

ACUTE CARE NURSES' SELF-REPORTED  
COMPETENCE IN PALLIATIVE CARE

by

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## ABSTRACT

Palliative care is a health care specialty that can provide patients and their families relief from burdensome symptoms and improve quality of life when faced with a life-limiting illness. Researchers have documented that nurses' knowledge and competence in palliative care results in more timely referrals for palliative care, which can promote comfort and increase the quality of care patients receive with life-limiting illnesses. Despite the known benefits of nurses' competence in providing palliative care, there is a need for more studies to further quantify nurses' self-competence in palliative care in the United States. The purpose of this study was to examine acute care nurses' self-reported competence in providing palliative care services. A non-experimental descriptive research design was utilized in this study to better understand acute care nurses' self-reported competence in palliative care services in one urban hospital in South Central Montana. All registered acute care nurses were eligible and invited to participate in an anonymous online survey. Nurse participants completed the online survey containing standard demographic questions and an instrument that examined their self-competence in 8 domains of palliative care. Mean scores of the instrument showed that nurses in this particular acute care hospital felt they are more than moderately capable in providing palliative care services to patients and their families. Despite this finding, some nurses indicated that they did not feel at all capable in performing some domains of palliative care. Implications for nursing include further education for acute care nurses' to increase self-competence in providing palliative care services to ensure quality care is delivered to patients and their families.

## CHAPTER 1

## INTRODUCTION

Palliative care is defined as medical care for persons and their families suffering from life-limiting illness (Health Research & Educational Trust [HRET], 2012). The focus of palliative care is relief from symptoms, particularly the symptoms of pain and stress, while also maximizing quality of life (HRET, 2012). It is important to note that palliative care is different than hospice and end-of-life care as palliative care services can be provided along with curative treatments (HRET, 2012). Palliative care is provided by a primary care provider and is supported by a team of specialists, usually a physician, nurse, social worker, and spiritual care counselor (HRET, 2012). The palliative care specialist team assists patients and families in discussion of goals of care based on their medical diagnosis, assessment and interventions of distressing symptoms, and assessment of their spiritual and emotional needs (HRET, 2012). Distressing symptoms relieved with palliative care include dyspnea, fatigue, nausea, anorexia, constipation, and difficulty sleeping (HRET, 2012). According to the American Hospital Association, in 2010, 66% of hospitals with over 50 beds reported having a palliative care program (HRET, 2012). It is estimated that by the year 2030, older adults will make up 20% of the population in the United States (Centers for Disease Control and Prevention [CDC], 2013). Chronic diseases are becoming the main focus of the health care environment due to the aging population and baby boomers. According to the CDC (2013) two out of three older Americans have a chronic

disease and care for chronic diseases accounts for 66% of health care costs. Palliative care focuses on quality of life and is the central component of chronic disease management. Chronic medical diseases that are appropriate for palliative care include Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD), kidney failure, Alzheimer's disease, human immunodeficiency virus (HIV)/ acquired immunodeficiency syndrome (AIDS), cancer, and Amyotrophic Lateral Sclerosis (ALS) (HRET, 2012).

Many chronic diseases require ongoing management for many years, not just at the end-of-life. Many health care providers, however, consider palliative care as coinciding with the end-of-life (Rodriguez, Barnato, & Arnold, 2007). Although a patient's primary care provider directs and orders palliative care services, in an acute care in-patient setting, nurses are often responsible for identifying and recommending patients for early referral to palliative care (Autor, Storey, & Ziemba-Davis, 2013). A nurse's knowledge of palliative care may effect early referrals to palliative care. The purpose of this study was to understand acute care nurses' self-reported competence in their ability to provide palliative care.

### Background and Significance

Palliative care is important to integrate into health care systems especially due to the Patient Protection and Affordable Care Act (ACA) (Fletcher & Panke, 2012). The ACA was passed in 2010 and focuses on increasing the number of people with health insurance and decreasing health care costs (Finkler, Jones, & Kovner, 2013). The ACA also aims for better quality health care and performance of health care organizations

(Finkler et al., 2013). When certain quality standards are met under the ACA, financial reimbursement is given to the organization (Tillett, 2011). Under the ACA, “palliative care is positioned to play a critical role in efforts to redirect health care in order to establish effective and efficient patient-centered care” (Fletcher & Panke, 2012, p. 452). Palliative care programs increase quality of life, reduce distressful physical and emotional symptoms, decrease length of stay in intensive care units, determine patient’s goals of care, increase discharge planning ability, decrease chronic illness readmission rates, improve survival in cancer patients, decrease adverse patient events, increase patient outcomes, and decrease health care costs (HRET, 2012).

Research has supported that palliative care referrals result in cost savings. Patients with chronic diseases such as HF, COPD, or kidney failure are responsible for over half of health care costs (HRET, 2012). Research conducted by Morrison and colleagues (2008) reported that when compared to usual patients, patients with a palliative care referral had overall cost savings per admission. Morrison et al. (2008) also reported cost savings for patients that died in the hospital with a palliative care referral. Another study by Goldsmith, Dietrich, Du, and Morrison (2008) reported that hospitals with palliative care programs had decreased Medicare spending, in-patient deaths, ICU and cardiac care unit (CCU) stays, and admissions during the last six months of life (Goldsmith et al., 2008).

The importance of early referral to palliative care has been proven paramount, not only in cost savings, but also for patients receiving palliative care services. A study conducted by Temel et al. (2010) supported that early use of palliative care services in the

disease process of metastatic non-small-cell lung cancer increased patient's life expectancy by two months. Temel and colleagues supported that participant's mood and quality of life improved and they reported lower depression rates and less aggressive end-of-life care with palliative care services (Temel et al., 2010). According to Temel et al. (2010) "to have a meaningful effect on patients' quality of life and end-of-life care, palliative care services must be provided earlier in the course of the disease" (p. 734).

Patient's families also report increased quality of care when their loved one receives palliative care services. A study by Gelfman, Meier, and Morrison (2008) reported that 65% of family members reported that their emotional or spiritual needs were met with palliative care compared to 35% of families that did not have palliative care services.

Research supports the importance of palliative care. However, health care providers continue to perceive palliative care as being for patients that are terminally ill, actively dying, for cancer patients, and care for terminal pain and symptoms at the end-of-life (Rodriguez et al., 2007). This perception causes barriers to palliative care referrals, resulting in underutilization of the service (Rodriguez et al., 2007). Rodriguez and colleagues (2007) found however that nurse's perception of palliative care was much different than other health care providers. Rodriguez et al. (2007) reported that nurses believed palliative care was not just for the end-of-life, but an option that "should be available to all patients for facilitating discussions and decision making about goals of care and quality of life" (p. 104). The nurse participants in the Rodriguez et al. (2007) study also stated that the discussions and decision-making surrounding goals of care were

“frequently neglected” (p. 104) by attending physicians. Rodriguez et al. (2007) concluded that a nurse’s knowledge of palliative care is important to the referral process. According to Autor et al. (2013) lack of knowledge of palliative care in bedside nurses is a barrier to referral and providing the service. The purpose of this study was to understand acute care nurses’ self-reported competence in providing palliative care services.

### Research Question

The research question addressed in this study was: What are acute care nurses’ self-reported competence in their ability to provide palliative care services to patients? To address the purpose and question, a sample of nurses who practiced in an urban hospital in South Central Montana were surveyed about their self-reported competence in providing palliative care services.

### Theoretical Framework

Bandura’s social cognitive theory and Orem’s conceptual model were used as the theoretical framework to inform this study.

#### Bandura’s Social Cognitive Theory

The basis of Bandura’s social cognitive theory (SCT) is that the achievement of self-efficacy results in overall competence (Desbiens, Gagnon, & Fillion, 2012). Self-efficacy is a person’s belief that they can reach and obtain a goal set before them and is developed through knowledge, training, and experience (Desbiens et al., 2012). Bandura

stated that self-competence is people's "beliefs of their capability to exercise some measure of control over their own functioning" (p. 10) to produce an outcome (Bandura, 2001). A competent nurse is able to perform and carry out difficult tasks and Bandura concluded, "these beliefs play a central role in the self-regulation of motivation and resiliency through goals challenges and outcome expectations" (Bandura, 2001, p. 10). A nurse's ability to provide care to clients and their families with life-limiting illnesses are a central component in providing palliative care in the acute care setting.

#### Orem's Conceptual Model

Orem's conceptual model is focused on self-care, which "corresponds to health related activities performed by individuals on their own behalf to maintain life, health and well-being" (Desbiens et al., 2012, p. 2115). Self-care, as proposed by Desbiens and colleagues (2012), is a necessary component in the context of life-limiting illness, or palliative care. According to Orem "nurses' capabilities extend to appropriately helping individuals with health-associated self-care deficits to know and meet with appropriate assistance the components of their therapeutic self-care demands and to regulate the exercise and development of their powers of self-care agency" (Orem, 1997, p. 27). Orem's model proposes that nurses are responsible for providing care to patients and their families with self-care deficits (Desbiens et al., 2012). Nurses play an important role in supporting patients with incurable or life-limiting illnesses, and their families, with their self-care needs.

