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**Nursing Attitudes to Hospice Care in the Intensive Care Unit**

by

Claudia LaCivita

A project submitted to the faculty of  
Gardner-Webb University Hunt School of Nursing  
in partial fulfillment of the requirements for the  
Master of Science in Nursing Degree

Boiling Springs, North Carolina

2021

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### **Abstract**

Nurses deliver care to patients 24 hours per day and are experts in the care of critically ill patients in the intensive care unit (ICU). The critical care nurse is trained to assess, treat, and monitor severely ill patients to facilitate their recovery, but may often feel ill-prepared and lacking the support usually available to the hospice or palliative care nurse. It also can be difficult to refocus when the desired outcome changes from stabilizing and getting a critically ill patient better to hospice or end-of-life care (EOLC). The purpose of this project was to improve the delivery of care to hospice patients in the ICU environment through education. To this end, a review of the literature was completed to gain insight into the care of the hospice patient at end-of-life and further, understand how support and awareness could be translated into better training and care of hospice patients and their families.

### **Acknowledgments**

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## **CHAPTER I**

### **Introduction**

Unlike other medical care, the focus of hospice care is not to cure but to support the highest quality of life possible for patients that are nearing the end of life. These services are usually provided by a team of health care professionals trained to maximize comfort by reducing pain and addressing physical, psychological, social, and spiritual needs and to help families with counseling, respite care, and other support. It helps in decreasing the burden on family, and their likelihood of having a complicated grief period and prepares families for the death of a loved one.

However, a problem exists in the intensive care unit (ICU) when there is a sudden transition from the need for acute care to hospice care. ICU nurses deliver care to patients 24 hours a day and are experts in the care of critically ill patients. The critical care nurse is educated and certified to assess, treat, and monitor severely ill patients to facilitate recovery but may often feel ill-prepared or frustrated with the lack of training and or experience when caring for the hospice patient. Algorithms, protocols, procedures, advanced training, continuing education, and the other members of the healthcare team help guide the critical care nurse to optimize the health of critically ill patients.

### **Significance**

According to Ciccarello (2003), nurses are uniquely equipped to change the way end-of-life care is managed in the ICU by having discussions about death and challenging the current delivery of care in the ICU. Many of these expert critical care nurses feel ill-equipped to deliver appropriate end-of-life care to patients who die in the ICU. The goal of this project was to assist in the education and training for nurses in the ICU, who are



outside of the hospice and palliative care environment, to help guide in the end-of-life care for patients and their families while improving the patient's and families' experience of this arduous process.

### **Purpose**

The purpose of this project was to provide education to critical care nurses regarding death and dying to ultimately improve the delivery of care to the hospice patient in the ICU environment through the use of support systems, such as the hospice unit. It can be difficult to refocus when the desired outcome changes from stabilizing and healing a critically ill patient to hospice care. Nurses, primary health care providers, and other clinicians need the support to meet the needs of end-of-life needs of the patient and family. The care of the patient continues; however, care is no longer focused on cure but on supporting the dying, where even small changes such as in the environment can make a very big difference in the overall experience.

### **Theoretical or Conceptual Framework**

There are multiple studies on death and dying from the patient and family perspective but few from the nurse or caregiver's perspective in the ICU, where it can be perceived as a vague, terrifying, and overpowering entity (Copp, 1998). The Corr approach to understanding and coping with death and dying proposes a task-based understanding for those who care for the dying and those who are dying. This model utilizes two central concepts which are the notions of tasks and coping with dying. The model's central premise is that dying is not confined to the individual but has a significant impact on family, friends, and caregivers and as such should contribute to 'improved understanding, empowerment, participation, and guidance for helpers to cope

with dying' (Copp, 1998). The first concept, tasks, deals with the physical, psychological, social, and spiritual tasks of dying. The physical task deals with satisfying physical needs and minimizing distress, the psychological task relates to autonomy and security, the social task involves enhancing personal relationships, and the spiritual task concerns the need to identify and affirm spiritual energy and foster hope. Corr (1992) asserts that 'there is no single right way in which to cope with dying, although there may be better, worse, and even unacceptable modes of coping from the standpoint of each of those involved'. The second concept deals with 'coping with dying' that is reacting to or awareness of events and challenges and how to overcome or contend with them.

