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Evaluation of Impact of End-of-Life Nursing Education Consortium (ELNEC) Education on Registered Nurses

Debra Behr

Submitted as Partial Fulfillment for the Doctor of Nursing Practice degree

Regis University

August 24, 2014

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Abstract

Seniors make up the fastest growing population in the United States. This population, with their multiple, chronic, progressive, ultimately terminal health conditions, is driving an urgent need to embed the knowledge and skills required to provide high-quality end-of-life (EOL) or palliative care within the education for nurses (Kelley & Meier, 2010). Although nurses routinely provide most of the care to patients at or near their EOL, studies report they feel unprepared for the challenge (Barrere, & Durkin, 2013). Regulatory and accrediting bodies have designated competencies for palliative care in the undergraduate nursing curriculum (Grant, 2013). Studies suggest that the EOL care receives even less attention in continuing education course work (Gillan, van der Riet, & Jeong, 2014). The recognition of the need for a skilled cadre of nurses committed to providing high-quality care for dying individuals and their families has led to adoption of the End Of Life Education Consortium (ELNEC) course for a volunteer group of nurses at a three hospital acute care system in an urban metropolitan area. ELNEC is international, evidence based, comprehensive program that utilizes mixed educational modalities (Grant et al., 2013). This study validated the findings of earlier work that administration of and ELNEC one day course demonstrated a statistically significant improvement in a volunteer sample of 29 nurses' knowledge of palliative care. A limitation of this project is that it does not address nurses' practice change resulting from knowledge acquisition. The greatest implication of this study is that with administrative support, the course would be expanded through the health care system, and promoted at the state wide level in order to acquire a critical mass of nurses able to practice excellent palliative care nursing.

Key words: DNP capstone project, palliative care, EOL care

Executive Summary

Evaluation of Impact of End-of-Life Nursing Education Consortium (ELNEC) Education on Registered Nurses

Problem

"*Improving end-of-life care should be a national priority, not just from a cost perspective, but from a quality perspective, because we can do much better"* (Carlson, 2010, p.17). This quote captures the essence of this capstone challenge.

Purpose

The purpose of this practice project is to describe nurses' baseline knowledge of End-of-Life (EOL) care, and evaluate the impact of a nurse-facilitator led, End-of-Life Nursing Education Consortium (ELNEC) curriculum on improving nurses' knowledge of EOL nursing care.

Goal

The goal is to improve care for all patients at or near their EOL by improve nursing knowledge of EOL care. This organization will support the implementation of an evidenced-based course to fill this gap, thus meeting both the educational needs of the nurses, and the growing EOL care needs of the community.

Objective

1. Provide a one day, evidence based ELNEC course to increase nurse's knowledge of quality palliative care.
2. Administer a pre course assessment utilizing a valid tool to demonstrate baseline palliative care knowledge of participant nurses.
3. Administer a post course assessment utilizing the same valid tool to demonstrate knowledge acquisition of palliative nursing care.

Plan

The plan was to offer a one day ELNEC course to nurses in order to increase their knowledge of quality palliative care. Marketing of this educational offering was to nurses employed at each of the three hospitals in the system via email, flyers, and word of mouth.

Outcomes and Results

Twenty nine nurse participants completed both the pre- and post-intervention ELNEC-KAT assessment. A statistically significant improvement in mean knowledge scores was noted on the post-intervention assessment, suggesting that the educational intervention was successful in increasing nurses' knowledge of palliative care.

ACKNOWLEDGEMENTS

I would like to express my appreciation to my capstone chair, Dr. Lora Claywell, my clinical mentor, Dr. Deb Bennett-Woods, and each member of the Regis DNP faculty for their support and encouragement throughout this program. Thank-you to my DNP classmates, many of you have become friends, and I look forward to learning from you as you go forward as nursing leaders. My admiration and respect has grown for each of you. Many of these DNP courses were 'team sports', and I was on a winning team. I want to especially express my gratitude for my colleague and friend, Dr. Sharon Schultz--without her encouragement I would not have even attempted this daunting challenge, she helped me to realize this was an achievable goal.

I dedicate this project to my long deceased father-in-law, Herbert Behr and the nurses who provided care to him in his final moments. Without that experience, I might have been a different kind of nurse. The nurses who cared for Herbert demonstrated what true nursing care was. Their care for our little family taught me a better way to care for a patients and families in a time of crisis and loss, than focusing on cure or treating diseases. This was my introduction to family centered care, and I seek to create this experience for other families by passing this lesson on for the rest of my career.

I would also like to express my love and appreciation for my husband Mike, he has encouraged and supported me every step of this journey. Thank-you and love to my beloved children, my parents, dear siblings and dear friends who have cheered me on. We are all celebrating the end of this journey, and look forward to starting the next. I am looking forward to rejoining the world with all of you, and as we heard in our commencement helping to "make a good world better".

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Evaluation of Impact of End-of-Life Nursing Education Consortium (ELNEC) Education on Registered Nurses

With the aging population and increase in means to continue life, individuals are living longer with a mean life expectancy of 78.7 years (Stewart, Cutler & Rosen, 2013). As healthcare costs rise, technology continues to grow, and treatments continue to prolong life, nurses are challenged to consider palliative care needs for patients and families when it is most often considered for terminal illness, not for chronic management of conditions (Kuebler, 2012). Nurses are the most consistent healthcare provider at the inpatient bedside and, as such, they play an important role in end-of-life (EOL) care. The purpose of this capstone project was to evaluate the impact of a nurse-facilitator led quality improvement initiative in one acute care hospital system using the End-of- Life Nursing Education Consortium (ELNEC) program. Impact was measured using the ELNEC 50 question Knowledge Assessment Tool (ELNEC-KAT) (Appendix A) (Lange, Shea, Grossman, Wallace & Ferrell, 2009). ELNEC is the only palliative nursing curriculum offered in the United States (and globally) and is delivered in a train-the-trainer format. The curriculum is evidence-based and highly rigorous: reaching approximately 4,500 nurses every year for the purpose of helping their hospitals improve the dying of patients in critical care (Grant et al., 2013). Descriptive and inferential analysis will be performed to demonstrate impact of this project.

Problem Recognition and Definition

Statement of Purpose

Nurses in the acute care clinical setting play an essential role in the care of patients by having the potential to improve the experience of dying for the patients and their families. Many nurses report receiving little education in EOL or palliative care, either within their

undergraduate studies, or as continuing education. Nurses cannot practice what they do not know. Therefore, providing palliative care education to nurses is vital, so that they are prepared to assess and manage the complexities involved in the care of this population. In order to improve the care of patients at or near their EOL nurses must have the knowledge and the tools to effectively provide care (Gillan, van der Riet, & Jeong, 2014; Grant et al., 2013; Malloy et al., 2006; Schlairet, 2009; White, & Coyne, 2011; White, Coyne, & Patel, 2001). The purpose of this practice project is to describe nurses' baseline knowledge of EOL care, and evaluate the impact of a nurse-facilitator led, ELNEC, evidencd-based curriculum on improving nurses' knowledge of EOL nursing care. The project is not intended to create new and generalizable knowledge, but rather to address an issue discovered at one healthcare institution.

Problem Statement

Nursing education for EOL care is especially crucial for high-quality care of patients because nurses play a major role in supporting patients and their families toward the EOL by virtue of a 24-hour caring relationship. Nurses' knowledge, skills, and expertise are the keys to improved healthcare outcomes (Brooten & Youngfield, 2006). To improve patient care, it is necessary for nurses to be educated in EOL issues to help patients achieve a higher quality of life. In the United States, results from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (Connors, et al., 1995) project have resulted in the development and initiation of educational interventions for key healthcare providers, such as nurses.

Facilitating better care by eliciting patient choice may be an outcome of this educational intervention that results in lower costs to the institution and the patient by avoiding unnecessary care. More importantly, improving a patient's well-being until the EOL with coordinated

symptom support is an important aim of this nurse education project. The ultimate goal is to improve the nursing care for patients in all settings, and enhance the experience of family members witnessing the dying process of their loved ones.

The intention of the ELNEC international program is to provide EOL education in order to enhance palliative care and care of the patient with life limiting diagnosis. Topics include: ethical/legal issues; cultural considerations; communication; loss, grief and bereavement; and preparation for care at the time of death. Currently over 13, 250 nurses and other healthcare professionals in all US states have received ELNEC curriculum training (Ferrell, Dahlin, Campbell, Paice & Virani, 2007). Multiple initiatives now exist to support the pressing efforts in healthcare to reform care of the dying patient. Nurses in multiple settings are in ideal positions to augment critical decision-making at EOL that is truly patient-directed and supportive of patients' rights to self-determination. In guiding patients through EOL conversations, nurse expertise facilitates the assessment of the patient's sociocultural and spiritual beliefs about quality of life issues. By facilitating the communication, nurses assist the patient to make an informed decision about his or her own healthcare (Ferrell, Dahlin, Campbell, Paice, & Virani, 2007).

PICO

This research project was eligible for exempt review procedures as this project involves no more than minimal risk. This evidenced-based quality improvement fits one or more of the categories for exempt review procedures as specified in the regulations [45 CFR 46.110 and 21 CFR 56.110] , nor does it contain any of the elements identified as exclusionary for an exempt review according to the DHHS.

This project is an evidence-based practice (EBP) project in which a nurse facilitator led; End-of-Life Nursing Education Consortium (ELNEC) curriculum was offered in which a pre-test and post-test evaluation will be completed by participants. The project will be internal to an agency and inform the agency of issues in health care quality, cost, and satisfaction. The results from this project are not meant to generate new knowledge or be generalizable across settings but address a specific population, at a specific time, in a specific agency. These projects translate and apply the science of nursing to the health care field. EBP Projects utilize the acronym "PICO" rather than using a hypothesis. PICO stands for: P – Population or disease; I – Intervention or Issue of Interest; C – Comparison or Current Practice; and O – Outcome.

P RNs caring for adult patients in an acute care setting at or near their EOL

I Delivery of a one day ELNEC Course

C Compared to survey of baseline knowledge as measured by 50Q ELNEC KAT**O** RN's knowledge about caring for patients at EOL is increased as measured by self-assessment.

Project Significance, Scope, and Rationale

Improving EOL care is the practice issue this author addresses in this capstone project. Nurses are crucial in providing EOL care to patients and their families as they spend more time at the bedside caring for patients at the EOL than any other professional group. Studies report many nurses report they have received little or no education about EOL or palliative care (Ferrell, Virani, Paice, Coyle, & Coyne, 2010). Palliative care is defined as care focused on comfort and quality of life concerns across the trajectory of serious illness from diagnosis to end-of-life care (Brown, Whitney, & Duffy, 2013). In the United States, approximately 44% of deaths occur in hospitals, 25% in nursing homes, and only 25% at home each year (Grant, Wiench, Virani, & Uman, 2013). Studies demonstrate nurses feel unprepared to meet the special

challenges of patients and their families at or near their EOL (Malloy, Virani, Kelly, & Munévar, 2010). Improvement in EOL care will occur by offering nurses an evidence-based program aimed at improving nurses' ability to provide compassionate care to patients at or near their EOL. The ageing US 'baby boomer' generation is providing an additional sense of urgency to better address EOL care in the US. By 2030, non-communicable conditions are projected to account for more than three-quarters of all deaths, according to the World Health Organization (WHO, 2014). However, with longevity comes more complex diseases of ageing that are harder and more costly to manage. Growing numbers of people live with heart failure, for example, rather than dying of a heart attack. These factors combine to create a need for the organization to respond with a new process that addresses the educational needs of the nursing staff in order to meet the growing care needs for hospitalized patients for palliative care.

Based on these factors of an aging populace, increased chronic terminal diseases, and nurses unprepared to meet this demand, there is increased momentum in the U.S. to improve nurses' expertise in EOL nursing practice. Nurses will accomplish this goal via the ELNEC standardized, evidence based curriculum course. The ELNEC program was developed by nurse researchers at the City of Hope National Medical Center in collaboration with the American Association of Colleges of Nursing (AACN) to provide recommended competencies and curricular guidelines for evidence-based EOL nursing care (Ferrell, Dahlin, Campbell, Paice & Virani, 2007).

The intention of the international program is to provide EOL education in order to enhance palliative care and care of the patient with a life limiting diagnosis. Topics include: ethical/legal issues; cultural considerations; communication; loss, grief and bereavement; and preparation for care at the time of death. Multiple initiatives now exist to support the pressing

efforts in healthcare to reform care of the dying patient. Nurses in multiple settings are in ideal positions to augment critical decision-making at EOL that is truly patient-directed and supportive of the patient's right to self-determination. In guiding patients through EOL conversations, nurse expertise facilitates the assessment of the patient's sociocultural and spiritual beliefs about quality of life issues. By facilitating the communication, nurses assist the patient to make an nformed decision about his or her own healthcare (Ferrell, Dahlin, Campbell, Paice, & Virani, 2007).

Theoretical Foundation

Benner's Theory of Skill Acquisition and Role theory provides the theoretical framework for this DNP capstone project. The seminal work of Patricia Benner sought to explore the question of how nurses know what they know (Benner, 1984). Alternately described as both a philosophy and a theory, Benner described stages of knowledge development and skill acquisition in clinical nursing development. This theory will provide the framework for understanding the developmental level of the practicing nurse's ability to provide care to patients at or near their EOL. Use of Benner's (1984) conceptual model is an opportunity to bring theory and intuition to nursing practice. Benner (1982) described a model for nursing based on skill acquisition. This model was originally developed by Professors Hubert and Stuart Dreyfus to identify the nature of skill acquisition that airline pilots and chess players pass through as they develop expertise in their positions (Benner et al., 1996). In application to nursing, Benner discusses five levels of proficiency that nurses will navigate when developing their practice (Benner, 1984): novice, advanced beginner, competent, proficient, and expert. Development through these phases is dependent on a combination of depth and range of clinical experience, which positively compares to the length of time the bedside nurse, provides care in a given area. Research has demonstrated that nurses practicing in an acute care setting provide care to patients at or near

their EOL require more knowledge and skills to develop this area of clinical expertise (Ferrell, Dahlin, Campbell, Paice, & Virani, 2007). Not all nurses pass through each identified phase or reach a level of expert practice. The goal of this project is to work toward the nurses' ability to provide expert end-of-life care.

The other theoretical foundation of this research project is Kurt Lewin's 'change theory' (Burnes & Cooke, 2012). Lewin was one of the outstanding social scientists of his day and his achievements were numerous (Connelly, 2011). Elrod and Tippett (2002) provided robust evidence for the efficacy of Lewin's three-step model of change. Lewin considered Field theory, to be the foundation of all his work (Burnes & Cooke, 2012). The basis of the Field theory argument was that if one does not understand the current situation, the forces that are maintaining the current quasistationary equilibrium, one cannot even begin to bring about change (Burns & Cooke). Beyond that, field theory allows individuals and groups to explore, understand and learn about themselves and how they perceive the world and how those around them perceive it. For Lewin, this learning was only the start of the change process; it enabled the unfreezing of behavior and the creation of a willingness to change. However, in order to bring about change, one has to establish which forces to modify in the life space, and to judge what effect this would have. To achieve this, it is necessary to understand group dynamics, the second element in Lewin's planned approach to change. In its turn, this relies on a structured, participative and iterative process for identifying and analyzing the change options-- and then implementing the chosen change, in the case of this DNP project-improving EOL nursing care. The third phase of Lewin's model is the sustainment, or 'refreezing'. This element of planned change is important because it focuses not just on motivating and bringing about change, but also on sustaining it. As Lewin noted, change is "frequently short lived"; after a "shot in the arm,"

group life soon "returns to the previous level" (1951, p. 228). . The process of participative learning, which is fundamental to field theory, allows individuals and groups both to map out their current life space (their reality) and construct a new, more desired life space (reality). However, this can only be done if there is widespread participation, understanding and learning. This is why changes that are imposed or that only have superficial participation tend to bring only limited benefits – those who have to make the changes have only limited understanding of, and commitment to, what is being changed and why (Burnes & Cook, 2012). Lewin's field theory offered a holistic view of human behavior that focused on the entirety of a person or group's perceptual or psychological environment (Lewin, 1951).

The aspects of a holistic view of patients and their family, and participative experiential learning are both important components of the ELNEC education program. Each of the eight modules has moving film clips, numerous opportunities to break into small groups, and role play exercises. The ELNEC curriculum is based on adult learning principle and as such is highly interactive learning experience (Matzo, Sherman, Penn, & Ferrell, 2003). The ELNEC curriculum is revised regularly based on participant recommendations and advances in the field. The current revision includes eight modules (AACN, 2005). In addition to didactic content, each module also contains an extensive list of references, case studies, and supplemental resources, including teaching strategies in which poetry, role playing, small group work, reflective journaling and film are used to emphasize key points (Dobbine, 2011; Gillan, van der Riet, & Jeong, 2014).

Literature Selection and Scope of Evidence

The purpose of a literature review is to evaluate the current theoretical and scientific knowledge surrounding a particular issue, resulting in a synthesis of what is known and what

remains unknown (Polit, 2010). A search was made for literature from the period between 1990 and 2014 using Google Scholar, CINAHL, Pubmed and supplemented with a search for relevant systematic reviews from the Cochrane Library. According to Polit and Beck there is no consensus about what constitutes useable evidence for EBP, but there is a general agreement that findings from rigorous studies are paramount (2012, p. 462). Relevant search terms for this search were determined by initial wider reading on this topic based on an initial search of the literature, exploring relevant hits and keywords used in articles relevant to the problem this capstone project addressed. The systematic search employed the free-text terms alone and in combinations; nursing education, palliative care, end-of-life care, palliative care need and palliative care demand. As a supplementary search strategy references from the articles used in the initial search were screened. Titles and abstract were read and assessed by this author, and the full texts of potentially relevant abstracts. Themes that emerged from review of the literature related to: first definition of 'palliative care', the increasing demand for palliative care services driving a growing need for palliative care services. The literature identified nurses are not educated to deliver palliative care, and feel unprepared to meet the challenge to deliver palliative care in the acute care setting.

The concept of EOL or Palliative Care (PC) originated with hospice movement and was developed to assist patients at EOL and their families by offering psychological and spiritual support along with symptom management interventions (Kim, Kim, Yu, Kim, Park, Choi, & Jung, 2011). In the March 2013 issue of *Palliative Medicine*, authors Van Mechelen et al. perform a systematic review of medical literature searching for randomized controlled trials (RCTs) in "palliative care" and "terminal care" in hopes of discovering a common definition for palliative care. Van Mechelen et al. concluded that despite the working definitions of "palliative

care" proposed by the World Health Organization and others, palliative care RCTs lack precise (or even approximate) characterizations of what constitutes a "palliative care patient" (p. 198). They suggest that reasons for this include patient diversity, ambiguity of the word "palliative," and poor agreement around what type of illness needs palliative intervention. This lack of consensus contributes to hampered implementation of researched palliative care interventions across care settings (Van Mechelen et al., 2013). These elements include the patient's clinical status, and shape of care delivered. A better definition of a palliative care patient might be based on need for services, rather than underlying disease or prognosis. Palliative care is focuses on optimizing quality of life for the patient and their family, and on providing patients with relief from the symptoms such as; pain, shortness of breath, anxiety and stress related to a serious illness. Palliative care is best provided by a multidisciplinary team, composition varies depending on site of service, needs of patient family, and resources available. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment (Maciasz, 2013). According to the National Consensus Project for Quality Palliative Care (Kim, Kim, Yu, Kim, Park, Choi, & Jung) the domains of quality EOL care go beyond those defined by the WHO to encompass physical, social, spiritual needs of the patient within the context of their family, however they define family.

Three level four articles, using primary and secondary level data address the growing need for palliative care (Humphreys, 2013; Meier, 2012; Vitillo & Puchalski, 2014). Three retro and prospective chart review studies, evidence level six, were examined for evidence of rising demand and need for palliative care services (Grant et al., 2013; Kelley et al., 2014; Weissman & Meier, 2011). One quality improvement study, level six was used to provide evidence for

increase palliative care demand and need (Gomes & Higginson, 2008). The rising demand for palliative care is driving up the need for healthcare providers to meet this growing demand.

