing care without the proper education needed. The project has the potential to improve nurses' knowledge, thereby improving patient and family experiences at the end of life. The project question was the following: Will evidence-based practice education on EoLC increase the ICU nurse's knowledge, skills, and confidence in caring for end-of-life patients? The gap in practice was that ICU nurses at the project site had not received sufficient training on caring for dying. This was a staff education project and was guided by Kolcaba's (1994) comfort theory, which includes the three forms of comfort (ease, relief, and transcendence) and the symptoms of a dying patient. This theory was chosen because within nursing, comfort is defined as one

of the basic human needs for relief, ease, or transcendence arising from health care situations that are stressful (Kolcaba, 1994). This project identified that there was a gap in the knowledge with the nurses providing end-of-life care to the patients within the ICU and that they were providing care with little to no evidenced-based training. Completing the capstone project gave me an opportunity to develop, collaborate, and lead an evidence-based project. It also provided me an opportunity to integrate and synthesize all the elements of what I learned in Walden's DNP program.

References

Adams, S. (2010). Preparing nurses for end-of-life care. *Kanas Nurse*, *85*(4), 6-8. Retrieved from http://ksnurses.com/?page=26

American Association of Critical Care Nurses. (2016). The essentials of doctoral education for advanced nursing practice. Retrieved from http://www.aacn.nche.edu/

American Nurses Association (2016). Call for action: Nurses lead and transform palliative care. Retrieved from http://nursingworld.org/CaliforAction-NurseLeadTransformPalliativeCare

Anderson, W. G., Puntillo, K., Boyle, D., Borbour, S., Turner, K., Cimino, J., … Pantilat, S. (2016). ICU bedside nurses' involvement in palliative care communication: A multi-center survey. *Journal of Pain and Symptom Management*, *51*(3), 589-596. doi:10.1016/j.jpainsymman.2015.11.003

Aslakson, R. A., Wyskiel, R., Thornton, I., Copley, C., Shaffer, D., Dauryne, Z., … Pronovost, P. J. (2012). Nurse-perceived barriers to effective communication regarding prognosis and optimal end-of-life care for surgical ICU patients: A qualitative exploration. *Journal of Palliative Medicine*, *15*(8), 910-915. doi:10.1089/jpm.2011.0481

Barello, S. (2015). Patient health engagement: Redefining ethical and medical professionalism in the era of participatory medicine. *Journal of Nursing Care Quality*, *30*(3), 247-310. doi:1097/ncq0000000000010

Barrere, C., & Durkin, A. (2014). Finding the right words: The experience of new nurses

after ELNEC education integration into a BSN curriculum. *MEDSURG Nursing, 23*(1), 35-43.

Bookbinder, M., & McHugh, M. E. (2010). Symptom management in palliative care and end-of-life care. *Nursing Clinics of North America, 45*(3), 271-327. https://doi.org/10.1016/j.cnur2010.04.002

Boone, A., Gomes, B., Etkind, S., Verne, J., Murtagh, F., Evans, C., & Higginson, I. J., (2018). What is the impact of population aging on the future provision of end-of-life care? Population-based projections of place of death. *Palliative Medicine, 32*(2) 329-336. doi:10.1177/0269216317734435

Campbell, M. (2015). Caring for dying patients in the ICU: Managing pain, dyspnea, anxiety, delirium, and death rattle. *Advanced Critical Care*, *26*(2), 110-120. doi:10.1097/NCI.000000000077

Choi, M., Lee, J., Kim, S., Kim, D., & Kim, H. (2012). Nurses' knowledge about end-oflife care: Where are we? Journal of Continuing Education in Nursing, 43(8), 379- 384. doi:10.3928/00220124-20120615-35

D'Antonio, J. (2017). End-Of-Life Nursing Care and Education: Past and Present. *Journal of christian Nursing*, *34*(1), 34-38. https://doi.org/10.1097/CNJ0000000000338

Dahlon, C. M., Coyne, P. J., Paice, J., Mallory, P., Thaxton, C. A., & Haskamp, A. (n.d). ELNEC-APRN Meeting the needs of advanced practice nurses through education. *Journal of Hospice & Palliative Nursing*, *19*(3), 261-265.