This model will be used to develop education material by focusing on Corr's physical and psychological tasks by chart reviews, facilitation by the inpatient hospice/palliative care services, identification of patient's advance directives or preferences about end-of-life care, assistance with the discussion of the prognosis and treatment options with patients and/or their families, and implementation of palliative care strategies when treatment goals change from acute care, to focus on comfort care measures.

### **Conclusion**

The purpose of this MSN project was to provide education to intensive care unit nurses on how to manage and care for patients nearing the end of life. The educational design will incorporate Corr's task-based theory, which is a holistic approach to death and dying, including the caregiver's reaction to the patient at end of life.

## **CHAPTER II**

### **Literature Review**

Under normal circumstances, outside of the acute care environment, a patient who can no longer benefit from curative modalities and is nearing the end-of-life, with consent, is referred to hospice and/or palliative care. Hospice and/or palliative care consists of a specialized group of professionals whose goal is to maximize comfort for the terminally ill by addressing physical needs, such as pain, psychological needs, social needs, and spiritual needs. These professionals also provide services to the families such as counseling to prepare for the death of a loved one and assistance through the grieving process, and respite care to help decrease the burden on family members. In an intensive care unit (ICU) the patient status may change after hours, on weekends, and during holidays when these professionals are not available. When this occurs, the nurse needs to be able to function in multiple roles and overcome barriers to provide a smooth transition to end-of-life care.

This literature review examined the factors that affect attitudes of nurses to hospice/end-of-life care in the ICU and discusses relevance in nursing practice. Additionally, this review looked at what can be done to improve the delivery of care as the patient transitions from an acute phase to palliative care, from a holistic standpoint. The databases used to conduct this literature search included CINAHL, Pubmed, and JSTOR, and keywords used included end-of-life care, palliative care, and intensive care unit.

## **Review of the Literature**

### **Attitudes of Nurses on Hospice Care**

According to Price et al. (2017), nursing professionals may not always be adequately prepared to deliver quality palliative and end-of-life (EOL) care to patients and families, and commonly recognized barriers include nurses' lack of experience, education, or involvement in the patient's plan of care. Price et al. (2017) also noted that the ICU nurse plays a key role in the integration of palliative care in the comprehensive treatment of critically ill patients, regardless of prognosis. The quantitative study surveyed 583 nurses from adult and pediatric intensive care units (ICUs) and acute care units. The specific aims were to assess nurses' self-perceived competence of knowledge, attitudes, and behaviors regarding the provision of palliative and end-of-life (EOL) care in the hospitalized patient and identify deficits in the delivery of quality EOL care. The study method surveyed the knowledge, attitudes, and behaviors of inpatient nurses around seven palliative and EOL care domains. Price et al. (2017) stated that these domains included decision making, communication, continuity of care, emotional support for patients and families, symptom management, spiritual support for patients and families, and emotional support for staff. A modified instrument known as the End-of-Life Care Questionnaire (EOLC-Q), was used to assess knowledge, attitudes, and behaviors in providing palliative and EOL care around the seven domains. The study concluded that continuity of care was a concern and that, "areas of lower perceived competence of ICU nurses pertained to behaviors associated with decision making in withdrawal of care, decision making related to goals of care and code status, and communication and collaboration with physicians" (Price et al., 2017). The limitations of

the study were being limited to nurses in large academic, inpatient settings and that respondents were more likely those that were already interested in EOL care (Price et al., 2017).