### Bandura and Orem as Shared Theories

The combined theories of Bandura's SCT and Orem's conceptual model were used as the theoretical framework for this study. Desbiens and colleagues (2012) proposed combining Bandura's SCT and extending the SCT as a part of Orem's conceptual model. Orem's conceptual model is specific to nursing in that "nursing is required when individuals' developed and operational powers and capabilities to know and meet their own therapeutic self-care demands, in whole or in part, in time-place frames of reference, are not adequate because of health state or healthcare-related conditions" (Orem, 1997, p. 26). Therefore, Orem's conceptual model supports the use of Bandura's SCT (Desbiens et al., 2012). Under the shared theories, Desbiens and colleagues (2012) hypothesized that self-competence improves patient self-care behaviors through better nursing care. The combined theories of Bandura's SCT and Orem's conceptual model can be applied to acute care nurses and their competence in providing patient's self-care in the palliative setting.

Desbiens and colleagues (2012) stated, "nursing competence, nursing self-competence, and nursing interventions provide the theoretical basis for quality care in palliative care situations" (p. 2120). It is important for nurses to be competent in their care for patients and families with palliative care needs in order to assure quality care is given. Nurses that demonstrate self-efficacy and are knowledgeable about palliative care can identify and collaboratively communicate with physicians for more timely and appropriate patient referrals to palliative care services. Nurses displaying self-efficacy

“demonstrate greater performance” (Desbiens et al., 2012, p. 2115) when providing quality of care to patients and their families with palliative care needs.

Self-care is also an important aspect in palliative care. It is imperative that nurses promote patient and family self-care to “emphasize empowerment and the acquisition of self management skills to cope with serious long-term illness problems” (Desbiens et al., 2012, p. 2121). Palliative care services are known to increase quality of life and reduce distressful physical and emotional symptoms. Self-care is an overall component in palliative care as it too promotes “symptom control, functioning, autonomy, improved coping with illness, and better quality of life” (Desbiens et al., 2012, p. 2121). Nurses that promote excellent self-care are essentially providing the holistic care intended with palliative care.

### Summary

Palliative care is an important service for patients and their families experiencing a life-limiting illness. The aging population, increase in chronic illness, and the ACA are reasons for growth of palliative care programs. Palliative care focuses on relief from distressing symptoms and promotes quality of life. Research has documented that palliative care decreases distressing symptoms, improves patient’s quality of life, increases patient’s life expectancy, and increases family’s perception of quality of care (Gelfman et al., 2008; HRET, 2012; Temel et al., 2010). Decreased costs in multiple aspects of health care have been proven with palliative care services.

Although palliative care can be provided along with curative treatments, the perception of palliative care continues to be consistent with hospice and end-of-life care. This perception prevents referrals to palliative care services. Nurses' self-competence regarding palliative care is important to ensure timely referrals to palliative care specialist teams.

## CHAPTER 2

## REVIEW OF LITERATURE

The review of the literature revealed a need to know more about acute care nurse's self-competence of palliative care in the United States. Chapter 2 includes a summary of the literature regarding palliative care, palliative care in the acute care setting, acute care nurses' knowledge of palliative care, available instruments for assessment of nurse's knowledge of palliative care, and theoretical frameworks that support nurse's knowledge of palliative care.

A literature search was conducted via Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Medline. Search terms used for the review included, *“palliative care” AND “acute care setting,” “nurse’s knowledge” AND “palliative care,” “hospital” AND “nurse’s knowledge” AND “palliative care,” “acute care” AND “nurse’s knowledge” AND “palliative care,”* and *“palliative care” AND “nurse competence.”* Six instruments were reviewed for potential use in this study, including the Palliative Care Knowledge Test (PCKT), Palliative Care Nursing Self-Competence Scale (PCNSC), Move to Palliative Care (MOVE2PC), Palliative Care Quiz for Nursing (PCQN), Self-efficacy Instrument for Palliative Care (SEP), and Knowledge of Care Options (KOCO).

### Palliative Care

According to the World Health Organization (WHO) (2014) palliative care provides symptom relief, spiritual, and psychosocial support to patients and their families with life-limiting illness. Crump, Schaffer, and Schulte (2010) reported that “palliative care is aimed at relieving pain, stress, and symptoms of serious illness and improving communication with patients who have a serious diagnosis regardless of their prognosis” (p. 298). Palliative care should be implemented at the time of diagnosis and carried out through the end of a patient’s life (WHO, 2014). Palliative care is not end-of-life care, is not only for patients that are dying, and does not hasten death (WHO, 2014). Palliative care can be provided in conjunction with curative treatments, promotes quality of living, and increases quality of life (WHO, 2014). Palliative care has many quality standards based on research for its services. The National Consensus Project for Quality Palliative Care ([NCPQPC], 2013) has 8 domains for quality palliative care including: “structure and processes of care, physical aspects of care, psychological and psychiatric aspects of care, social aspects of care, spiritual, religious and existential aspects of care, cultural aspects of care, care of the patient at the end of life, and ethical and legal aspects of care” (p. 616). These 8 domains are included in clinical practice for any patient or family receiving palliative care services (NCPQPC, 2013).

The need for palliative care is expected to grow (Bradley et al., 2001; Cotterell, Lynch, & Peters, 2007; McCourt, Power, & Glackin, 2013; Rodriguez et al., 2007) due to several reasons. The population is continuing to age and so is the increase in people living with chronic illnesses (Morrison et al., 2008). People are living longer with chronic

illness due to the advances in health care technology (Rice & Betcher, 2010). Palliative care is the way through which people with chronic disease can have quality of life. Palliative care is also growing due to the Patient Protection and Affordable Care Act (ACA) of 2010. Health care in the United States is one of the most expensive in the world, however the quality of health care in the United States is lacking (Finkler et al., 2013). The ACA's goal is to improve quality of care to patients and bring value to the health care system (Fletcher & Panke, 2012). One of the provisions under the ACA is value based purchasing or pay for performance (Fletcher & Panke, 2012). The pay for performance provision under the ACA promotes payment for quality care instead of payment for volume of patients seen (Fletcher & Panke, 2012). Another provision under the ACA is Accountable Care Organizations (Finkler et al., 2013). Accountable Care Organizations are a "group of providers that work together to provide and coordinate care for a specified patient population across settings" (Fletcher & Panke, 2012, p. 453). The providers under the Accountable Care Organizations are collectively responsible for the cost and quality of care provided to their specified patient populations (Fletcher & Panke, 2012). Palliative care programs increase the quality of care given to patients and their families and also decreases costs, therefore palliative care is central to the new mandates under the ACA (Fletcher & Panke, 2012).

Research conducted by Temel and colleagues in 2010 supports that palliative care improves quality of life for patients. The WHO (2014) reports that most cancer diagnoses are made at advanced stages, therefore palliative care is needed at the time of diagnosis for patients with cancer. Temel and colleagues (2010) conducted a study of 151 patients

with metastatic non-small-cell lung cancer (NSCLC). Patients in the Temel (2010) study were randomly placed into two groups, one with palliative care services along with oncology care, and one with oncology care alone. Overall, patients in the palliative care group had a longer survival rate, 11.6 months, versus those that did not receive palliative care services, 8.9 months (Temel et al., 2010). All participants in the Temel (2010) study performed A Functional Assessment of Cancer Therapy-Lung (FACT-L) scale, to measure their quality of life, and the Hospital Anxiety and Depression Scale, to measure their mood. Patients who received palliative care had FACT-L median scores of 98.0 versus 91.5 for patients who did not have palliative care services (Temel et al., 2010). The Hospital Anxiety and Depression Scale revealed that palliative care patients reported depressive symptoms 16% of the time versus 38% for those who did not have palliative care services (Temel et al., 2010). The study by Temel and colleagues (2010) reveals that patients with metastatic NSCLC who receive palliative care at the time of diagnosis report better quality of life, decreased depressive symptoms, and an overall increased survival time.