Dobson, J. (2017). Providing high quality care at the end of life: The role of education

and guidance. *British Journal of Nursing, 26*(20), 1116-1120: doi 10.12968/bjon.2017.26.20.1116

Efstathiou, N., & Walker, W. (2014). Intensive care nurses' experiences of providing end-of-life care after treatment withdrawal: A qualitative study. *Journal of Clinical Nursing, 23*(21/22), 3188-3196. doi:10.1111/jocn.12565

Emanuel, L., Bennett, K., & Richardson, V. E. (2007). The dying role. *Journal of Palliative Medicine, 10*(1), 159-168. https://doi.10.1089/jpm.2006.0134

End of Life Nursing Education Consortium. (n.d.). End-of-life nursing education consortium: Celebrating 15 years. Retrieved from http://www.aacn.nche.edu/elnec/pdf/ELNEC-15.pdf

Fernandez, R., Deutsch, A., Janairo, M., & Compton, S. (2012). Development of a content valid tool for assessing end-of-life communication in acute care settings. Journal of Palliative Medicine, 15(4), 381-387. doi:10.1089/jpm.2011.0427

Frommelt, K. H. (2003). Attitudes toward care of the terminally ill: an educational intervention. *The American Journal of Hospice and Palliative Care, 20*(1), 13-22. /doi-org.ezp.waldenulibrary.org/10.1177/104990910302000108

Glover, T. L., Garvan, C., Nealis, R. M., Citty, S., & Derrico, D. (2017). Improving end-of-life care knowledge among senior baccalaureate nursing students. *American Journal of Hospice and Palliative Care Medicine, 34*(10), 938- 945. doi:10.1177/1049909117693214

Goebel, J. R., Guo, W., & Wood, K. A. (2016). Teamwork and Perceptions of Palliative Care Quality. Journal of Hospice & Palliative Nursing, 18(3), 242.

doi:10.1097/NJH.0000000000000239

Griffiths, J., Ewing, G., Wilson, C., Connolly, M., & Grande, G. (2015). Breaking bad news about transitions to dying: A qualitative exploration of the role of the district nurse. *Palliative Medicine, 29*(2), 138-146. https://doi.org/10.1177/0269216314551813

Grossman, S. (2013). Development of the palliative care of dying critically ill patients' algorithm: Implications for critical care nurses. *Journal of Hospice and Palliative Nursing*, *15*(6), 355-359. doi:10.1097/NJH.0b013e3182987b1c

Harris, M., Gaudet, J., & O'Reardon, C., (2014) Nursing care for patients at the end-of-life within an adult intensive care unit. Journal of Nursing Education and Practice 4(36), 84-89. doi: 10.5430/jnep.v4nbp84

Holms, N., Milligan, S., & Kydd, A. (2014). A study of lived experiences of registered nurses who have provided end-of-life care within an intensive care unit. *International Journal of Palliative Nursing, 20*(11), 549-556. https://doi.org/org/10.12968/ijpn.2014.11.549

Institute of Medicine. (1997). approaching death: Improving care at the end of life. Retrieved 9/1/2017, from http:// nap.edu/open book.php? record_id=5801

Jeffers, S., & Ferry, D. (2014). Nursing care at the end of life. *Nurse Educator, 39*(6), 307-310. https://doi.org/10.1097/NNE00000000000000088

Hansen, L., Goodell, T., DeHaven, J., & Smith, M. (2009). Nurses' perceptions of end of-life care after multiple interventions for improvements. *American Journal of Critical Care, 18*(3), 263-272. doi:10.4037/ajcc2009727

Johansson, B., & Lindahl, B. (2012). Moving between rooms- moving between life and death. Nurses experiences of caring for terminally ill patients in hospitals. *Journal of Clinical Nursing, 21*(13/14), 2034-2042. https://doi.org/10.1111/j.1365-2702.2011.03952

Kinoshita, H., Maeda, I., Morita, T., Miyashita, T., Yamagishi, A., Shirahige, Y., & Eguchi, K. (2015). Place of death and differences in patient quality of death and dying and caregiver burden. *Journal of Clinical Oncology*, *33*(4), 357-363. https://doi.org/10.1200/JCO.2014.55.7355

Kolcaba, K. (1994). A theory of holistic comfort for nursing. *Journal of Advancing Nursing*, *19*(6), 1178-1184.