A study by Moir et al. (2015) surveyed nurses at a large hospital to determine the perceived needs of inpatient nurses for communicating with patients and families about palliative and EOL care. It was also noted that inpatient staff nurses were not prepared to provide optimal hospice care to patients no longer receiving curative treatment and that skilled nurses comfortable with hospice care communication may improve the quality of life for these inpatients. Moir et al. (2015) also state that an assumed lack of education and accompanying uneasiness among clinical nurses in discussing palliative care with patients and their families may negatively impact the transition from curative-based care to hospice care. A non-experimental survey design was used which included an End-of-Life Caregiver Survey tool to examine the differences based on the age of the nurse, years of nursing experience, and kind of unit on which they worked. The study found that scores were lowest in the effective care delivery domain, suggesting that nurses across all populations may benefit from EOL care education in order to increase their own skill and comfort in caring for the patients.

### **Providing Hospice Care to ICU Clients**

Communication is also an integral part of EOL care in the ICU, and according to Gonella et al. (2021), understanding nurses' perceptions about the impact of EOL communication on the EOL goals, is critical to better understand and address the challenges of providing high-quality and thorough communication. As part of the interdisciplinary team, the nurse is in a unique position to identify issues such as goals of

care or conflicts between the family and patient (Gonella et al., 2021). Therefore, the attitudes of nurses have clear implications on the quality of EOL care to ensure meeting the goals of the patient and family. In addition, Gonella et al. (2021) suggest there needs to be some standardization of care that can be adapted to the individual based on preferences and values.

Romano et al. (2017) studied the effects of early palliative/end-of-life care on improving quality of life and other outcomes in cancer patients. Romano et al. (2017) found that early palliative care significantly reduced ICU stay but did not change ICU events. Romano et al. (2017) did find a clear benefit in improved quality of life, reduced incidence of death in the hospital environment as more patients opted to die at home. Meier (2011) also found that palliative care and hospice services improve patient-centered outcomes such as pain, depression, and other symptoms; patient and family satisfaction, and that palliative care prolongs life compared to usual care. Meier (2011) concluded that policies focused on enhancing the palliative care workforce, investing in the field's science base, and increasing the availability of services in U.S. hospitals and nursing homes are needed to ensure equitable access to optimal care.

### **Other Factors Impacting Nursing Attitudes in Relation to EOL Care in the ICU**

A study by Noome et al. (2017) defined end-of-life care (EOLC) as the care provided before, during, and after withholding or withdrawing life-sustaining treatment and examined the role and responsibilities of ICU nurses regarding the spiritual aspects of EOLC in the ICU. Noome et al. (2017) noted that to understand the role of ICU nurses during EOLC regarding the spiritual aspects of EOLC of patients and family, and their spiritual questions, it is important to know how to deal with the needs and wants of

patients and families regarding spiritual aspects of EOLC. Because many ICU patients may not be conscious and able to make their own determinations, the nurse and family play a major role during this period and may have to address questions, about life and death (existential questions) and feelings about life and death. In this study, questions about life and death are referred to as spiritual questions. This study focused on the role of ICU nurses regarding the spiritual needs and wants of patients and families because the ICU is a setting where life and death go hand in hand.

Other factors impact the provision of hospice care in the ICU. A study involving 20 nurses, by Keall et al. (2014) investigated the facilitators, barriers, and strategies that Australian palliative care nurses identify in providing existential and spiritual care for patients with life-limiting illnesses. The nurses' interviews yielded several themes including the development of the nurse-patient relationship and good communication skills. Barriers were identified as lack of time, skills, privacy and fear of what you may uncover, unresolved symptoms, and differences in culture or belief. The study concluded that palliative care nurses, and nurses in general, are well placed to provide existential and spiritual care to patients with the primary facilitator being the nurse-patient relationship. It also identified ongoing nursing education as a strategy.

