Palliative Care

Improving nursing knowledge, attitudes, and behaviors

Karen Harden, MS, RN, AOCNS®, BMTCN®, Deborah Price, DNP, RN, Elizabeth Duffy, DNP, RN, CPNP, Laura Galunas, BSN-MSN, MBA, BS, OCN®, RN-BC, CNML, and Cheryl Rodgers, PhD, RN, CPNP, CPON®

BACKGROUND: Oncology nurses affect patient care at every point along the cancer journey. This creates the perfect opportunity to educate patients and caregivers about palliative care early and often throughout treatment. However, healthcare providers frequently do not have the knowledge and confidence to engage in meaningful conversations about palliative care.

OBJECTIVES: The specific aims were to improve oncology nurses’ palliative care knowledge, attitudes, and behaviors by providing a palliative care nursing education program. An additional aim was to increase the number of conversations with patients and families about palliative care.

METHODS: This project had a pre-/post-test design to assess knowledge, attitudes, and behaviors at baseline and one month after implementation of an established education curriculum. The teaching strategy included one four-hour class for oncology RNs with topics about the definition of palliative care, pain and symptom management, and how to have palliative care conversations.

FINDINGS: Results showed a statistically significant difference after the educational intervention for knowledge, attitudes, and behaviors. The number of conversations with patients and caregivers about palliative and end-of-life care increased significantly.

THE NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN, 2017) defines palliative care as a special type of patient- and family-centered care emphasizing the management of physical, psychosocial, and spiritual care that is guided by patient goals and values. NCCN (2017) asserts that palliative care should begin at diagnosis of a serious illness and be provided throughout life-prolonging treatment, including end-of-life (EOL) care. Significant improvements in quality of life and mood have been noted when early palliative care was initiated among patients with lung cancer (Temel et al., 2010). In addition, patients with lung cancer who received palliative care had less aggressive care at EOL but experienced significantly longer survival. The Oncology Nursing Society (2014) position on palliative care states that all patients with cancer can benefit from palliative care, and palliative care interventions should always include the patient, the caregiver, and other healthcare disciplines involved in caring for the patient. In addition, Jacobs and Mayer’s (2015) standards of oncology nursing education highlight the need to represent the scope of teaching in all phases of cancer care, including prevention, early detection, rehabilitation, survivorship, and supportive care. Palliative care education for oncology nurses is encompassed in this directive.

Oncology nurses affect patient care at every point along the cancer journey. When nurses continuously provide feedback about the benefits of palliative care and advocate for it, it is more likely to be integrated into a patient’s care (Perrin & Kazanowski, 2015). However, many healthcare providers and leaders are not familiar with the concept of palliative care or choose not to embrace it in their practice (Gibbs, Mahon, Truss, & Eyring, 2015). Therefore, healthcare providers are not equipped with the knowledge or confidence to engage in meaningful conversations about palliative care with patients and their caregivers in a way that will provide patients with that extra layer of palliative care education and support. Pretesting of nursing populations about palliative care concepts continues to show that nurses are not prepared to support patients using palliative care knowledge, skills, and resources. However, research does show that time spent educating nurses about palliative care practice is successful but must be implemented using a variety of methods and sustained over time to fully affect patient care (Broglio & Bookbinder, 2014). Nurses who feel empowered to teach palliative care to patients feel confident in their role of the assessment of patient readiness and can provide education at the appropriate time (Harden & Schembri, 2016). Oncology nurses are expected to participate in the multidisciplinary team coordinating palliative care for patients, but they need structured preparation to feel knowledgeable and comfortable so they can

KEYWORDS
palliative care; end-of-life care; knowledge; attitudes; behaviors; nurse education

DIGITAL OBJECT IDENTIFIER
10.1188/17.CJON.E232-E238
engage in conversations with patients and their families and answer questions related to palliative care. Abernathy et al. (2013) back the notion that healthcare providers should be educated about palliative care practices and use that knowledge to support patients and their caregivers. Ongoing education supporting the palliative care initiative will need to continue to maintain momentum and sustain the overall initiative.

