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College of Education and Health Professions Honors Thesis

Nursing Faculty and Care of the Dying

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ABSTRACT

Background: There is a demand for effective and efficient palliative and end of life nursing care that will meet the needs of the aging Baby Boomer generation. Though advancement has been made, palliative and end of life care for the seriously ill adult is still lacking. That deficiency can be traced to deficiency in nursing education. Further still, nursing faculty attitudes, knowledge and self-efficacy in palliative care may present a barrier for adequate palliative care nursing curriculum.

Objective: Explore the current knowledge, attitudes and self-efficacy of nursing faculty regarding care for seriously ill adults.

Methods and Design: A quantitative, descriptive research design using an online survey was sent to current Eleanor Mann School of Nursing (EMSON) faculty and adjunct clinical instructors. Measurement tools include the Palliative Care Knowledge Test (PCKT), Frommelt Attitudes Toward Care of the Dying (FATCOD) and Death Anxiety Scale (DAS). Results of the individual surveys were assessed for correlation against each other and respondent's demographic information as well as against respondents who had taken additional palliative care course work.

Data Analysis: Descriptive analysis and ANOVA correlations were run on survey results.

Results: No significant correlation was assessed between Knowledge, Attitudes, and Death Anxiety. There was no significant correlation between these measures or age. There was no significant difference between respondent's knowledge responses or anxiety responses when comparing respondents who had taken additional palliative coursework and respondents who had not. There was a significant difference in attitude scales between respondents who had taken additional palliative coursework and those who had not; those who had additional courses had more positive attitudes.

Conclusion: This preliminary study indicates the need for further studies performed on nursing faculty to fully assess the effectiveness of experiences in nursing school. While many studies are conducted utilizing student and patient data, successes and deficits in practice efficacy begin with nursing school and faculty. Teachers must advocate for implementation and focus of competencies as outlined by the American Association of Colleges of Nursing (AACN) to improve nursing curriculum in palliative and end-of-life care.

INTRODUCTION

Essential problems regarding end-of-life care exist within our healthcare system (Institute of Medicine, 2015). These issues include insufficient attention to palliative care in nursing and medical school curricula and educational silos that impede the development of interprofessional teams. Not only are the palliative systems in need of improvement, but they need immediate improvement because of the aging Baby Boomers. Nurses, as patient advocates, therefore must be sufficiently prepared for palliative and end of life care. Integration of care for the seriously ill or dying adult into the curricula is not yet being required by accreditation bodies and there is insufficient understanding of how faculty knowledge, death attitudes and self-efficacy in palliative care obstruct adequate palliative care education for nurses.

Therefore, this study will explore the knowledge, attitudes, and self-efficacy of faculty in caring for seriously ill and dying persons.

LITERATURE REVIEW

Nurses cannot practice what they do not know. Nurses who do not understand the competencies of end of life care will not practice appropriate measures for the challenging situations presented in end of life care. Studies have examined the performance of nurses on the Palliative Care Knowledge Test (PCKT). Repeatedly, PCKT scores show knowledge deficits among nurse participants (Evans, 2016; Evans, 2015; Prem, et al, 2012). The results show insufficient knowledge, attitudes, and self-efficacy in palliative care. Correlational analyses suggest that higher levels of education and clinical experience deepen the understanding of palliative care (Sato et al., 2014). Education on how to care for patients at the end of life in addition to emotional training and death education has resulted in increased knowledge, decreased anxiety and increased confidence among nursing students (Herrerro, Sabado, & Gomez 2012; White et al, 2014; White, 2001).

Integration of end-of-life care education into nursing schools requires faculties that are knowledgeable of, have positive level of confidence (self-efficacy) in, and have low anxiety toward end-of-life care. Jeffers (2014) conducted a phenomenological study of nursing faculty's attitudes toward a palliative care curriculum. The following themes were identified: "Transforming students' perspectives on end-of-life-care; wondering if the students understand end-of-life-care; weaving faculty experiences into teaching practices; advocating for students, patients and families; developing a balance between cure vs. care; striving to integrate end-of life learning "opportunities" (Jeffers, 2014, p. 79-109). These themes reinforce the idea that end of life care education is indispensable to future nursing practice, and that begins with competent, caring educators. "Transforming students' perspectives on end-of-life care" (Jeffers, 2014 p.79) is defined as a theme speaking to the experience of helping a student get through those first-time death experiences, and the satisfaction of seeing them benefit from the jarring experience. "Wondering if the students understand end-of-life care" (Jeffers, 2014, p. 90) describes the questioning