### **Nursing Attitudes Towards Death in the ICU**

Approximately 20% of deaths in the United States occur during or shortly after a stay in the ICU. Critical care represents an important and expensive setting for end-of-life care (Curtis et al., 2012). With improved nursing attitude and comfort in the final stages of the patient's life, there is a potential for improved patient outcomes, better satisfaction with care, and avoidance of undesired interventions. Hospitals, especially ICUs, are not

where patients prefer to die, yet ICU admissions at the end of life are increasing, probably because of patients' and providers' lack of comfort with a more palliative approach. According to Higginson and Sen-Gupta (2000), the site of death has been proposed as a quality measure for end-of-life care because, despite general population surveys indicating the majority of respondents and those with serious illness want to die at home, in actuality, most die in an institutional setting. The study also found a poorer quality of care in the institutional setting compared with care at home, especially with hospice services. The place of care and site of death have implications for the grief and posttraumatic stress disorders experienced by family members (Teno et al., 2013).

There are increasing demands for hospitals to provide end-of-life care. Also, the quality of care provided in hospital settings may be an issue of growing concern because many dying patients receive their care from general nurses, unrelated to the nurses' specialty or level of training. Hussin et al. (2018), conducted a study for the associations among three variables: nurses' knowledge of EOLC, their attitudes towards EOLC, and their perceptions of quality of EOLC in a hospital setting, and found that the nurses in this study have a low level of knowledge on the topic. The nurses' lowest score for knowledge was related to pain and symptom management. The recommendation emphasized the need for nurse managers and hospital policymakers to provide EOLC courses and training for nurses, especially with respect to knowledge regarding pain and symptom management (Hussin et al., 2018).

Other efforts were noted to improve EOLC in hospitals and address the unmet need for palliative care. This included a study by Morris et al. (2015), where a Hospice-In-Place (HIP) quality improvement project was initiated in a large medical



intensive care unit (MICU), and patients were discharged and readmitted to a hospice organization while categorizing the hospital bed as a satellite in-patient hospice bed. At the conclusion of the project, the percent of MICU patient hospitalizations with HIP increased from a baseline value and remained greater throughout the reporting period, helping to address patients' needs for hospice that the traditional ICU nurse/staff cannot fully meet.

Clarke et al. (2003), performed a study to address the documented deficiencies in end-of-life care (EOLC) in intensive care unit settings by identifying key EOLC domains and related quality indicators for use in the intensive care unit through a consensus process. Seven EOLC domains were identified for use in the intensive care unit: (1) patient- and family-centered decision making, (2) communication, (3) continuity of care, (4) emotional and practical support, (5) symptom management and comfort care, (6) spiritual support, and (7) emotional and organizational support for intensive care unit clinicians. In conclusion, these EOLC domains and the associated quality indicators provided clinicians and researchers with a framework for understanding the quality of EOLC in the intensive care unit. These indicators might be used to improve the quality of EOLC in the intensive care unit settings.

There are many surveys that examine the nursing experiences with EOLC. One study by Boyd et al. (2011) looked at oncology nurses' attitudes and their experiences in caring for terminally ill patients, hospice discussions with patients and families, and the use of palliative care practices. Boyd et al. (2011) utilized an adapted version of the Caring for Terminally Ill Patients Nurse Survey, with 31 nurses in a large magnet-certified hospital. Boyd et al. (2011) found that nurses reported missed opportunities for

discussions and patient referrals to hospice, and the need for strategies to enable nurses to have a stronger voice during this critical time for their patients.

Another study by Kinoshita and Miyoshita (2011) developed a scale for assessing “difficulties felt by ICU nurses providing end-of-life care” (DFINE). This involved surveying nurses in ICUs at general hospitals in Japan to assess feelings and emotions of ICU nurses regarding the difficulties of implementing end-of-life care, as well as their understanding of the causes of these emotional difficulties. The study found that the content created proved consistent with the obstacles and barriers found in the literature on end-of-life care in the ICU.