**Literature Review**

Two major considerations regarding palliative care education include the essential components of palliative care training programs for nurses and methods for successful delivery of educational programs. Three studies have identified the essential components for palliative care training sessions. Liu and Yuan (2009) identified a small panel of experts who determined 69 essential training components, including palliative care overview, symptom care, psychological care, communication, ethics, and terminal care. Pavlish and Ceronsky (2007) talked to 33 nurses in focus groups and determined that essential educational components were (a) “Palliative care should include the family,” (b) “Palliative care is a process or journey over time,” and (c) “Palliative care allows patients to focus on goals and quality of life.” Pavlish and Ceronsky (2007) showed that palliative care creates a shift to holistic care and symptom management with a focus on patient and family preferences. White and Coyne (2011) had nurses rank the core competencies for palliative care education. Symptom management and how to talk to patients and families about dying were selected as the top-ranked essential competencies. The conclusion of these three studies revealed similarities among core topics considered to be essential for palliative education and practice (symptom management; comfort, pain, EOL, and hospice; family focus and patient and family preferences; and quality of life and psychosocial issues). By identifying these components, programs can begin to standardize the teaching content and practice for palliative care.

A second important consideration from the literature focuses on the training of nurses on the topic of palliative care and includes the method of education. Most training programs involve lecture and discussion formats (Coyne et al., 2007; Ferrell, Virani, Paice, Coyle, & Coyne, 2010; Lippe, Volker, Jones, & Carter, 2017; Paice, Ferrell, Coyle, Coyne, & Callaway, 2008; Steginga et al., 2005). A few programs are associated with the EOL Nursing Education Consortium (ELNEC), which is a successful educational initiative for palliative and EOL care (Coyne et al., 2007; Ferrell et al., 2010; Lippe et al., 2017; Paice et al., 2008). Studies using the ELNEC content for palliative care demonstrated high participant satisfaction scores (Coyne et al., 2007; Ferrell et al., 2010; Paice et al., 2008). Participants from ELNEC courses taught other nurses in their work settings and participated in additional palliative care activities, such as conferences and journal subscriptions (Coyne et al., 2007; Ferrell et al., 2010; Paice et al., 2008). David and Banerjee (2010) created a palliative care educational booklet and found a significant improvement in nursing knowledge after using the booklet. Henoch, Danielson, Strang, Browall, and Melin-Johansson (2013) realized that, with a cancer diagnosis, patients tend to engage in more existential thinking, and nurses are not always equipped to help them. A randomized, controlled trial showed significant improvement in confidence in communication with a group that received training in existential support (Henoch et al., 2013). Steginga et al. (2005) delivered general oncology education classes using small-group, interactive, and didactic methods to 53 RNs at a cancer control agency in Australia. The nurses in the intervention group reported increased cancer-related knowledge and confidence in discussing care holistically with patients and physicians. Witkamp, van Zuylen, van der Rijt, and van der Heide (2013) described a successful 25-day educational program with lessons, examinations, and assignments that improved nursing knowledge, attitudes, and skills regarding palliative care, showing a significant increase in post-test scores from pretest scores. The combination of experiential and didactic learning continues to be the mainstay of successful education about palliative care. In addition, the creation of measurable goals for participants to develop projects at their own institution and ongoing mentoring are key components of palliative care education initiatives (Dahlin, Coyne, & Cassel, 2016).

Barriers continue to prevent nurses from being able to implement successful palliative care programs. Common barriers include lack of adequately trained palliative care physicians, nurses, and social workers; lack of knowledge among patients and families; and lack of training opportunities for existing healthcare team members, all of which add to implementation difficulties (Gibbs et al., 2015). Sato et al. (2014) determined barriers to be lack of confidence in nurses; low support by experts; and difficulty managing pain, delirium, and general symptoms. White and Coyne (2011) concluded that nurses need better continuing education based on top-ranked competencies to move palliative care initiatives toward realization for patients and families.