Kondo, M., & Nagata, H. (2015). Nurses' involvement in patients dying and death: Scale development and validation. *Omega: Journal of Death & Dying*, *70*(3), 278-300. https://doi.org/10.1177/0030222815568959

Lange, M., Thorn, B., Kline, N.E., (2008). Assessing Nurses Attitudes toward Death and Caring for Dying Patients in a Comprehensive Cancer Center. *Oncology Nursing Forum*, 35, 955-959: doi 10.1188/08ONF955-959.

Marian, G., Clareen, W., Rose, V., Gwen, U., Carla, M., Pam, M., & Betty, F. (2013). End of life care education in acute and critical care: The California ELNEC Project. *AANC Advanced Critical Care*, *2*(), 121. https://doi.org/10.1097/NCI.0b013e3182832a94

Matzo, M., Sherman, D., Sheehan, D., Ferrell, B., & Penn, B. (2003). Communication skills for end of life nursing care: teaching strategies from the ENLEC

curriculum...End of Life Education Consortium. *Nursing Education Perspectives (National League of Nursing), 24*(4), 176-183. https://doi.org/Retrieved from

.Melvin, C. S. (2015). Historical review in understanding burnout, professional compassion fatigue, and secondary traumatic stress disorder from a hospice and palliative care nursing perspective. Journal of Hospice and Palliative Care Nursing, 17(1), 66-72. http://dx.doi.org/10.1097/NJH.0000000000000126

Noome, M., Dijkstra, B. M., Leeuwen, E. V., & Vloet, L. C. (2016). The perspectives of intensive care unit nurses about the current and ideal nursing end of-life care. *Journal of Hospice & Palliative Care Nursing*, 18(3), 212-218 doi: 10.1097/NJH.00000000000000221.

Moir, C., Roberts, R., Martz, K., Perry, J., & Judith, T. (2015). Communicating with patients and their families about palliative and end-of-life care: comfort and educational needs of nurses. *International Journal of Palliative Nursing, 21*(3), 109-112.

Owens, D. (2006). Airway Secretions at the End-of Life. *Journal of Hospice and Palliative Nursing, 8*(1), 12-14 doi: 10.109700129191-2006010000-00008

Pattison, N., Carr, S. M., Turnock, C., & Dolan, S. (2013). Viewing in slow motion: patients, families, nurses and doctors perspectives on end-of-life care in critical care. *Journal of Clinical Nursing, 22*(9/10), 1442. https://doi.org/10.1111/jocn.12095

Pulsford, D., Jackson, G., O'Brien, T., Yates, S., & Duxbury, J. (2013). Classroom-based and distance learning education and training courses in end-of-life for health and

social care staff: a systematic review. *Palliative Med*, *27*(3), 221-235. https://doi.org/1177/0269216311429496

Raphael, D., Waterworth, S., & Gott, M. (2014). The role of practice nurses in providing palliative and end-of-life-care to older patients with long-term conditions. *International Journal of Palliative Nursing, 20*(8), 373-379. https://doi.org/10.12968/ijpn.2014.20.8.373

Schulam-Green, D., Ercolano, E., LaCoursiere, S., Ma, T., Lanzenby, M., & McCorkle, R. (2011). Developing and testing a web-based survey to assess the educational needs of palliative and end-of-life health care professionals in Connecticut. . *American Journal of Hospice and Palliative Medicine*, *8*(4), 219-229.