Hov et al. (2007), conducted a study using ICU nurses’ experiences with the aim of acquiring a deepened understanding of what good nursing care is for EOL patients. The study was performed at an adult ICU in Norway, where 14 ICU female nurses were included as participants. Findings showed that the nurses understood the patients’ situation and thought they knew what good nursing care was in the areas of continuity in nursing care, nurses’ knowledge, competence and cooperation.

Few studies have evaluated the healthcare professionals’ experience and perception of dying and death. A multicenter study by Boissier et al. (2020), aimed to develop an instrument designed to assess the experience of physicians and nurses of patients who died in the ICU. The instrument was administered to physicians and nurses of patients who died in 41 ICUs within 24 hours after the death. The study showed factors associated with a better experience that includes quality communication, both with family members and interprofessional communication and collaboration; family presence in the ICU; and avoidance of aggressive care.

Hansen et al. (2009) suspected that caring for dying patients and their families without sufficient education, an adequate practice environment, or emotional and instrumental support could influence critical care nurses' experiences in providing end-of-life care. The study involved 218 nurses in four intensive care units at a university medical center, to determine their attitudes and perceptions of end-of-life care and how the use of multiple interventions could improve nurses' experience of end-of-life care. This study provided information that helped guide improvements in end-of-life care in the ICUs at the medical center and served as an example of how an institution identified its own problems with delivering end-of-life care and created approaches to remedy the problems.

### **Nurses' Education in EOLC**

In a study to explore nurses' experiences and perceptions of caring for dying patients in an ICU, Fridh et al. (2009), interviewed nine nurses and found that they had received very little education or training in EOLC. The study also noted that the nurses did not refer to literature or research in their reasoning about the provision of EOLC but reported that they learned EOLC from colleagues and experience. Although EOLC should be an integral part of nurses' training, many state that they have learned over time. This is apparent in a study by Holms et al. (2014), who interviewed a small group of ICU nurses and found that nurses are expected to confidently deal with challenges of EOLC although ICU training rarely covered the subject, but focused on life-sustaining treatment. It also concluded that all patients at the end of their lives should have the right to high-quality, compassionate, and dignified care. Levy et al. (2005) also studied EOLC among nurses and providers in two ICUs and found that nurses often acted on conscience

when delivering care. The study also suggested that formal training is required to successfully deal with this care as opposed to on-the-job training.

The need for better education in EOLC is well documented. Dobson (2017) wrote that, care of the dying is a complex skill that requires nurses to provide some of the most challenging care, and for which many nurses have received little or no training. This study included a review of the Liverpool Care Pathway used in a country that is ranked as the best in palliative care in the world. Dobson (2017) found that many nurses have received little or no education in palliative or end-of-life care. Furthermore, that many health professionals have had little or no formal training in this area and, despite this being a problem for decades, for many doctors, death and breaking bad news may still be seen as a failure. One recommendation was for EOLC scenarios to be included in pre-registration nurse training modules on communication skills.

Since nurses are in a position to influence the care of the dying patient, it is essential that nurses receive both didactic and clinical education on end-of-life nursing care in their nursing curriculum before entering the healthcare workforce (Jeffers, 2014). This study involved full-time nursing faculty from baccalaureate nursing programs in the mid-Atlantic region of the United States who taught and specialized in adult or pediatric acute care, home care, or hospice clinical settings. In conclusion, it was evident that educating nursing students on the care of a dying patient is not only important but essential to future nursing practice. Nurses who learn about end-of-life care from trusted nursing educators may enter the profession prepared to address patients' questions regarding end-of-life issues (Jeffers, 2014).

### **Limitations of Studies on EOLC**

There were several factors identified in the literature that affected findings. One problem was small sample sizes. In addition, the study by Holms (2014) reported that the research was executed by a student researcher operating within a limited timeframe. Further to this, participants were recruited from the researchers' own workplace which may have influenced their openness during the interviews. Another limitation related to the ICU setting where assessments directly from the patient were hampered by the inability to communicate directly, and according to Levy et al. (2005), family member assessments are often not representative of patient preferences. Other study limitations were associated with response rates, Hansen et al. (2009) indicated as such and felt that a higher response rate combined with less variability in the sample would have improved the project's internal validity.