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that teachers undergo when their students have profound experiences in school. They wonder if the student does or will one day understand the gravity of what they witnessed in those intimate death experiences. The third theme defined by Jeffers' (2014) phenomenological perspective is "weaving faculty experiences into teaching practices." This emphasizes the importance of sharing profound personal experiences with students to promote their understanding and learning. "Advocating for students, patients and families" was a major theme discussed. Participants in Jeffer's (2014) study had found themselves having meaningful advocacy experiences for not just students but also for patients and families. The fifth theme was "developing a balance between cure vs. care" (Jeffers 2014 p. 96) discussing an issue nurses face in especially at end of life care. Participants shared this common theme when teaching students. The final theme "striving to integrate end of life learning opportunities." –A challenge faced by all nursing instructors because of varying availability of terminally ill patients, but also a fear of offending the families and patients experiencing end of life. While the common theme among participants was to seek out those opportunities, most reported missing those opportunities to learn. The themes Jeffers touches on in the phenomenological study could be widely felt among nursing faculty. This study is interesting, yet qualitative. Descriptive, quantitative studies utilizing reliable instruments to measure knowledge and attitudes of nursing faculty are lacking.

The American Association of Colleges of Nursing (AACN) has recommended integration of end-of-life care education into undergraduate nursing program curricula. The competencies, listed below, outlined within the recommendation are a response to the current lack of comprehensive, accurate and well delivered information regarding end of life care. Integration of end-of-life competencies to curriculum could combat poor knowledge and attitudes (O'Connor 2016).

CARES: Competencies and Recommendations for Educating Nursing Students

1. Promote the need for palliative care for seriously ill patients and their families, from the time of diagnosis, as essential to quality care and an integral component of nursing care.

2. Identify the dynamic changes in population demographics, health care economics, service delivery, caregiving demands, and financial impact of serious illness on the patient and family that necessitate improved professional preparation for palliative care.

3. Recognize one's own ethical, cultural, and spiritual values and beliefs about serious illness and death.

4. Demonstrate respect for cultural, spiritual, and other forms of diversity for patients and their families in the provision of palliative care services.

5. Educate and communicate effectively and compassionately with the patient, family, health care team members, and the public about palliative care issues.

6. Collaborate with members of the interprofessional team to improve palliative care for patients with serious illness, to enhance the experience and outcomes from palliative care for patients and their families, and to ensure coordinated and efficient palliative care for the benefit of communities.

7. Elicit and demonstrate respect for the patient and family values, preferences, goals of care, and shared decision-making during serious illness and at end of life.

8. Apply ethical principles in the care of patients with serious illness and their families.

9. Know, apply, and effectively communicate current state and federal legal guidelines relevant to the care of patients with serious illness and their families.

10. Perform a comprehensive assessment of pain and symptoms common in serious illness, using valid, standardized assessment tools and strong interviewing and clinical examination skills.

11. Analyze and communicate with the interprofessional team in planning and intervening in pain and symptom management, using evidence-based pharmacologic and nonpharmacologic approaches.

12. Assess, plan, and treat patients' physical, psychological, social, and spiritual needs to improve quality of life for patients with serious illness and their families.

13. Evaluate patient and family outcomes from palliative care within the context of patient goals of care, national quality standards, and value.

14. Provide competent, compassionate, and culturally sensitive care for patients and their families at the time of diagnosis of a serious illness through the end of life.

15. Implement self-care strategies to support coping with suffering, loss, moral distress, and compassion fatigue.

16. Assist the patient, family, informal caregivers, and professional colleagues to cope with and build resilience for dealing with suffering, grief, loss, and bereavement associated with serious illness.

17. Recognize the need to seek consultation (i.e., from advanced practice nursing specialists, specialty palliative care teams, ethics consultants, etc.) for complex patient and family needs.

In conclusion, our current nursing workforce lacks knowledge and skill in caring for patients as the near the end of their lives. Nursing faculty knowledge, skills and attitudes are not currently well understood. Nursing schools' accreditation agency, the American Association of College of Nursing, has recommended the integration of end-of-life care content into nursing school curricula. Through integration of this content, it is hoped that future nurses will be prepared to skillfully carry out their key roles in caring for the increasing numbers of patients who will benefit from knowledgeable, compassionate end-of-life care.

METHOD

Design: This project was a quantitative descriptive survey.

Subjects: Participants were Eleanor Mann School of Nursing (EMSON) faculty and

adjunct clinical instructors during the 2017-2018 academic year. (N = ~100).

Ethics: This study was conducted following approval from the University of Arkansas Institutional Review Board. Confidentiality was maintained through anonymous data collection within the Qualtrix data base.