Tan, A., & Manca, D. (2013). Finding common ground to achieve a "good death": Family physicians working with substitute decision-makers of dying patients. A qualitative grounded theory study. BMC Family Practice, 1414 doi:10.1186/1471-staff. *Journal of Pain and Symptoms Management, 50*(5). https://doi.org/dor,.10.1010/j.painsymman.2015.06.006

Walker, K. A., Mayo, R. L., Camire, L. M., & Kearney, C. D. (2013). Effectiveness of integration of palliative medicine specialist services into the intensive care unit of a community teaching hospital. Journal of Palliative Medicine, 16(10), 1237-1241. doi:10.1089/jpm.2013.0052

Walter, J. K., DeCamp, L. R., Warrier, K. S., Murphy, T. P., & Keefer, P. M. (2013). Care of the complex chronically ill child by generalist pediatricians: lessons learned from pediatric palliative care. *Hospital Pediatrics, 3*(2), 129-138.

Whitaker, K. S. (2016). Adequacy of end-of-life care knowledge & skills in nursing education: Investigation into family and nurses' experiences in critical care setting, educational needs of nurses and barriers to adequate education. , (), . https://doi.org/

White, K., & Coyne, P. (2011). Nurses perception of educational gaps in delivery of end-of-life care. *Oncology Nursing Forum, 38*(6).

Wilkie, D., & Ezenva, M. (2012). Pain and symptom management in palliative care and at the end-of-life. *Nursing Outlook, 60*(6), 357-364. https://doi.org/10.1016/j.outlook.2012.08.002

Appendix A: Frommelt Attitude Toward Care of the Dying (FATCOD)

Demographic Part

1. Age

_____ 18-22 years
_____ 23-27 years
_____ 28-35 years
_____ 36-45 years
_____ 46- 55 years
_____ 56- 66 years
_____ 66 years and older

2. Sex ___Male _____Female

3 Highest degree level

_____ High School Equivalency (GED)
_____ High School Diploma
_____ Associate Degree
_____ Bachelor's Degree
_____ Master's Degree
_____ Education Beyond Masters
_____ Others (Please Specify)

4. Previous Education on death and dying

_____ I took a course in death and dying previously
_____ I did not take a specific course on death and dying but material on the subject was included in other courses.
_____ No information dealing with death and dying was previously presented to me.

5. Previous education in dealing with terminally ill person

_____ I have cared for terminally ill person and their family members previously.
_____ I have had NO experience caring for terminally ill persons and their family members previously.

Appendix B: Frommelt Attitude Toward Care of the Dying Scale

Original Form A Part 2

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

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

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

	SD	D	U	A	SA
Q1. Giving nursing care to the dying person is a worthwhile learning experience.		1 (3%)	1 (3%)	11 (31%)	23 (64%)
Q2. Death is not the worst thing that can happen to a person.	SD	D	U	A	SA
Q3. I would be uncomfortable talking about impending death with the person.	SD	D	U	A	SA
Q 4. Nursing care for the patient's family should continue throughout the period of grief and bereavement.	SD	D	U	A	SA
Q5. I would not want to be assigned to care for a dying person.	SD	D	U	A	SA
Q6. The nurse should not be the one to talk about death with the dying person.	SD	D	U	A	SA
Q7. The length of time required to give nursing care to a dying person would frustrate me.\	SD	D	U	A	SA
Q8. I would be upset when the dying person I was caring for gave up hope of getting better .	SD	D	U	A	SA
Q 9. It is difficult to form a close relationship with the family of the dying person.	SD	D	U	A	SA
Q 10. There are times when death is welcomed by the dying person.	SD	D	U	A	SA
Q 11. When a patient asks, "Nurse am I dying.? I think it is best to change the subject to something cheerful.	SD	D	U	A	SA

Q 12. The family should be involved in the physical care of the dying person.	SD	D	U	A	SA
Q 13. I would hope the person I'm caring for dies when I am not present.	SD	D	U	A	SA
Q 14. I am afraid to become friends with a dying person.	SD	D	U	A	SA
	SD	D	U	A	SA
Q 15. I would feel like running away when the person died	SD	D	U	A	SA
Q 16. Families need emotional support to accept the behavior changes of the dying person.	SD	D	U	A	SA
Q 17. As a patient nears death, the nurse should withdraw from his/her involvement with the patient.	SD	D	U	A	SA