### **Conclusion**

This literature review identified the need for improved communication and delivery of EOLC for inpatients, particularly those in areas that experience more patients transitioning from curative-based care to EOL care, such as the ICU. Future research in this area would provide a deeper understanding of factors impacting nursing attitudes to hospice or EOL care. Such knowledge may lead to the refinement of existing education and the development of more inpatient-centered programs aimed at the nurse outside of the hospice environment. Hospice can provide quality EOL care and offer benefits such as better assessment and management of pain. The improved provision of hospice care can also have positive secondary effects on all members of the interdisciplinary team which overall improves clinical practice. The findings of this literature review have also

revealed that patients dying in hospitals may currently receive an inadequate quality of EOLC. Nurses' levels of knowledge and attitudes were found to be the most influential factors associated with the quality of EOLC, suggesting that hospitals need targeted interventions to improve the quality of EOLC and, in particular, EOLC courses and training must be provided for all nurses working in hospital ICU settings. Since EOLC can be a difficult and challenging process, dying patients and their families need to be continuously supported, critical care nurses also need to be taken care of for them to continue providing the best possible end-of-life care (Kisorio & Langley, 2016).

## **CHAPTER III**

### **Needs Assessment**

Nurses provide care to inpatients around the clock. In the ICU the nurses are trained to deliver care to acutely ill patients but may feel ill-equipped to provide EOLC when the focus changes from curative care. This needs assessment provides information to develop a plan to improve nursing attitudes towards hospice care in the ICU and ultimately improve care delivery.

### **Target Population**

The target population for this project is the nurses working in the intensive care unit (ICU) at the selected facility who care for patients transitioning from curative care to end-of-life hospice care. These nurses may not have the support of traditional hospice guidance due to unforeseen circumstances at the time that the transition occurs.

### **Target Setting**

The target setting is the ICU at a veteran's medical center in the southeastern US. The facility is a small 10-bed unit with a wide range of patients including cardiac, renal, pulmonary, neurological, muscular-skeletal, and gastrointestinal problems. The facility does not have an intermediate care unit therefore the level of care varies from stable to critical, with periods of rapid census changes as patients are sometimes transferred quickly to a higher level of care.

### **Sponsors and Stakeholders**

The stakeholders are the ICU nurses, nursing assistants, patients, and members of the interdisciplinary teams involved with the care of hospice patients. The interdisciplinary teams include physicians, therapists, pastoral care, pharmacists, social

workers, and discharge planners. This would also include any family, friends, or caregivers involved in the care of the patient. This can be expanded to include hospice facilities, home hospice care, equipment companies for things like hospital beds, and dieticians for nutritional support if requiring enteral feeding.

### **Desired Outcomes**

Although hospice care is based on a terminal prognosis, there are certain desired outcomes. These include effective management of physical, psychological, and spiritual symptoms, timely communication about appropriate goals of intensive care in relation to the patient's condition, treatment to coincide with patient and family preferences, attention to families' needs, and concerns, and support for nurses/clinicians.

### **SWOT Analysis**

#### **Strengths**

Death is an inevitable event (Haisfiel-Wolfe, 1996). With nurses' roles expanding, there is a need to increase the nurses' level of knowledge and improve their attitude towards EOLC in order to enhance the quality of care provided to patients. Nurses continue to play a key role in providing care for the terminally ill. Rafii et al. (2016) explored the meaning of caring for terminally ill patients from the perspective of Kurdish ICU nurses and found that they experienced a range of feelings from emotional strain to being optimistic while working within limited resources in the ICU. Nurses are also involved in the withdrawal of the care process which causes emotional reactions. They considered debriefings to be helpful in dealing with emotions as well as thorough planning, good communication, pain relief, and the creation of a peaceful environment were perceived as important.