Families of patients who receive palliative care in the acute care setting also report improved quality of care. Gelfman and colleagues (2008) conducted 54 interviews with family members of patients who received palliative care and 95 interviews with family members who did not receive palliative care services (n=149). Forty-six percent of family members of patients in the palliative care group reported that their spiritual beliefs were addressed versus 24% for non-palliative care family members (Gelfman et al., 2008). Seventy-three percent of palliative care family members reported that they had

support in dealing with their own feelings verses 55% for those families who did not have palliative care services (Gelfman et al., 2008). Eighty two percent of families of patients with palliative care reported they knew what to expect when their loved one was dying verses 68% for families without palliative care (Gelfman et al., 2008). Lastly, 87% of palliative care patient's families reported that they were confident in what steps needed to be taken after their loved one died, verses 71% of families that did not have palliative care services. Overall, Gelfman and colleagues (2008) findings support that palliative care promotes confidence and self-efficacy for family members, as well as increased family reports of quality care.

Palliative care is not only beneficial to the patients and families it serves, but also in regards to cost savings. Research by Morrison et al. (2008) supports the cost savings associated with palliative care in the hospital setting. Morrison and colleagues (2008) analyzed data from eight hospitals in the United States over a two-year period and compared costs between patients who received palliative care verses patients who did not receive palliative care services. Patients who received palliative care and were discharged alive had \$2642 in total savings per admission, \$279 in savings per day, and \$5178 in savings with regards to intensive care unit (ICU) admission costs as compared to usual care patients (Morrison et al., 2008). Patients also had \$424 in savings for laboratory costs when they received palliative care services (Morrison et al., 2008). Patients who received palliative care and died in the hospital had \$6896 in total savings per admission, \$549 in savings per day, \$1544 in pharmacy savings, \$926 in laboratory savings, and \$6613 in savings with ICU admission costs (Morrison et al., 2008). Morrison and

colleagues (2008) reported \$1.3 million per year in cost savings for a palliative care team that saw 500 inpatient consults in one year. Overall, research by Morrison and colleagues (2008) supports the need for palliative care services in the acute care setting due to the large cost savings.

### Palliative Care in the Acute Care Setting

According to the Center to Advance Palliative Care ([CAPC], 2010), palliative care programs in the inpatient setting grew by 125.8% between 2000 and 2008. In 2008, 70% of nonprofit hospitals with at least 50 or more beds had a palliative care program, however less than ¼ of for-profit hospitals reported having a palliative care program (CAPC, 2010). Hospitals with 300 or more beds had a palliative care program 81% of the time versus 40% of hospitals with only 50-74 beds (CAPC, 2010).

Research by Rice and Betcher (2010) supports the need for palliative care programs in the inpatient setting in order to decrease inpatient mortality rates. Intensive Care Units (ICUs) tend to have high rates of inpatient mortality. A retrospective study conducted by Rice and Betcher (2010) compared ICU mortality rates before and after a palliative care program was initiated in the hospital setting. These investigators reported that before palliative care services, 65.7% of all hospital deaths occurred in the ICU. After implementation of a palliative care program, however, deaths in the ICU decreased to 13.6% in the first year, and decreased even more in the second year to 9.9%. Research by Teno and colleagues (2004) reported that 68.9% of patients with chronic illness die in hospitals or nursing homes. Teno et al. (2004) reported that 70.7% of patient's families

reported greater satisfaction with care when their loved one died at home with hospice services. Rice and Betcher (2010) reported that patients were referred to hospice more often and had increased documentation of advanced directives with the implementation of an inpatient palliative care program. Therefore, palliative care programs refer to home hospice services when appropriate, resulting in increased patient and family satisfaction, and overall decreased inpatient mortality rates.

Although the need for palliative care is supported in the literature to prevent inpatient deaths and improve quality of care for patients and their families, the culture of palliative care does not correlate with the current philosophy and definition of palliative care. Many health care providers perceive palliative care as being end-of-life care (Bradley et al., 2001; Mahon & McAuley, 2010; McCourt et al., 2013; Rodriguez et al., 2007). Research conducted by Docherty and colleagues (2007) supported the perception of palliative care in the pediatric setting as also being end-of-life care. Docherty et al. (2007) reported that half of children with acute and chronic illnesses die in the inpatient acute care setting and most children do not receive palliative care services until they are actively dying. Palliative care is not perceived by health care providers as chronic disease management or as having the ability to coincide with curative treatment; but rather as care for patients that are actively dying, patients with malignant or terminal cancer, patients in need of pain management, or for when decisions need to be made to stop life sustaining treatments (Davidson et al., 2003; Rodriguez et al., 2007). Due to health care provider's perceptions of palliative care, implementing palliative care services is viewed as discontinuing curative medical treatments and transitioning to end-of-life care

(Rodriguez et al., 2007). Patients who do not receive palliative care services may have increased suffering due to lack of relief from burdensome symptoms (Docherty et al., 2007; Pavlish & Ceronsky, 2007). Research supports the implementation of palliative care at the time of diagnosis (Docherty, Miles, & Brandon, 2007; Knapp et al., 2009), however less than 10% of HF patients receive palliative care (Autor et al., 2013). Many acute care nurses and health care providers reported never talking to patients about their prognosis or even mentioning hospice in an appropriate situation (Bradley et al., 2001). Lack of discussion surrounding prognosis or goals of care results in acute care nurses feeling like they are providing unnecessary or inappropriate care interventions (Sibbald, Downar, & Hawryluck, 2007).

One of the first steps needed to promote utilization of palliative care in the inpatient setting is to assess acute care nurses' self-reported competence with palliative care services. After a knowledge and competence assessment is performed, nursing interventions can be created and implemented accordingly to improve nurse's competence of palliative care, resulting in increased utilization of palliative care services.

#### Acute Care Nurses' Barriers and Perceptions of Palliative Care

Mahon and McAuley (2010) conducted a qualitative study of 12 oncology nurses and found that nurses reported patients' symptoms are not adequately controlled (Mahon & McAuley, 2010), thus supporting a need for palliative care in the acute care setting. Acute care nurses, however, reported barriers to palliative care services (Docherty et al., 2007; Mahon & McAuley, 2010; Pavlish & Ceronsky, 2007).

Pavlish and Ceronsky (2007) interviewed 33 acute care oncology nurses regarding their perceived barriers to palliative care. The highest perceived barrier in providing palliative care services reported by the acute care oncology nurses was lack of time (Pavlish & Ceronsky, 2007). Other barriers perceived by the acute care oncology nurses were the value of advanced medical technologies to treat patients in hope for a cure, and lack of communication, continuity, and coordination of care among health care professionals providing palliative care services (Pavlish & Ceronsky, 2007).

Mahon and McAuley (2010) studied oncology nurse's perceived barriers to palliative care. One persistent barrier is that acute care nurses perceive that palliative care is synonymous with hospice care (Mahon & McAuley, 2010). The acute care oncology nurses reported that patients and physicians are the ones that make decisions and factors affecting decisions regarding palliative care, and the nurse's roles are limited and indirect (Mahon & McAuley, 2010). Acute care nurses' role ambiguity indicates a presence of insufficient knowledge regarding their specific role and ability to positively effect palliative care services.

The literature documents that acute care nurses have differing perspectives of palliative care. Docherty and colleagues (2007) interviewed 17 acute care health providers, including 6 pediatric nurses regarding their perceptions of palliative care. All except one study participant viewed palliative care as an additional component of care instead of care that should be integrated at the beginning of diagnosis (Docherty et al., 2007). Acute care pediatric nurses viewed the palliative care team as outsiders since they had not provided care to the patient since the beginning of diagnosis (Docherty et al.,

2007). Many of the study participants reported that palliative care “moves away from intensive curative treatment” (Docherty et al., 2007, p. 337). The perception that palliative care is a separate entity of care resulted in challenges and reported difficulty by the participants in utilizing palliative care services (Docherty et al., 2007).

Overall, acute care nurse’s perceptions of palliative care services are inconsistent with the definition and philosophy of palliative care. The acute care nurse’s perceptions of palliative care effect the utilization of palliative care services in the acute care setting. However, acute care nurses did report that they felt confident in their ability to communicate, displayed comfort when discussing difficult topics, and are able to provide psychosocial and holistic care to patients (Mahon & McAuley, 2010; Payne et al., 2007; Steginga et al., 2005). It is the characteristics of communication, psychosocial support, and ability to provide holistic care to patients that make nurses the cornerstone for palliative care services.

#### Acute Care Nurses’ Knowledge of Palliative Care

Nurses in the acute care setting act as liaisons between physicians and patients, relaying critical information, and act as patient advocates (Bradley et al., 2001; Davidson et al., 2003; Rodriguez et al., 2007). Consequently, the more knowledgeable an acute care nurse is regarding palliative care, the more likely palliative care services will be utilized in the acute care setting (Autor et al., 2013; Bradley et al., 2001; Davidson et al., 2003; Rodriguez et al., 2007).