Protocol/Procedure: The survey was constructed using Qualtrix survey software. Surveys were distributed to faculty and adjunct clinical instructors of EMSON. A link to the surveys with a letter of

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introduction and implied consent was sent via the University of Arkansas email system. Responses were returned anonymously to the Qualtrix database. Initial requests were sent in October of 2017 with two reminders sent at one-week intervals. Additional distribution of the survey was done in January of 2018.

Measures: The Palliative Care Knowledge Test (PCKT) is a self-report questionnaire with 20 statements about palliative care. Respondents indicate "correct, "incorrect" or "unsure" for each of the items. The PCKT has 5 subscales (philosophy, pain, dyspnea, psychiatric problems, and gastrointestinal problems) with intraclass correlations of 0.81 (Nakazawa, 2009). Frommelt Attitudes Toward the Care of the Dying Scale (FATCOD) is a 30-item scale designed to measure attitudes toward providing care to dying patients. There are an equal number of positive and negative worded statements with 5-point Likert-type response options that indicate the level of the respondent's agreement with the statements. Negative items are reverse scored, and a higher score indicates a more positive attitude (range 30-150). Reliability coefficient of 0.90 and content validity index of 1.00 have been established (Frommelt, 1991). Templer's 15-item Death Anxiety Scale asks respondents for to indicate a true or false agreement to each item. It has an established test-retest reliability of 0.83. These three measures were assessed for correlation between each other, age, and the variable of taking additional palliative care education within the past two years.

Data Analysis: Using SPSS statistics software, descriptive analysis of survey responses was compiled. Correlation and t tests were used to assess the relationship between self-efficacy, knowledge and attitudes of nursing faculty and demographic data.
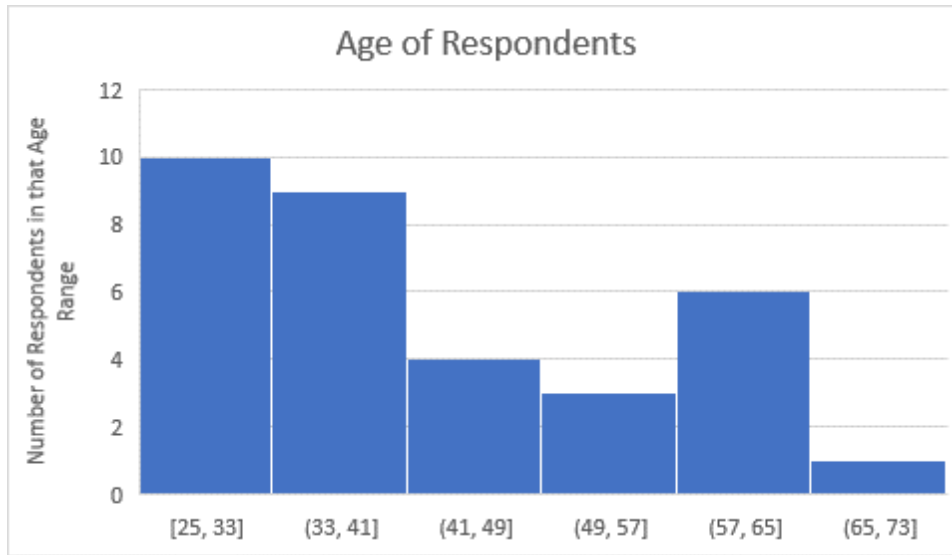
RESULTS

Subject Demographics of Nursing Faculty

Gender	Female (31)	Male (2)	Other (0)
Hispanic or Latino	Hispanic or Latino (31)	Non-Hispanic or Non-Latino (1)	Unreported (1)
Race	White (31)	Asian (1)	Other (1)

Table 1 Demographic Information 1

Graph 1 Demographic Information 2

Results were assessed for any correlation across all three surveys. 33 complete responses were recorded.

Anxiety results (Graph 2): There was a large range of responses from no death anxiety to a fair amount of

death anxiety (Max= 0.6). Attitude results (Graph 3): The minimum and maximum for attitude are

centrally focused, reducing the range. It could be expected to have had a wider range of responses for

attitude. Knowledge results (Graph 4): Mean score was 63%, with higher scores indicating better

knowledge of palliative care. Minimum score was 40% and maximum score was 85%

There were no significant correlations between the three scales; and age (Q83 in the graph) did

not correlate to any of the three scales either (See Table 2 and Graph 5). The anxiety and attitude scales

were not significantly correlated to each other, $r(N = 33) = -.14237$, $p = .4293$.