FATCOD SCORES FOR ICU NURSES CONTINUED

Q 18. Families should be concerned about helping their dying member make the best of his/her remaining life.	SD	D	U	A	SA
Q 19. The dying person should not be allowed to make decisions about his/her care	SD	D	U	A	SA
Q 20. Families should maintain as normal an environment as possible for their dying member	SD	D	U	A	SA
Q 21. It is beneficial for the dying person to verbalize his/her feelings.	SD	D	U	A	SA
Q 22. Nursing Care should extend to the family of the dying person.	SD	D	U	A	SA
Q 23. Nurses should permit dying persons to have flexible visiting schedules.	SD	D	U	A	SA
Q 24. The dying person and his/her family should be in-charge decision makers.	SD	D	U	A	SA
	SD	D	U	A	SA

FATCOD SCORES FOR ICU NURSINES CONTINUED

	SD	D	U	A	SA
Q 25. Addition to pain relieving medication, should not be a concern when dealing with a dying person.					

Q 26. I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.	SD	D	U	A	SA
Q 27. Dying persons should be given honest answers about their condition.	SD	D	U	A	SA
Q 28. Educating families about death and dying is not a nursing responsibility.	SD	D	U	A	SA
Q 29. Family members who stay close to a dying person often interfere with the professionals' job with the patient.	SD	D	U	A	SA
Q 30. It is possible for nurses to help patients prepare for death.	SD	D	U	A	SA

Appendix C: End of Life Care Questionnaire

CONTINUING EDUCATION ACTIVITY EVALUATION FORM

Activity Title: End Of Life Education Date:_____
Your Job Title: __RN _____Other

As a learner, please assist in the evaluation of this presentation. Please circle the number beside each statement that best reflects the extent of your agreement. Thank you.
Strongly Disagree 1, Disagree 2, Uncertain 3, Agree, 5 and Strongly Agree 5.

Content

The content was interesting to me……. 1 2 3 4 5
The content extended my knowledge of the topic…….. 1 2 3 4 5
The content was consistent with the objectives……. 1 2 3 4 5
The content was related to my job……. 1 2 3 4 5
Objectives were consistent with purpose/goals of activity…… 1 2 3 4 5

Setting

The room was conducive to learning…….. 1 2 3 4 5
The learning environment stimulated idea exchange…….. 1 2 3 4 5
Facility was appropriate for the activity……. 1 2 3 4 5

Presenter Effectiveness (*Kimberly Hare, Advanced Clinical Educator*)

1. The presentation was clear and to the point…… 1 2 3 4 5
2. The presenter demonstrated mastery of the topic…….…… 1 2 3 4 5
3. The method used to present the material held my attention…….…… 1 2 3 4 5
4. The presenter was responsive to participant concerns…… 1 2 3 4 5

Instructional Methods

The instructional material was well organized……..… 1 2 3 4 5
The instructional methods illustrated the concepts well…… 1 2 3 4 5
The handout materials given are likely to be used as a future reference …. 1 2 3 4 5
The teaching strategies were appropriate for the activity…….. 1 2 3 4 5

Learner Achievement of Objectives

By the end of the presentation, I was able to…

Define the medications commonly used in the treatment of symptoms in end of life care……..;;;;;;;.. 1 2 3 4 5

Identify and discuss the comfort measures that are needed in EoLC …… 1 2 3 4 5

Participate in case studies and discuss strategies for drip titration and recognizing symptoms of the dying patient. …….. …… 1 2 3 4 5

Appendix D: End of Life Education PowerPoint

END OF LIFE CARE TRAINING WITHIN THE ICU

KIMBERLY HARE

LEARNING OBJECTIVE

- After taking this course, you should be able to :
- Assess an imminently dying patient and list five physical signs and symptoms of the dying procress
- Assess physical, psychological, social and spiritual care needs and interventions for an imminently dying patient and their family.
- Discuss the role of the Intensive Care Nurse surrounding the death of a patient.
- Discuss the current hospital polices that involve the dying patient, code status, death packet completion, Life Link alert in EPIC. What is brain death at this facility and what the ICU needs to know about this information

Kolcaba's Theory of comfort

Learning Objectives

- The learner will be able to describe the three basic types of comfort care.
- The learner will be able to discuss the three areas of comfort care actions.
- The learner will be able to compare and contrast the art of comfort for the patient and for the care giver.