“When the care team and family understand their role in palliative care, conversations will be early, deep, and meaningful.”
The specific aims of this project were to improve oncology nurses’ palliative care knowledge, attitudes, and behaviors by providing a palliative care nursing education program. The definition of palliative care in this project was inclusive of EOL care. An additional aim was to increase the number of conversations with patients and their families about palliative care as a result of nurses’ improved knowledge, attitudes, and behaviors.

**Methods**

This project had a pre-/post-test design to test knowledge, attitudes, and behaviors at baseline and one month after implementation of an established education curriculum for palliative and EOL care. The setting for this palliative care education project was a 32-bed oncology unit at Michigan Medicine in Ann Arbor.

**FIGURE 1.**

**PALLIATIVE CARE EDUCATION CLASS OUTLINE**

**CONCEPTS HIGHLIGHTED IN FOUR-HOUR CLASS**

Vision for the future
- Conversations with all patients with cancer about palliative care
- New mindset
- Nurses provide palliative care every day
- Expectations going forward
- Initiate conversations about palliative care
- Assess and manage pain and symptoms
- Discuss patient goals and values
- Record conversations about palliative care

**SAMPLE FOUR-HOUR PALLIATIVE CARE COURSE CONTENT**

Overview of palliative care
- Dying in America
- What is palliative care?
- Difference between hospice and palliative care
- Quality of life
- Pain management
- Pain assessment
- Pain medications
- Pain management strategies
- Chronic pain
- Symptom management
- Common symptoms at the end of life (e.g., dyspnea, gastrointestinal, psychosocial, fatigue)
- Strategies for symptom management
- Communication
- Barriers to and myths about communication
- Active listening
- Empathy
- Nonverbal communication

**Note.** Based on information from Ferrell et al., 2010.
management and comfort care, (f) spiritual support, and (g) emotional and organizational support for clinicians (Clarke et al., 2003). The scale consists of questions that are answered on a five-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree), including options for “neutral” and “not applicable.” Twelve knowledge questions ask whether nurses are prepared for certain aspects of care, five attitude questions ask if nurses feel comfortable about aspects of EOL care, and 11 behavior questions ask how nurses provide care. The EOLC-ICU scale has been deemed reliable and valid in ICU settings for providers working with patients with higher-level care needs (Montagnini et al., 2012). The ICU version of the tool was modified to be used in settings beyond the ICU, with alterations only to remove wording specific to the ICU. This new version, the EOLC-Q, does not have reliability or validity data but has been used in other studies (Price et al., 2017). The same number of questions remains in each domain for knowledge (12), attitude (5), and behavior (11). This version of the tool was used for the current study. Demographic information was also obtained by self-report, including how long nurses have worked on the unit, age, gender, level of education, and number of palliative care conversations had. The questionnaires were distributed on paper and in Qualtrics® electronic format. Nurses were informed by email and weekly updates on the unit to complete either the paper or electronic format of the questionnaires. Paper forms were returned to a secure container on the unit to maintain confidentiality.

Data from the paper questionnaires were manually entered into SPSS®, version 23.0, and electronic data from Qualtrics were downloaded into SPSS for analysis. Data on knowledge, attitudes, and behaviors were grouped into subscales and analyzed using descriptive statistics and a t test to evaluate the difference of the mean scores pre- to post-test.

Results

Forty-six of 54 nurses on the unit attended the four-hour class. Seven nurses were deemed temporary employees and were not enrolled into a class; only one nurse was a no-show to the class. Forty-eight nurses completed the pretest questionnaire, and 36 completed the post-test questionnaire. Forty-one nurses were female, and all validated that they frequently worked with patients with potentially life-limiting illness. Other sample characteristics from the pretest questionnaire are listed in Table 1. As documented by post-class evaluations, participants were engaged and energized during the palliative care classes. Evaluative comments by the participants at the end of class showed evidence of this positive experience (see Figure 2).