Multiple journal articles involving the work of researchers associated with the American Association of College of Nursing (AACN) were authored by leaders in international nursing palliative care education. These researchers have generated numerous studies describing nurses' lack of formal education in palliative care nursing, and their perceptions regarding their lack of preparedness to meet this rising demand. One qualitative study, level six, was used to provide evidence for the gap in nurses' preparedness to meet the growing palliative care need in the acute care setting (Malloy, Paice, Coyle, Coyne, Smith, & Ferrell, 2014). Three single descriptive studies, level six, were examined for evidence related educational gaps (Grant et al., 2013; Jackson & Motley 2014; Hennessy, Lown, Landzaat, & Porter-Williamson, 2013). Lastly three level three quasi-experimental studies examined the reliability and validity of the ELNEC-KAT (Lange & Mager, 2013; Head, Schapiro, & Faul, 2013; Lange, Shea, Grossman, Wallace, & Ferrell, 2009).

Absence of educational preparation in nursing curriculum and continuing education were identified in the literature. Two level three articles identified nurses feel unprepared to address palliative care needs at the bedside in (Brajtman, Fothergill-Bourbonnais, Casey, Alain, & Fiset, 2007; Scherer, Jezewski, Graves, Wu, & Bu, 2006;). To address this gap, the American Association of Colleges of Nursing and the City of Hope National Medical Center formed the ELNEC in February 2000 with initial funding from Robert Wood Johnson Center. The original nine module program was later revised into eight modules for nurses. Integrated throughout the modules are themes of family, culture, special population needs (e.g., children, the poor or

uninsured, older adults, veterans), the impact of EOL care on organizational systems, financial considerations and inter-professional collaboration.

Instruments to measure knowledge of EOL care in this broader context are few. Researchers revealed that most published instruments regarding EOL focus on patient-centered indicators such as depression, pain, quality of life, symptom distress, spirituality, and EOL legal issues. End-of-life instruments from the perspective of healthcare professionals most often rely on self-reported attitudes, death concern, program satisfaction, or feelings of comfort or self-efficacy toward providing EOL care. Self-report instruments are inherently prone to participant response bias and do not effectively measure knowledge attainment (Nunnally & Bernstein, 1994). Only two instruments that measure EOL care knowledge among nurses have published analysis of the tests' construction. The second of those was selected for this project as it was identified as more comprehensive. This test, the ELNEC-KAT was designed to evaluate participant mastery of the modules in the ELNEC program. The content domain was derived from the literature, and items were written by the ELNEC faculty according to a test plan (Lange, Shea, Grossman, Wallace, & Ferrell, 2009).

Multiple-choice tests designed to sample EOL content are less prone to participant opinion and can provide a more objective measure of achievement. Achievement tests are typically created using a process known as content validation (Nunnally & Bernstein, 1994). Content validation begins with identifying relevant domains of what is to be measure followed by a detailed test plan of items to measure each domain. Following administration of the test, item analysis (difficulty and discrimination indices or item-to-item correlations) and internal consistency estimates are calculated. The results provide evidence for the validity of a test with respect to its ability to measure students' mastery of the desired content.

Review of Evidence

Background of the Problem

End-of-life care and palliative care are relatively recent concepts, and the terms are often used synonymously. The WHO (2010) defines *palliative care* as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems (physical, psychosocial and spiritual). Ageing population coupled with advances in the treatment of chronic degenerative diseases is likely to lead to an increased demand for health professionals who are well educated in the knowledge and skills required to provide quality care to those diagnosed with a life limiting illness (Gardiner, Cobb, Gott, & Ingleton, 2011; Lloyd-Williams, Kennedy, Sixsmith, & Sixsmith, 2007; Hall, Petkova, Tsouros, Constantini, & Higginson, 2011). The changing nature of palliative care has also seen a rise in its demand. In particular, older people are more likely than younger people to die from cardiovascular diseases, stroke, some cancers (e.g. prostate cancer), and following neurological conditions, such as Parkinson's disease and dementias (Murray, & Boyd,2011). Data indicates that these conditions typically have a very different dying trajectory than cancer the disease for which models of palliative care were originally developed (Gardiner, Cobb, Gott, & Ingleton, 2011; Lloyd-Williams, Kennedy, Sixsmith, & Sixsmith, 2007; Hall, Petkova, Tsouros, Constantini, & Higginson, 2011). In response, palliative care has evolved to include a wide array of treatments and therapies, provided across diverse settings including acute care, intensive care, emergency services as well as hospice and home-based care. A growing demand for palliative care will require nurses educated in palliative care, beginning with undergraduate healthcare training (Gomes, Calanzani, Gysels, Hall, &

Higginson, 2013; Gome, & Higginson, 2008). According to Keating and Teed, "Growing social demand for skills in the provision of palliative care services places pressure on health professional courses to produce exemplary graduates" (2009, p. 5). Various authors have offered suggestions as to the content for palliative care training including: an understanding of the basic principles of palliative care, appropriate interventions, planning and assessment as well as an understanding of both the diversity and inter-professional team working of clinical specializations in the delivery of palliative care (Alsop, 2010). That being said, there continues to be a chasm between the need for palliative care and healthcare staff educated to deliver this level of care (Gillan, van der Riet, & Jeong, 2014). This work focuses on addressing that knowledge gap for nursing, however effective palliative care is very much a team sport, and all members of the healthcare team must be educated and competent to work together for the best outcome for the patient.

From the time of the landmark SUPPORT study (Connors et al., 1995) to the present time, research has documented deficiencies in palliative care, such as untreated pain and other symptoms; unmet needs for family care; inadequate communication; conflict among clinicians, patients, and their families; divergence of treatment goals from patient and family preferences; inefficient resource utilization; and clinician moral distress and burnout (Ho et al., 2011). For these reasons, the quality of palliative care has moved to the top of the priority list by important stakeholders, such as the Institute of Medicine (IOM), The Joint Commission, The Commission on Cancer of the American College of Surgeons, and the Critical Care Societies Collaborative—which is composed of the American Association of Critical-Care Nurses, the American College of Chest Physicians, the American Thoracic Society, and the Society of Critical Care Medicine—as well as national hospital and health care networks, the Veterans Health

Administration health care system, the Voluntary Hospitals of America, Inc., the Institute for Healthcare Improvement, and commercial insurers (Center to Advance Palliative Care, 2010; The Commission on Cancer, 2012; Fashoyin-Aje, Martinez, & Dy, 2012; Institute of Medicine, 1997; Joint Commission Resources, 2012; Nelson et al., 2006; Rosenfeld & Rasmussen, 2003).

By the year 2050, the number of Americans aged 65 and older will top 88.5 million, more than double the aged population in 2010. As baby boomers approach EOL, the demand for appropriate healthcare resources will expand. Since the publication of the IOM's landmark 1997 report, *Approaching Death: Improving Care at the End of Life*, the need for better communication between patients, families, and healthcare providers has been well documented (IOM, 1997). Failure to communicate EOL preferences has been associated with significant negative health outcomes, including care inconsistent with preferences, unwanted intensive interventions, and delayed referral to hospice, all leading to poor quality of life at EOL. Yet patients, families, and healthcare providers often avoid communication about difficult EOL decisions. Moreover, spending on health care at EOL continues to rise while quality of life for patients continues to decline, particularly for patients who receive aggressive care at EOL. This author's practice site is located "at the bleeding edge of healthcare reform, in an ageing, older community and a rapidly rising Medicare patient population" according to the CEO of this facility (G. Wicklund, personal communication, December 2013).

Systematic Review of the Literature

A literature review looks at the most important research in a particular area. It may or may not be systematic. A systematic review of literature yielded four themes related to this capstone project. The first is a definition of palliative care. Secondly, descriptions of the rising

demand for palliative care which is creating an increased need for excellent palliative care. Thirdly, nurses were found to have received inadequate palliative care education in either their nursing curriculums or continuing education opportunities. Lastly, an evidenced based evidenced-based palliative care education program was identified and utilized to narrow the educational gap and formed the basis of this capstone project intervention. (Refer to Appendix B for Systematic Review of the Literature).

Defining the term palliative care was the first challenge in the literature search. The term 'palliative care' was introduced in the early 1970s by Balflour Mount to describe care of patients living with a potentially life-limiting illness that focused on maximizing quality of life. Unlike hospice care from which it evolved, palliative care was not limited by prognosis or clinical setting of care (Lynch, Dahlin, Hultman, & Coakley, 2011). Hui et al., in an extensive review of this literature on this topic, identified that over the past few decades, numerous other terms have been used to describe this ever evolving entity, including "care of the dying," "terminal care," "end-of-life care," "continuing care," "total care," "holistic care," "comprehensive care," "comfort care," "pain and symptom management," and "quality-of-life care" (Hui et al., 2013, p. 672). More recently "supportive care" and "best supportive care" are gaining popularity, although some opinion leaders have called these terms euphemisms (Cheney, 2011). Palliative care leaders continue to argue for standardized definitions (Hui et al., 2012). According the WHO definition of palliative care is cited in the literature most frequently. The WHO defines palliative care as: an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems; including physical, psychosocial and spiritual (Vitillo & Puchalski, 2014).

The second theme that emerged as a result of an exploration of the literature was the growing demand for palliative care driving a growing need for nurses able to deliver palliative nursing care. Murtagh et al. (2013) in their descriptive study identified that between 2000 and 2030, the proportion of the world's population age 65 years and older is expected to increase from 6.9% to 12% largely due to improved public health, nutrition, and medical care. In the United States, the "old age" demographic is accelerating even more rapidly (estimated to increase from 12.9% to 20% between 2000 and 2030) as baby boomers enter their senior years (Murtagh et al.). Lacroix's (2013) expert opinion piece. Fried and Boyd's descriptive study (2012) described a population living increasingly longer with chronic, progressive and life-limiting conditions, which have altered death trajectories. These same researchers identified that expectation toward the healthcare systems' ability to meet needs is often heightened with an expectation for best practice approaches along the continuum and across settings, including hospice and palliative care where appropriate. Death is historically considered to be the worst possible outcome of illness by most patients and health care providers, and this belief leads to a desire for loved ones to receive every drug and treatment possible to prolong life (Barry & Edgman-Levitan, 2012). The care provided to people with advanced progressive and incurable illness is also increasingly in demand by educated healthcare consumers. Giovanni (2012) found that patients with non-cancer disease during the last month of life might benefit from a 'palliative approach', one that utilizes the principles of palliative care, but not necessarily the specialist staff. There are currently not enough Palliative Care Specialists such as specialty trained physicians and advanced practice nurses to meet the current demand let alone the growing demand. Patients with cancer often inevitably decline until death; however those with other chronic, progressive illnesses usually deteriorate slowly until an unpredictable exacerbation

changes prognosis or leads to death according to Cherny's descriptive study (2009). The progressive nature of these disease arcs enables patients and their families to plan for meeting their EOL health care needs in accordance with their own values and beliefs delivered by nurses educationally prepared to provide excellent palliative care (Grant et al., 2013).

The third theme addresses the nurses' lack of educational preparedness for palliative nursing care. There are multiple studies of nurses' end-of-life knowledge, attitudes, and skills indicating the need for more education of nurses (Malloy, Virani, Kelly & Munévar, 2010; Grant et al., 2013). Nurses are in a unique position to substantially contribute to the improvement of care because nurses spend more time with patients at the EOL than do any other health care professionals; they can readily identify the need for and facilitate the use of hospice and palliative care programs (Barrere & Durkin, 2013; Malloy, Virani, Kelly, & Munévar, 2010; Schlairet, 2009; White & Coyne, 2011). The IOM stated in its report *Approaching Death: Improving Care at the End of Life* that all patients with potentially fatal, advanced, chronic illnesses should receive competent care (Kuehn, 2010). Several studies have also demonstrated the lack of palliative care information in nursing texts, where only 2% of the books include content on end-of-life care (Ferrell, Virani, & Grant, 1999; Ferrell, Virani, Grant, Vallerand, & McCaffery, 2000). Nurses themselves have reported that key elements of end-of-life care were not covered in their undergraduate education. These key elements include such essential topics as how to talk to patients and families about dying, pain control techniques, and interventions to provide comfort at the EOL (White, Coyne, & Patel, 2001). In one survey of nurses, 89.5% stated that end-of-life content is important for basic nursing education, yet 62% rated their undergraduate preparation on these issues as inadequate (Ferrell et al., 2002). The extent and quality of continuing education is particularly important to ensure provision of the highest

known quality of patient care (White, Coyne, & White, 2012). In the case of palliative care, continuing education is inadequate. More education of care providers is needed, along with continued improvements in the way care is designed, implemented, measured, and reported, especially in intensive care units (ICUs) (Nelson, Mulkerin, Adams, & Pronovost, 2006). Additional studies have indicated that nurses do not feel competent or confident in implementing end-of-life care (Ferrell, Virani, Grant, Coyne, & Uman, 2000). The research literature also points us to interventions to narrow this knowledge gap.

The last theme explored in the literature was the identification and selection of an evidenced-based solution to close the palliative care nursing educational gap. The solution selected from the literature is the ELNEC course for this capstone intervention (Robinson, 2004). ELNEC is an educational program designed to improve EOL care by nurses, funded by the Robert Wood Johnson Foundation (Wallace et al., 2009). ELNEC teaching strategies include a range of interactive teaching methods including group discussion, cumulative loss exercises, case studies, storytelling, testimonials, poetry and pictures. ELNEC is a dynamic course updated as new research becomes available and is utilized internationally (Robinson, 2004). The ELNEC program can be adapted to meet the needs of undergraduate, post-graduate and as continuing education in a variety of clinical settings (critical care, pediatric, home settings, long term care) and has been validated as impactful (Sherman, Matzo, Rogers, McLaughlin, & Virani, 2002). There are a number of quantitative studies that sought to assess the effects of various experiential educational programs on EOL care. These studies include experimental studies (Hurtig & Stewin, 1990; Hutchison & Scherman, 1992) and quasi-experimental studies (Kwekkeboom et al., 2005; Mallory, 2003; Mooney, 2005). The lessons learned from these studies include that EOL education should involve a combination of both clinical experiences and didactic

approaches for a comprehensive EOL care learning experience (Gillan, van der Riet, & Jeong, 2013). Several researchers' efforts to integrate these methods into their programs are notable. Barrere et al. (2008), Dobbins (2011), and Weissman (2011) used quasi-experimental study designs, while Wallace et al. (2009) used a mixed methods approach to evaluate the impact of ELNEC education content on students' attitudes towards caring for dying patients. Researchers Gillan, van der Riet and Jeong (2013) performed an extensive search of the literature focused on two themes: Modes of EOL education delivery and EOL care educational initiatives. The gap identified is the lack of qualitative research on EOL care teaching strategies prompting a question as to how to effectively assess learning strategies for depth of learning experiences in EOL care education. The literature has highlighted that nursing students feel unprepared to deal with issues related to death and dying. These researchers also found that schools of nursing are not adequately educating nursing students to care for patients at the EOL and this has been identified as a crucial reason for inadequate care. The paper reviewed literature available to examine how EOL care education has been delivered to undergraduate nursing students and discussed the research on modes of delivery and teaching strategies utilized in EOL care education. Gillian, van der Riet and Jeong identified when implementing teaching strategies for EOL care education it is recommended that: 1) the characteristics and demographics of the cohort; and 2) the experience with death and dying (either personal or professional) need careful consideration. Because undergraduate nursing student cohorts across the world vary significantly in characteristics, a number of teaching strategies are required to provide a range of learning experiences that meet all learners' needs. ELNEC program is responsive to this recommendation and does utilize a wide variety of teaching methodologies in its course program (Benner, Sutphen, Leonard, & Day, 2010; Dobbins, 2011; Gillian, van der Riet, & Jeong, 2014).

The ELNEC program includes an assessment tool, the "ELNEC- KAT" which has been tested and found to be valid (Lange, Shea, Grossman, Wallace, & Ferrell, 2009). This is the tool utilized in this capstone work to demonstrate impact of knowledge acquisition.

Table 1: Literature Selection

Key Terms	Google Scholar	CINHAL	Chochrane	PubMed	Totals
ELNEC	1590	60	1	29	
Palliative Care Nurse	168000	2089	6	2788	
Palliative Care Education	104	3579	37	781	
Palliative Care Need	537000	1938	9	3322	
Palliative Care Demand	59100	362	39	917	
Articles Used					41

Project Plan and Evaluation

The project plan and evaluation covers the market and risk analyses which are the strengths, weaknesses, opportunities and threats (SWOT), as well as the driving and restraining forces. Also included are the needs assessment, resources and sustainability, feasibility, risks and unintended consequences for the project. The stakeholders and project team are introduced, and the mission, vision and goals are stated with the process and outcomes objectives and logic

model. In addition, the population and sampling parameters, setting and Evidence Based Practice (EBP) design and methodology and measurement are provided. The protection of human rights component was completed and included in the appendices. Finally, the instrumentation, intended statistics and data collection procedure are discussed.

Market/Risk Analyses: SWOT Analysis

A Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis has been completed related to this Capstone Project. The major strength of this project is system wide administrative backing. System backing from each of the CNO's from the three sites as well as a request from the professional nurses' practice committee validating they would like more education on end-of-life care. Another major strength is that the AACN has developed the ELNEC program and offers it in a train the trainer format. The Lutheran Foundation supported the training and education of this author to become an ELNEC trainer. Another strength of this project is that the AACN has published all materials, including audio-visual, interactive and mixed learning methods to support this program, and this is provided to the ELNEC trainers.

Weaknesses include time, both the instructor's and attendee's in terms of competing priorities. Another weakness was a limited ELNEC instructor pool for this first ELNEC course. This course is ideally taught from a multi-disciplinary format, palliative care is best delivered by a multidisciplinary team. Minimal time was available to market the ELNEC course, so the course was not filled to capacity. Nurses were not paid for their time to attend, nor is this course 'required' at this time, both of these conditions are barriers to class attendance.

Opportunities for improvement that were found in the SWOT analysis include: a) improved patient satisfaction with care, b) increased hospital reputation, increased nurses knowledge leading to skill development in delivery of palliative nursing care, d) increase quality

of life for patients/families, and increased and earlier palliative care consults. A lengthening of the time interval between death and the request for a palliative services consult is viewed as a sign of increased adoption of palliative care services by patients, families and healthcare team members (Hall, Petkova, Tsouros, Constantini, & Higginson, 2011).

Threats include patient and staff lack of understanding about what is palliative care. They may decline the level of care before they really understand what it is. The highly politicized public outcry by some of 'death panels' had fed the fear of EOL discussion and care, and this is also exacerbated by nurses confusion about what is palliative care (Flaskerud, 2011, p.720). Competing priorities for time are ongoing enemies of any initiative that requires staff time.

Figure 1: SWOT Analysis

Strength	**Weakness**
• Free to nurses • Supported by Exempla in terms of material, internal advertising, salaried instructor time • Evidenced-based program • Promotes collaboration • Addresses a demonstrated nursing educational need • Addresses a demonstrated patient and family need • May decrease health care expenses • Is in alignment with patient values and cultural beliefs • One day course • Nurse receive CEU's • All materials provided by sponsoring organization • ELNEC organization will mentor instructor	• At present, limited instructor pool • Nurses are not paid to attend • Lack of awareness about what is palliative care from clinical staff and patients and their families. • Primary instructor has never taught this course before • A lot of AV materials, always a risk of not working. • Short amount of time to advertise for the first course. • No internal mentors for ELNEC program
Opportunities	**Threats**
• Aging population in served community • Increase in chronic progressive terminal diseases of aging population • Lack of advanced directive for patients • Increased numbers of 'un-befriended' patients • More newer nurses entering market as 'more experienced ' nurses reach retirement • Public concerns about 'death squads' • Lack of knowledge about what is palliative	• Public concern over 'death squads' • Lack of knowledge about what is palliative care from both staff and the public • Currently no increased reimbursement as a part of the healthcare reform act • Partisan politics play role in EOL care reimbursement options • Best Practices not yet widely adopted by

care from staff and public • Currently no increased reimbursement as part of the healthcare reform act • Partisan politics play role in funding EOL care • Best practices not yet widely adopted in acute care setting • Website lists other ELNEC instructors in state.	acute care settings.