Autor and colleagues (2013) studied palliative care knowledge in oncology, ICU, and HF nurses (n=143) in the United States using the Palliative Care Quiz for Nursing (PCQN) instrument. This sample of nurses had a mean score of 67.6% and answered 13.5 out of 20 questions on the PCQN correctly (Autor et al., 2013). Approximately 83.2% of acute care nurse participants correctly identified that patients appropriate for palliative care do not need to be deteriorating rapidly (Autor et al., 2013). However, Autor and colleagues (2013) reported that only 34.3% of acute care nurses understood that palliative care is compatible with curative treatment.

A study of acute care pediatric nurses (n=279) conducted by Knapp and colleagues (2009) also used the PCQN instrument to test nurse's knowledge of palliative care. Knapp et al. (2009) revealed that 50% of pediatric acute care nurses answered 12 out of 20 questions correctly, for an overall mean score of 60%. Knapp et al. (2009) reported that only 14% of pediatric nurses correctly identified that palliative care can be provided in addition to aggressive medical treatments.

Proctor and colleagues (2000) studied acute care nurse's knowledge of palliative care. The acute care nurse participants had a mean score of 62% on the PCQN instrument for the acute care nurses, therefore, 12.4 out of 20 questions were correctly answered (Proctor et al., 2000). The study revealed that acute care nurses have insufficient knowledge of complex symptoms and pain control (Proctor et al., 2000). Forty-four percent of acute care nurses reported that they did not know that morphine treated dyspnea and only 53% of the participants knew that morphine was the standard opioid used to compare other opioids gauging their analgesic effect (Proctor et al., 2000).

Acute care nurses have limited knowledge in the concepts of palliative care (Autor et al., 2013; Knapp et al., 2009; Proctor et al., 2000). The literature supports that oncology and experienced nurses have the highest scores regarding their knowledge of palliative care (Autor et al., 2013; Proctor et al., 2000). Mahon and McAuley (2010) predicted oncology nurses to be the trendsetters for understanding the concepts of palliative care. Overall, the literature revealed few studies that quantify acute care nurse's self-competence of palliative care in the United States.

#### Educational Interventions to Increase Nurses' Knowledge of Palliative Care

Acute care nurses stated that palliative care is mostly learned through on the job experience and mentorship (Docherty et al., 2007; Proctor et al., 2000). Overall, the literature review revealed that acute care nurses need more education in palliative care in order to be effective care providers of palliative care (Davidson et al., 2003; Docherty et al., 2007; Loftus & Thompson, 2002; Mahon & McAuley, 2010; Pavlish & Ceronsky, 2007; McCourt et al., 2013; Payne et al., 2007; Sibbald et al., 2007).

Cotterell and colleagues (2007) conducted a qualitative study of 31 acute care nurses who were educated in palliative care. Acute care nurses in the Cotterell (2007) study reported increased confidence when caring for palliative care patients, reported greater ability to address patient's symptoms, communicated better, attended to patients psychological concerns more often, were able to pass on their knowledge of palliative care practice to their coworkers, and overall, felt they improved the care given to palliative care patients after education in palliative care. Research by Cotterell et al.

(2007) supports a palliative care education intervention for nurses as greater nursing knowledge resulted in increased quality of care for palliative care patients in the acute care setting.

Steginga and colleagues (2005) stated that with increased knowledge, nurses can become the change agents of palliative care. The literature revealed acute care nurses who had training in palliative care had increased palliative care knowledge and competence post testing scores, increased insight, confidence, self-efficacy, psychosocial skills, and increased communication with physicians regarding palliative care (Adriaansen, van Achterberg, & Borm, 2005; Knapp et al., 2009; Loftus & Thompson, 2002; Payne et al., 2007; Steginga et al., 2005).

### Theoretical Framework

Desbiens, Gagnon, and Fillion (2011) proposed a shared theory for palliative care nursing that combines Bandura's social cognitive theory and Orem's conceptual model, which were used as the theoretical framework to inform this study.

#### Bandura's Social Cognitive Theory

Social cognitive theory (SCT) was developed by Albert Bandura in 1986. Social cognitive theory is a theory based in psychology, with a foundation in self-efficacy (Bandura, 2001). Social cognitive theory has been used in many studies to assess nurse's knowledge of palliative care (Adriaansen & Achterberg, 2004; Desbiens & Fillion, 2011; Witkamp et al., 2013). Social cognitive theory states that behaviors are produced "through psychological mechanisms of the self system" (Bandura, 2001, p. 15). Bandura

(2001) proposed that a person's self-system behaviors are regulated not only by their own self-efficacy, but are also influenced by external factors, such as a person's economic status, educational background, and family systems. Social cognitive theory is grounded in people's belief that they have the capability to control their own functioning, which is a component of self-efficacy. Self-efficacy is central to people's functioning as it "causes people to act or to persevere in the face of difficulties" (Bandura, 2001, p. 10). Therefore, SCT is used as one of the combined theoretical frameworks in this study as the theory can be applied to acute care nurses and their perceived self-efficacy in the care of palliative care patients.

Desbiens and colleagues (2011) use competency and efficacy "interchangeably because they are conceptually equivalent" (p. 2114). Competence is defined as a "capability, a mental structure underlying any performance" (Desbiens et al., 2011, p. 2114). Additionally, competence "represents the capability to translate subskills, knowledge, values, and attitudes into proficient actions. It is obtained through training and experience" (Desbiens et al., 2011, p. 2114). Perceived self-competence is people's belief that they can obtain a desired outcome (Desbiens et al., 2011). Acute care nurses with "high self-perceived competence demonstrate greater performance when providing quality care" (Desbiens et al., 2011, p. 2115). Self-competence is important in palliative nursing. If acute care nurses do not believe that they are competent in palliative care, they are likely to avoid patients and families with palliative care needs (Desbiens et al., 2011). When palliative care services are given, they increase quality of care and perceived

quality of life of patients and their families. Therefore, perceived self-competence in SCT is an important factor to figure into acute care nurse's knowledge of palliative care.

### Orem's Self-Care Theory

Dorothea E. Orem developed a conceptual model in 1971, which is specific to nursing and founded in self-care. Orem (1997) stated "individuals throughout their life cycles are viewed as having a continuing demand for engagement in self-care, in care of self" (p. 26). Orem (1997) reported that people have the ability to develop and demonstrate their own self-care needs. Orem's theory proposes that nurses are needed when "individuals' developed and operational powers and capabilities to know and meet their own therapeutic self-care demands are not adequate because of health state or healthcare-related conditions" (Orem, 1997, p. 26). When an individual can no longer meet his or her own self-care needs, it becomes known as a self-care deficit (Orem, 1997) and nursing interventions (wholly compensatory, partly compensatory, and supportive-educative) are carried out when a patient displays a self-care deficit (Orem, 1997). Desbiens et al. (2011) stated that nurses assist patients "whose quality of life is compromised" (p. 2115) and therefore, their self-care needs cannot be met. Orem's theory proposes that acute care nurses help patients with self-care deficits due to life-limiting illness and has important consideration for end of life situations.

### Overlap of Social Cognitive Theory and Self-Care Theory

Desbiens and colleagues (2011) proposed that Bandura's SCT and Orem's conceptual model overlap and thus guide nursing self-competence and patient's self-care. Desbiens and colleagues (2011) stated that self-care is important in the palliative care setting as it promotes "symptom control, functioning, autonomy, improved coping with illness, and better quality of life" (p. 2121). These researchers also reported that a nurse's self-efficacy results in improved quality of life for patients and is important in the palliative care setting (Desbiens et al., 2011). According to Desbiens et al. (2011) "perceived self-competence directly or indirectly influences an individual's self-care or health behaviors" (p. 2116) and stated that the concepts of self-care and self-efficacy affect a patient's behaviors and therefore there is an overlap between SCT and Orem's self-care theory.

Desbiens and colleagues (2011) reported a comparison of Orem's model and SCT using two of three criteria: paradigm comparison and theoretical comparison, with future plans to test for "empirical coherence and relevance in nursing care situations" (p. 2119). These researchers reported that constructs between SCT and Orem's theory of self-care are complementary and that quality care is achieved through nursing self-competence in the palliative care setting and that Orem's conceptual model promotes the nurse to develop the capability to care for patients or takes into consideration their own self as well as the patient. Orem's conceptual model encompasses nursing interventions and when a nurse demonstrates self-efficacy, as with Bandura's SCT, the result will be

quality palliative care (Desbiens et al., 2011). Therefore, SCT influences nurse's behaviors and Orem's conceptual model influences a nurse's actions, resulting in engaging patients in self-care (Desbiens et al., 2011). If a patient is unable to perform his or her own self-care due to illness, the nurse then assists the patient in self-care activities (Desbiens et al., 2011).