**Weaknesses**

Although nursing care is a major strength, there are noted weaknesses in the care of the hospice patient in the ICU. These include symptom management such as pain relief, limited communication between ICU physicians and families such as insufficient time spent in conferences to share their perspectives on the patient's goals and values or express their own concerns. Some patients spend their last days in the ICU because planning for care in a more suitable or preferred setting is inadequate. For patients who do transition from one setting to another (for example critical care to home care), there is often a lack of adequate support for their families. Finally, the need to support the nurses and other clinicians more effectively from the emotional strains of hospice ICU care may be evident from the widespread problems of burnout, depression, moral distress, and conflict sometimes noted in the critical care team.

**Opportunities**

There are many external factors that affect the nursing care of hospice patients in the ICU. There are hospital and community-based hospice programs that offer support to patients transitioning from curative care to hospice/palliative care. The ICU nurse or clinician can utilize these services for support, or refer to the individual service lines based on the patients' individual needs. These would include pastoral care, dietician services, physical, occupational, and/or massage therapists, and any other care or comfort services to help the patient approaching end-of-life.

**Threats**

Threats to the comprehensive care of the patient in the ICU include barriers such as unrealistic expectations on the part of patients, families, and clinicians about patient

prognosis or effectiveness of ICU treatment; the inability of patients to participate in treatment discussions or being dependent upon surrogates; insufficient training of physicians and nurses in relevant communication skills; and time constraints that is competing demands for the nurses' time.

### **Resources**

Resources would include things that would improve the delivery of care to the hospice patient. Since the focus is on nursing attitude such things as culture of the ICU environment, support from sponsors and stakeholders, budget support for training and education, nursing personnel, materials for education and training development, and financial support to modify existing spaces to be more conducive to the care of the dying patient and support of the family.

### **Team Members**

In addition to the project leader, the team members would include a hospice nurse, ICU nurse, physician, nursing assistant, hospital chaplain, and the ICU nurse manager. The latter would also serve as liaison to upper management, interior decorator, housekeeping, and finance departments for any structural changes such as signage.

### **Cost-Benefit Analysis**

Although hospice care may be available outside of the ICU, the cost would be greater, not only monetarily, but what can be measured by the physical and emotional stress that the patient may experience. The family and friends would also bear the emotional toll and finance of changing facilities or units. An example would be an unstable patient where moving them would cause undue pain and fast progression of a life-limiting illness, as opposed to remaining in the ICU for hospice care. Since the care

patients receive in the ICU is highly dependent on the ICU nurse's knowledge, skill, and comfort level in caring for the dying patient and the family (Harris et al., 2014), and education and training opportunities are essential to ensure ICU nurses develop the right knowledge and attitude to provide high-quality end-of-life care (Efstathiou & Walker, 2014) it would be more cost-effective to train and educate the ICU nurse to provide hospice care.

## **CHAPTER IV**

### **Project Design**

This chapter outlines the plan to improve the nursing end-of-life care (EOLC) of patients in the intensive care unit (ICU). This chapter will discuss goals, objectives, plan and material management, timeline, budget, and evaluation plan.

#### **Goals**

Unlike curative care, hospice is based on prognosis. Although there are successful models for hospice care, the nurses' provision of hospice care in the ICU has not been fully addressed. The goal of this project is to develop educational materials and a series of in-services to teach and guide ICU nurses in understanding how to provide patients with EOLC to improve patients', family, and caregivers' overall experience.

#### **Objectives**

To meet the overall goal of improving hospice care, the objective is to develop educational material for nurses to gain an understanding of EOLC. This would include:

- Define EOLC.
- Compare and contrast curative care and EOLC.
- Discuss how the interdisciplinary team can provide EOLC to patients.
- Identify ways to include family in EOLC.
- Improve nurse's competence on dealing with EOLC.
- Identify barriers to providing EOLC.
- Identify strategies to improve communication.
- Identify resources for hospice education.