Twelve questions on the EOL questionnaire regarding preparedness examined the impact of the education innovation on knowledge. A statistically significant increase was seen in the overall mean scores from before the educational intervention (X = 3.5, SD = 0.64) compared to after the intervention (X = 4.2, SD = 0.54; p = 0.000) (see Figure 3). Three questions had a large effect size and included increasing knowledge in the areas of neuropsychiatric issues, such as delirium, seizures, anxiety, and restlessness (p < 0.000, Cohen’s d = 0.92); withdrawing life support from a dying patient (p < 0.000, Cohen’s d = 1.03); and identifying cultural needs of dying patients and their families (p < 0.000, Cohen’s d = 0.93).

Five questions on the EOL questionnaire were used to evaluate the impact of the education on attitudes. A statistically significant increase was seen in the overall mean scores from before the intervention (X = 3.5, SD = 0.74) compared to after the intervention.

<table>
<thead>
<tr>
<th>TABLE 1. SAMPLE CHARACTERISTICS (N = 48)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHARACTERISTIC</td>
</tr>
<tr>
<td>Age (years)</td>
</tr>
<tr>
<td>20–30</td>
</tr>
<tr>
<td>31–40</td>
</tr>
<tr>
<td>41–50</td>
</tr>
<tr>
<td>51 or older</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Education level</td>
</tr>
<tr>
<td>Associate degree</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
</tr>
<tr>
<td>Master’s degree</td>
</tr>
<tr>
<td>Doctorate</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Years in current practice</td>
</tr>
<tr>
<td>0–1.9</td>
</tr>
<tr>
<td>2–3.9</td>
</tr>
<tr>
<td>4–5.9</td>
</tr>
<tr>
<td>6 or more</td>
</tr>
<tr>
<td>No response</td>
</tr>
<tr>
<td>Palliative care certification</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No response</td>
</tr>
</tbody>
</table>
Educate all nurses about the principles and benefits of palliative care. Increase opportunities for nurses to discuss their knowledge, attitudes, and behaviors about palliative care. Encourage nurses to initiate conversations with patients and families to educate them about palliative care.

Discussion

Based on the pre-/post-test results, the project demonstrated a significant increase in knowledge, attitudes, and behaviors among oncology nurses participating in a palliative care educational program. The rate of compliance for attending the classes was high because of managerial support and scheduling of each nurse into one of six classes. Classes were held on-site and usually occurred before or after a shift. In addition, continuing education credits and salary were provided for attending a class. The population was a homogeneous group of oncology nurses who were primarily aged younger than 40 years who had earned their Bachelor of Science in Nursing degree. Additional projects evaluating the merit of palliative care education can target nurses who represent more diverse levels of education or clinical specialties.

Education initiatives for nurses provide the foundation for changes in knowledge, attitudes, and behaviors regarding palliative care. A significant increase was seen in the knowledge category regarding symptom management, cultural needs, and nurses feeling prepared to support the withdrawal of life support from a dying patient. In the oncology setting, the question about withdrawing life support may have been interpreted as care for a patient receiving comfort care. Oncology nurses do not withdraw life support as is seen in the ICU, but they often care for patients who have chosen the comfort care option at EOL.

During the education session, nurses were given specific actions to put into practice, which led to comments and engagement that the authors interpreted as positive feelings about the education and a considerable feeling of empowerment in delivering palliative care to their patients and families. A statistically significant increase was seen in three of five questions under attitudes. These three items addressed nurses’ confidence, showing a change in attitude, whereas the final two questions addressed interdisciplinary collaboration and benefits of commemorating a death. Although interdisciplinary collaboration and benefits of commemorating death are important in palliative care, this educational program did not focus on this content, so the lack of improvement is not surprising. Additional projects could involve providing education to interdisciplinary team members to incorporate the importance of team collaboration.

