

Nurses' Perceptions of Educational Gaps in Delivering End-of-Life Care

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The approach toward life-limiting diseases or conditions in the United States generally involves highly technical interventions meant to prolong life and sustain hopefulness for a cure in hospitals. Although most Americans die in hospitals or nursing homes, most healthcare organizations are ill-prepared to offer their patients a peaceful death (Martensen, 2008) through adequate symptom assessment and amelioration, communication, and emotional support (Meier, 2010). Nurses, more than any other health professionals, are the frontline caregivers for patients with life-limiting diseases or conditions (Cummings, 2008). However, gaps are evident in undergraduate (Wallace et al., 2009), graduate (Paice et al., 2006), and continuing education (Murray, Wilson, Kryworuchko, Stacey, & O'Connor, 2009) programs.

When a person has a life-limiting condition or disease, they may choose to forego highly technical and expensive interventions in exchange for palliative care to improve the quality of life. Palliative care services may be continuous or episodic depending on the stage of advanced illness. A person's life expectancy could be years, months, or days, and palliative care services can be initiated at any point in the disease process. As palliative care becomes more normative and is contained in the curricula of nursing and medical schools, included in textbooks and licensure examinations, and integrated into clinical practice guidelines, improvements will be made in nurses' competencies regarding end-of-life (EOL) care. Despite a greater awareness of EOL and palliative care services, nurses may be uncomfortable discussing death and dying with patients and their families (Schulman-Green, McCorkle, Cherlin, Johnson-Hurzeler, & Bradley, 2005; White, Coyne, & Patel, 2001) and often misunderstand palliative care (Mahon & McAuley, 2010).

Palliative care in the late 20th century was focused mainly on managing pain. In the early 21st century, researchers continue to investigate knowledge gaps in pain assessment and relief (Morrison et al., 2006), although the concept of palliative care now is extended beyond pain management to include assessment and management of other physical, psychosocial, emotional, and spiritual dimensions (Coyle, 2010); facilitation of

Purpose/Objectives: To assess end-of-life (EOL) care core competencies deemed most important with corresponding educational needs from oncology nurses and to describe the characteristics of the respondents that are associated with selection of the top-ranked core competencies.

Design: Descriptive, cross-sectional study.

Setting: Mailed and online surveys.

Sample: 714 members of the Oncology Nursing Society from Georgia, Virginia, Washington, and Wisconsin.

Methods: Responses to a mailed or e-mailed researcher-developed questionnaire during a six-month period were collated and analyzed.

Main Research Variables: Ranking of EOL care core competencies and perceived gaps in EOL continuing education.

Findings: Almost all of the respondents indicated that EOL care was a part of their practice and that continuing education was important, but more than half of the respondents had fewer than two hours of continuing education regarding EOL care in the past two years. Twenty-five percent of the respondents do not believe they are adequately prepared to effectively care for a dying patient. Symptom management was the top-rated core competency, consistent across age, education level, practice role, and practice setting. How to talk to patients and families about dying and what comprises palliative care also was selected frequently.

Conclusions: Symptom management is the number one core competency, and the quantity and quality of EOL continuing education is inadequate. Educational gaps exist in EOL nursing care.

Implications for Nursing: Assessing what nurses believe to be leading EOL core competencies is useful in improving educational curricula along with considering characteristics of nurses when planning EOL educational programs.

communication with patients and families (Ferrell & Winn, 2006; Matzo, Sherman, Sheehan, Ferrell, & Penn, 2003); preparation of the family and staff for death (Coyle, 2010); alternative sites of care (Ferrell et al., 2007; Quest, Marco, & Derse, 2009); and care of pediatric (Malloy, Sumner, Virani, & Ferrell, 2007) and geriatric (Ersek & Ferrell, 2005) populations. Cost savings have been identified for inpatient palliative care units (White & Cassel, 2009), transfers from higher acuity units (White,