### **Plan and Material Management**

To meet these objectives, the plan for this project is to provide a series of PowerPoint in-services to educate ICU nurses and other stakeholders. This will incorporate information on the roles of members of the hospice team, including the physician, nurse, social worker, dietician, nursing assistant, and chaplain. In the future, the unit manager and educator will also be involved to develop annual competencies and plan future training for nurses in general orientation or as a new staff nurse to the ICU.

### **Timeline**

The timeline for this project has been approximately 8 months for research and development and another 3 months are expected before implementation approval received. Once approval to implement is granted, the project will take another month to allow for dissemination to the nurses on the day and night shifts.

### **Budget**

In order to develop this project, the only projected cost would be paid time for the nurses to attend the in-services. Cost of educational materials and binders are anticipated to be covered in the unit's operational budget.

### **Evaluation Plan**

The evaluation of the project will be carried out by a survey of the 22 nurses assigned to the ICU where implementation will take place. Questions would be open-ended and qualitative in nature. Nurses would be asked to rate the overall presentation, the extent to which expectations were met, identify if knowledge of EOLC was gained and thought provoking, and indicate if the information will be used in daily practice and how.

## **Summary**

ICU nurses are essential in the EOLC of patients, including those that are actively dying. Lack of knowledge and communication is frequently identified as an obstacle in providing care. Therefore, education regarding symptom management, pain management, communication, and other strategies are needed to improve the delivery of care and the overall patient/family experience. A plan is necessary to meet these goals and objectives in a comprehensive and timely manner with an evaluation of interventions.

## **CHAPTER V**

### **Dissemination**

By providing education, this project will ultimately impact the intensive care unit (ICU) nurses in their delivery of hospice and/or end-of-life care (EOLC) to the affected patient population. It will also involve the interdisciplinary team members, patients, family, and caregivers for an overall better patient-care experience.

#### **Dissemination Activity**

A series of PowerPoint presentations were utilized to present information to the ICU nurse manager, educator, and nurses. Dissemination was in the form of in-person and e-mail presentations to ensure the target audience was reached. This project addressed the problem that ICU nurses, though experts in the care of the critical care patient, report feeling ill-prepared to deliver EOLC to the dying patient. However, education and continued competency will improve care to patients and their families. The presentation included the definition of hospice and EOLC, the objectives of the presentation, differentiation of curative care versus EOLC, barriers including communication, and goals of EOLC.

#### **Limitations**

The project covered a limited aspect of the barriers involved in EOLC. Further information could be included to cover a broader range of EOLC for the ICU nurse. This project can be expanded to include the development of a standard operating procedure (SOP) for patients nearing end-of-life. This will provide guidelines to help the ICU nurse provide consistent care and maximize the patient-care experience.

### **Implications for Nursing**

Through a review of the literature, it was found that there was a lack of education in hospice and EOLC among ICU nurses. This project sought to fill that gap to ultimately improve the provision of care by providing ICU nurses with current education and utilizing the information for future competencies. It is important for nursing because the nurse is uniquely equipped to challenge and change the way EOLC is managed in ICU. Better education and communication about terminal care would improve care to dying patients and families.

### **Recommendations**

Recommendations for the success of the project include providing continued education to new ICU nurses. The Project Leader also recommends the inclusion of the project into orientation for all new nurses' hired at the facility of implementation. Including this project in new nurse orientation sessions would allow the education of nurses in other acute care areas to improve EOLC. Expanding on the information and ensuring all provided education is current are also recommended.

### **Conclusion**

The project identified a problem that impacted nursing and the provision of care to a particular patient population. It addressed the problem that ICU nurses lack education in EOLC and means to improve the provision of care. Future projects could address subjects such as a lack of involvement in care, differences in medical and nursing care models, disagreements regarding EOLC among physicians, standardization of care, and communication between patient, family, and caregivers.



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