Desbiens et al. (2011) stated that SCT and self-care theory need to be explored within the nursing context itself and empirically tested. To date, no studies have been conducted on the concept of nursing self-competence, and the combined theories have not been empirically tested, therefore "no shared theory can be proposed using Bandura's SCT and Orem's conceptual model" (Desbiens et al., 2011, p. 2116). The researcher in the study reported here has been in contact with Dr. Desbiens and with her permission (see Appendix B), has conducted this study using the combined theories as well as the PCNSC instrument to assess acute care nurses' self-reported competence in providing palliative care services. The raw data obtained for the current study has been shared with Dr. Desbiens.

#### Instruments to Assess Nurses' Knowledge of Palliative Care

Research supports that lack of nurse's knowledge of palliative care results in under-utilization of palliative services and decreased quality palliative care (Desbiens & Fillion, 2011; Nakazawa et al., 2009; Schulman-Green, Ercolano, Jeon, & Dixon, 2012). There have been six instruments developed to assess nurse's knowledge of palliative care including, Palliative Care Knowledge Test (PCKT), Palliative Care Nursing Self-

Competence Scale (PCNSC), Move to Palliative Care (MOVE2PC), Palliative Care Quiz for Nursing (PCQN), Self-efficacy Instrument for Palliative Care (SEP), and Knowledge of Care Options (KOCO).

The PCKT instrument is a 20-item questionnaire which is designed to examine nurses' and physicians' knowledge of palliative care (Nakazawa et al., 2009). The PCKT instrument tests nurse's knowledge of the philosophy of palliative care, pain, dyspnea, psychiatric problems, and gastrointestinal problems (Nakazawa et al., 2009), therefore it is missing key assessment areas of nurse's knowledge. The PCKT has no theoretical framework to guide the development of the instrument and was tested for validity with nurses in the country of Japan (Nakazawa et al., 2009); therefore the PCKT was not deemed applicable to nurses in the United States. The MOVE2PC instrument uses a 5-point Likert scale to assess nurse's knowledge of palliative care on a 63-item questionnaire (Witkamp, van Zuylen, van der Rijt, & van der Heide, 2013). The MOVE2PC is based on the theoretical framework of Bandura's SCT, however it has limited content validity and was designed specifically for Dutch speaking countries in the Netherlands (Witkamp et al., 2013), it was therefore not applicable to nurses in the United States. The PCQN instrument is a 20-item instrument that tests nurses' basic knowledge of palliative care (Ross, McDonald, & McGuinness, 1996). The PCQN has limited predictive validity, is based on the theoretical framework of the Canadian Palliative Care Curriculum, and is not a comprehensive assessment of overall palliative care knowledge as it test nurses' basic palliative care knowledge (Ross et al., 1996), it therefore was not chosen as the instrument for this study. The SEP instrument is a 36-

item test for nurses' knowledge and self-efficacy of palliative care (Adriaansen & Achterberg, 2004). The SEP is based on the theoretical framework of Bandura's SCT and assesses nurse's knowledge on the basic principles of palliative care, controlling symptoms and pain, and psychosocial and spiritual care (Adriaansen & Achterberg, 2004); it therefore is missing key assessment areas of nurse's knowledge of palliative care. SEP was designed specifically for Dutch speaking countries in the Netherlands (Adriaansen & Achterberg, 2004), therefore this instrument was not applicable to nurses in the United States. The KOCO instrument is an 11-item test regarding curative, palliative, and hospice care options (Schulman-Green et al., 2012). No theoretical framework was identified in the literature to guide the development of the KOCO instrument and it is directed more towards patients' versus nurses' knowledge of care options (Schulman-Green et al., 2012), therefore this instrument was not utilized for the study.

This researcher chose the PCNSC instrument to assess nurses' self-competence of palliative care for this study. The PCNSC instrument is a 34-item questionnaire with eight domains to assess nurses' competence in their ability to provide palliative care services (Desbiens & Fillion, 2011). The PCNSC was developed using Bandura's SCT and Orem's self-care theory (Desbiens & Fillion, 2011). To date, no research has been conducted to assess nurses' self-competence of palliative care using the PCNSC in the United States. Therefore, this research study was designed to use the PCNSC instrument for its direct relationship to the selected shared theoretical frameworks of Bandura and

Orem, and its eight comprehensive assessment domains for nurses' competency of palliative care.

### Summary

The current study is designed to examine acute care nurses' self-reported competence in providing palliative care services. It is important to understand nurses' self-competence of palliative care in order to increase the utilization of palliative care in the acute care setting and promote quality of living in the patients and families that palliative care serves. Strengths of the current study include the utilization of a validated assessment tool, the PCNSC, to assess acute care nurses' competency regarding palliative care and also the utilization of the overlapping theories of SCT and self-care theory to guide the research. The current study seeks to provide an avenue for gathering important information for nurses and other health care professionals caring for patients and families with incurable illnesses.

## CHAPTER 3

## METHODS

Design

A non-experimental descriptive research design was utilized in this study. According to Polit and Beck (2012) the “purpose of descriptive research is to observe, describe, and document aspects of a situation as it naturally occurs and sometimes to serve as a starting point for hypothesis generation or theory development” (p. 226). The purpose of this study was to understand acute care nurses’ self-reported competence in providing palliative care services. The research question addressed in this study was: What are acute care nurses’ self-reported competence in their ability to provide palliative care services to patients? To address the purpose and question of the study, a sample of nurses who practiced in an urban hospital in South Central Montana were surveyed online regarding their self-competence in providing palliative care.

Population and Sample

All eligible registered acute care nurses (approximately N= 450) working in a South Central Montana hospital were asked to participate in the study. Registered nurses working on all inpatient units were eligible and invited to anonymously participate in the online survey.

Setting

The study was conducted at a 286-bed hospital setting in South Central Montana. The hospital serves as a regional health care center to populations of patients from Central and Eastern Montana, as well as Northern Wyoming. The hospital's inpatient services include emergency, cardiology, medical, oncology, neuroscience, orthopedics, surgical, pediatrics, obstetrics, neonatology, radiology, imaging, laboratory, and rehabilitation. The organization also has an air medical program with a fixed wing aircraft and helicopter. According to the American Hospital Association (2013) the organization had 11,250 admissions, 30,687 emergency visits, 4,037 inpatient surgeries, and 1,280 births in 2012.

The inpatient palliative care program in the selected organization was established in 2012. From 2012 through October 2014, the palliative care program had 1,104 total consults; with 487 consults for symptom management, 458 consults to identify goals of care, 49 consults to assist with disposition planning, 26 consults to assist with code status, 22 consults to assist with medications for comfort at end-of-life, 20 consults to assist with advanced directives, and 42 "other" category consults, including emotional support. Consultation for inpatient palliative care services at this organization increased from 87 total consults in 2012, to 556 consults in 2013, and 740 consults through October of 2014.

### Procedures for Data Collection

All eligible full time and part time registered nurses were sent an online study packet through the hospital's secure Intra-net system using Survey Monkey software. The online study packet consisted of the survey instrument, demographic questions, a cover letter that had an explanation of the study, procedures to maintain confidentiality, contact information for the primary investigator and faculty sponsor, and instructions to complete the online survey (see Appendix A for participant explanation form). No signed consents from participants were obtained as willingness to complete the online survey was deemed as consent. Data collection occurred during a two-week time period in March 2015. Two reminders were sent out to all eligible registered nurses during the two-week data collection time period. In the reminder emails, nurses who had already responded to the survey were thanked and asked to delete the reminder message. Participants' responses were anonymous and no identifiable data were collected from the study participants.

### Instrument

Two parts of the online study packet included 1) Palliative Care Nursing Self-Competence Scale (PCNSC), and 2) standard demographic questions. The questionnaire took approximately 20 minutes to complete. The instrument selected for this study was the English version of the Palliative Care Nursing Self-Competence Scale (PCNSC). Permission to use the PCNSC instrument was granted by its developers (see Appendix B for instrument and permission to use). The PCNSC is a 34-item questionnaire with eight domains to assess nurse's self-reported competence in their ability to provide palliative

care services to adult patients (Desbiens & Fillion, 2011). The eight domains of the PCNSC include physical, psychosocial, spiritual, and functional status needs, as well as ethical and legal issues, interprofessional collaboration and communication, personal and professional issues, and end-of-life care. To date, no research has been conducted to assess nurses' self-competence of palliative care using the PCNSC in the United States. The psychometric properties of the French version of the PCNSC have been reported (Desbiens & Fillion, 2011), however the psychometric evaluation of the English version of the PCNSC has not been published to date. The 34-item questionnaire has Likert type response options that range from 0 to 10; with 0 corresponding to not at all capable, 5 corresponding to moderately capable, and 10 corresponding to highly capable. Scoring of the PCNSC involved calculating the mean response for each of the separate eight domains, as well as computing an overall mean score for nurses' self-reported competence in providing palliative care services.