Results on separate surveys were measured against having taken additional palliative care

coursework and not having additional palliative care coursework. There was no significant difference

between reported anxiety between the group who reported taking a class and the group that reported not

taking a class, $t(31) = .10$, $p = .9246$ (Figure 1). There was a significant difference between those who

took training in dying in terms of attitude, $t (31) = 2.49$, $p = .0185$. The people who didn't have training

had more positive attitudes ($M = 3.1127$, $SD = .1951$) than those who did have training, ($M = 2.9529$, SD

= .1410). Cohen's d is .9394 which indicates the difference between the two groups is nearly a whole standard deviation (Figure 2). There was no significant difference in knowledge between those who have or have not taken a class, $t(31) = 1.11$, $p = .2771$.
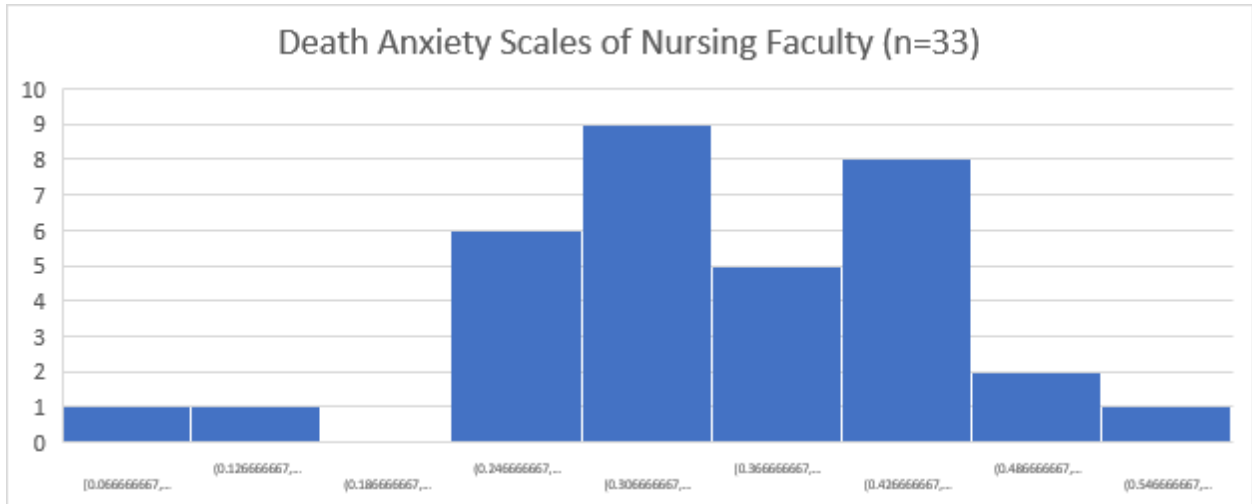
Graph 2 Distribution of death anxiety scores among faculty.
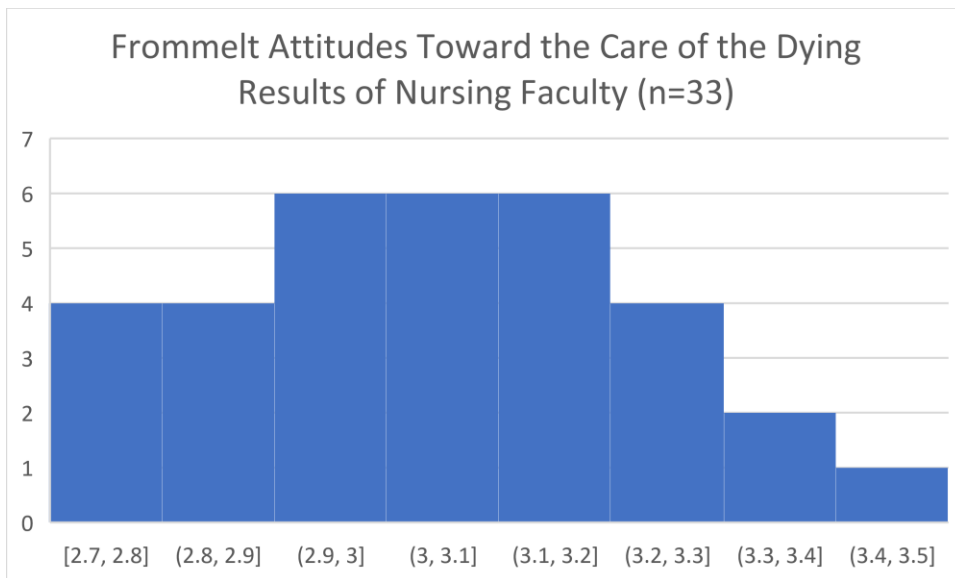
Graph 3 Attitude Scales Distribution of Nursing Faculty
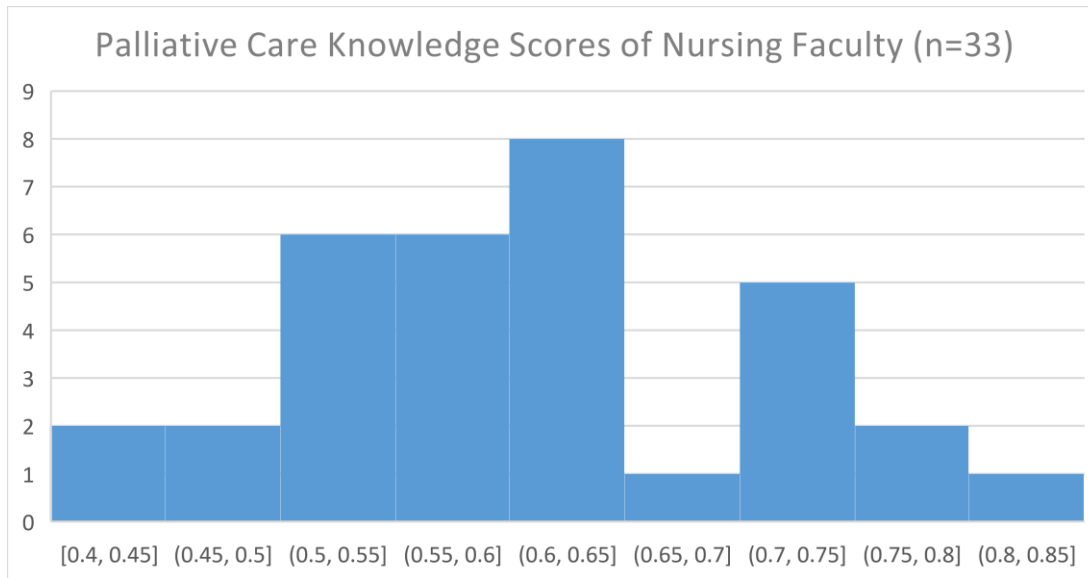
Graph 4 Knowledge Scores Distribution on PCKT of Nursing Faculty.