Driving/Restraining Forces

A driving force is patient need for increased palliative care services, staff identification of their educational gap, and administrative support. Increased marketing support can also help to create a sense of need or urgency on this topic and raise awareness. A flyer was developed and was emailed to nurses. The ELNEC-KAT 50 Question version is utilized as the pretest survey, inclusive of minimal demographic data (refer to Appendix C) , and without participant name was provided in the ELNEC course registration packet. This information was used to establish nurses' knowledge baseline of EOL nursing care. On the one hand this was baseline need for those attending, on the other some nurses may be adverse to an 'assessment'.

Potential restraining forces to this ELNEC program implementation were identified in a study in California in which ELNEC trainers completed a survey at six and twelve months and reported their successes in educating staff about EOL care utilizing this model (Grant,Wiencek, Virani, Uman, Munevar, Malloy & Ferrell, 2013). Their research identified the following barriers to full achievement of their goals; lack of time, lack of financial support, staff availability, and lack of administrative support. The most frequently cited barriers were negative attitudes and misinformation about palliative care by members of the multidisciplinary team.

Need, Resources, and Sustainability

Going forward, an educational needs assessment should be performed on at least on an annual and as needed basis to identify that palliative care education remains a priority for nurses. For purposes of this capstone project this author was able to validate the need for this palliative

care education based on role as Ethics Committee chair and critical care Clinical Practice specialist. The extensive literature review validated the need for nurses to receive this education as part of their continuing education program, based on patient needs and absence of this education in most nurses' pre-licensure educations (Schlairet, 2009). Patients and families have a need to receive palliative care due to their progressive, ultimately terminal, chronic diseases, associated with advancing age and prevalent in this community.

Resources to meet the need for palliative care education are primarily provided by the AACN to the ELNEC trainers. Additional resources include tools to market the ELNEC program, the printed materials for handouts, space to hold the class, audio visual equipment, and certified ELNEC trainers. This course is best taught by a multidisciplinary team, and palliative care is best delivered by a multidisciplinary team.

Sustainability of the project, does not just speak to keeping this particular project up and running. The rising demand for palliative care has gained momentum in light of national and international projections showing dramatic rises in numbers of deaths due to increased life expectancy and large cohorts of "baby-boomers". As chronic conditions are increasingly the leading causes of death, most people should expect a period of terminal illness to precede death. This lead time provides an opportunity for the patient and their family to be an active participant in decision making; nurses knowledgeable in palliative care are able to support their care goals and promote quality of life and symptom management.

A palliative care continuing education program is offered at a modest cost for the increased patient/family satisfaction, as well as the potential cost saving for patients who may prefer their symptom management to occur in the comfort and safety of their own homes. Palliative nursing care in the acute care setting will assist patients and families to receive the care

they prefer. Nurses will be better prepared to meet this growing demand if educated on palliative care. Palliative care is all about quality of life maintenance. Care is provided in accordance with patient and family wishes, this will create value and sustainability.

Feasibility/Risks/Unintended Consequences

Offering the ELNEC course on a regular basis is very feasible in this organization. Since the first one has been accomplished successfully there is now an infrastructure to support additional offerings to meet demand from nurses and administration. The research site organization supports educational offerings on a regular and reoccurring basis.

Risks are minimal. It is always a risk that there will be some topic deemed a higher priority that might 'bump' the ELNEC course from the nurses' educational agenda. This author does not identify any risk to participants related to attendance of this course going forward.

One unintended consequence that may occur, as a critical mass of nurses become educated in palliative care is an, increase in palliative care referrals. The rise in demand may exceed their ability to respond. The site of this capstone project has a small palliative care team, which does struggle to meet its current patient load. Another possible unintended consequence might be a decrease in hospital census. .If patients were better able to manage their symptoms in their home setting, and clarified their advance directives, which may not include hospitalization—this could result in a decrease in hospital admissions.. One more unintended consequence may be those patients spend more time in hospice, if they are better prepared to self-refer.

Stakeholders and Project Team

Stakeholders of this project include this DNP candidate, the nurses who will participate in the educational intervention and the patients and their families who will be the recipients of the care received at or near their EOL. The hospital organization is a primary stakeholder in this

project; they are committed to providing excellent care to patients and to meet their healthcare needs. Impact of this educational program will ultimately be reflected by the site's patients' satisfaction scores. The patient and their families are the primary stakeholders of this capstone project and the ultimate beneficiary of the educational initiative.

The project was led by this author as an outgrowth of the career-long passion for promoting quality EOL care. The project team also included my capstone chair, clinical mentor, and DNP classmate cohort for ongoing feedback. Other team members included additional ELNEC trainers within the organization who self-identified once this project became 'public' and asked to participate. Having a more diverse team strengthened this intervention, as palliative care is best delivered by a multidisciplinary team to insure patients and their family's needs are met (Campbell, 2006; Ferrell et al., 2007).

Cost-Benefit Analysis

Actual start-up costs of the ELNEC program were nominal for course offered. The main expense was the cost of printed material for students at $50/student. ELNEC course instructor fees were covered by the host site for this course; they would otherwise run $50/hour. There was a one-time cost of $1300 to attend the advanced ELNEC training to become a certified ELNEC trainer. The cost of the training was covered by a foundation grant. Future scheduled ELNEC courses will charge $150 dollars per day, as suggested by the AACN course developers. Support for the initial course was provided by the project host site. Refer to Appendix D for a more detailed report.

One of the barriers to palliative care in the acute care setting is the absence of reimbursement and the amount of time it takes. Approximately ninety million Americans are living with at least one chronic illness, and this number is expected to more than double over the next twenty-five

years with the aging of the baby boomers (Dobbins, 2011). This older population consumes the most hospital resources, experiences the longest hospitalizations of any demographic age group, and once admitted- these older patients are also most likely to die there (Vitillo, & Puchalski, 2014). This is another advantage of educating and promoting development of this expertise to the bedside nurse, they in turn can be more responsive to the patient needs as they spend the most time with the hospitalized patients. At present there are inadequate numbers of clinical staff with this education to meet the palliative care needs even at present levels (Meir, 2012).

One of the costs of not building a more comprehensive palliative care service is the high cost of healthcare dollars that are not contributing to an improved patient outcome. A sleeper provision of the Affordable Care Act (ACA) encourages greater use of shared decision making in health care. For many health situations in which there is not one clearly superior course of treatment, shared decision making can ensure that medical care better aligns with patients' preferences and values. One way to implement this approach is by using patient decision aids — written materials, videos, or interactive electronic presentations designed to inform patients and their families about care options; each option's outcomes, including benefits and possible side effects; the health care team's skills; and costs (Oshima, Lee & Emmanuel, 2013). Studies also illustrate the potential for wider adoption of shared decision making to reduce costs. Consistently, as many as 20% of patients who participate in shared decision making choose less invasive surgical options and more conservative treatment than do patients who do not use decision aids (Stacey, Bennett, & Barry, 2011). In 2008, the Lewin Group estimated that implementing shared decision making for just 11 procedures would yield more than $9 billion in savings nationally over ten years. In addition, a 2012 study by Group Health in Washington State showed that providing decision aids to patients eligible for hip and knee replacements

substantially reduced both surgery rates and costs — with up to 38% fewer surgeries and savings of 12 to 21% over six months (Arterburn et al., 2012). The myriad benefits of this approach argue for more rapid implementation of Section 3506 of the ACA. Unfortunately, implementation of ACA Section 3506 has been slow (Oshima, Lee & Emanuel). More rapid progress on this front would benefit patients and the health care system as a whole and would be facilitated by increased expertise of a palliative care by the practicing bedside nurse.

Mission/Vision

"*Improving end-of-life (EOL) care should be a national priority, not just from a cost perspective, but from a quality perspective, because we can do much better"* (Carlson, 2010, p.17). This quote captures the essence of the challenge. The vision of this author is "all patients deserve to have their EOL wishes known and honored." The mission is nurses are uniquely positioned to apply EOL research and best practice interventions to insure patient identify their EOL options, and receive excellent care based on their cultural values and beliefs.

Goals

The goal for this DNP Capstone project is to provide excellent end-of-life or palliative nursing care.

Project Process Objectives

Process objectives are about tactics, which are the actions needed to accomplish the goal. This capstone project sought to address the following objectives:

1. Provide a one day, evidence based ELNEC course to increase nurses' knowledge of quality palliative care.
2. Administer a pre course assessment utilizing a valid tool to demonstrate baseline palliative care knowledge of participant nurses.

3. Administer a post course assessment utilizing the same valid tool to demonstrate knowledge acquisition of palliative nursing care.

Outcomes Objectives

Outcome objectives identify a specific result, and are a basic tool that underlies all strategic activities.

1. Participant nurses' demonstrated increased knowledge of EOL or palliative care as measured on the ELNEC-KAT.
2. Knowledge acquisition post educational intervention was statistically significant.

Logic Model

The conceptual model for this capstone project, the logic model, is based upon the W.K. Kellogg Foundation's template (2001). The logic model is explained by the narrative description below and illustrated in Appendix E. The purpose of this model is to illustrate the relationship of key components of this project as a communication tool. The sections of the logic model include; Resources, Activities, Potential Outputs, Anticipated short and long term Outcomes and Ultimate Impact (Zaccagnini & White, 2011). Relevant inputs in the resource section lists a needs assessment and surveys of the participants in order to document a beginning point of reference to compare to the endpoint evaluations. Goals for this section include measure of impact of increased knowledge of palliative care nursing. The logic model does identify some longer term objectives in that patients may report an increase in satisfaction with EOL care, there may be an increase in palliative care referrals, and completion of advance directive documentation. Those are outside the scope of this capstone project, but are outcomes of quality palliative care.

Population/Sampling

This is a voluntary educational opportunity for nurses practicing in an acute care setting. A minimum of 26 participants was desired for this quality improvement nurse education project. A conveniance sample of RNs comprised a convenience sample population. Eligibilty to participate includes RNs employed by one of the three Denver Metro Exempla area acute care facilities in the adult acute care setting. Flyers were will be emailed to all nurses practicing in these areas utilizing the usual methods for making nurses aware of voluntary educational offerings, and will include information this ELNEC course is part of a research study. No remuneration was provided to nurses participating in this project, although participants will receive contact hours for attendance .

Determining the sample size in a quantitative research study is challenging (Polit, 2010). There are certain factors to consider, and there is no easy answer. Each experiment is different, with varying degrees of certainty and expectation. Typically, there are three factors, or variables, one must know about a given study, each with a certain numerical value. They are significance level, power and effect size. When these values are known, they are used with a table found in a statistician's manual or textbook or an online calculator to determine sample size. Significance level establishes the probability of the results occurring by chance alone. An alpha value of $p = .05$ was chosen as the significance level (alpha value). This means that the probability that the results found are due to chance alone is .05, or 5%, and 95% of the time a difference found between the control group and the experimental group will be statistically significant and due to the manipulation or treatment. Next, a power level of .8, or 80%, was chosen. This means that 80% of the time the experiment will detect a difference between the control and experimental groups if a difference actually exists. Thirdly the effect size was estimated. Generally, a moderate to large effect size of 0.5 or greater is acceptable for clinical research. This means that

the difference resulting from the manipulation, or treatment, would account for about one half of a standard deviation in the outcome. The sample size was calculated for this project, and a sample size of 26 would meet the minimum sample for this project. This sample size will enable the author to have confidence that the results are representative (Polit). According to the Central Limit Theorem the bigger the sample, the less the standard error expected (Cullen, 2012). The class size was 29.

Setting

The site of this capstone project is a 300 bed non-profit community hospital which serves an ageing population with concomitant increases of chronic, progressive, terminal diseases.

Design Methodology and Measurement

This quality improvement project will be conducted with one-group utilizing both a descriptive and inferential approach with a pre-posttest measure. This study seeks to report and compare changes in nurses' knowledge and attitudes following an ELNEC education course. Within subject pre-posttest comparison evaluation was used to examine the effectiveness of the educational intervention. Demographic data was used to provide descriptive detail. Range and average, including standard deviations will be reported. The level of measurement for the ELNEC curriculum and certain demographic variables will be nominal (e.g., experience working on palliative care unit/service, experience personal loss, formal EOL education). A t-test for dependent groups was used to detect any differences in means between the scores pre and post interventions.

Human Rights Protection

This DNP candidate's DNP capstone project was identified as an exempt study, as it will not involve members of vulnerable populations, data collection related to Federal Departments,

their employees, nor eligible beneficiaries; nor international studies. This project received approval from the Regis and project host site Institutional Review Boards (IRB).

This research used educational testing survey procedures. The information obtained was not recorded in such a manner that human subjects can be identified directly or through identifiers linked to the subjects, and no disclosures of the human subjects responses outside the research could reasonable place the subject at risk of criminal or civil liability or be damaging to the subjects financial standing, employability or reputation. In summary, the DNP student facilitating the educational intervention will strictly adhere to the nursing discipline code of ethics and ethical principles as well as established federal guidelines surrounding participant involvement in the study. See Appendices F, G, and H for the CITI certificate and IRB approval documentation.

Federal guidelines impacting the study include informed consent, self-determination, human rights and vulnerable populations (Cullen, 2012). Written consent is not necessary for the pre and post assessment survey during the study according to Terry, who states the 'Code of Federal Regulations does not require written consent for surveys unless the information that is collected is recorded in a manner that allows participants to be identified' (2011, p.54). Data collected in the pre and post assessments was anonymous with no associated identification for persons and will be used merely for needs assessment and outcomes measurements of individuals in the group. The worldwide agreement set forth in the Nuremberg Code (Cullen, 2012) mandates the DNP student facilitator will advise the participants that participation is optional, right to self-determination, and that any time during the discussion, their right to leave is preserved without prejudice or judgment. In addition, the participants will be reminded of their right to privacy, anonymity and confidentiality. The study is not directed to vulnerable

populations as defined by Cullen (2012) to include very old, disabled or institutionalized persons or pregnant women. The volunteer participants in the study population did not comprise any minor children or institutionalized persons. Participant information sheet was provided to subjects upon registration, and reviewed verbally during introduction portion of course (refer to Appendix I). Participants were also reminded at the end of the course, that completion of the ELNEC-KAT was voluntary; information would remain anonymous, and was being utilized in conjunction with DNP capstone project.

Instrumentation Reliability/Validity and Statistics

A pre-experimental, one group, pretest–posttest design was undertaken for the study. Within subject pre-posttest comparison evaluation was used to examine the effectiveness of the educational intervention. Demographic data was used to provide descriptive detail. Range and average, including standard deviations have been reported. The level of measurement for the ELNEC curriculum and certain demographic variable are nominal (e.g., experience working on palliative care unit/service, experience personal loss, formal EOL education). The t-test was used to detect any differences in means between the scores pre and post interventions.

The ELNEC 50 Question KAT has been evaluated and found to be valid. The overall internal consistency estimate exceeds the 0.80 standard of measurement (Lange, Shea, Grossman, Wallace, & Ferrell, 2009). According to the Spearman--Brown prophecy formula, adding items to attain a higher estimate will produce limited answers and are of little value in a test that is considered reliable (Lange et al.). Unless the results will be used to make important decisions about individuals, which were not the case in this project, there is little reason to strive for a higher reliability estimate than 0.80 (Polit & Lake, 2010).

Data Collection and Treatment Protocol

The educational intervention was a one day, one time, seven hour course, and the accompanying pre and post evaluations each took up to thirty minutes so was another hour. Upon participant arrival to the course they were greeted by this author and received a packet with the participant information sheet and the survey tool. The intervention began with introductions, a brief overview of the course, the study and the ELNEC-KAT. Participants were invited to review the participant information sheet and the DNP student facilitator read it out loud and explained each section. Next a thorough explanation of the survey tool was provided. Each participant had two identical surveys in their packet which were stapled together. One was labeled before and one labeled after. Prior to the actual educational intervention, participants were given time to fill out the survey labeled before and instructed to keep the surveys stapled together, not to put their names or any identifying information on the survey, and reminded that participation is completely voluntary. Upon completion of the thirty minutes for the baseline assessment the course began. After completion of the ELNEC educational intervention and ensuing discussion and question answering session, participants were given time to fill out the after survey, and reminded again that filling out the survey is completely voluntary.

Project Findings and Results

Objectives

The project findings and results are presented as they relate to the project process objectives and outcomes objective which are included again below for reference. The objectives were not linked to benchmarks for a similar intervention since no benchmarks were located in the literature.

Project Process Objectives

1. Provide a one day, evidence based ELNEC course to increase nurses' knowledge of quality palliative care.

2. Administer a pre course assessment utilizing a valid took to demonstrate baseline palliative care knowledge of participant nurses.
3. Administer a post course assessment utilizing the same valid tool to demonstrate knowledge acquisition of palliative nursing care.

Outcomes Objective

Participants report increased understanding of EOL care benefits related to Palliative Care and Hospice options for care as measured by the ELNEC-KAT.

Demographics

There were a total of 29 RN's employed at this acute care hospital system who voluntarily participated in this educational intervention on EOL care. Overall, 62% (n = 18) of RNs held a BSN degree. Twenty-four percent (n = 7) of participants held an associate's degree in nursing (ADN). Ten percent of participants held a master of science (MSN), and 3% (n= 1) held a diploma in nursing. Based on 18 valid demographic surveys, experience in clinical practice ranged from 1 to 36 years (mean = 17.9 years). None of the participants reported previous work experience on a designated palliative care unit or service. Ninety-five percent (n = 19) of the RNs reported previous personal experience with the death of someone close to them. Forty-three percent (n = 6 of 14) of nurses reported some type of previous EOL education, primarily delivered via a workplace in-service. Only two subjects reported prior attendance at any EOL education class. Based on 18 valid demographic surveys for the number of dying patients cared for in the past year, results ranged from 0 to 30, with an average of 3.71 (SD = 5.23) patients. Eighty-six percent of the participants (n=25) reported experience caring for a dying patient within the last year, the range was 0-30 patients with a mean of 6.83 (SD 7.85). Years of nursing practice experience ranged from 1-35 years, with the mean 15.10. Lastly, 83% (n=25) of participants reported prior personal experience with death.

Statistical Test

Statistical Software

Statistical analysis can be conducted using two main methods. One is simply by using a generalized spreadsheet or data management program such as MS Excel or through using a specialized statistical package such as SPSS (Palant, 2010). Both were utilized for this capstone project. Excel was used to organize the raw data into an electronic format, and SPSS 22.0 for the actual data analysis. In SPSS, a row represents one subject and a column denotes one variable. SPSS is specifically developed for analyzing statistical data and those offers a great range of methods, graphs, and charts. SPSS is designed to make certain that the output is kept separate from data itself. In fact, SPAA stores all results in a separate file that is different from the data (Palant). Even though Excel still offers a good way of data organization, using dedicated statistical analysis software like SPSS 22.0 is more suitable for in depth data

Effect

Determining the sample size in a quantitative research study is challenging (Polit, 2010). There are certain factors to consider, and there is no easy answer. Each experiment is different, with varying degrees of certainty and expectation. Typically, there are three factors, or variables, one must know about a given study, each with a certain numerical value. They are significance level, power and effect size. When these values are known, they are used with a table found in a statistician's manual or textbook or an online calculator to determine sample size. Significance level establishes the probability of the results occurring by chance alone. An alpha value of $p = .05$ was chosen as the significance level (alpha value). The probability that the results found are due to chance alone is .05, or 5%, and 95% of the time a difference found between the control group and the experimental group will be statistically significant and due to the manipulation or

treatment. Next, a power level of .8, or 80%, was chosen. This means that 80% of the time the experiment will detect a difference between the control and experimental groups if a difference actually exists. Thirdly the effect size was estimated. Generally, a moderate to large effect size of 0.5 or greater is acceptable for clinical research. The difference resulting from the manipulation, or treatment, would account for about one half of a standard deviation in the outcome. The sample size was calculated for this project, and a sample size of 26 would meet the minimum sample for this project. This sample size will enable the author to have confidence that the results are representative (Polit). According to the Central Limit Theorem the bigger the sample, the less the standard error expected (Cullen, 2012). The class size was 29.