Nine demographic questions asked of participants and adapted from Autor, Storey, and Ziemba-Davis (2013) included: years worked as a registered nurse, unit worked, additional certifications held, experience as a hospice nurse, awareness of the selected hospital's palliative care program, number of patients cared for with a palliative care referral, history of suggesting or participation in palliative care referral, and suggestion for palliative care referral resulting in a formal palliative care consult. (See Appendix C for demographic questions).

### Human Subjects Consideration

The Montana State University Institutional Review Board approved the study on November 21, 2014, as well as the Billings, Montana Institutional Review Board on December 17, 2014. Permission was also obtained from the Chief Nursing Officer of the hospital where data collection occurred.

### Data Management and Analysis

Following data collection, the completed online study packets were exported from Survey Monkey to Microsoft Excel for analysis. Descriptive statistics and frequencies were produced to identify possible data entry errors. When implausible entries were discovered, the response was excluded from the data set.

Descriptive statistics were used to summarize the results on the demographic questions and produce a description of the respondents. Descriptive statistics were also used to summarize the results on the PCNSC instrument. To address the research question of what are acute care nurses' self-reported competence in their ability to provide palliative care services to adult patients; nurses' responses were computed using a mean score for each of the eight domains of the PCNSC as well as an overall mean score of their responses on the PCNSC.

## CHAPTER 4

## RESULTS

In this study, an answer to the following research question was sought: What are acute care nurses' self-reported competence in their ability to provide palliative care services to patients? Presentation of the results are organized according to the following categories: sample description, experience with palliative care, respondent description, respondents' experience with palliative care, palliative care nursing self-competence scores on the PCNSC, mean scores for the eight domains, and mean scores for each item under the eight domains.

Sample Description

There were 450 surveys sent out to all eligible registered nurses working on inpatient units in a South Central Montana hospital. The survey was sent via the hospital's secure Intranet over a 14 day time period in March 2015. Surveys were distributed on day one with reminders sent on days 11 and 13. A total of 132 surveys were completed, resulting in a 29% response rate. The most common response option selected for experience as a registered nurse was one to five years (40.8%;  $n = 53$ ), 37 (29.1%) held a current nursing certification, and ten (7.6%) reported experience as a hospice nurse. The largest group of participants worked on the Medical-Oncology unit (23.5%;  $n = 31$ ) and the smallest group of participants (5.3%;  $n = 7$ ) worked on the Obstetric unit. If respondents indicated "Other" when asked where they worked, they

were asked to specify what other unit. The other units included: two respondents for the Float Pool, and one respondent each for Flight, Labor and Delivery, Hospice, St. Vincent Healthcare University, and Administration.

### Experience with Palliative Care

One hundred and eleven participants (84.1%) reported awareness of the hospital's inpatient palliative care program, with 91 (70%) having cared for a patient with a palliative care referral within the past five years, and 47 (51.6%) having cared for more than ten patients with a palliative care referral. Sixty-seven nurses (52.8%) reported they had recommended or participated in a palliative care referral, with 25 (37.3%) recommending between two to five patient referrals, and 25 (37.3%) recommending more than ten patient referrals to palliative care. See tables 1 and 2 for further details about respondents' experience with palliative care.

Table 1. Respondents' Description

<u>Years of Experience</u>	<u>N (%)</u>
< 1	6 (4.6%)
1-5	53 (40.8%)
6-10	37 (28.5%)
> 10	34 (26.2%)
Skipped Question	2 (0.02%)
<u>Area of Employment</u>	<u>N (%)</u>
Medical Oncology	31 (23.5%)
Intensive Care	26 (19.7%)
Cardiac Telemetry	25 (18.9%)
Neurological Surgical	21 (15.9%)
Emergency	19 (14.4%)

Table 1. Respondents' Description Continued

Pediatrics	16 (12.1%)
Neonatal Intensive Care	16 (12.1%)
Orthopedics	16 (12.1%)
Total Joint Repair	14 (10.6%)
Rehabilitation	10 (7.6%)
Operating Room	9 (6.8%)
Obstetrics	7 (5.3%)
Other	7 (5.3%)
<u>Hospice Experience</u>	
	<u>N (%)</u>
Yes	10 (7.6%)
No	122 (92.4%)
<u>Nursing Certification</u>	
	<u>N (%)</u>
Yes	37 (29.1%)
No	90 (70.9%)
Skipped Question	5 (0.04%)

Table 2. Respondents' Experience with Palliative Care

<u>Awareness of Inpatient Palliative Care</u>	
	<u>N (%)</u>
Yes	111 (84.1%)
No	21 (15.9%)
<u>Cared for a Patient with Palliative Care</u>	
	<u>N (%)</u>
Yes	91 (70.0%)
No	39 (30.0%)
Skipped Question	2 (0.01%)
<u>Number of Patients Cared for with Palliative Care</u>	
	<u>N (%)</u>
1	4 (4.4%)
2-5	27 (29.7%)
6-10	13 (14.3%)
> 10	47 (51.6%)
Skipped Question	41 (31%)

Table 2. Respondents' Experience with Palliative Care Continued

<u>Recommended/Participated in Palliative Care Referral</u>	<u>N (%)</u>
Yes	67 (52.8%)
No	60 (47.2%)
Skipped Question	5 (0.04%)
<u>Number of Referrals Recommended/Participated In</u>	<u>N (%)</u>
1	6 (9.0%)
2-5	25 (37.3%)
6-10	11 (16.4%)
> 10	25 (37.3%)
Skipped Question	65 (49%)

#### Palliative Care Nursing Self-Competence Scores

The PCNSC is a measure of nurses' reported self-competence with palliative care services. The scale, as according to Desbiens and Fillion (2011), ranges from zero, not at all capable; to ten, highly capable; with five corresponding to moderately capable.

Participants were instructed to choose the number on the scale of zero to ten that best fit with their perception of how competent they felt with regards to the questions under each domain. The possible range of scores for each domain and for overall score is 0 to 10.

The highest mean domain score in this study was in the domain of physical needs for pain and other symptoms with a mean score of 7.37. The lowest mean domain score was 5.99 in the domain of ethical and legal issues related to palliative care (Table 3). The overall mean score across all eight domains was 6.79, indicating the nurses' in this study felt moderately capable in providing palliative care services. With the data collection

software used, it was not possible to calculate individual mean scores for each participant. See table 4 for each item's mean score under the eight domains.

Table 3. Mean Scores for Eight Domains on the PCNSC

<u>Domain</u>	<u>Mean (N)</u>	<u>Actual Range of Scores</u>
Physical Needs: Pain and Other Symptoms	7.37 (106)	0-10
Psychosocial Needs	6.51 (104)	0-10
Spiritual Needs	6.58 (105)	0-10
Needs Related to Functional Status	6.84 (102)	0-10
Ethical and Legal Issues	5.99 (105)	0-10
Interprofessional Collaboration and Communication	6.52 (104)	0-10
Personal and Professional Issues Related to Nursing Care	7.16 (105)	0-10
End-of-Life Care	7.33 (105)	0-10

\*N < 132 resulted from missing data due to participants skipping questions within the survey.

Table 4. Mean Scores for Each Item in the PCNSC

<u>Item</u>	<u>Mean</u>
Assess pain for a palliative care patient unable to communicate	7.51
Effectively use pharmacological interventions to alleviate pain in a palliative care patient	7.92
Use non-pharmacological and complementary interventions to alleviate pain in a palliative care patient	7.29
Provide effective care to alleviate nausea and vomiting in a palliative care patient	7.57
Provide effective care to alleviate constipation in a palliative care patient	7.30

Table 4. Mean Scores for Each Item in the PCNSC Continued

Provide effective care to alleviate dyspnea in a palliative care patient	7.23
Provide proper mouth care to promote comfort in a palliative care patient	7.97
Provide early detection of delirium in a palliative care patient	6.21
Provide effective care to reduce psychological distress in a palliative care patient and their family	6.67
Provide support to a palliative care patient and their family when they experience grief	6.97
Assess the impact of a life-threatening illness on family dynamics	6.48
Assist a palliative care patient and their family in identifying personal resources in order to cope with problems related to a life-threatening illness	5.92
Assess the spiritual needs of a palliative care patient and their family	6.66
Recognize signs of spiritual distress in a palliative care patient and their family	6.51
Assist a palliative care patient to explore the meaning of their illness experience	6.77
Adapt the nursing care in accordance with the spiritual beliefs of a palliative care patient and their family	6.38
Assess the needs associated with activities of daily living in a palliative care patient	6.97
Assist a palliative care patient to maintain their functional independence for as long as possible	6.84
Implement appropriate interventions to help alleviate burden on family members caring for a palliative care patient	6.72
Promptly identify ethical issues related to the care of a palliative care patient	6.36
Provide information to a palliative care patient concerning the legal issues associated with life-threatening illness	4.84
Assist a palliative care patient to make informed decision regarding end-of-life care	5.77
Advocate for a palliative care patient and their family with other members of the healthcare team	7.01
Actively participate in discussions regarding a palliative care clinical situation during interdisciplinary team meetings	5.93
Promote communication between the palliative care patient, their family, and health care professionals in order to ensure information sharing	6.86
Promote communication between health care professionals when conflicts arise in the care of a palliative care patient and their family	6.76
Recognize how my own personal and professional beliefs may influence the care I provide to a palliative care patient and their family	7.32