	Death Anxiety	Attitude Toward Care for the Dying	Palliative Care Knowledge	Age
Death Anxiety	1.00000	-0.14237 0.4293	-0.20673 0.2484	0.20863 0.2439
Attitude Toward Care for the Dying	-0.14237 0.4293	1.00000	-0.03738 0.8364	-0.22473 0.2086
Palliative Care Knowledge	-0.20673 0.2484	-0.03738 0.8364	1.00000	0.21024 0.2402
Age	0.20863 0.2439	-0.22473 0.2086	0.21024 0.2402	1.00000

Table 2 Numerical statistics of matrix correlation analysis assessing for correlation between all three scales (Death Anxiety, Attitude, Palliative Care Knowledge) and age.
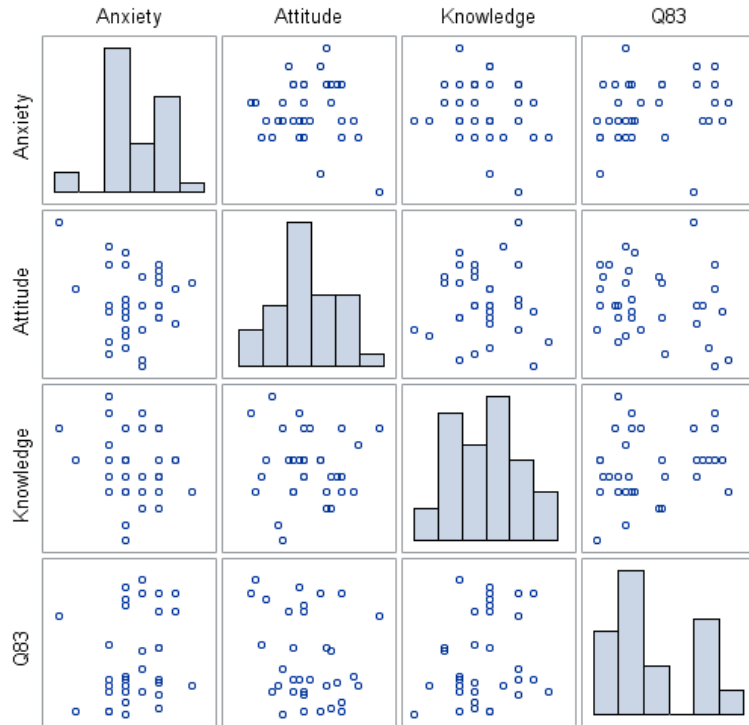
Graph 5. Combination Graph. Correlation analysis assessing for correlation between all three scales (Death Anxiety, Attitude, Palliative Care Knowledge) and Age.