Coding Data

The collected data is comprised of 58 documents, a pre and post ELNEC-KAT from each subject. The pre-course ELNEC assessment contains 6 demographic questions. The pre and post course surveys were numbered for purposes of matching the subject's pre and post course assessment. The following narrative describes the coding process. The hard copy documents were numbered 01-40. The ELNEC-KAT is comprised of 50 multiple choice questions with one correct answer per question. Following completion of the ELNEC course, the ELNEC-KAT results were scored, and results were entered into an Excel spreadsheet. Hard copies of the data were coded to insure anonymity**,** the data results could not be linked to the subject by this author. Responses were coded for entry into Excel, i.e. a 'no' response was entered as a 'one', a 'yes' as a two, 'a-b-c-d' responses were also entered as '1-2-3-4' respectively. Hard copies were secured, and the Excel spreadsheet was encrypted to secure the content. In a new SPSS data file, each document was given a participant number (01-29) which was entered in the first column of the Under the Variable View tab of SPSS, each of the six demographic questions and each of the 50

pre/post education questions were listed under Name in the first column, using Pre Q1.1 through Pre 1.50 and Post 1.1 through Post 1.50. The Type column for all variables is numeric, and ordinal is chosen for each variable for the Measure column. Next, under the Data View tab, the response (one through four) for each question was recorded under the participant number. The data entry was completed and readied for analysis.

Descriptive statistics (means and percentages) were computed to report the demographic variables of participants. Descriptive statistics were used to describe the variables collected as part of the demographic variables (nurse education level, years of experience, number of dying patients cared for in the past year, personal experience with death, and formalized EOL education). All analyses were conducted using SPSS version 22 (IBM Solutions, 2014) to assure the integrity of results, using a $p < .05$ as the level of statistical significance.

Project Findings

This DNP Capstone Project study used descriptive and inferential statistics to measure the impact of knowledge acquisition on the 29 subjects before and after the educational intervention. A six question survey was utilized to collect demographics information from subject prior to ELNEC course. These questions were part of the ELNEC-KAT survey (Appendix A). The level of knowledge acquisition was measured using the overall grand mean score on the ELNEC-KAT between the pre-course and post course scores (Grant et al, 2013).

Inferential Results

The question in this capstone quality improvement project was: “does use of the ELNEC course with RNs affect the RN’s score on the ELNEC KAT-50 assessment tool?” Using an alpha level of .05, a dependent-samples *t* test was conducted to evaluate whether RN’s subject knowledge of EOL care prior to the ELNEC educational intervention and the grand mean scores on the knowledge assessment of EOL score after the intervention, as displayed in Table 1. There

was a statistically significant difference in the scores for post ELNEC-KAT scores (M=.90, SD= .091) and prior to intervention (M= .81, SD= .123); t (50) = - 6.222, $p < .001$, $d = .09$. The 95% confidence interval for the mean difference between the two conditions was -.111 to .060, as displayed in Table 2. Results demonstrate the ELNEC education course does increase RN's knowledge of EOL, as measured by the ELNEC-KAT.

Figure 2. Comparison of Means Pre and Post ELNEC Intervention

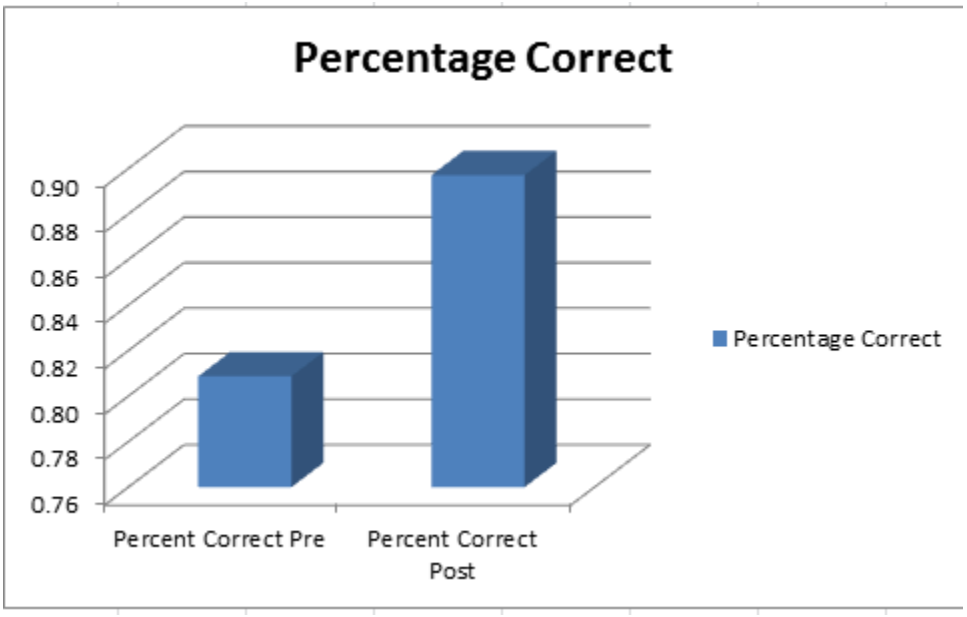

Figure 3: SPSS T-Test Results

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Percentage Pre	.81	51	.123	.017
	Percentage Post	.90	51	.091	.013

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Percentage Pre & Percentage Post	51	.593	.000

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Percentage Pre - Percentage Post	-.088	.101	.014	-.117	-.060	-6.262	50	.000

Interpretation and Application of Test Results

Discussion

The purpose of this project was to effectively implement the ELNEC standardized curriculum into a hospital environment and evaluate the impact on voluntary nurse participants. Findings indicate this intervention did result in a statistically significant change. Nurses demonstrated increased knowledge of EOL care. The nurses post intervention results on the ELNEC-KAT were demonstrated an increased knowledge of EOL care. Although the importance of quality EOL nursing care has been emphasized in the literature, studies have revealed that psychosocial care and support for families at patients' EOL have been insufficient to meet their needs and the growing demand (Grant et al., 2013; Kowal et al., 2012; Stewart, Cutler, & Rosen, 2013). Studies indicate lack of knowledge of EOL care is a barrier to deliver excellent EOL care by RNs (Scherer, Jezewski, Graves, Wu, & Bu, 2006). RN's report EOL care was not part of their primary nursing education, nor was EOL care offered as continuing education by their employer (Ferrell, Dahlin, Campbell, Paice, & Virani, 2007; Sadhu, Salins, &

Kamath, 2010). The ELNEC course curriculum includes education of the definition of palliative care; this is foundational to the nurses understanding of this emerging specialty. The ELNEC course materials are organized around eight modules of palliative care content; communication, cultural sensitivity, maintenance of quality of life, ethics and goal clarification are evident in each of these modules (Grant et al.; Kuebler, 2012). The ELNEC course content addresses these issues, and more, preparing the clinician to better meet the patient and family's EOL care needs (Grant et al., 2013).

Will this statistical significance of EOL knowledge acquisition be translated into practice changes at the bedside? That remains to be seen, however the nurses are unable to implement into practice what they do not know; so it is necessary, but not sufficient, to provide them with the needed information. Offering the ELNEC course to RNs is just one of the strategies needed to meet patients' and families' needs at or near the EOL. This capstone project demonstrated that the ELNEC course will serve as a useful tool, and deserves to be part of a larger strategy to meet patients EOL needs.

Limitations

First and foremost, this project was a quality improvement initiative in an acute care, community hospital system. It was intended to demonstrate impact or efficacy of an educational intervention designed to close a gap in nurses' knowledge of EOL care. The results are pertinent to this particular health care system. Limitations of this study include an absence of evaluation of change in practice. Another limitation is that a convenience sample was used, which limits the generalizability of the findings. No attempt was made to randomize the participants in this early-stage improvement project. While randomization is the gold standard for research, this was a quality improvement initiative, and as such a convenience sample was utilized. Thus, the

project design was descriptive, using within-subjects, pre-posttest measures. Limitations of this study include the sample size; a larger sample size would increase the power and generalizability of this study, decreasing risk of type I and II errors (Polit, 2010). A second limitation to generalization of this study to a larger population is selection effect (Polit, 2010), where preexisting similarities/differences threaten validity between group comparisons. More time to market the program would be expected to raise enrollment. The participants were a convenience sample all employed by one hospital system, it could be contended that the findings are less transferable to other populations. Another limitation was nurse's lack of familiarity with the 'ELNEC' course; participants who attended the course stated they knew it had something to do with 'end of life' care, but were not familiar with the course. Finally, another limitation was an initial absence of a strong multi-disciplinary ELNEC instructor pool, and this author's first time teaching the course.

Recommendations

Recommendations include future studies or inquiry. The design of this project would have been enhanced if there had been an ability to track the changes in the ELNEC-KAT scores over time such as at three months, six months and twelve months post course. Another recommendation would be to explore patient and family reaction to the impact of ELNEC on the nurses. Do the patients feel their EOL needs are being met? Is there an increase in the numbers of palliative care consults, earlier palliative care consults, and completions of advance directives?

Other recommendations to optimize impact of the ELNEC course would be to utilize the ELNEC organization web site and market the course to the entire city or state. The local, state and national chapters of professional nursing organization could form an alliance with ELNEC and offer the course as part of their ongoing continuing education courses. Work is being done

to move forward with this initiative. The course should be offered on a regular basis; at least twice annually to meet the request of the professional nurse shared governance and nursing administration. Another recommendation would be to require this course for nurses, and pay them to attend this course. This author would also like to see the course expanded to two days. Additional time would allow for more time to reflect on content, utilize more multi-modal educational options, and for interaction between instructors and participants. This course would be enhanced by simulation opportunity to give participant a chance to apply new knowledge and skills with coaching. Results of this study are being shared with organizational leadership from the senior suite to the professional nurses' practice committees and unit based councils. It will be necessary to promote the topic to insure there is sense urgency keep palliative care as a priority, constrained resources of time and financial resources are likely to be an ongoing limitation.

Implications for Change

A challenge remains to the healthcare organization to offer this course on a regular basis against competing priorities for the organization's funds for education, not to mention the nurse's time personally and professionally. Implications include the commitment by senior leadership to finance ongoing education for excellent EOL care, and the RN's awareness this is a gap in their practice knowledge. At this time when focus is on pay-for- performance metrics, scarce resources are focused on improving quality care for these performance metrics, such as prevention of hospital acquired conditions. On a larger scale, there is no metric attached to the provision of quality end-of-life care. The ability to demonstrate impact for the ELNEC intervention will aid in this challenge. This is an opportunity for DNP prepared nurse leaders to advocate for changes in priorities like palliative care.

Conclusion

On one hand there is an aging population leading to a rise in chronic, progressive, terminal diseases and an increase in means to continue life, and on the other hand there are nurses who state they are not prepared to address patients' and families' EOL needs. The ELNEC curriculum is an evidence-based intervention developed to address that need. The purpose of this capstone project was to evaluate the impact of a nurse-facilitator led quality improvement initiative using the ELNEC program and measuring impact with the ELNEC-KAT. There was a statistically significant difference in the mean scores representing RN knowledge acquisition of EOL care at baseline compared to post ELNEC intervention. A paired-samples t-test of dependent groups was conducted to measure difference in the baseline scores compared to the post intervention scores (pre: M=.81, SD=.123, post: M=.90, SD .091, t (50) = - 6.262, p < .001, d = .09, CI = (-.111 to .060). The findings on this capstone project will serve as a launch pad to improve the delivery of EOL care to patients in this researcher's healthcare community.

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Appendix A: Measurement Tool

End-of-Life Nursing Education Consortium (ELNEC) Knowledge Assessment Tool (KAT)
Pre/Post Assessment
50-item Version
(9/29/06)

Directions: DO NOT MARK ON THIS TEST BOOKLET. Enter all answers on the answer sheet provided. Each multiple choice item has one correct answer.

1. The nurse is developing the content for an interdisciplinary discussion on the concept of healing. Which of the following statements should be included?

   a. Healing is a medical outcome and is most appropriately directed by physicians.
   b. Healing can occur only after the client's spiritual issues have been resolved with a chaplain.
   c. Healing is possible if attention is paid to the multiple dimensions that influence a person's quality of life.
   d. Healing occurs when the patient and family realize and accept when cure is not possible.

2. The nurse is discussing aspects of suffering with the wife of a client. The client is dying from complications related to acquired immune deficiency syndrome (AIDS). Which of the following statements indicates that the nurse understands the concept of suffering?

   a. "Most people have multiple sources of suffering."
   b. "Suffering leads to finding a deeper meaning in life."
   c. "You will be able to determine what is causing your husband's suffering."
   d. "Your husband's suffering is related to the amount of pain he experiences."

3. The nurse is caring for a 48-year-old woman recently diagnosed with breast cancer. The client is married and has 3 small children. Which of the following is the best time to begin a spiritual assessment?

   a. when the patient enters the health care system
   b. after chemotherapy is initiated
   c. once the patient asks for spiritual support
   d. as soon as the client begins to deteriorate

4. The nurse is orienting a new staff member on a unit that cares for many patients at the end of life. Which of the following comments by the nurse correctly reflects a principle of palliative care?

   a. "We're busy because most people prefer to die in a hospital rather than at home where they would be a burden."

b. “Death and dying are not discussed much here in order to maintain hope for patients and families.”
c. “Because our patients often are uncomfortable, they need physical care more than psychological or spiritual care.”
d. “Patients are eligible for palliative care even though they are also receiving curative treatment.”

5. The nurse is rightfully concerned with the suffering that patients experience at the end of life. Which of the following statements is most accurate about suffering?

a. Suffering is a physical concept primarily concerned with pain and its prompt and continuous relief.
b. Suffering involves the whole person and transcends the bio-psycho-social-spiritual dimension.
c. Suffering is relatively easily recognized and interpreted by loved ones who know the patient well.
d. Suffering can be diminished for the patient if the staff continues to focus on curing the disease.

6. Mr. F has advanced prostate cancer with bone metastesis. He is unresponsive, and is being cared for at home by his daughter. The home health nurse is teaching the daughter about assessing her father’s pain. Which of the following statements by the daughter indicates understanding of her father’s pain status?

a. “If he is not moaning, he’s probably not experiencing pain.”
b. “I’ll have to guess when he is in pain since he can’t tell me.”
c. “Now that he’s unable to communicate, we can stop his pain medication.”
d. “Since he was in pain when he was conscious, I assume he’s still in pain.”

7. The nurse is talking with the parents of a 2-year-old boy diagnosed with leukemia about pain management. Which of the following statements by the nurse indicates understanding about pain management in children?

a. “He needs to be assessed carefully so that he gets enough pain medication.”
b. “He may require less analgesia since he has limited memory of the pain.”
c. “He is at risk for addiction due to his early exposure to pain medications.”
d. “He doesn’t have full pain sensitivity due to an underdeveloped nervous system.”

8. The nurse has attended a staff development conference on end-of-life pain management for clients who are substance abusers. Which of the following statements by the nurse indicates a correct understanding of pain management for these clients with a history of substance abuse?

a. "They should not be given opioids for pain because of the high addiction risk.”
b. "They will need smaller doses of analgesia to prevent cumulative overdose.”
c. "They may require higher does of opioids to relieve their pain."

d. "They need to withdraw from the substance prior to receiving analgesia."

9. The nurse's 68 year old patient is in the last hours of life after a lengthy illness. The patient has been receiving opioids for pain management. In assessing the patient as death approaches, the nurse knows that the opioid dose may need to be:

a. increased or decreased to maintain pain control
b. given only if requested by the patient
c. monitored as neuropathic pain increases as death approaches
d. discontinued due to diminished consciousness and altered mental state

10. The nurse is caring for Ms. P, a 55-year old woman with cancer. She received pain medication less than two hours ago after which she expressed significant relief. A colleague now reports that Mrs. P is complaining of pain. The colleague says "She *can't* be hurting as much as she says she is." What is the nurse's most appropriate response?

a. "Pain is whatever she says it is. Let's assess her further."
b. "We need to explore the cultural meaning pain has for her."
c. "I will tell her gently that she must wait four hours between doses."
d. "I'll wait to give the next dose and re-assess her a little early, in an hour."

11. The nurse is caring for the following four clients. Which of the following clients is at the highest risk for developing constipation?
a. A 48-year-old with metastatic cancer of the spine on high doses of opioids and has dehydration.
b. A 76-year-old with cancer of the bowel who has begun treatment for Clostridium difficile.
c. A 85-year old with hepatic encephalopathy who is receiving prescribed neomycin (Mycifradin) and lactulose.
d. A 90-year-old with uterine cancer and laboratory evidence of hypocalcemia and hyperkalemia.

12. The nurse is developing a plan of care for a client with terminal cancer who has a prescribed fentanyl (Duragesic) patch has started to take Dilaudid as a PRN medication. Which of the following goals would be essential to include in the client's plan of care?

a. Client will remain continent of urine and stool.
b. Client will have usual bowel pattern.
c. Client will not report dyspnea.
d. Client will not report fatigue.

13. The nurse is caring for a client who is in advanced stages of AIDS. The client is reporting fatigue. Which of the following assessment findings is commonly associated with the symptom of fatigue?

a. anorexia /cachexia
b. reduced serum calcium

c. hyperthyroidism
d. increased hemoglobin/hematocrit

14. The home health nurse is caring for a client at the end of life who has a recent history of constipation. The nurse should assess the client for which of the following indicators of fecal impaction?

a. foul smelling diarrhea
b. sudden onset of liquid stool
c. fatty looking stools
d. blood and mucous strands in stool

15. The nurse has been assigned to care for a woman who was recently admitted for advanced cancer, and who reports ongoing fatigue. Her husband offers observations about his wife's fatigue. Which of the following statements by the husband indicates the most correct understanding of his wife's fatigue?

a. "She sleeps quite a bit, so she shouldn't be as tired as she is."
b. "She's lost some weight. I know she'll feel better if she eats more."
c. "She's been in pain. If we control that maybe she'll have more energy."
d. "She seems moody, so we need to cheer her up and make her laugh."

16. An 84-year-old widow with diabetes and end-stage renal disease has been sent to the hospital from a nursing home. She has gangrene of the left foot with multiple, open infected wounds. Surgery is recommended, but the client does not want any invasive procedures. She wants to go back to the nursing home. She is alert, oriented, and has good decision-making capacity. Her children are emotionally distraught and pull the nurse aside to say, "We want the surgery. We want to do everything that can be done." What should the nurse do **first**?

a. Ensure the client and family understands the treatment options and risks.
b. Ask the hospital ethics committee to consider this case as soon as possible.
c. Offer to discuss the children's preferences with the physicians.
d. Encourage the children to talk their mother into having the surgery.

17. The hospice nurse is caring for a dying patient whose family disagrees with the patient's decisions about end-of-life care. Which of the following actions should the nurse take **first**?

a. Present the case to the agency's ethics committee for a resolution.
b. Ask the healthcare team to make decisions regarding end-of-life care.
c. Initiate a referral to social services and request a home visit.
d. Encourage the family and client to discuss the conflict.

18. Ethical issues abound in palliative care. Which of the following statements most accurately describes the nurse's role in role in addressing ethical issues in palliative care?

a. Consider patient decisions according to the nurse's own values and beliefs.
b. Help the patient/family understand all options and their consequences.
c. Refer patient care ethical issues to ethics experts within the health care system.
d. Determine when patients are no longer competent to make their own decisions.

19. The nurse can contribute to ethical practice in end-of-life care by doing all of the following **except:**

a. Working closely with physicians to meet the needs of patients and their families.
b. Ensuring that patients/families are aware of treatment options and consequences of those options.
c. Participate in creating systems of care that specifically meet end-of-life needs for patients and families.
d. Using personal values and morals to determine best courses of actions for patients and families.