Kolcaba's Theory of comfort

- Katherine Kolcaba, Ph.D., RN is a nursing theorist who developed her theory of comfort care while working with dementia patients. Providing comfort has long been a focus for nursing and historically dates back to the early years of professional nursing. She views *comfort* as both:

a verb – an active process
a noun – a product or outcome

Dowd, T. (2006) Katherine Kolcaba Theory of comfort. In A.M. Tomey and M.B. Alligood (Eds.), Nursing theorists and their work (pp. 726-742) St.Louis, MO: Mosby Elsevier.

Kolcaba's Theory of comfort

Enhancing the Patient Experience

The principles of Comfort Theory that are relevant to the patient experience include:

a. each interaction involves the therapeutic use of self.
b. nursing staff identify the holistic comfort needs of patients and family members and design their interaction to meet those needs.
c. nursing staff approach each family member with the intent to comfort and make a personal, culturally relevant connection.
d. nursing staff regularly reassess comfort of patients and family members.
e. nursing staff document comfort levels routinely.

http://www.thecomfortline.com/patientexperience

Kolcaba's Theory of comfort

Comfort was traditionally defined as a negative – the absence of or freedom from pain or discomfort. Kolcaba chooses to define comfort in a positive way.

"Comfort is the experience of being strengthened through having needs met for any of the three types of comfort"

Relief
Ease
Transcendence

Dowd, T. (2006) Katherine Kolcaba Theory of comfort. In A.M. Tomey and M.R. Alligood (Eds.), Nursing theorists and their work (pp. 721) St Louis, MO: Mosby Elsevier.

Kolcaba's Theory of comfort

Kolcaba's types of comfort can be described as:

- ***Relief:*** the state of a recipient who has had a specific need met.
- ***Ease:*** the state of calm or contentment.
- ***Transcendence:*** the state of in which an individual rises above his or her problems or pain.

Dowd, T. (2006) Katherine Kolcaba Theory of comfort. In A.M. Tomey and M.R. Alligood (Eds.), Nursing theorists and their work (pp. 728) St Louis, MO: Mosby Elsevier.

Kolcaba's Theory of comfort

Kolcaba describes four contexts in which comfort is experienced:

- ***Physical:*** pertaining to bodily sensations
- ***Psychospiritual:*** pertaining to internal awareness of self, including esteem, self–concept, sexuality, and meaning in life; the relationship to a higher order or being
- ***Environmental:*** pertaining to external surroundings, conditions, and influences
- ***Sociocultural:*** pertaining to interpersonal, family, and societal relationships

Dowd, T. (2006) Katherine Kolcaba Theory of comfort. In A.M. Tomey and M.R. Alligood (Eds.), Nursing theorists and their work (pp. 728–729) St Louis, MO: Mosby Elsevier.

Kolcaba's Theory of comfort

	Relief	Ease	Transcendence
Physical			
Psychospiritual			
Environmental			
Sociocultural			

Kolcaba's taxonomic structure of comfort needs.

http://www.thecomfortline.com/taxanomicstructure.html

Kolcaba's Theory of comfort

Example: Patient with post-operative surgical pain

	Relief	*Ease*	*Transcendence*
Physical	Surgical Site Pain	Restless Uncomfortable	Will I be alright? How long will the pain last?
Psychospiritual	Anxiety Distress	Unknown surgical results	Spiritual Distress Questions & Doubts
Environmental	Unfamiliar Noises Loud Roommate Lights & Temperature	Lack of Privacy Loss of independence R/T impaired mobility	Need for calm Need for restfulness
Sociocultural	Need for the support of family and friends	Need for ressurance	How will I pay for this? Who will take care of my family?

What are some ways to offer comfort?.....

Kolcaba's Theory of comfort

Example: Patient with post-operative surgical pain

Comfort Care Actions

Comfort Interventions: pain medications, turning or repositioning, splinting incision, obtaining assessment & vital signs

Coaching: reassurance, emotional support, listening, teaching, answering questions

Comfort Food for the Soul: filtered lighting, quiet room, calming music, facilitate family coming to the bedside, allow periods of undisturbed rest.