Variable: Anxiety

ClassTaken	N	Mean	Std Dev	Std Err	Minimum	Maximum
0	21	0.3683	0.1167	0.0255	0.0667	0.5333
1	12	0.3722	0.1118	0.0323	0.2667	0.6000
Diff (1-2)		-0.00397	0.1149	0.0416		

ClassTaken	Method	Mean	95% CL Mean		Std Dev	95% CL Std Dev	
0		0.3683	0.3152	0.4214	0.1167	0.0892	0.1685
1		0.3722	0.3012	0.4432	0.1118	0.0792	0.1898
Diff (1-2)	Pooled	-0.00397	-0.0888	0.0809	0.1149	0.0922	0.1528
Diff (1-2)	Satterthwaite	-0.00397	-0.0888	0.0809			

Method	Variances	DF	t Value	Pr > |t|
Pooled	Equal	31	-0.10	0.9246
Satterthwaite	Unequal	23.87	-0.10	0.9239

Equality of Variances				
Method	Num DF	Den DF	F Value	Pr > F
Folded F	20	11	1.09	0.9155

Figure 1 How additional palliative care course work affects anxiety. SPSS statistic system produced. Results: no significant correlation.

Variable: Attitude

ClassTaken	N	Mean	Std Dev	Std Err	Minimum	Maximum
0	21	3.1127	0.1951	0.0426	2.7333	3.5000
1	12	2.9528	0.1410	0.0407	2.7000	3.1667
Diff (1-2)		0.1599	0.1778	0.0643		

ClassTaken	Method	Mean	95% CL Mean		Std Dev	95% CL Std Dev	
0		3.1127	3.0239	3.2015	0.1951	0.1492	0.2817
1		2.9528	2.8632	3.0424	0.1410	0.0999	0.2395
Diff (1-2)	Pooled	0.1599	0.0287	0.2911	0.1778	0.1425	0.2364
Diff (1-2)	Satterthwaite	0.1599	0.0395	0.2804			

Method	Variances	DF	t Value	Pr > |t|
Pooled	Equal	31	2.49	0.0185
Satterthwaite	Unequal	29.081	2.71	0.0110

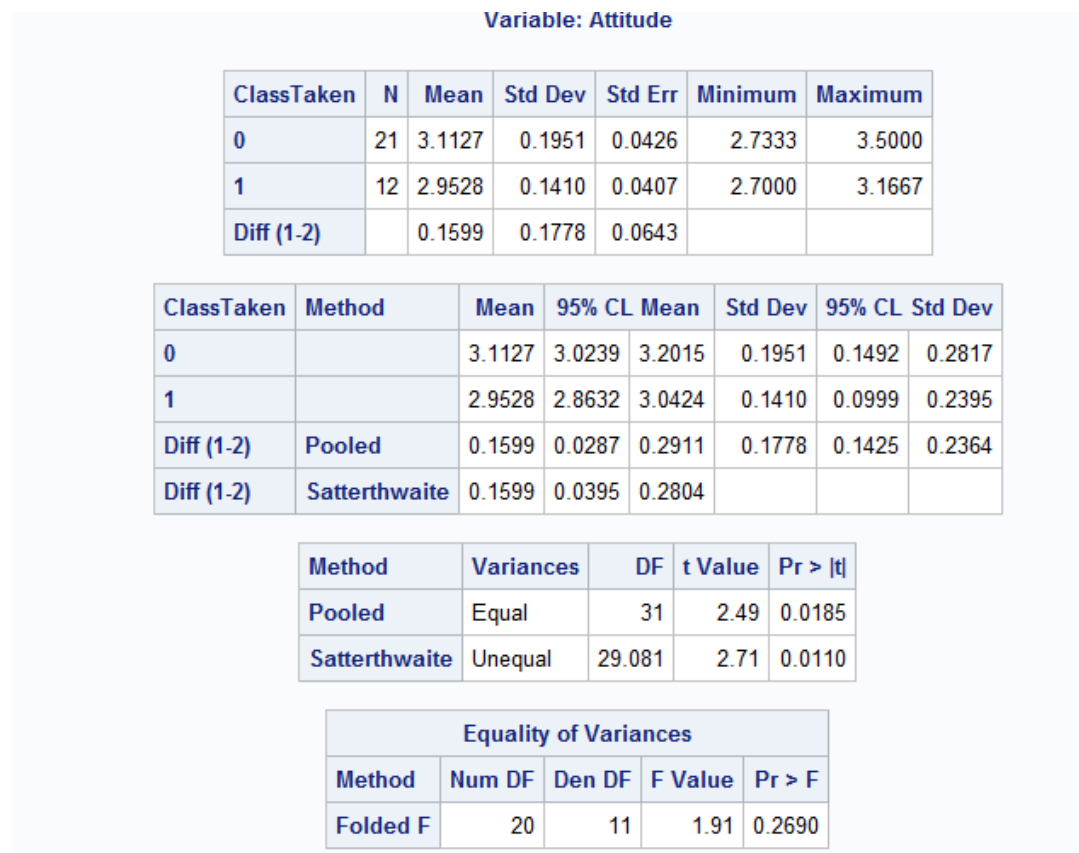| Equality of Variances				
Method	Num DF	Den DF	F Value	Pr > F
Folded F	20	11	1.91	0.2690

Figure 2 How additional palliative care course work affects attitude based on FATCOD scores. SPSS statistic system produced. Results: significant positive correlation.