20. The nurse is caring for a man hospitalized with advanced metastatic disease. He has declined further treatment, and he is aware that his disease may progress more rapidly. The patient is considered to have good decision-making capacity. Who should make the decision to terminate treatment for this patient, and what ethical principle is applicable?

a. The patient refuses treatment for himself according to the right to self-determination.
b. The physician decides to withdraw treatment based on the principle of medical futility.
c. The family declines further treatment, exerting their option to claim surrogacy or proxy.
d. The executive board determines the patient's competence and applies hospital policies.

21. The nurse is caring for a client from Cambodia who has terminal lung cancer. The client is reluctant to discuss the illness. Which of the following actions should the nurse take?

a. Remind the client that it is important to talk about the illness.
b. Allow the client to remain in denial by not discussing the cancer.
c. Ask the family about their beliefs regarding full disclosure.
d. Refer the client to a mental health professional for evaluation.

22. The nurse is teaching a nursing student how to perform a cultural assessment for patients at the end of life. Which of the following statements indicates a correct understanding by the student?

a. "The best strategy for evaluating sexual orientation is to ask clients if they are heterosexual or homosexual."
b. "To assess spirituality, questions regarding religious affiliation and religious practices are generally sufficient."
c. "Financial status is an invasive question and should be asked by the social worker."

d. “Ethnic identity varies within ethnic groups, so ask clients how strongly they identify with a particular group.”

23. The nurse is orienting to palliative care, and is identifying necessary learning activities. In order to provide culturally sensitive care to those at the end of life, one of the nurse’s earliest orientation tasks should be to:

a. evaluate the cultural beliefs of co-workers
b. identify one’s own cultural background and values
c. learn to predict how various races deal with end-of-life issues
d. become informed about state laws concerning end-of-life care

24. In palliative care, the nurse cares for people of many cultures. When conversing with persons of another culture, the nurse should:

a. use the patient’s first name to establish warm rapport
b. determine who makes decisions for the patient and family
c. speak primarily to the translator rather than the patient or family
d. act as if the patient is fully informed of the diagnosis and prognosis

25. The nurse is part of a collaborative team providing end-of-life care. Which remark by another team member indicates the best understanding of culturally sensitive end-of-life care?

a. “I ask the patient who he wants to include in conversations about his illness.”
b. “I hold the patient’s hand and get physically close to her to show I care.”
c. “I can predict how members of a particular ethnic group will respond to pain.”
d. “I feel it’s our obligation to tell a patient bad news, even if the family objects."

26. Nurses are concerned with religion and spirituality of patients in palliative care. Which of the following questions is the LEAST appropriate during a spiritual assessment?

a. “What church do you attend?”
b. “Are spiritual beliefs important in your life?"
c. “What aspect of your faith gives your life most meaning?”
d. “How would you like me to address spirituality in your care?”

27. The nurse is being oriented to palliative care. Which of the following factors should the nurse identify as a crucial requirement to quality end-of-life care?

a. maintaining cost-effective analgesic regimens
b. restricting care to symptom management algorithms
c. communicating effectively with clients and families
d. employing volunteers to ensure clients are not alone

28. The nurse is preparing a staff development conference on adaptive and maladaptive mechanisms clients and families use when dealing with the diagnosis of a life-threatening

illness. Which of the following should the nurse use as an example of an adaptive behavior?

a. use of humor as a means to reduce stress
b. expressions of guilt by either patient or family
c. a patient or family member exhibiting depression
d. use of denial over a prolonged period of time

29. The nurse is caring for a man with advanced prostate cancer. He has been told that his therapy is not working. He asks the nurse, "*Why* is this happening to me?" What is the nurse's most appropriate response?

a. "I don't know. I wish I had an answer for you, but I don't."
b. "Perhaps you're being tested and this will make you a stronger person."
c. "I'll ask the doctor to more fully explain the disease process."
d. "If I were you, I'd explore additional therapies and treatment options."

30. The nurse is facilitating a staff discussion about myths and realities of communication in palliative care. Which of the following is a correct statement about communication?

a. We can never give someone too much information.
b. We communicate only when we choose to communicate.
c. The majority of messages we send are non-verbal.
d. Communication is primarily words and their meanings.

31. Clients and families facing life-threatening illness expect that communication between themselves and a health care professional will include all of the following **except**:

a. the professional will be honest/truthful in all communications
b. the professional will discuss the client's care with the health care team
c. the professional will decide what client issues need to be addressed first
d. the professional will be available to listen to a client's concerns

32. An 85-year-old client with end-stage heart disease arrives unconscious at the emergency department after sustaining her third myocardial infarction. The physician has told the daughter that without resuscitation, her mother could die today. The nurse finds the daughter crying by the client's bedside. Which of the following interventions by the nurse is most appropriate in communicating with this family member?

a. ask the daughter if she would like to reconsider treatment
b. talk to the physician about moving the client to a unit with more privacy
c. remain present with the daughter, using silence to impart comfort
d. assure the daughter that she doesn't need to stay with her mother

33. The hospice nurse is caring for the family of a man who died several days ago after a long illness. His wife is concerned that their 9 year old son has become withdrawn and is easily angered. Which of the following actions is most appropriate for the nurse?

    a. Recommend the boy be referred to a specialist for complicated grief reaction.
    b. Suggest to the mother that the boy be excused from his usual activities.
    c. Give permission and opportunities for the boy to express feelings of loss.
    d. Provide information about death to the boy by telling stories rather than giving facts.

34. The new nurse is caring for a number of patients and family members who are facing loss or death. In speaking with them about grief, the nurse correctly conveys that grief:

    a. is an orderly process with predictable stages of work to be done
    b. begins before a loss or death, as people consider a pending loss
    c. lasts a year or less, at which time survivors should be able to move on
    d. includes personal feelings that are universal and understood by everyone

35. The nurse is talking with colleagues about the emotional challenges of working with dying patients and their families. The nurse identifies all of the following as appropriate responses to staff grief **except**:

    a. helping plan a unit ceremony to honor all patients who have died recently.
    b. seeking the support of a trusted colleague who has had similar experiences.
    c. recognizing that personal grief should not be expressed by the nurse.
    d. consulting with a pastoral care worker or spiritual advisor for assistance.

36. The nurse is caring for a 55-year-old female client with metastatic breast cancer. During a home visit, the nurse finds the client's 22-year-old daughter weeping at the kitchen table. The daughter explains that she just realized that her mother will not be alive when she gets married or has children of her own. Recognizing anticipatory grief in the young woman, the best nursing intervention is:

    a. educate about signs and symptoms of disease progression
    b. foster hope by stressing that prognosis is difficult to predict
    c. provide therapeutic presence and practice active listening
    d. advise the daughter to focus more on the present than the future

37. The wife of a recently deceased patients states: "Last night I thought I heard him say ‘Good night, Honey’ just like he always did. Do you think I am going crazy?" The most helpful response by the nurse will be:

    a. "You might want some extra support accepting your husband's death. I'll have the doctor make a referral to a psychologist."
    b. "Many persons have similar experiences of seeing or hearing the one who has died. You must miss him saying 'good night'."

c. "Many persons believe in ghosts or spirits who visit their loved ones. Do you believe in ghosts or spirits?"
d. "That must be frightening for you. Do you have a friend or relative who can stay with you so that you are not alone?"

38. The nurse is orienting new staff to a clinical unit that provides palliative care. A new employee asks what "grief" is exactly. The nurse correctly defines grief as:

a. the emotional response to a loss
b. the outward, social expression of a loss
c. the depression felt after a loss
d. the loss of a possession or loved one

39. The emergency department nurse is speaking with the sister of a male client who died after suffering fatal injuries in a car accident. In order to plan for bereavement follow-up for the client's family, it is important that the nurse assess all of the following **except**:

a. family support systems
b. spiritual belief systems
c. concurrent stressors
d. advanced directives

40. The nurse is caring for a man who is imminently dying. During morning care, the man asks the nurse if he is dying. An example of the best response for the nurse to give is:

a. "Yes. I suppose you've known this all along. I promise I'll be right with you all the way."
b. "Not today. Why don't we look at some of the things you would like to accomplish now?"
c. "Yes. Tell me about any concerns, fears, or questions you have about what will happen."
d. "Why do you ask that? You look like you feel so much better today than you did yesterday!"

41. The nurse has been caring for a Latino client with advanced obstructive lung disease for the past several weeks. The client's family has been at the bedside daily, with one member spending the night throughout the client's hospital stay. In assessing cultural beliefs and practices related to death and dying for the client and family, it is necessary that the nurse should take into consideration all of the following factors **except**:

a. how long the client has been in this country
b. the age of the client and family members
c. aspects of spirituality, traditions, rites and rituals
d. specific beliefs about pain, suffering and death

42. The nurse is caring for a patient who has just died. In caring for the body after death, the goal of care is to:

    a. make sure the body is sent to the morgue within an hour after death
    b. have the family members participate in the bathing and dressing the deceased
    c. notify all family members and team members regarding the patient's death
    d. provide a clean, peaceful impression of the deceased for the family

43. The parents of a terminally ill 7 month old child are at the bedside when the child dies. The nurse supports the family's initial grief reactions by initiating all of the following interventions **except**:

    a. encourage the parents to hold the child
    b. support inclusion of siblings in death rituals
    c. wrap the child securely in a blanket
    d. avoid remarks regarding the child’s life

44. The nurse may experience feelings of anxiety and grief when caring for clients and families facing death and the dying process. In order for the nurse to be able to continue to provide quality care, it is important to obtain personal support by:

    a. seeking out the assistance of team members whenever necessary
    b. periodic transfer to another unit to avoid caring for dying patients
    c. maintaining an emotional distance from clients and families
    d. scheduling counseling at regular intervals to deal with loss issues

45. In order to improve the quality of end-of-life care in the clinical environment, the nurse should do all of the following **except**:

    a. strive to make transfers of clients less frequent and less disruptive
    b. create standardized protocols and measures for this population
    c. ensure continuity of care across time and provider settings
    d. delay referral to hospice to maintain the patient's primary care

46. The nurse is caring for a terminally ill client who wishes to be discharged so that he can die at home. When planning for the discharge of this client with the interdisciplinary team, it is important to consider costs of care. The nurse understands that for a family caring for a dying patient at home:

    a. costs of care can exhaust a family's financial resources
    b. Medicare will cover all the older client's medical expenses
    c. services are readily available to allow the client to stay at home
    d. Medicaid will be the primary provider of services

47. The nurse who wants to make changes in the health care system in end of life care realizes that it is important to:

a. become knowledgeable with system shortcomings in order to develop commitment to change
b. concentrate on care that focuses on life-prolonging therapies rather than those that shorten life expectancy
c. ask management to identify the primary aim of end-of-life care for the patient care team to implement
d. realize that efforts towards system change are not in the scope of nursing practice

48. Change in the health care system begins on the clinical unit. In order to improve end-of-life care within an agency, the nurse should do all of the following **except**:

a. develop outcome measures for improved end-of-life care against which to measure progress
b. ask physicians, as health team leaders, to direct the end-of-life care team and make system improvements
c. be conscious of end-of-life care financial costs and treatment burdens on patients and families
d. focus on quality end-of-life care so that death is a positive outcome rather than a treatment failure

49. As a way of improving end-of-life care, Americans for Better Care of the Dying suggests making "seven promises" to those needing end-of-life care. These promises include all of the following **except**:

a. Health professionals will determine care priorities, sparing the patient and family from care decisions.
b. The health care team will do all they can to make sure the patient and family make the best of every day.
c. The patient and family will be prepared for everything that is likely to happen in the course of the illness.
d. Patient and family wishes concerning care will be sought and respected, and followed whenever possible.

50. An effective way to accelerate improvement of end-of-life care services is by utilizing rapid cycle quality improvement. The fundamental questions that need to be addressed include all of the following **except**:

a. What are we trying to accomplish?
b. How will we know that a change is an improvement?
c. How many changes can we implement in the first year?
d. What changes can we make that will result in improvement?

End of Assessment. Thank you for participating in this important evaluation project!

Appendix B: Systematic Review of Literature

Article/Journal	Peaceful death: Recommended competencies and curricular guidelines for end-of-life nursing care.	Collaborative working in end-of-life care: developing a guide for health and social care professionals/*International Journal of Palliative Nursing*
Author/Year	American Association of Colleges of Nursing (AACN). (2005).	Alsop, A. (2010).
Database/ Keywords	CINHAL, Google Scholar/ EOL, palliative care, ELNEC, nursing education	CINHAL, Google Scholar/ EOL, palliative care, ELNEC, nursing education, collaborative
Research Design	Descriptive study, analysis and overview	Exploratory, retrospective, descriptive
Level of Evidence	VI	VI
Study Aim/Purpose	Identify key competencies for undergraduate curricula	Examine and describe interventions and care provided by multidisciplinary team
Population/ Sample size Criteria/ Power	Response from survey to university programs and input from content leader review. 47 survey respondents	Series of 6 focus groups with palliative care nurse specialist and SW to review literature. Focus group size ganged from 6-13.
Methods/ Study Appraisal Synthesis Methods	Selected content competencies recommend best practice for core curriculum on EOL care	This article describes a project to develop collaborative working between palliative CNS and community SW for patients with a non-cancer diagnosis. Designed to identify models of effective, replicable end-of-life care provision for patients with a non-cancer diagnosis, and to widen access to specialist palliative care.
Primary Outcome Measures/	Nursing curriculum will adopt these competencies as part of their	Pathways to clarify decision-making in end-

Results	curricula	of-life care were created as part of the project and were subsequently developed into a guide for use by health or social care professionals caring for any patient, irrespective of diagnosis.
Conclusions/ Implications	Nursing schools were in large part missing this content historically. This will help them to identify the needed content	Palliative care specialist will increase access to patients using guidelines or algorithms. The guide is designed to facilitate best practice in end-of-life care, by identifying the key questions which need to be addressed and the appropriate responses at different stages of the patient journey.
Strengths/ Limitations	Beneficial to have EB content, increase likelihood of adoption. Limitation... potential lack of buy in as schools not part of process. Limited time resource	Double blinded peer reviewed , Identified best practices
Funding Source	None noted	St. James Place Foundation
Comments		VG tables and charts and algorithms

Article/Journal	Finding the right words: the experience of new nurses after ELNEC education integration into a BSN curriculum/ *Medsurg Nursing: Official journal of the Academy of Medical-Surgical Nurses*	Providing direction for change: Assessing Canadian nursing students' learning needs/ *International Journal of Palliative Nursing*
Author/Year	Barrere, C., & Durkin, A. (2013).	Brajtman, S., Fothergill-Bourbonnais, F., Casey, A., Alain, D., & Fiset, V. (2007).
Database/ Keywords	CINHAL, Google Scholar/ ELNEC, EOL care, nursing education	CINHAL, Google Scholar/ ELNEC, EOL care, nursing education, assess learning needs
Research Design	Phenomenological study	Quantitative, quasi

		experimental
Level of Evidence	IV	III
Study Aim/Purpose	Lived experiences of recent nursing graduates who received ELNEC education in their nursing programs and who cared for a dying patient within the first year of clinical practice were explored.	Develop, implement and Demonstrate impact of ELNEC course
Population/ Sample size Criteria/ Power	12 recent nursing schools BSN graduates w 1 yr experience. NYC public University w student from 147 countries	27 colleges, 659 students, took a minimum of 4/8 modules
Methods/ Study Appraisal Synthesis Methods	Open ended semi-Structured interviews	Cross sectional and longitudinal designs, plus lit search
Primary Outcome Measures/ Results	Nurses developed strategies to address these challenging encounters. Their narrative was shared and themes identified.	Significant outcomes in 6 metrics demonstrated
Conclusions/ Implications	Findings offer helpful insight into how new graduates utilize ELNEC education concepts in clinical practice. Facilitating, a good death, intrinsic rewards, learning through impressionable experiences	Major step forward in EOL care education for nurses at all levels of education
Strengths/ Limitations	Transformative learning theory used. Used ELNEC,	Inception of ELNEC,
Funding Source	None noted	RWJ
Comments	Of interest to NG and educators	4 assessment tools used

Article/Journal	The Voice of Nurse Educators In US Schools of Nursing on EOL Pedagogy: A Survey// In *Sigma Theta Tau International's 22nd International Nursing Research Congress*.	End-of-life education in undergraduate nursing curricula/DCCN
Author/Year	Todaro-Franceschi, V. (2011, July).	Robinson, R. (2004).
Database/ Keywords	CINHAL/EOL care, nurses	CINHAL, Google Scholar/ ELNEC, EOL care, nursing education
Research Design	An exploratory descriptive approach was used, and a survey was created expressly for this study	descriptive approach with a pre-posttest measure to report and compare changes in death anxiety and communication apprehension

Level of Evidence	IV	VI
Study Aim/Purpose	A study was undertaken to explore whether alumni (*N* = 154) from years 2001 to 2007 at our school of nursing perceive that the end-of-life (EOL) undergraduate education they received (a) prepared them to provide quality care to the dying and their loved ones and (b) contributed to changes in their way of being in the world.	Evaluate the impact of a nurse-facilitator led QI initiative in 1 hospital using the (ELNEC) communication Module 6
Population/ Sample size Criteria/ Power	Generic and RN/BSN graduates from years 2001 to 2007 (*n* = 520)	Convenience sample n=20
Methods/ Study Appraisal Synthesis Methods	Curriculum changes took place in two key ways: creation of an elective offering and ELNEC integration in the generic program. Survey followed completion with quantitative and qualitative components	nurse attitudes regarding death anxiety (using the Revised Death Anxiety Scale [DAS-R]) and communication apprehension (using the Communication Apprehension with Dying [CA-Dying] scale) were evaluated pre and post education
Primary Outcome Measures/ Results	Survey results, and comparison of responses to those not taking the ELNEC course.	Descriptive approach was selected because little research has been centered on the role of the RN relative to advocacy communication for patient choice; measured by the DAS-R and CA-Dying scales.
Conclusions/ Implications	large effect size, over one standard deviation difference in the means of the two groups, those who took the elective vs. those who did not	Nurses who cared for more dying patients/ year, had a statistically significant lower CA-Dying score. Experiential learning and reflection are central to creating a culture of innovation, improvement and effectiveness
Strengths/	Personal attitudes, beliefs, values, and past	Demonstrated stat sig

Limitations	experiences with death and dying will contribute to one's willingness to teach and to be taught EOL care.	impact, small sample size and single site
Funding Source	STTI grant	None noted
Comments	Very useful study for this capstone.	So far---most similar to my own project

Article/Journal	Outcomes following acute exacerbation of severe COPD. The SUPPORT investigators / *American Journal of Respiratory and Critical Care Medicine*	ELNEC training program: Improving palliative care in critical care/*Critical Care Nurse Quarterly,*
Author/Year	Connors Jr, A. F., Dawson, N. V., Thomas, C., Harrell Jr, F. E., Desbiens, N., Fulkerson, W. J., ... & Knaus, W. A. (1996).	Ferrell, B., Dahlin, C., Campbell, M., Paice, J. & Virani, R. (2007).
Database/ Keywords	Google Scholar, CINHAL/EOL, palliative care,	CINHAL, Google Scholar/ ELNEC, EOL care, nursing education
Research Design	Prospective longitudinal study	Quasi experimental pre-post test
Level of Evidence	III	IV
Study Aim/Purpose	Describe the outcomes of patients hospitalized with an acute exacerbation of severe chronic obstructive pulmonary disease (COPD) and determine the relationship between patient characteristics and length of survival	Demonstrate impact of ELNEC course on Critical Care nurse specifically
Population/ Sample size Criteria/ Power	1,016 adult, 5 hospitals - admitted with an exacerbation of COPD and a PaCO2 of 50 mm Hg or more.	Fifty-seven nurses attended, representing 17 states within the United States (
Methods/ Study Appraisal Synthesis Methods	Patient characteristics and acute physiology were determined. Outcomes were evaluated over a 6 mo period	Survey using Likert scale Using a 1 (poor) to 5 (excellent) s
Primary Outcome Measures/ Results	Survival time was independently related to severity of illness, body mass index (BMI), age, prior functional status, PaO2/FI(O2), congestive heart failure, serum albumin, and the presence of cor pulmonale	ELNEC-Critical Care course attendees rated the conference on an average of 4.8. They highly rated the extent to which the course met their objectives and expectations (4.7), and found the information to be stimulating and thought provoking (4.85). Attendees rated the clarity, content, and value of each presentation,

		with an average of 4.5 to 5.0.
Conclusions/ Implications	Patients/caregivers should be aware of the likelihood of poor outcomes following hospitalization for exacerbation of COPD associated with hypercarbia.	ELNEC CC course statistically and clinically significant.
Strengths/ Limitations	Not a nursing journal, large patient population in need of PCS	Convenience sample
Funding Source	None noted	RWJ & COH
Comments	Oft cited pt pop non cancerous needs PCS	