Dowd, T. (2006) Katherine Kolcaba Theory of comfort. In A.M. Tomey and M.R. Alligood (Eds.), Nursing theorists and their work (pp. 739) St Louis, MO: Mosby Elsevier.

Kolcaba's Theory of comfort

Discussion Break

Divide into groups of 4 people each.

Think of some comfort interventions that we offer to our patients. Divide these into the four contexts that we previously discussed:

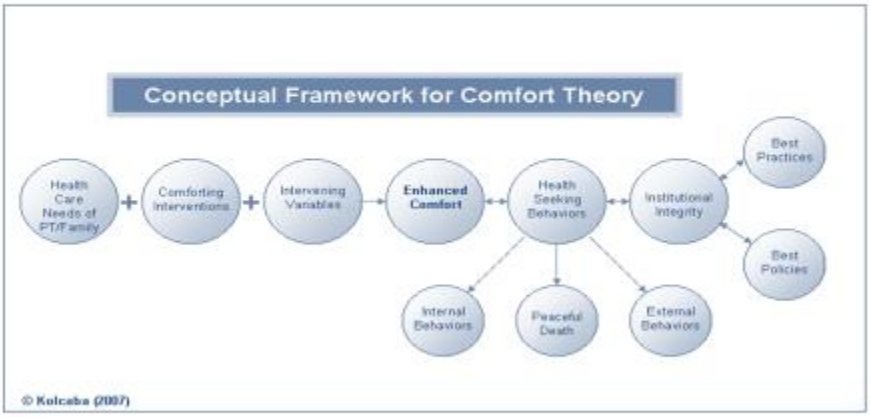
Physical

Psychospiritual

Environmental

Sociocultural

Kolcaba's Theory of comfort



http://www.comfortline.com/conceptualframework.html

Kolcaba's Theory of comfort

Recipients of comfort measures can be diverse:

- *Patients*
- *Family Members*
- *Health Care Providers*
- *Students*
- *Prisoners*
- *Workers*
- *Older Adults*
- *Communities*
- *Institutions*

Dowd, T. (2006) Katherine Kolcaba Theory of comfort. In A.M. Tomey and M.R. Alligood (Eds.), Nursing theorists and their work (pp. 728) St Louis, MO: Mosby Elsevier.

Kolcaba's Theory of comfort

Application of Comfort for Nurses

"Comfort Theory proposes that when the comfort of nurses is enhanced, nurses are more satisfied, more committed to the institution, and able to work more effectively. These nurse outcomes result in improved patient outcomes and increased organizational strength."

Drouin, Kolcaba, & Tilton

Drouin, C., Kolcaba, K., Tilton, C., (2006). Comfort theory a unifying framework to enhance the practice environment. *Journal of Nursing Administration*, 36(11), 538.

Kolcaba's Theory of comfort

Example: Staff person caring for a patient who is dying

	Relief	*Ease*	*Transcendence*
Physical	Heavy patient requiring 3-4 staff to lift or reposition	Need for others to help	Exhaustion "How long will this shift last?"
Psychospiritual	Frustration Anger Distress	"I don't have time to see any of my other patients."	Need to affirm that the patient has been cared for properly.
Environmental	Assignment to heavy Patients in large area Supplies not available	Need for the patient environment to be organized	"What changes will facilitate patient care?"
Sociocultural	Need for team work Humor	Need for support from other care givers	Positive feedback from patient and fellow caregivers

What are some ways to offer comfort?....

Kolcaba's Theory of comfort

Example: Staff caring for a patient with morbid obesity

Comfort Care Actions

Comfort Interventions: willing offers to help, adjust assignments so that the work load is lighter, select patient assignment that is closer geographically, organize equipment and supplies close to hand.

Coaching: offer positive feedback, limit setting with the patient, team approach to problem-solving, organizing care tasks to work more efficiently.

Comfort Food for the Soul: accepting help and understanding from others, a sense of humor, take breaks away from the unit.