Overall, the behavior questions were significantly improved, even though the palliative care classes did not specifically address many of the topics. The change in behavior could reflect an overall sense of how nurses learning about palliative care benefits patients and families and represents an environment where nurses are beginning to take ownership of their own practice. Scores were lower for behavior in comparison to knowledge and attitudes. Behaviors are always the last to change, and whether this education has had a clinical impact will be seen with time. Barriers, such as lack of education or lack of experience, continue to play a role but have the capacity to improve as nurses embrace palliative care in their practice (Espinosa, Young, & Walsh, 2008; Gibbs et al., 2015).

Oncology nurses initiated more conversations with patients and their families about palliative care after attending the formal palliative care education class. Numbers of conversations increased, showing that nurses felt more empowered to teach their patients about the benefits of palliative care. Ongoing educational initiatives and inclusion of the multidisciplinary team may help to increase these types of discussions. The leadership team and nurses on the unit are excited to continue this palliative

\( X = 4, SD = 0.58, p = 0.002 \). Statistically significant changes were noted for the nurse feeling comfortable discussing advanced care planning \( (p = 0.011) \), talking about code status \( (p = 0.004) \), and withdrawing life support from a dying patient \( (p = 0.000) \).

To evaluate the impact of the education on behaviors, nurses completed 11 questions on the EOL questionnaire and reported the number of palliative care conversations with patients or families. The questionnaire responses showed a statistically significant increase in behavior scores from pre- to postimplementation, with a mean score of 2.9 before the education and a mean score of 3.4 after the education \( (p = 0.002) \). Oncology nurses reported increases in conversations about palliative care from pre- to postimplementation. Prior to the palliative care education, 29 nurses had zero to two conversations, and only 15 had more than three conversations, whereas after the education, the number of nurses who had zero to two conversations was 22, and the number of nurses with more than three conversations per month increased to 19. Although a statistically significant increase was not seen from the number of palliative care conversations pre- to post-test \( (p = 0.06) \), a notable increase occurred in the percentage of nurses having three or more conversations after the intervention \( (34\% \text{ compared to } 54\%) \).

FIGURE 2.
COMMENTS FROM NURSES AFTER TAKING THE PALLIATIVE CARE EDUCATION CLASS

- ‘Listening is powerful.’
- ‘Make palliative care a more common topic of discussion.’
- ‘Palliative care is not just symptom management.’
- ‘Feel empowered to start conversations with patients and families.’
- ‘Palliative care can be integrated into every patient care experience.’
- ‘You just gave me some tools to be a more effective nurse.’
- ‘Interdisciplinary coordination/communication is important for quality care for patients.’
- ‘We, as nurses, can start palliative care.’
When each facet of the care team and family understands his or her role in palliative care, conversations will be early, deep, and meaningful and will be focused on the patient’s goals, values, and preferences.

Karen Harden, MS, RN, AOCNS®, BMTCN®, is a clinical instructor, and Deborah Price, DNP, RN, and Elizabeth Duffy, DNP, RN, CPNP, are assistant clinical professors, all in the School of Nursing at the University of Michigan; Laura Galunas, BSN-MSN, MBA, BS, OCN®, RN-BC, CNML, is a nurse manager at the University of Michigan Hospitals and Health Centers, all in Ann Arbor; and Cheryl Rodgers, PhD, RN, CPNP, CPON®, is an assistant professor in the School of Nursing at Duke University in Chapel Hill, NC. Harden can be reached at karehard@umich.edu, with copy to CJONEditor@ons.org. (Submitted November 2016. Accepted March 3, 2017)

The authors take full responsibility for this content. During the writing of this article, Rodgers was supported by funding from the Alex’s Lemonade Stand Foundation. The article has been reviewed by independent peer reviewers to ensure that it is objective and free from bias.

REFERENCES
Harden, K.L., & Schembri, J.A. (2016). Early intervention with transplantation recipients to