Article/Journal	Evaluation of EOL nursing education for continuing education and clinical staff development educators. *Journal for Nurses in Professional Development*	EOL care education in acute and critical care: The California ELNEC project/*AACN Advanced Critical Care*
Author/Year	Malloy, P., Ferrell, B. R., Virani, R., Uman, G., Rhome, A. M., Whitlatch, B., & Bednash, G. (2006).	Grant, M., Wiencek, C., Virani, R., Uman, G., Munevar, C., Malloy, P., & Ferrell, B. (2013).
Database/ Keywords	CINHAL, Google Scholar/ ELNEC, EOL care, nursing education	CINHAL, Google Scholar/ ELNEC, EOL care, nursing education
Research Design	Descriptive, retrospective	Descriptive, qualitative
Level of Evidence	VI	VI
Study Aim/Purpose	Demonstrate impact of ELNEC course on nurses knowledge	Describe impact of ELNEC-CC on California nurse community
Population/ Sample size Criteria/ Power	261nurses attended the national ELNEC courses, and 12-month data were collected on 227 educators (87%) and used	N=444; 388 ELNEC trainers taught 2,900 classes from 2007-2010
Methods/ Study Appraisal Synthesis Methods	Likert scale 12 months post educational intervention “was content adequate to meet care needs?”	Descriptive statistics for participant demographic data and postcourse outcomes were analyzed and are reported here. Qualitative methods were used to identify themes in the participants' outcomes
Primary Outcome Measures/ Results	Post-course ratings demonstrated participants believed their content were moderately adequate in EOL care with a range of 6.23–7.35 with culture as the lowest (6.23) and pain content as highest (7.35) rated.	Rated the provision of care to dying patients by nurses in their work setting to be moderately effective (mean score, 6.26). Three themes emerged from the content analysis: educational outcomes, institutional or system changes,

		and nursing or direct patient care improvements.
Conclusions/ Implications	This is a positive finding, particularly given the many constraints	ELNEC-CC/Archstone courses from 2007 to 2010 improved acute and critical care nurses' palliative/EOL care education and, ultimately, practice.
Strengths/ Limitations	Budget and time ID as limitation, long time from course another	Scope impacted by inability to tell if respondent came for CC, was an individual respondent or part of a team response
Funding Source	COH	Archstone foundation
Comments		

Article/Journal	Factors influencing older adults to complete advance directives. *Palliative and Supportive Care*	Noncompletion of advance directives. *American Journal of Critical Care*
Author/Year	Alano, G., Pekmezaris, R., Tai, J., Hussain, M., Jeune, J., Louis, B., El-Kass, G., Ashraf, M., Reddy, R., Lesser, M., & Wolf-Klein, G., (2010) Comer, S. (2009)	Aust, M. (2012)
Database/ Keywords	CINHAL/ Advance Directives, Knowledge, Belies and Attitudes/ None	CINHAL/ Advance Directives, Critical Care Nursing
Research Design	Prospective study with questionnaires and face-to-face interviews/non-interventional	Not a study, Experts opinion-supported by evidence
Level of Evidence	Level V	Level VII
Study Aim/Purpose	Determine factors that influence AS completion among older adults	Service provided by this journal intended to be reproduced and shared to educate.
Population/ Sample size Criteria/ Power	200 adults>65 in 3 settings, Cognitively intact	NA
Methods/ Study Appraisal Synthesis Methods	Multiple logistics regression	NA
Primary Outcome	Reviews specific research designs and provides examples of ethical issues to be	NA

Measures/ Results	considered. Provides alternative methods to consider re not doing research on own students. If those not possible provide suggestions how best to conduct re-search to protect the student participant.	
Conclusions/ Implications	7 Factors predict AD completion: being asked to complete AD, having someone explain the importance of Ads; thinking an AS will help in the relief of suffering; having had a major surgery; having "never heard of or received information about Ads"; female gender; and increasing age. HCP play a major role. Family and caregivers should be included.	A one page summary of recent article with prescriptive bullet points highlighted and succinctly written. This document or one like it could be used as part of a strategy to educated nurses.
Strengths/ Limitations	Not felt to be representative of state as a whole according to authors. No info gathered on approached patients who declined to participate	Sources cited EB
Funding Source	None noted	AACN
Comments	Speaks to the validity of nurses taking time to address ADs w/ pt. /family.	Very useful 1 page 'tip sheet' on promoting completion of ADs

Article/ Journal	Advanced care planning: A study on home health nurses/Applied Nursing Research	Enhancing patient-professional communication about EOL issues in life-limiting conditions: A critical review of the literature. *Journal of Pain and Symptom Management*
Author/Year	Badzek, L., Leslie, N., Schwertfeger, R., Deiriggi, P., Glover, J., & Friend, L. (2006)	Barnes, S., Gott, M., Chady, B., Seamark, D., & Halpin, D. (2012)
Database/ Keywords	EBSCO/ Advanced care planning/nurses	OVID/ Communication, life-limiting illness, EOL care, Palliative care, COPD, heart failure
Research Design	Descriptive correlational design,	Comprehensive Lit Search of 10 databases
Level of Evidence	Level VI	Level V
Study Aim/ Purpose	Assess HHN knowledge, comfort levels, barriers, and personal participation in ACP.	Identify existing communication interventions developed for

		life limiting conditions and explore the applicability of the cancer model to other diagnostic groups
Population/ Sample size Criteria/ Power	Home Health Nurses (HHN)1.394 questionnaires mailed,44% return,	755 articles identified and 16 met inclusion criteria of English related to communication w patients with life-limiting conditions receiving EOL care.
Methods/ Study Appraisal Synthesis Methods	Developed an ACP questionnaire	Carried out following the principles of a systematic narrative review search conducted over 2 month period and then 2 researchers independently evaluated the abstracts.
Primary Outcome Measures/ Results	Barriers to ACP included time, education, written models, and support.	Three core themes emerged around using communication: education to enhance communication skills, to improve patient understanding, and to facilitate ACP
Conclusions /Implication	Nurses overestimated their knowledge of AD and may give inaccurate information.	Findings suggest a successful intervention would include combined components of training, patient discussion and education.
Strengths/ Limitations	HCP need to be made aware of the barriers in order to overcome them.	Themes identified/Unable to include non-English articles. Inclusion of articles from a range of research methods and approaches can broaden the overall evidence available. Lack of precision of search terms
Funding Source	Emily Davie and Joseph S. Kornfeld foundation	Bupa Foundation of London, U.K.
Comments	Increasing nurses' knowledge found to increase comfort level, EOL discussions can occur while delivering care. Disconnect btw nurses perceived and actual knowledge of ACP laws & documents	Patients may prefer prognostic ambiguity. Communication training needs to be focusses, relevant and tailored to participant individual needs.

		Focus on goals of care, surrogate decision maker, and encouraging regular communication.

Article/Journal	Decision making in acute care: A practical framework supporting the 'best interests' principle/ *Nursing Ethics 2006*	The need for safeguards in advance care planning/*Journal of General Internal Medicine*
Author/Year	Bailey, S., 2006	Billings, J. A./2011
Database/ Keywords	CIHAL/Ethics, Communication, EoL	Advance Care planning, advance directives
Research Design	Systematic Review of the Literature	Literature review
Level of Evidence	Level V	Level V
Study Aim/Purpose	Describe factors required to be incorporated into an account of QOL that will provide a morally justifiable basis for making a judgment about the future QOL of critically ill mentally incompetent adult.	Interventions need to demonstrate convincingly that ACP improves the concordance of patient wishes with outcome of care.
Population/ Sample size Criteria/ Power	NA-not a study	XXX
Methods/ Study Appraisal Synthesis Methods	Systematics Review compiled to obtain finding describing authors elements of QOL	NA
Primary Outcome Measures/ Results	3 major components identified--pain and suffering, body functioning and autonomy and is applicable in situations where very limited information is available to guide decision making.	Geared toward physician, again stressing need for education and communication and importance of understanding patient vales and culture's to help them establish goals of care.
Conclusions/ Implications	Important that nurses be involved in a collaborative decision-making process, with the goal of making ethically defensible decisions about individual patients 'treatments anchored in an ethical framework and principles.	ACP deals w life or death decisions. Procedural safeguards are appropriate both for promoting excellent clinical care, addressing patient and public concerns

		about limiting life sustaining Tx, and assuring safety. Taking seriously the concerns underlying the scare over "death panels" and recognizing the vicissitudes of patient decisions making about EOL care may help refine ACP as fundamental and deeply serious clinical task for promoting patient autonomy.
Strengths/ Limitations	These elements impact EoL decision making and improve communication, use an an ethics principle /not tested on a population	Good list of interventions to protect the vulnerable patients/not very nursing focused
Funding Source	None noted	None noted
Comments	Framework helps to make decisions about the provision of life saving TX	Very prescriptive interventions to protect vulnerable patients

Article/Journal	Nurses' ACP communication: An investigation/ *Geriatric Nursing*	Developing a mid-range theory of patient advocacy through concept analysis. *The Authors. Journal Compilation.*
Author/Year	Black, K., Emmet, C. /2006	Bu, X., Jezewski, M./ 2006
Database/ Keywords	CINAHL/ ACP; communication,	CINAHL/ Nursing Role; Patient Advocacy; Theory Construction
Research Design	Descriptive study	Expert opinion of authors, based on some quantitative empirical studies
Level of Evidence	Level VI	VII
Study Aim/Purpose	Measure and establish an empirical baseline of nurses' AD communication practices w hospitalized older patients.	Clarify and refine the concept of patient advocacy through synthesizing the advocacy literature in nursing and to establish a theoretical basis for future studies on patient advocacy in nursing.
Population/	75 Nurses	NA

Sample size Criteria/ Power		
Methods/ Study Appraisal Synthesis Methods	Surveyed nurses using a self-administered questionnaire about their AD communication practices.	Not a study per se. Model constructed by authors- supported by some evidence from the literature
Primary Outcome Measures/ Results	AD communication was measured with 7 subscales: initiation of the topic, disclosure of information, identification of a surrogate decision maker, discussion of treatment options, elicitation of patients values, interaction w family, & collaboration w other HCP./	Search for some consistency of definition and description of this role in nursing.
Conclusions/ Implications	suggest nurses communication regarding AD reflects a broader process of ACP and that age, years of experience, and personal experience w AD are associated w communication practices.	Proposed mid-range theory may be useful in guiding advocacy practice in nursing.
Strengths/ Limitations	/Convenience nonprobability sampling design, Social desirability may have compelled respondents to report they did engage in various communication practices and self-reported behavior is subject to recall error and bias. Low response rate (27%).	Developing a new theory of patient advocacy that can be operationalized is necessary for advancing nursing science and patient advocacy practice.
Funding Source	None noted	None Noted
Comments	Describes using family to elicit pt. values. Geriatric patient more likely to present with disease trajectories that can be anticipated.	This theory is one of them I am utilizing with my PICO project as it speaks to a primary impetus for this work. Nurse as advocate.

Article/Journal	Deciding in the dark: Advance directives and continuation of treatment in chronic critical illness/ Critical Care Medicine	Factors influencing completion of AD in hospitalized patients/ International Journal of Palliative Nursing
Author/Year	Camhi, S., Mercado, A., Morrison, S., Quingling, D., Platt, D., August, G., Nelson, J./ 2009	Duke, G., Thompson, S., Hastie, M., /2007
Database/ Keywords	CINAHL/ prolonged mechanical ventilation; prolonged critical illness; DNR; decision making; withholding treatment; withdrawing treatment	CINAHL/ AD; EOL

Research Design	Prospective, comprehensive, and longitudinal cohort study	Cross sectional, descriptive, exploratory
Level of Evidence	Level IV	Level IV
Study Aim/Purpose	Studies chronically critically ill patients to determine how often AD and HCP were available to guide EOL decision making.	Identify factors that affect completion of AD of IP in an acute care setting
Population/ Sample size Criteria/ Power	Critical care patients transferred to an RCU after trach and failing to wean./203 patients/	IP two E Texas acute care facilities w an average of 350 bed/per./Convenience samples, English speaking, cognitively intact, will to be interviewed. 47 patients were interviewed
Methods/ Study Appraisal Synthesis Methods	Interviewed patients and reviewed medical record to id proxy appointments, living wills or oral statements of EOL preferences.	theoretical framework was the SUPPORT study Every 2 weeks interviewed patients meeting inclusion criteria.
Primary Outcome Measures/ Results	21% ID HCP, 16% oral or written AD, limitation of life limiting was rare (19%) and occurred late in hospital stay (39 days).	HCP roles are vague in terms of responsibility for AD discussion and education
Conclusions/ Implications	Most chronically ill patients fail to designate a surrogate decision-maker or express preferences regarding EOL wishes.	HCP roles are vague in terms of responsibility for AD discussion and education
Strengths/ Limitations	Finding found to be consistent across state lines/Inconsistent documentation skews results, no factors selected that may influence surrogates decision making, Physician related variables not collected, Conducted at a single center, laws vary by state,	Did provide information clinicians can use to facilitate ADs completion as part of primary health care./Use of new tool without established internal consistency, small convenience sample, no comparison group,
Funding Source	None noted	None noted
Comments	Opportunities exist to improve communication and decision-making in chronic critical illness.	“Not wanting to be a burden to their family” main driver, Health status, family influences all identified as key drivers

Article/Journal	/ Journal of American Geriatrics	The critical care nurse’s role in EOL care: issues and challenges/*British*

		Association of Critical Care Nurses
Author/Year	Hames/2010	Efstathiou, N., Clifford, C.,/2011
Database/ Keywords	CINHAL/advance care planning, AD, EOL, ethics	CINHAL/ Care professionals, critical care nursing, family care in critical care, withholding/withdrawing treatment
Research Design	A comparative, retrospective, observational study	Lit search and synthesis of findings utilizing Clarke's seven domains used as a framework.
Level of Evidence	Level IV	Level VII Expert Opinion
Study Aim/Purpose	of the prevalence, availability and specificity of Advanced care plans in a county that implemented an advance care planning microsystem/ retrospective comparison of medical records/level of evidence not addressed	Discuss the challenges nurses face when looking after patients needing EoL care.
Population/ Sample size Criteria/ Power	/540 adults who died 1995-96 and 400 who died 2007-2008 in all health care organizations in Lacrosse WI.	Critical care nurses caring for acutely ill patients in a single acute care setting./NA
Methods/ Study Appraisal Synthesis Methods	retrospective chart audits /all data analyzed using SAS, univariate analysis of categorical variable using chi-square test. Analysis of continuous variable over two classes was performed with a two-tailed t test. Consistency was determined by document comparison	This is not a true study but more of a lit search and synthesis of current state of nurses' ability to meet needs of patient at EoL. Integrates principles of Palliative care
Primary Outcome Measures/ Results	Significantly greater prevalence of AD's (90% vs. 85%) and availability of these directives in the medical record at the time of death. Suggest quality effort improved the prevalence, clarity and specificity of AD's	Nurses have an essential role in the provision of effective EoL care. Educational opportunities need to be provided for nurses to increase knowledge on planning and delivering EoL care.
Conclusions/ Implications	A system for advanced care planning can be managed in a region so that at time of death almost all adults have an advance care plan that is specific, available, and treatment is consistent with their plan	Skills development in key aspects of care provision may improve the provision of EoL care

Strengths/ Limitations	may have missed some deaths d/t inaccessibility of death certificates, change may be d/t unknown variable, unknown what family or health care provider believed at time of death, lack of cultural diversity.	Collaborates others finding regarding need to improve nurses ability and knowledge around EoL care and ability to communicate to patient/families.
Funding Source	funded by Gundersen Lutheran Medical Foundation	None Noted
Comments	Good description of the educational needs of nurses to support completion of AD at a higher rate.	Supports need for education of nurses on EoL Care. Communication, family centered decisional making,

Article/Journal	A patient and healthcare professional factors influencing EOL decision-making during critical illness: a systematic review/*Critical care Med*	Preventative Ethics: Addressing ethics quality gaps on a systems level/ *The Joint Commission Journal on Quality and Patient Safety*
Author/Year	Frost, Cook, Heyland, Fowler/2011	Foglia, M., Fox, E., Chanko, B., Bottrell, M.,/ 2012
Database/ Keywords	CINAHL/AD, EOL, critical care	CINHAL/Recommended to me by clinical Mentor./ Ethics
Research Design	structured lit search of ovid medline using keywords/	Performance Improvement Project
Level of Evidence	Level V	Level VII
Study Aim/Purpose	providing compassionate EoL care/	To describe the VA model of 'Preventative Ethics' (PE) which is a key component of IE
Population/ Sample size Criteria/ Power	102 of 6259 publications were identified as relevant to review question	Implemented in all 153 VA Medical Centers
Methods/ Study Appraisal Synthesis Methods	searched observational and controlled clinical trials not just RCT/	IE Model developed over 5 years by a mx disciplinary design team who use a rigorous consensus development process include lit reviews across multiple fields of study and input from internal and

		external stakeholders.
Primary Outcome Measures/ Results	Factors that influence decision-making of patients and HCPs. MD's w more ICU experience were less likely to prescribe technological intervention.	Quality Improvement Project
Conclusions/ Implications	mx variable id's that impact EOL decision/limitations of the published literature/English/observational studies	authors feel this model is robust enough to directly transfer to any health care organization
Strengths/ Limitations	comprehensive search of relevant literature	Strong organizational infrastructure within VA system-able to deploy model system wide tested and validated tools. /Other HC facilities lack similar administrative support and infrastructure as the VA.
Funding Source	None noted	Funding provided by the VA
Comments	Speaks to individual clinician and patient factors that affect decision making. So relevant around nursing education and EoL training	VA a leader in PE

Article/Journal	Using diffusion of innovations theory to implement the confusion assessment method for the intensive care unit/Journal of Nursing Care Quality	Ethical challenges within veterans administration healthcare facilities: Perspectives of managers, clinician, patients, and ethics committee chairpersons/ *American Journal of Bioethics*
Author/Year	Bowen, Stanton, Manno (2012)	Foglia, M., Pearlman, R., Bottrell, M., & Altemose, J., & Fox, E.,/The American Journal of Bioethics
Database/ Keywords	OVID/assessment, delirium, diffusion of innovation, EBP, intensive care	CINHAL/ Organizational Ethics, qualitative research, resource allocation
Research Design	Quality improvement project	Focus group interviews using semi-structured interviewed interviews
Level of Evidence	Level VII	Level IV
Study	use diffusion of innovation to increase	Promote ethical practices by

Aim/Purpose	frequency of delirium assessment	better understanding the ethical challenges encountered by key stakeholders.
Population/ Sample size Criteria/ Power	Critical care units in single site-patients assessed for delirium utilizing the CAM-ICU tool.	32 patients; 39 managers, 55 clinicians, and 21 ethic chairs.
Methods/ Study Appraisal Synthesis Methods	descriptive case study of 9 bed ICU observation, surveys	Data from interviews analyzed using content analysis
Primary Outcome Measures/ Results	Measured impact of education on tool w interventions on nurses ability to evaluate Delirium	Perspectives on ethical challenges varied depending on the respondent's role.
Conclusions/ Implications	diffusion of innovation worked to implement an EBP change	Understanding these differences in perspective can help us to better understand and take steps to address them.
Strengths/ Limitations	small unit	A focus on the micro ethics/ Absence of detailed demographic data, was very VA Focusses-may not be transferable, convenience sample, may have investigator bias in interview.
Funding Source	None Noted	VA Funded
Comments	A research utilization project with pre and post intervention assessment on nurses ability to perform intervention	Gives insight into how Ethics Committee could be better aligned to meet patient and or staff needs.