Variable: Knowledge

ClassTaken	N	Mean	Std Dev	Std Err	Minimum	Maximum
0	21	0.6167	0.0827	0.0180	0.4500	0.7500
1	12	0.6583	0.1346	0.0388	0.4000	0.8500
Diff (1-2)		-0.0417	0.1041	0.0377		

ClassTaken	Method	Mean	95% CL Mean		Std Dev	95% CL Std Dev	
0		0.6167	0.5790	0.6543	0.0827	0.0632	0.1194
1		0.6583	0.5728	0.7438	0.1346	0.0953	0.2285
Diff (1-2)	Pooled	-0.0417	-0.1185	0.0352	0.1041	0.0834	0.1384
Diff (1-2)	Satterthwaite	-0.0417	-0.1325	0.0492			

Method	Variances	DF	t Value	Pr > |t|
Pooled	Equal	31	-1.11	0.2771
Satterthwaite	Unequal	15.851	-0.97	0.3452

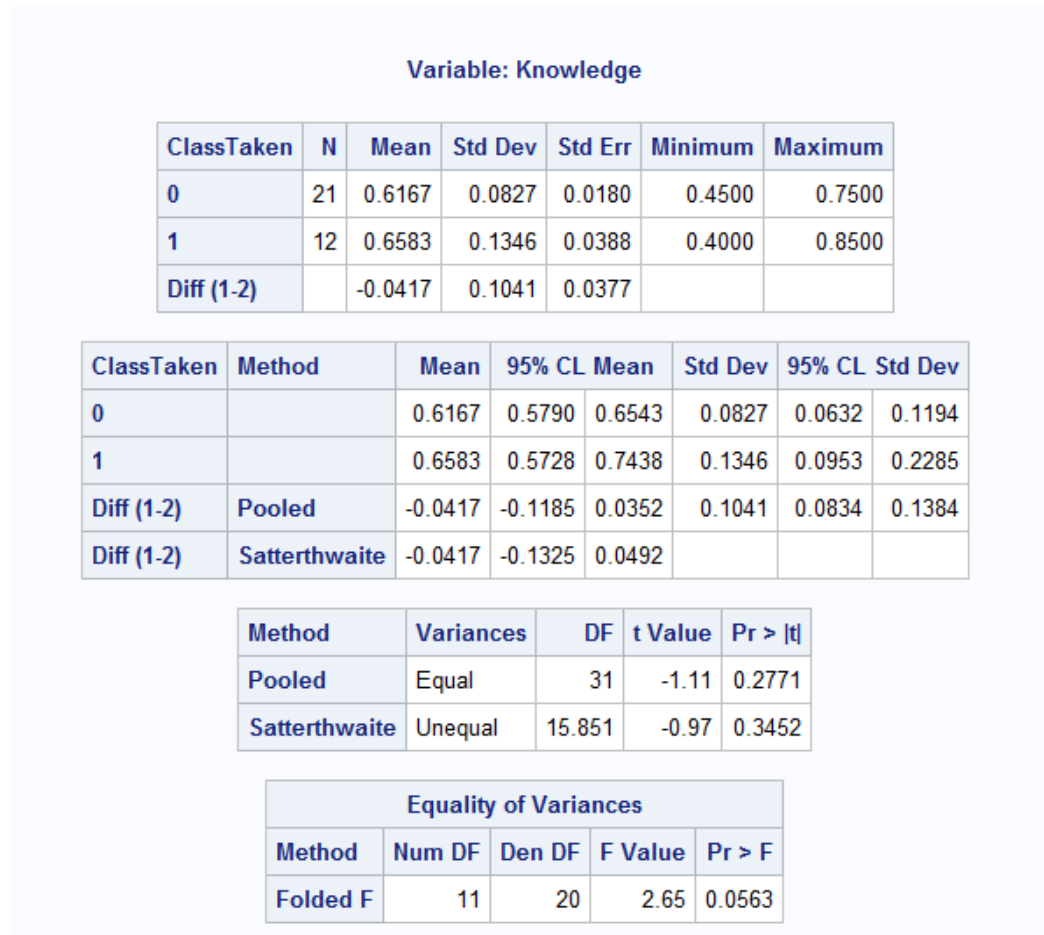| Equality of Variances				
Method	Num DF	Den DF	F Value	Pr > F
Folded F	11	20	2.65	0.0563

Figure 3 How additional palliative care course work affect palliative care knowledge scores on the PCKT. SPSS statistic system produced. Results: no significant correlation.