Table 4. Mean Scores for Each Item in the PCNSC Continued

Cope with loss and grief related to the care of a palliative care patient and their family	7.34
Identify your own personal resources to manage stress related to caring for palliative care patient and their family	7.12
Discuss death and dying with a palliative care patient and their family	6.84
Provide effective care to relieve respiratory distress during the last hours of life	7.31
Identify the signs and symptoms of imminent death in a palliative care patient	7.38
Provide an authentic presence during the last hours of life to a palliative care patient and their family	7.45
Encourage expression of cultural and religious traditions for a palliative care patient and their family during the last hours of life	7.16

## CHAPTER 5

## DISCUSSION

As the health care system in the United States transitions to a system based on quality of care, palliative care can serve as the cornerstone of the transformed system. It has been demonstrated in numerous studies that palliative care improves patient and family's quality of life, reduces suffering associated with distressing symptoms present with life limiting illnesses, increases patient life expectancy, and decreases the cost of care (Gelfman et al., 2008; Goldsmith et al., 2008; HRET, 2012; Morrison et al., 2008; Temel et al., 2010). It is important to recognize nurses' self-competence in providing palliative care services to patients as nurses are a constant presence in all aspects of health care. In this study acute care nurses' perceived self-competence in providing palliative care services was explored.

Summary of Results

The research question addressed in the study was: What are acute care nurses' self-reported competence in their ability to provide palliative care services to patients? To address the purpose and question in this study, a sample of nurses who practiced in an urban hospital in South Central Montana were surveyed about their self-reported competence in providing palliative care services. The instrument used to answer the research question was the Palliative Care Nursing Self-Competence Scale (PCNSC)

developed by Desbiens and Fillion (2011). The instrument was administered online to a sample of all registered nurses and 132 nurses participated.

Nurses in this study had an overall mean score of 6.79 in meeting palliative care patients' needs. The findings of this study indicated that acute care nurses in this specific hospital reported feeling more than moderately capable in the 8 domains of palliative care, which included patient's physical needs, psychosocial needs, spiritual needs, functional status needs, ethical and legal issues, interprofessional collaboration and communication, personal and professional issues related to nursing care, and end-of-life care. Despite the moderately high overall mean score on the PCNSC, some nurses in the study indicated that their self-perception of competence in certain domains of palliative care was 0 or not at all capable.

The results of this study are consistent with those of a rural Canadian study by Pesut, Potter, Stajduhar, Sawatzky, McLeod, and Drabot (2015) in which the scores on the PCNSC were compared before and after a palliative care educational intervention. The Pesut et al. (2015) study involved 30 participants, including 18 nurses and 12 healthcare workers, and used a different version of the PCNSC, which evaluated 10 dimensions of palliative care on a five point Likert scale. This study concluded that pre-test scores of the participants' perceived self-competence in providing palliative care services were the lowest for the domains of spiritual needs, social needs, and ethical and legal issues, with the domain of ethical and legal issues being the lowest scored domain. The highest pre-test domain scores reported by Pesut et al. (2015) were those of personal and professional issues related to nursing care, last hours of life,

inter-professional collaboration and communication, and physical needs and other symptoms. Post-test score results reported an increase in all 10 dimensions of palliative care post education intervention for the health care workers in the study, but no statistically significant changes were found for the 18 nurses in the study (Pesut et al., 2015). Lastly, Pesut et al. (2015) concluded the domain of social needs was the lowest post-test score for health care workers and the domain of spiritual needs was the lowest post-test score for nurses in the study.

Although an educational intervention was not conducted in the study reported here, the findings of Pesut et al. (2015) are consistent with the findings in this study. The nurses in this study reported the highest self-competence in the domain areas of physical needs, which included pain and other symptoms, end-of-life care, and personal and professional issues related to nursing care. The lowest domain scores were those of ethical and legal issues, psychosocial needs, and interprofessional collaboration and communication. There are no studies to date that explored nurses' self-competence in palliative care utilizing the PCNSC tool in the United States or any other countries in which the health care system is similar to that of the United States.

The combined theoretical frameworks used in this study were Bandura's social cognitive theory and Orem's conceptual model. Desbiens and colleagues (2012) proposed combining these frameworks specifically for the palliative care setting, as increased nurses' perceived self-competence results in improved self-care of patients with life-limiting illness. The combined theories guided the development of the primary instrument for this study and were used by the instrument developers, Desbiens and colleagues

(2012). The combination of Bandura's social cognitive theory and Orem's conceptual model complement the goals of palliative care being quality of life and relief of burdensome symptoms, which guides acute care nurses when providing such services.

### Study Limitations

There were several limitations to this study. This study was conducted in one urban South Central hospital in Montana, therefore the results cannot be generalized to all urban acute care nurses, as the nurses who participated may be different from acute care nurses in other urban hospitals across the United States.

Another limitation was that the survey was sent out anonymously to all acute care nurses' emails via the hospital's Intranet, which did not permit sending individual reminders to non-respondents. It was assumed that all nurses would check their emails, however some may not have and therefore did not participate in the study. Additionally, some nurses may not feel comfortable using the Intranet and therefore did not complete the survey. This limitation resulted in a lower than anticipated response rate of 29%.

Another limitation of the study is that of the wording "self-competence." According to the Merriam-Webster Dictionary (2015a) competence means "having the necessary ability or skills; able to do something well or well enough to meet a standard" (p. 1). As a nurse you can be competent in one aspect of care, however your own perception of how competent you are may be limited by your self-confidence. According

to the Merriam-Webster Dictionary (2015b) the definition of confidence is “a feeling or belief that you can do something well or succeed at something” (p. 1). Participants of the study may have blended the terms self-competence and self-confidence, or misunderstood the term self-competence, resulting in under or over perceived self-competence scores.

There were limitations due to the software used to capture responses in the study. Survey Monkey was used to gather data and data were then imported into Excel for analysis. The Excel data file did not permit identification of individual responses, which prevented the exclusion of partially completed surveys and computing individual scores on the PCNSC. Additionally, the Excel file did not allow for comparison of one groups’ responses versus another groups’ responses. For example, there was no ability to compare Pediatric nurses to Oncology nurses’ perceived self-competence in providing palliative care services. The comparisons of different groups of nurses across the acute care hospital would have been helpful to observe for differences in perceived self-competence and in order to develop education specific to the areas with lower scores.

The PCNSC tool used in this study was developed in the French language by Desbiens and Fillion in 2011. The English version of the PCNSC is translated from the French version that has undergone psychometric evaluation. To date the English version of the PCNSC has not been psychometrically evaluated, resulting in another limitation to this study.

Lastly, there have been no studies to date utilizing the PCNSC tool to assess nurses’ perceived self-competence in regards to palliative care services conducted in the

United States and only one study with nurses in Canada. Therefore, the results of this study are limited in that they cannot be compared to other studies in the United States, which limits making conclusions surrounding acute care nurses' perceived self-competence with palliative care.

### Implications for Future Research, Education, and Practice

This study apparently is the first conducted in the United States in which the specific PCNSC study instrument was utilized, resulting in contributions to research focused on acute care nurses' perceived self-competence in providing palliative care services. This study's results compare similarly to another study conducted in a rural Canadian area (Pesut et al., 2015). Additional research is needed in all aspects of palliative care; including in acute, outpatient, and long-term care settings, as well as urban and rural settings across all of the United States. It would be of interest to conduct the survey with different health care disciplines and compare the results. As well, it may be beneficial to conduct a research study comparing nurses' perceived self-competence with actual competence in palliative care. In addition, the English version of the PCNSC needs psychometric testing to evaluate its validity and reliability.

It is important for nurses and all health care providers to feel competent in providing palliative care services, as it promotes patient and family's comfort during life-limiting illness. Research results utilizing the PCNSC can guide the development of educational interventions surrounding palliative care, which could result in positive outcomes for patients in need of palliative care services.

For future practice, it will be important for nurses, Advanced Practice Registered Nurses (APRNs), and other providers to understand the areas in which they feel less competent and take measures to become competent in those areas to assure quality palliative care services are provided. If these health care providers do not feel comfortable in any aspect of palliative care, they need to seek out and identify the appropriate resources to improve their own comfort and competence so that patients and families receive the services they need.