Dowd, T. (2006) Katherine Kolcaba Theory of comfort. In A.M. Tomey and M.R. Alligood (Eds.), Nursing theorists and their work (pp. 759) St Louis, MO: Mosby Elsevier.

Final hours of life

- Maintain, open and honest communication. With this communication show the patient and family nurturing, caring, sensitivity and compassion. You must provide presence to the patient and the family allowing them to to be heard, connect with you. When a patient is aware that they are dying, they ususaly know how they want to die and who they want with them.

Preparing for a good death

- Dying is aphyscial, psychological, social, and spiritual event, so planning and consulting with an interdisciplinary team is vital. A good death does not generally occur with thoughtful planning and anticipation. Family members who witness the last days, hours, and minutes of their love one's life will remember the death as long as they live.

Final hours of life

- No two deaths are the same. When each person dies, it should be an individualized and personal experience

Final hours of life

- Maintain, open and honest communication. With this communication show the patient and family nurturing, caring, sensitivity and compassion. You must provide presence to the patient and the family allowing them to to be heard, connect with you. When a patient is aware that they are dying, they ususaly know how they want to die and who they want with them.

FINAL HOURS OF LIFE

- For those living with serious life-threatening illness, recongnizing approaching death allows the patient, family, and care team to prepare for the actively dying phase. When a patient's death is imminent, nurses should have two overwhelming commimnets (Bakitas, Bishop, & Hahn, 2014).
- 1. Providing expert symptom management
- 2. Preparing the family for what to expect; as death is approaching.

FINAL HOURS OF LIFE

- Nurses are exposure to more death than any other healthcare professional. Nurses are in the role of an advocate, educator, professional, caregiver, companion, and support. Nurses are the facilitator to help dignify, provide comfort to the patient and the family.

- INTERPERSONAL COMPETENCE
- EMPATHY
- UNCONDITIONAL POSITIVE REGARD
- GENUINENESS
- ATTENTION TO DETAIL(Berry & Griffie, 2015)

Final hours of life

Final hours of life

- Patients can experience psychological and emotional issues during this time . They may express:
- A. Fear of the dying process
- B. Fear of abandonment
- C. Fear of the unknown
- D. Nearing death awareness
- E. Withdrawal.

Final hours of life

- Medications cab be used to control frequent symptoms that the patient may be experiencing. Some of those medication are

A. Morphine
B. Hydromorphone and oxycodone
C. Benzodiazepine for myoclonus
D. Methadone
E. Haloperidol, Clonazepam, or Lorazepam.
F. Anticholinergics and opiod for oral sections and improve dyspnea (Death rattle).
G. NitroglyerinBenzodiazepines and dipehnhydramine

,

Final hours of life

- Nurse need to learn how to coach families about the "Five Tasks" that serve as parting words.
- 1. To ask forgiveness
- 2. To forgive
- 3. To say "thank you"
- 4. To say " I love you"
- 5. To say goodbye

- Must also remember to honor cultural beliefs, traditions, rites and rituals.

Kolcaba's Theory of comfort

References

Dowd, T. (2006). Katherine Kolcaba Theory of comfort. In A. M. Toomey & M. R. Alligood (Eds.), *Nursing theorists and their work* (pp. 726-742). St. Louis, Missouri: Mosby Elsevier.

Drouin, C., Kolcaba, K., Tilton, C. (2006). Comfort theory a unifying framework to enhance the practice environment. *Journal of Nursing Administration,* 36(11), 538-543.

Kolcaba, K. Y., & Kolcaba, R. I. (1991). An Analysis of the Concept of Comfort. *Journal of Advanced Nursing, 16(3),* 1301-1310.

Kolcaba, K. (2008, October 15) Enhancing the patient experience. Retrieved from http://www.thecomfortline.com/patient_experience.html

Kolcaba, K. (2003, October 27) Taxonomic structure. Retrieved from http://www.thecomfortline.com/taxonomicstructure.html

Kolcaba, K. (2002, November 18) Conceptual framework for comfort theory. Retrieved from http://www.thecomfortline.com/conceptualframework.html

Appendix E Permission to Use the Frommelt Attitude Toward Care of the Dying Scale