LIMITATIONS

Response rates to the survey and some wording errors within the survey did not allow for additional analysis. The complexity of inadequate palliative care extends past nursing. The responses yielded an appropriate number of responses, but a larger pool of faculty would create a clearer picture. The study did not assess correlations associated with practical years of nursing or practical years of teaching with results. The study also did not assess levels of higher education degrees received or in what specialty. An additional challenge is that there is little research looking at nursing school faculty.

There will need to be more research completed after this to integrate the competencies into the mandated curriculum for registered nurses, due to the profession focusing on evidence-based practice. This was a preliminary study conducted in a focused group. This study was constructed utilizing known

tools of measure but had never been tested against each other for correlation among faculty. The challenge of future studies will be to complete the research in such a way that is beneficial to the practice of nursing, and appropriately supporting the immediate necessity to enforce palliative care.

DISCUSSION

The objective of this study was to explore the knowledge and attitudes of nursing faculty and care of the terminally in addition to assessing their own anxieties regarding death. It could be expected that some correlation would be present between knowledge, attitudes toward care, and personal anxiety but none such was found in this study. These are all separate constructs so lack of correlation is not entirely unexpected. When measured against age, no correlation was present between results on the individual surveys of knowledge, attitudes toward dying care and death anxiety. Some participants reported taking a class within the past two years related to palliative care. However, there was not a significant correlation between the class and knowledge. This goes against expectations. Faculty self-reported "yes" or "no" to taking additional palliative care classes. Even though no single or controlled class was offered for the purposes of this study, it would be expected that any supplemented education regarding palliative care would increase scores on the PCKT. It would be helpful to pretest and posttest those classes using the PCKT to assess effectiveness of education by comparing results. There was also no significant difference in death anxiety between the group who reported taking a class and the group reporting not having taken a class. Again, expectations were not met. It would be expected that further education in palliative and death care would alleviate individual anxieties. In this study, however, no such significant correlation was found among nursing school faculty. This could be because they already have lower death anxieties because of experiences in their profession, therefore even extended education would not significantly affect them. There was a significant result among attitudes between faculty who had taken additional classes for palliative care and those who had not. Taking additional classwork correlated with more positive attitudes toward care of the dying.

As for individual survey results of nursing faculty, there was a wide range of death anxiety among them. It could be expected that similar results would be yielded but anxiety scales ranged from almost none to a fair amount (max= 0.6 with highest possible score being 1). Attitude scores were all close in response score. Results indicated that this group of nursing faculty felt strongly in the middle about care for the terminally ill, neither liking or disliking it. Usually, there are wider ranges in response scores, but for attitude, the responses were similar. As for nursing faculty's knowledge regarding care for the terminally ill, response scores were low, indicating poor knowledge. Ranging from 40% correct to 85% correct, the average response score falls around 63%. With a knowledge score this low in nursing faculty, even those who had taken continuing education classes, students may not be gaining the appropriate knowledge they need to know for their practice when they care for the terminally ill and their families.

CONCLUSION AND SUGGESTIONS FOR FUTURE RESEARCH

While no significant correlations were found between death anxiety, self-efficacy, and attitudes toward dying care, it would be interesting to measure these before and after continuing education classes for nurses and nursing faculty utilizing pre and posttest measures. An additional factor to consider would be the years of nursing experience against all three factors. Scores could also be compared to only adjunct, or clinical instructors, versus only class room instructors.

Correlations not found between anxiety and knowledge or attitudes and knowledge may indicate that the faculty do well at teaching with little bias. However, the low scores of nursing faculty on the palliative care knowledge test indicate a risk of inappropriate preparation for nursing students who will one day care for the terminally ill or dying. This study was not to minimize the teaching of faculty assessed, or to minimize their cognition. They all come from different areas of specialty and some have not practiced bedside nursing for years. This preliminary research suggests that lack of planning for terminal illness and death is not just affecting the public, but the health care field too. Questions regarding death and terminal illness come at the wrong time—almost always too late. Nurses will care for patients

that will die. It is the duty of nurses to advocate for the highest level of comfort for a terminally ill patient and their family, as outlined by the CARES competencies. Faculty have a duty to advocate to emphasize these competencies, because the nurses they are teaching will have the duty to advocate for the highest level of care at the beginning, during the good, during the bad, and at the end of life.

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