Article/Journal	Reasons for noncompletion of AD in a Cardiac ICU/	Theories in action and now nursing practice changed/*Nursing Science Quarterly*
Author/Year	Johnson,R., Yanfang,Z./2012	Jasovsky, Morrow, Clementi, Hindle / 2012
Database/ Keywords	CINAHL/Advanced Directives, Intensive Care Unit/	CINHAL/ Nursing Theory,
Research Design	Cross sectional, descriptive, exploratory /	Leininger, model of care,

		nursing practice, nursing theory, Parse, Watson/
Level of Evidence	Level IV	Level VII
Study Aim/Purpose	describe & explore implementation of the PSDA in a CC Unit	Clinical practice change based on nursing theories
Population/ Sample size Criteria/ Power	All adults admitted to the cardiac ICU physically able to answer the questions/505 sample size/Criteria as stated/Power:	Nurses on just one new nursing unit
Methods/ Study Appraisal Synthesis Methods	Semi-structured cross -sectional /all eligible patients were asked 3 open ended questions to ascertain understanding of AD	Rogers diffusion of innovation/Parse and Leininger
Primary Outcome Measures/ Results	645 did not have an AD PTA, of the patients who declined the opportunity to complete an AD 33>8% said they did not understand the questions when initially asked and	successful change implementation
Conclusions/ Implications	Current practice meets the requirement for the PSDA for documentation. However simply asking do you have an AD does not elicit an accurate reflection of pt. understanding of AD.	Magnet journey impetus for change. Survey, pt. outcome data, patient satisfaction data
Strengths/ Limitations	strengths not addressed/limitations timing sub-optimal d/t health crisis, family presence may have created bias	Derived from several nursing theorist; used open ended survey, patient satisfaction and outcome data to measure efficacy/Just one site, not reproduced
Funding Source	None Noted	None noted
Comments	This article seminal to my practice issue.	Quality improvement project infusing a change in practice-similar to what I am going to be trying to do. I like their change model which is built on Rogers's diffusion of innovation framework.

Article/Journal	Facilitating goals of care discussions for patients w life limiting disease-communication strategies for nurses/*Journal of Hospice & Palliative Nursing*	The challenges of developing and evaluating complex care scenarios using simulation in nursing education/ *Journal of*

		Research in Nursing.
Author/Year	Peereboom, Coyle/2012	Gobbi, M., Monger, E., Weal, M., McDonald, J., Michaelides, D., & De Roure, D., (2012)
Database/ Keywords	CINHAL/ communication, discussion. EOL, Goals of care, life limiting disease	CINHAL/ mixed methodologies, new technologies, mixed methods, research impact, simulation
Research Design	Quality Improvement Project	Lit search
Level of Evidence	Level VII	Level V
Study Aim/Purpose	Provide nurse with tools to communicate w patient family to elicit their EOL wishes	Develop and evaluate the necessary infra-structures to conduct, research, and analyze the extent to which virtual interaction activities were as effective as other models in achieving competency.
Population/ Sample size Criteria/ Power	Addresses needs of patients/families w life limiting diseases and nurse communication.	Two purposely designed mini wards of 6 beds a piece with nurses' station and 360 degree view which student activities could be analyzed and recorded.
Methods/ Study Appraisal Synthesis Methods	A synthesis of the literature including very practical communication strategy tools to aid nurses in having EoL conversations.	Search of the literature around simulation high and low tech/ Search for data speaking to student outcomes w simulation education
Primary Outcome Measures/ Results	Strategies to help nurse discuss goals of care with patient.	Interpret data from different data streams, search for analytical tools.
Conclusions/ Implications	seems very helpful for bedside nurses, good change project tools	Simulation can increase competency and confidence in clinicians, provide instant feedback and reduce patient risk BUT lack necessary analytical tools to measure and understand the complexity of student performance over time.

Strengths/ Limitations	Practical, prescriptive,/*NOT* EB	Absence of clinical targets in order to analyze key elements.
Funding Source	None Noted	Economic and Social Research Council, and the Higher Education Academy
Comments	This is most similar to *MY* Capstone project! They read my mind and did my project!	Explored possibility of scenario for EoL education- might be a longer range goal with scripting

Article/Journal	Advance Directives: Limitations to completion/ *American Journal of Hospice & Palliative Care*	Professional values, self-esteem, and ethical confidence of baccalaureate nursing students/*Nursing Ethics*
Author/Year	Hinders, D., / 2013	Iacobucci, T., Daly, B., Lindell, D., Griffin, M.Q. / 2012
Database/ Keywords	CINHAL/ EoL Care, AD, Living Will, DPOA, DNR	CINHAL/Ethical confidence, ethical decision making, professional identity, professional nursing values, self-esteem
Research Design	Review of the Literature	Descriptive correlational study
Level of Evidence	Level VII	Level VI
Study Aim/Purpose	Identify opportunities for AP Nurses to overcome barriers and assist patients to complete AD.	To explore the relationship between professional nursing values, self-esteem, and ethical decision making among senior baccalaureate nursing students.
Population/ Sample size Criteria/ Power	NA	Convenience sample of 47 senior baccalaureate nursing students. / a non – probability convenience sample./ A significant positive relationship ($p<0.05$) was found between nursing students professional nursing values and levels of self-esteem.
Methods/	NA	A descriptive correlational

Study Appraisal Synthesis Methods		research study conducted at a university BSN program in a large Midwestern city. A survey questionnaire was administered to participants during the fall semester of 2011./Data was analyzed using the SPSS version 20 to analyze the sample's demographic characteristics and the scores obtained from the survey. Relationships among the variable were examined using Pearson's r. All tests were two tailed.
Primary Outcome Measures/ Results	Changes in patient population and barriers to completion identified as surmountable obstacles where nurse may intervene and increase AD completion	A significant positive relationship ($p<0.05$) was found between nursing students professional nursing values and levels of self-esteem.
Conclusions/ Implications	AD can be very confusing for patients and family members therefore the number of older adults with completed AD remains <30%. AD Forms written at 12th grade level even though 40% read at less than that. Physician reluctant to tackle Ads w patient d/t time constraints and reimbursement.	Results of this study useful for nursing educators whose efforts are focused on promoting professional identify development and competent ethical behaviors.
Strengths/ Limitations	Identifies weakness in documents-lack clarity.	/Given the study design, lack of reported effect size among previous research, and restrictive sample size, this low power level is noted as a limitation. In additional the use of a convenience sample and the large number of mostly white female students limits generalizability.
Funding Source	Known noted	None noted
Comments	Nurses can help patient to articulate and prioritize goals	The linkage here is the close connection between clinical ethics-EoL issues-and communication around same.

Article/Journal	Effect of a disease-specific planning intervention on surrogate understanding of patient goals for future medical treatment / *Journal of American Geriatric Society*	Confidence and knowledge regarding ethics among advanced practice nurses./ *Nursing Education Perspective*
Author/Year	Kirchoff, K., Hammes, B., Kehl, K., Briggs, L., & Brown, R./2010	Laabs, C./2012
Database/ Keywords	CINHAL/Advance care planning; communication; intervention studies	CINHAL/ Nursing, Ethics, ACP
Research Design	Multisite RCT	This article reported on a cross-sectional descriptive survey of nurses regarding their knowledge of ethics and their perceived level of confidence in their ability to manage ethical problems in clinical practice.
Level of Evidence	Level I	Level III
Study Aim/Purpose	Determine whether a disease-specific planning process can improve surrogate understanding of goals of patients with life limiting illnesses for future medical treatments.	Determine nurses' ethics knowledge and perceived level of confidence in their ability to manage ethical problems.
Population/ Sample size Criteria/ Power	313 patient surrogate pairs completed this study. English speaking adults 18 and over with chronic CHF or Renal Failure.	All graduates of one MW University college of masters prepared nurses 1992-2007 (N363)
Methods/ Study Appraisal Synthesis Methods	RCT patient with HF or RF w their surrogates were randomized to receive the intervention or the usual care using the sealed envelope method within each setting and disease conditions.	Adapted a tool used for Physician residents a 5 pt. Likert scale eval their perception of confidence. 14 demographics and 27 how well their ethics education prepared them to manage clinical issues.
Primary Outcome Measures/ Results	Surrogate understanding of patient goals for care with regard to four expected, disease-specific outcomes situations and of the degree of surrogate latitude in decision making./1.Knowledge of ACP, 2. Statement of Tx preferences completion, &3. Quality of patient-Client Communication about EoL care (completed only by intervention group)	Scores on survey indicating confidence in their ability to recognize a genuine ethical problem in clinical practice and lowest confidence in ability to understand ethical aspects of reproductive health. Ethics scores varied

		widely. Average score was 55.05% correct (SD=26.43) Highest was understanding their accountability ANA code then PSDA, last was knowledge of definition of classic utilitarian.
Conclusions/ Implications	Surrogates in the intervention group had a significantly better understanding of patient goals and preferences than surrogates in the control group.	APN in this sample showed a fairly high level of confidence in their ability to manage ethical problems, but their overall ethics knowledge was low. There were wide variations in knowledge. APN's scored higher than med residence.
Strengths/ Limitations	Intervention did show trained facilitators made a positive impact on surrogate's ability to be better prepared to help patient make medical decisions. /Required that facilitator meet w surrogate decision maker. Some were interested by died before able to complete study, predominantly white, Sample smaller than projected.	/Limited by homogeneity and small sample size. Absence of consensus on ethics content knowledge of APN's.
Funding Source	Funded by a grant from the Agency of Health Care Research and Quality awarded to Dr. Kirchoff.	None noted
Comments	This is the first step toward ensuring that patient goals for care are known and honored.	Demonstrates that ethics education better prepares nurses on ethics and ability to address EoL issues.

Article/Journal	Knowledge, attitudes, and predictor of AD discussions of registered nurses/*Western Journal of Nursing Research.*	EoL discussions, goal attainment, and distress at the EoL; Predictors and outcomes of receipt of care consistent w preferences/ *Journal of Clinical Oncology.*
Author/Year	/Lipson, A., Hausman, A., Higgins, P., Burant, C., /2004	Mack, J., Weeks, J., Wright, A., Block, S., Prigerson, H./ 2012
Database/ Keywords	CINHAL/AD, predictors, discussions, attitudes, knowledge	CINHAL/ EoL,
Research Design	Data collected using a cross-sectional survey	Longitudinal multi-

	design with a random sample design stratified by zip codes.	institutional cohort study
Level of Evidence	Level II	Level III
Study Aim/Purpose	Describe nurse's knowledge, attitudes, and experiences regarding Ads. A secondary purpose was to examine predictors of AD discussions btw nurses and patients.	Physicians have an ethical obligation to honor patient's values for care, including at the EoL. Evaluate factors consistent with their preferences.
Population/ Sample size Criteria/ Power	Random selection from all nurses in Ohio. N+1,600.	325 patients with advanced cancer
Methods/ Study Appraisal Synthesis Methods	52 Item questionnaires were created from 3 existing instruments plus items developed by the authors. Final version 7 demographics, 19 knowledge, 9 attitudes, and 17 AD questions. Alpha for entire sample was .69./Univariate, bivariate, and multivariate statistics were used to evaluate the data.	Longitudinal multi institutional cohort study. We measured baseline preferences for life extending versus symptom-directed care and actual EoL care received in
Primary Outcome Measures/ Results	Logistical regression was used to answer the question "what variable best predicts ADs discussion among RNs…"/Increase confidence in AD discussion skills among the respondents as found to be a sig predictor of actual AD discussions.	Treatment Preference c/w EoL treatment received and was it consistent w preferences? Association between receipt of care and preferences was determined using logistical regression. Assoc between preferred care and received and possible outcomes of care using t test for pairwise comparison. All were conducted using the SAS STS package version 9.1
Conclusions/ Implications	Age was negatively correlated with levels of AD discussion with patients.	Patients w cancers are more likely to receive EoL care that is consistent w their preferences when they have had the opportunity to discuss their wishes for EoL care w a physician.
Strengths/ Limitations	Large sample size, replication study/Conflicting information on age years of clinical experience and ADs discussion. Older study, variety of clinical settings/	/Preferences may not have remained stable. No relationship found between survival from baseline and

		either treatment preferences or care consistent w preferences. Relied on patient report of EoL discussions.
Funding Source	None noted	Grant from National Institute of Mental and the National Cancer Institute.
Comments	Validates more education on AD increases nurses confidence in having an AD discussion w patient/surrogate.	Findings that patients who desired symptom directed care were more likely to receive life prolonging care when EoL discussions did not take place strongly suggest that more patients would benefit from EoL discussions.

Article/Journal	Patients' and surrogates' decision-making characteristics/*Journal of Hospice and Palliative Care Nursing*	Advance care planning: eliciting patient preferences for life-sustaining treatment./ *Patient Education and Counseling*
Author/Year	Melhado, l., Byers, J./ 2011	Pearlman, R., Cole, W., Patrick, D., Starks, H., & Cain, K./ 1995
Database/ Keywords	CINHAL/ advance planning, EoL, decision making and communication, medical futility, withholding and withdrawing life sustaining treatment	CINHAL/AD, Living will, patient education, ethics, patient autonomy, health promotion
Research Design	Integrated literature review	Integrated literature review used to illustrate Author's model
Level of Evidence	VII	VII
Study Aim/Purpose	Which decision making characteristics in patients or their surrogates lead to withdrawing treatment compared with those continuing life-sustaining treatments?	ACP discussions between patients and HC providers often ignore insights from 2 related activities, health care promotion and human information processing. Authors' thesis is that ACP

		should occur with greater attention to the concepts of stages of change and self-efficacy, the Health Belief Model, and the necessary requisites for cognitive integration.
Population/ Sample size Criteria/ Power	Inclusion/Exclusion parameters studies 1995-2010, adults, English speaking, peer reviewed yielded 19 articles/ NA	Not a study
Methods/ Study Appraisal Synthesis Methods	Criteria used to review literatures to determine which characteristics in patients and surrogates were associated with decision mailing in withdrawing and withholding life sustaining treatment c/t life sustaining treatment.	Utilized a search of relevant literature to support premise.
Primary Outcome Measures/ Results	19 articles met inclusion criteria, answered the research question and were analyzed for relevancy.	Support found to support Authors premise
Conclusions/ Implications	Identified patterns and specific characteristics of patients and surrogates in EoL decision making, /Implication for HC policies and education of HC providers	A semis-structured discussion and employment of a workbook can facilitate a ACP discussion
Strengths/ Limitations	Comprehensive and recent review validated my PICO Intervention/Specific communication strategies not tested for efficacy	Integration of Health Belief Model into patient education/not a study-a unique viewpoint to improve efficacy of ACP
Funding Source	None Noted	None noted
Comments	An ethical and moral responsibility to ensure that patients and surrogates receive adequate decision making support and communication. Clinicians must be helped to be made comfortable and competent in engaged in EoL discussion. **Clinicians must shift focus from AD as asking task to expand the focus to a comprehensive discussion of ACP.	Identified how ACP parallels s to other health promotion activities.

Article/Journal	Facilitating goals of care discussions for patients with life limiting disease—communication strategies for nurses/ *Journal of Hospice and Palliative Care Nursing*	Family members informal roles in EoL decision making in adult ICU's/ *American Journal of*

		Critical Care Nurses
Author/Year	Peerboom, K., Coyle, N/ 2012	Quinn, J., Schmitt, M., Baggs, J., Norton, S., Dombeck, M., Seller, C., /2012
Database/ Keywords	CINHAL/ communication, EoL, goals of care, life-limiting disease	CINHAL/ EoL, nurses, critical care, communication, decision-making
Research Design	Quality Improvement Design	Ethnographic study-qualitative research
Level of Evidence	Level VII	Level VI
Study Aim/Purpose	Outlines a variety of communication strategies designed to enhance nurses communication skills and to provide them with tools to use as they discuss goals of care and treatment options w patients throughout their disease trajectory	Describe some informal roles consistently enacted by family members involved in the process of EoL decision making in an ICU
Population/ Sample size Criteria/ Power	Interventions geared toward communication with critical ill adults with ultimately life limiting diseases	HC clinicians, patients, family members
Methods/ Study Appraisal Synthesis Methods	NA-other than relevant articles cited for communication strategies highlighted	Data collected via participant observation with field notes and semi structured interviews of 4 ICU's in an academic health center in the mid- Atlantic US from 2001-2004.
Primary Outcome Measures/ Results	Several strategies identified from the literature that can be used as communication tools.	Primary roles identified as: primary caregiver, primary decision maker, family spokesperson, out-of-towner, patient's wishes expert, protector, vulnerable family member, and health care expert.
Conclusions/ Implications	Communication is central to nursing care especially in the setting of progressive disease, which will end in patient's death. This article outlined a variety of communication strategies designed to provide tools for nurses to use to discuss treatment options and goals of care.	Promoting family responses the EoL questions that honor the wishes of the patient require an understanding of informal family roles such as those observed and describes and an awareness of how those

		roles are in acted. /Identification and description of theses informal roles of family members can help clinicians recognize and understand the functions of these roles in families' decision making with EoL.
Strengths/ Limitations	Prescriptive /Identified how "clumsy' communication can harm, "paralyze" action, and destroy the relationship.	Analysis was /Conducted only in 1 setting, data collected a while ago, presence of researcher and videotaping may have influences responses.
Funding Source	None noted	Supported by NIH grant
Comments	Practical, relevant, love this article!	Nurses engaging in EoL conversations effectively would be more effective if they recognize and understand how EoL decision making involves intersection of the Health care and family domains.

Article/Journal	Knowledge, Attitudes, Experiences and confidence of nurses in completing AD: a systematic synthesis of three studies/ *The Journal of Nursing Research*	'There is only narrative': Using case studies in nursing ethics/ *Nursing Ethics*
Author/Year	Ryan, D, Jezewski, M.A./ 2012	Woods, M./ 2012
Database/ Keywords	CINHAL/ AD, EoL, nurses, systematic synthesis	CINHAL/Ethics
Research Design	Search of the literature to answer the research question	Editorial Comment
Level of Evidence	Level V	Level VII
Study Aim/Purpose	What are the knowledge, attitudes, experience, and confidence of RNs with regard to ADs, and what is the relationship among these study variable?	Illustrate the value of case studies
Population/ Sample size Criteria/ Power	RN in a variety of setting (ICU, Oncology, ED) response rate 15-23%	One ethicist opinion
Methods/ Study Appraisal	Purpose of each of the 3 studies selected was to determine the AD completion knowledge,	NA

Synthesis Methods	attitudes, experiences, and confidences of RNs. All used descriptive correlational design and survey approach. Mailed a large number of surveys to a sample of RNs	
Primary Outcome Measures/ Results	Overalls knowledge among nurses was about 60%-a grade typically below what would be acceptable in nursing school! Moderate level of confidence, Over half felt patients excluded from decision making d/t impaired capacity. Over half felt Ads do serve as guides to care at EoL.	Illustrates authors antidotal examples of how use of case scenarios can be effective to change practice
Conclusions/ Implications	Nurses want/need more education/tools to feel more confident in having this conversation. Nurses need to refine their role in AD discussion w patients.	A call for OUR narrative, each nurse has a meaningful story to tell.
Strengths/ Limitations	Validates authors' exact concerns and observation around needs of nurses to be better able to meet patient family needs around ability to have meaningful EoL conversation and obtain ADs/low Cronbach's alpha values in the attitude scales within the survey instrument posed limitation in the original research on the use of the attitude scale score in statistical analysis. . Data obtained from published reports	Ability to change practice especially when emotions are engaged/Not an actual study and not tested
Funding Source	None noted	None Noted
Comments	Advocacy a theme, time a limitation	Case studies are an effective educational strategy

Article/Journal	Reasons, considerations, difficulties and documentation of EoL decisions in European ICU: the ETHICUS Study/ *Intensive Care Medicine*	Strategies to Help Initiate and Maintain the End-of-Life Discussion With Patients and Family Members/*Med Surg Nursing*
Author/Year	Sprung, C., Woodcock, T., Sjokvist, P., et al/ 2008	Clabots, S.,/ 2012
Database/ Keywords	CINHAL/ ethics, EoL, AD,	CINHAL/ ADs , EoL, nurses, communication
Research Design	Prospective observational study	Quality Improvement Initiative
Level of Evidence	Level III	Level V
Study Aim/Purpose	Evaluate reasoning, considerations and possible difficulties in EoL decision-making	Identification of and strategies to overcome

	for ICU patients	barriers nurses experience regarding the initiation and maintenance of EoL discussions
Population/ Sample size Criteria/ Power	3,086 patients in 37 ICUs in 17 countries/	Synthesis of research evidence describes nurses' barriers, patients' needs for communication and strategies to close this gap.
Methods/ Study Appraisal Synthesis Methods	Physician indicated which of pre-determined set of reason for, considerations in, and difficulties with EOL decision making was germane in each case as it arose.	Synthesis of recent journal literature identifies nurses barriers to initiation of conversation; inexperience w death and dying, unrealistic expectations by providers and family members, difficulty in predicting death, cultural differences w different needs for support, impact of stress on patient/family ability to communicate.
Primary Outcome Measures/ Results	69% of decisions were documented in medical record, varied by geographical region.	Strategies to help nurses initiate and maintain EoL discussions w patient/family members; self and cultural awareness, honest and timely communication, offering support and being an advocate, gain experience and knowledge
Conclusions/ Implications	Primary reason given were medical condition, unresponsive to therapy, chronic disease, QOL, age, patient family request	Health care providers face many barriers when attempting to create the best EOL care plan for their patients. The literature offers evidence-based strategies to overcome these barriers and improve end-of life communication.