Additionally, APRNs serve as leaders in their profession. If APRNs felt capable in any area of palliative care, it would be imperative for them to facilitate this palliative care education to their patients, nurses, and other health care providers. An APRN can and should provide support, consultation, and education to all nurses and others who provide palliative care services to patients with life-limiting illnesses and their families.

### Conclusion

The results of this study demonstrated that nurses in this particular sample felt more than moderately capable in providing palliative care services. Despite this finding, some nurses indicated that they did not feel at all capable in some domains of palliative care, indicating that further education is warranted in order to promote their competence with palliative care. This study is the first known investigation in the United States of acute care nurses' palliative care competence using the PCNSC. With the increase in the size of the aging population and more people living with chronic disease, palliative care is implicated as an important resource for our changing health care system. Again,

Desbiens and colleagues (2012) stated, “nursing competence, nursing self-competence, and nursing interventions provide the theoretical basis for quality care in palliative care situations” (p. 2120). It is with nursing’s perceived self-competence that palliative care services will be provided in the holistic way it was very first intended.

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APPENDICES

APPENDIX A

PARTICIPANT EXPLANATION FORM

**ACUTE CARE NURSES' SELF-REPORTED COMPETENCE WITH  
PALLIATIVE CARE****Chelsi Hayter, BSN, RN****Participant Explanation Form**

I am a graduate nursing student interested in learning more about acute care nurses' self-reported competence in providing palliative care services. Palliative care is a service that provides health care for persons and their families suffering from life-limiting illness. Please take 20 minutes to complete the attached electronic survey.

If you decide to complete the survey, you will help the researcher to better understand acute care nurses' self-reported competence with palliative care services. Your participation is strictly voluntary and anonymous. Your answers will be grouped with other participants' answers and reported as a part of a research study I am conducting for my thesis requirement in the graduate nursing curriculum at Montana State University. If you feel uncomfortable completing the survey, you do not have to participate. Or if you begin taking the survey and feel uncomfortable, you may stop or discontinue answering the questions at any time.

You are welcome to contact me, Chelsi Hayter, BSN, RN, should you have any questions or concerns regarding the survey. I can be reached at (406) 853-1990. You may also contact my advisor, Dr. Jean Shreffler-Grant at (406) 243-2540. If you have concerns about your rights as a research participant, please contact the Institutional Review Board at Montana State University, Mark Quinn, (406) 994-4707.

Thank you for your time and consideration in order to assist me better understand your self-reported competence with palliative care services.

Sincerely,

Chelsi Hayter, BSN, RN

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APPENDIX B

INSTRUMENT AND PERMISSION TO USE

## PALLIATIVE CARE NURSING SELF-COMPETENCE SCALE

### Study Questionnaire

*Desbiens, J. F. & Fillion, L. (2011). Development of the palliative care nursing self-competence scale. Journal of Hospice & Palliative Nursing, 13(4), 230-241.*

Palliative care is an approach to care that aims to improve quality of life for patients and their family members (including relatives, friends and significant others) with life-limiting illness. Participation is voluntary, and you can choose to not answer any question that you do not want to answer, and you can stop filling out the questionnaire at any time.

**I would like to know how confident you presently are in providing palliative care. For each of the following items, please record a number from 0 to 10 using the scale given below:**

0	1	2	3	4	5	6	7	8	9	10
Not at all capable				Moderately Capable				Highly Capable		

#### PHYSICAL NEEDS: PAIN AND OTHER SYMPTOMS

1. Assess pain for a palliative care patient unable to communicate.
2. Effectively use pharmacological interventions to alleviate pain in a palliative care patient.
3. Use non-pharmacological and complementary interventions to alleviate pain in a palliative care patient.
4. Provide effective care to alleviate nausea and vomiting in a palliative care patient.
5. Provide effective care to alleviate constipation in a palliative care patient.
6. Provide effective care to alleviate dyspnea in a palliative care patient.
7. Provide proper mouth care to promote comfort in a palliative care patient.
8. Provide early detection of delirium in a palliative care patient.

#### PSYCHOSOCIAL NEEDS

9. Provide effective care to reduce psychological distress in a palliative care patient and their family.
10. Provide support to a palliative care patient and their family when they experience

grief.

11. Assess the impact of a life-threatening illness on family dynamics.

**I would like to know how confident you presently are in providing palliative care. For each of the following items, please record a number from 0 to 10 using the scale given below:**

0      1      2      3      4      5      6      7      8      9      10

Not at all capable

Moderately Capable

Highly Capable

12. Assist a palliative care patient and their family in identifying personal resources in order to cope with problems related to a life-threatening illness.

#### SPIRITUAL NEEDS

13. Assess the spiritual needs of a palliative care patient and their family.
14. Recognize signs of spiritual distress in a palliative care patient and their family.
15. Assist a palliative care patient to explore the meaning of their illness experience.
16. Adapt the nursing care in accordance with the spiritual beliefs of a palliative care patient and their family.

#### NEEDS RELATED TO FUNCTIONAL STATUS

17. Assess the needs associated with activities of daily living in a palliative care patient.
18. Assist a palliative care patient to maintain their functional independence for as long as possible.
19. Implement appropriate interventions to help alleviate burden on family members caring for a palliative care patient.

#### ETHICAL AND LEGAL ISSUES

20. Promptly identify ethical issues related to the care of a palliative care patient.
21. Provide information to a palliative care patient concerning the legal issues associated with life-threatening illness.
22. Assist a palliative care patient to make informed decisions regarding end-of-life

care.

23. Advocate for a palliative care patient and their family with other members of the healthcare team.

**I would like to know how confident you presently are in providing palliative care. For each of the following items, please record a number from 0 to 10 using the scale given below:**

0	1	2	3	4	5	6	7	8	9	10
Not at all capable			Moderately Capable				Highly Capable			

#### INTERPROFESSIONAL COLLABORATION AND COMMUNICATION

24. Actively participate in discussions regarding a palliative care clinical situation during interdisciplinary team meetings.
25. Promote communication between the palliative care patient, their family, and health care professionals in order to ensure information sharing.
26. Promote communication between health care professionals when conflicts arise in the care of a palliative care patient and their family.

#### PERSONAL AND PROFESSIONAL ISSUES RELATED TO NURSING CARE

27. Recognize how my own personal and professional beliefs may influence the care I provide to a palliative care patient and their family.
28. Cope with loss and grief related to the care of a palliative care patient and their family.
29. Identify your own personal resources to manage stress related to caring for palliative care patient and their family.
30. Discuss death and dying with a palliative care patient and their family.

#### END-OF-LIFE CARE

31. Provide effective care to relieve respiratory distress during the last hours of life.
32. Identify the signs and symptoms of imminent death in a palliative care patient.
33. Provide an authentic presence during the last hours of life to a palliative care patient and their family.

34. Encourage expression of cultural and religious traditions for a palliative care patient and their family during the last hours of life.

Thank you so much for taking the time to complete this survey.

**PERMISSION TO USE INSTRUMENT FROM DEVELOPER**  
**Chelsi Hayter, BSN, RN**

Dear Chelsi,

Sorry for this delay! This is a very busy period of time for me!

Attached you will find the PCSNC scale. There are 8 factors. A score can be computed for each of these factors using the mean. Also, a total score can be computed again using the mean. I give you the authority to use the PCSNC scale for your study with acute care nurses in a hospital in South Central Montana with great pleasure. If you would need more information about the scale, I will be pleased to share with you content expertise. We have collected some data that could be used for comparison with yours. Also, I can provide you more information about the conceptual framework that we used to developed the scale.

I would appreciate that you keep me informed about any publication that come out of this work and that you acknowledged Desbiens and Fillion in these publications.

Best,

Jean-François

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Nursing Faculty  
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Note: Permission to use retyped from original email.

APPENDIX C

DEMOGRAPHIC QUESTIONS

**DEMOGRAPHIC QUESTIONS**

**Chelsi Hayter, BSN, RN**

1. How many years have you worked as a registered nurse?
  
2. What unit do you work on? (Check all that apply)
  
3. Do you have experience as a hospice nurse?
  
4. Are you aware of the hospital's inpatient palliative care program?
  
5. Have you cared for a patient with a palliative care referral in the last 5 years?  
If yes, how many patients with a palliative care referral have you cared for?  
If no, skip to question #6.
  
6. Have you recommended or participated in a palliative care referral in the last 5 years?  
If no, skip this question and move on to the Palliative Care Nursing Self-Competence Scale on the next page.
  
7. If you answered "yes" to question #6, did your suggestion for a palliative care referral result in a formal palliative care consult?
  
8. Are you certified registered nurse?
  
9. If you answered "yes" to question #9, what is your certifying body?