Strengths/ Limitations	Direct reporting of actions rather than theoretical responses to a questionnaire, prospective enrollment of large numbers, and evaluation of all treatment limitations and deaths in all admitted patients. /physician studied-not nurses; sample may not be representative, severity of illness not documented.	/ A great deal of work remains to be done to ensure patients experience a good death and family members receive support through the grieving process
Funding Source	MX funding sources: European Concerted Action Project, European Commission, the Chief Scientist Office of the Ministry of Health, European Society of Intensive Care Medicine and the Walter and Alice Gorham Foundations Inc.	None noted
Comments	Reinforce need for shared decision making and need for increased education and communication.	Valuable synthesis of opportunities to create positive impact on EOL care in acute care setting, and on the success of the EoL discussion with the patient and family.

Appendix C: Demographic Survey

Demographic Survey **ID number _ _ __**

Instructions:
Check the appropriate box for each answer. Legibly enter any additional comments.

1. What is the highest level of education you have completed? If currently enrolled,
mark the previous highest degree received.
 2-year college degree (ADN)
 3-year degree - Diploma
 4-year college degree – Nursing
 4 – year college degree - other _____
 Master's degree – Nursing
 Master's degree – other _____
 Doctoral Degree – Type (PhD, DNP, EdD, other) _____

2. Years of experience as Registered Nurse _____ (report in rounded years. If less than one year report in months).

3. Do you have any experience working on a designated palliative care unit?
 Yes: Amount of time (report in rounded years. If less than one year report in months). _____
 No
4. Number of dying patients you have personally cared for in the past year _____
5. Do you have personal experience with the death of someone close to you?
 Yes
 No
6. Have you had any type of formal End of Life Education?
 Yes (please indicate where/when) _____
 No

Thank-you for your participation.

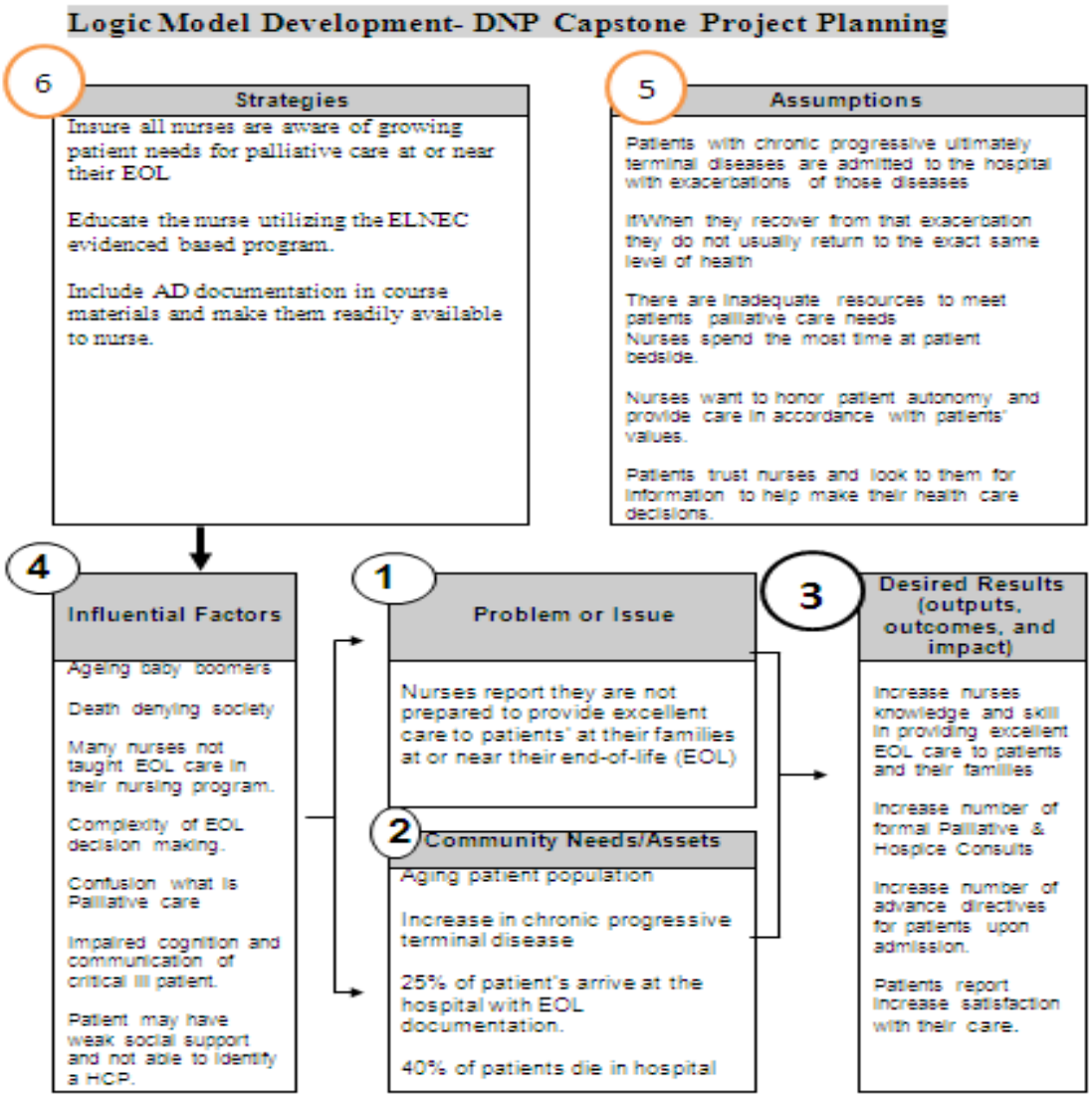
Appendix D Budget and Resources

In order to replicate this particular study, the following budget and resource needs can be anticipated.

Instructor time	50/hr. x 8	$400.00
Preparation/organization	10hr	$500.00
Course Syllabus printing		
1000pg/5cent/per page X 15		$750.00
Total Expenses		$1650.00
Student Fees $150/participant*		$2500.00
Net expenses to organization		$+600.00*

*$150.00 per student per day, as suggested by the AACN for an ELNEC course.

Appendix E Logic Model



Appendix F: Regis IRB Approval

Approval of Submitted Proposal...

Institutional Review Board

This message was sent with High importance.
You replied on 1/24/2014 11:34 PM.

Sent: Thursday, January 23, 2014 12:41 PM

To: Behr, Debra J; Claywell, Lora G.

Cc: Institutional Review Board

Dear Ms. Behr...

The Institutional Review Board has completed a thorough evaluation of your submitted proposal, *Evaluation of the Impact of End-of-Life Nursing Education Consortium (ELNEC) Educatic on Registered Nurses.* I am pleased to inform you that the proposal has been approved as an Exempt study per Category # 2. You may begin study implementation and data collection upon receipt of this email. An official letter of approval for your study files will be forthcoming. Dr. Claywell forwarded a readable copy of the approval from Lutheran Medical Center (we apologize that embedding such files in the application makes it unreadable to the reviewer!). We wish you success with your investigation!

Patsy McGuire Cullen, PhD, PNP-BC
Chair, Institutional Review Board
irb@regis.edu

Appendix G: Exempla IRB Approval

Exempla HEALTHCARE

A member of Sisters of Charity of Leavenworth Health System

August 28, 2013

Debra Jo Behr RN, MS, CCRN
ELMC – Nursing Administration

Re: IRB # 201335, Evaluation of Impact of End-of-Life Nursing Education Consortium (ELNEC) Education on Registered Nurses

Dear Ms. Behr,
The above-mentioned study has been reviewed and all requested changes have been received. The study received has been approval, as of August 28, 2013 under HHS 45 CFR 46.110 and FDA 21 CFR 56.110, Category # 7. The study is approved for no more than twelve (12) months. **Approval will expire on 08/27/2014.**

The following are included in this approval:
1. Protocol, Evaluation of Impact of End-of-Life Nursing Education Consortium (ELNEC) Education on Registered Nurses, (no version # or date)
2. ELNEC recruitment Flyer and Information for RN sheet.
2. Exempla IRB Fee Waiver

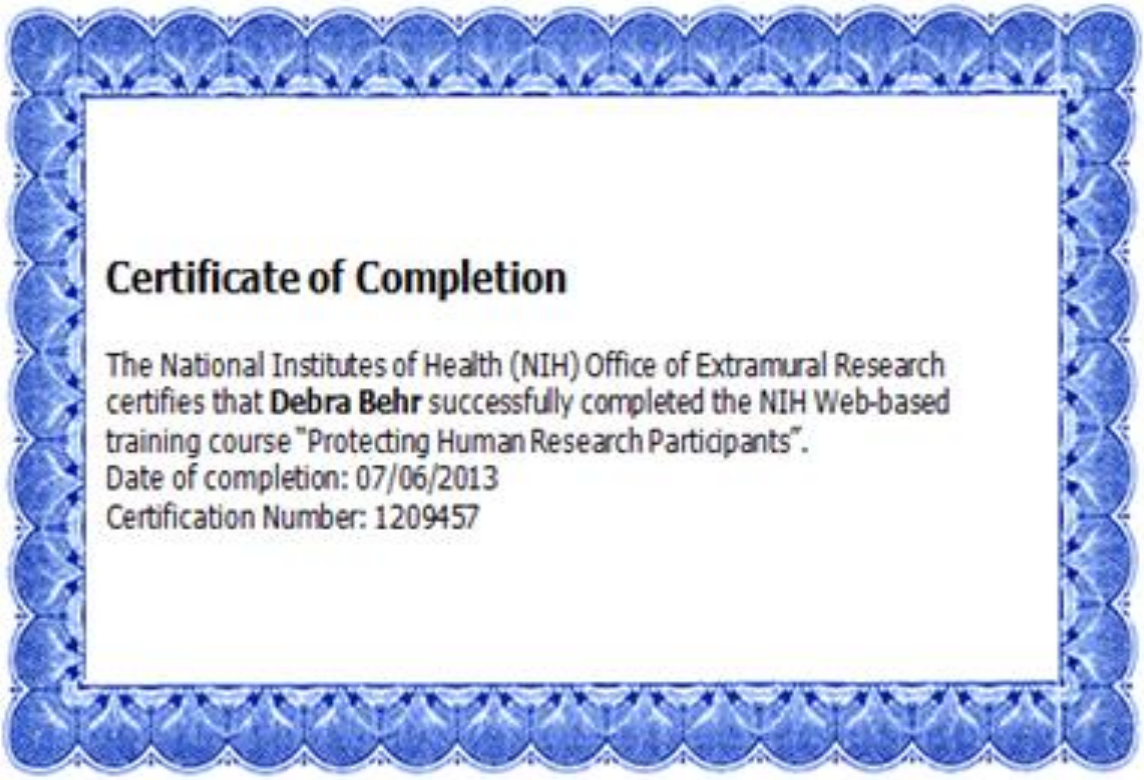
As a reminder, written approval from the IRB must be obtained prior to initiating any changes/modifications in this study. This includes but is not limited to changes in procedures, co-investigators, funding agencies, consent forms, protocols, participant and advertising materials, and investigator brochures unless a change is necessary to eliminate an apparent hazard to the participants in the study (See IRB Policies and Standard Operating Procedures and Submission Forms*).

Any unanticipated problems, serious adverse events, or serious protocol deviations that may occur in the course of this study must be reported promptly. Promptly for internal events means a phone or email notification within 2 business days and a written report within 5 business days; for external events promptly means within 5 business days (See IRB Policies and Standard Operating Procedures*).
If you have any questions, please contact the IRB Office at (303) 837-6529.
Thank you,

Philip Neff, MD
Chair, Exempla Healthcare Institutional Review Board

Appendix H: CITI Certificate

CITI Certificate



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Debra Behr** successfully completed the NIH Web-based training course "Protecting Human Research Participants".
Date of completion: 07/06/2013
Certification Number: 1209457

Appendix I

Information for RN volunteers to participate in ELNEC
End-of-Life Nursing Education Consortium (ELNEC)

You have agreed to participate in the first ELNEC course offered by this organization. You are eligible to attend as you provide acute inpatient nursing care to adults at Exempla Healthcare site; Good Samaritan Hospital, Saint Joseph's Hospital, or Lutheran Medical Center. Nurses are the most consistent healthcare provider at the bedside, and play an important role in conversations by acting as a patient advocate for self-determination of care.

A Regis University Doctor of Nursing Practice student will facilitate this one hour ELNEC course. The data collected in the pre and post educational intervention will be analyzed as part of the student's DNP capstone project. Participation in the pre and post course assessment is completely voluntary. You may still attend the ELNEC course if you choose to opt out of either or both assessment. You may withdraw at any point from the assessment or course. Participation is voluntary. Results of the assessment will be anonymous and data will be secured for three years and then destroyed.

Objective
The End of Life Nursing Education Consortium (ELNEC) education evaluation will explore the impact of an Exempla Healthcare quality improvement initiative to improve end of life (EOL) care between nurses and patients with life-limiting illness.

Question include:
1. The impact the ELNEC Course curriculum on RN responses on Modified ELNEC-KAT scores

Materials
If you agree to voluntarily participate in the evaluation, you will be asked to complete the following surveys *before and after* the ELNEC class:
1. Demographic survey (take before class only)
2. Modified ELNEC-KAT Pre/Post Assessment 50-item Version

Procedure
1. Watch your email and unit communication areas for the ELNEC Communication class flyer and register for this course.
2. If you would like to participate in the evaluation, arrive early to the class to ask any questions, receive the evaluation instructions and your confidential survey packets. Evaluation participation is not mandatory to take the class.

Risks & Benefits
1. While we do not think there is any risk to you from participating in this project, the surveys will ask you about your feelings and emotions when

caring for people with a terminal or life-limiting diagnosis.
2. An inconvenience associated with participation would be the time that it takes to fill out the surveys.
3. Continuing education credit

Questions?
Contact the Project Manager Debra Behr RN, MS, CCRN at dbehr@regis.edu/ behrd@exempla.org, or cell phone: 303-908-3595. This project is being conducted for the partial fulfillment of the requirements for the degree of Doctor of Nursing Practice (DNP) at Rueckert-Hartman College for Health Professions, Regis University, Denver Colorado .

This *EXEMPT* research protocol has been approved by the Human Research Review Committee at Exempla Healthcare System and Regis University.

If you have any questions about your rights as a research participant, you may contact: Cami Lind, CIP Exempla IRB Coordinator IRB Administrative Office 1835 Franklin Street Saint Joseph Hospital Denver, Colorado 80218 Phone: 303.837-6529 Fax: 303-837-6527

Appendix J Timeframe

August 2012	Exempla IRB approval
September 2013	Project compilation
October 2013	Written and Oral Proposal
December 2013	Regis IRB submission
January 2014	Regis IRB approval
	Capstone intervention
	Data collection
January-May 2014	Literature searches and integration
	Data organization
May 2014	Data analysis begins
June 2014	Statistical analysis completed
July 2014	Capstone power point and paper
August 2014	Project defense, Written submission
August 2014	Capstone project completion

Appendix I Agency Letter of Support-Exempla Lutheran

DEPARTMENT AGREEMENT FOR RESEARCH PROJECT
For Exempla Lutheran Medical Center

STUDY TITLE: Evaluation of Impact of End-of-Life Nursing Education Consortium (ELNEC) Education on Registered Nurses

PRINCIPAL INVESTIGATOR: Debra Behr, RN, MS, CCRN

ANTICIPATED START DATE: September 2013
ANTICIPATED ENROLLMENT: 25+

Protocol requirements:

Nurses from in-patient departments will be invited to attend this one day course. The course will include a pre and post assessment survey provided by the ELNEC (End of Life Education Consortium- see attached fact sheet) developed to demonstrate acquired knowledge.

Service Needed: Provide nurses with information (on participant Flyer) needed to enroll in course -if they are interested in participating

Geri Towndrow **Date:** May 2013
C.N.O. Exempla Lutheran Medical Center

Geri Towndrow
Vice President & Chief Nursing Officer
303-425-2692
303-425-8198 (fax)
Lutheran Medical Center
geraldine.towndrow@sclhs.net

Appendix J: Agency Letter of Support-Exempla Saint Joseph

DEPARTMENT AGREEMENT FOR RESEARCH PROJECT
For Saint Joseph Hospital

STUDY TITLE: Evaluation of Impact of End-of-Life Nursing Education Consortium (ELNEC) Education on Registered Nurses

PRINCIPAL INVESTIGATOR: Debra Behr, RN, MS, CCRN

ANTICIPATED START DATE: September 2013
ANTICIPATED ENROLLMENT: 25+

Protocol requirements:

Nurses from in-patient departments will be invited to attend this one day course. The course will include a pre and post assessment survey provided by the ELNEC (End of Life Education Consortium- see attached fact sheet) developed to demonstrate acquired knowledge.

Service Needed: Provide nurses with information (on Flyer) needed to enroll in course if they are interested in participating.

Mary Shepler _____ **Date:** 8/13/13

C.N.O. Exempla Saint Joseph Hospital

Mary Shepler
Vice President & Chief Nursing Officer
Exempla Saint Joseph Hospital
Mary.Shepler@scths.net

Appendix K: Agency Letter of Support-Exempla Good Samaritan

DEPARTMENT AGREEMENT FOR RESEARCH PROJECT
For Good Samaritan

STUDY TITLE: Evaluation of Impact of End-of-Life Nursing Education Consortium (ELNEC) Education on Registered Nurses

PRINCIPAL INVESTIGATOR: Debra Behr, RN, MS, CCRN

ANTICIPATED START DATE: September 2013
ANTICIPATED ENROLLMENT: 25

*If the study involves any service, the supervisor of the sub-department where the service is located must be contacted and the service must be acceptable to the supervisor. After the supervisor's review and signature, the form must be signed by the Director.

Protocol requirements:

Nurses from in-patient departments will be invited to attend this one day course. The course will include a pre and post assessment survey provided by the ELNEC developed to demonstrate acquired knowledge.

Service Needed: Provide nurses with information (on Flyer) needed to enroll in course if they are interested in participating

CNO 's Signature: _____ **Date:** 8/14/2013