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**BRIDGING COMMUNICATION IN END-OF-LIFE CARE AT A  
MIDWEST VETERANS HOME**

Taylor Karrow

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BRIDGING COMMUNICATION  
IN END-OF-LIFE CARE  
AT A MIDWEST VETERANS HOME

DNP Project  
Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Nursing Practice

St. Catherine University  
St. Paul, Minnesota

Taylor Karrow

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ST. CATHERINE UNIVERSITY  
ST. PAUL, MINNESOTA

This is to certify that I have examined this  
Doctor of Nursing Practice DNP project manuscript  
written by

*Taylor Karrow*

and have found that it is complete and satisfactory in all respects,  
And that any and all revisions required by  
the final examining committee have been made.



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Graduate Program Faculty

Gwendolyn Short DNP, MPH, FNP-BC

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DEPARTMENT OF NURSING



## **Abstract**

Palliative care is specialized care for those with serious disease and focuses on providing relief from symptoms (Radbruch et al., 2020). The goal of palliative care is to improve quality of life for both the patient and the family. As the COVID-19 pandemic continued to change healthcare delivery and visitor restrictions, alternative approaches to safely deliver care to both the patient and family have been uncovered. A Midwest veterans home was looking to bridge the gap in communication between staff, resident, and family during end-of-life care.

Creation of an online accessible educational resource for nursing home staff is an alternative format for providing staff education. This project focused on online education supplied in a central location with the expected outcome to be increased communication between staff and family during residents' end-of-life.

Patient care staff participated in this quality improvement project by responding to two online surveys. Results demonstrate that staff were satisfied with the online resources as a tool to promote conversation with family. This can assist in future education and training surrounding end-of-life care and communication while achieving positive palliative care outcomes. Evolving to an online education platform provides flexibility in convenience, equity, service, and access.

While the ongoing COVID-19 pandemic demands attention towards traditional end-of-life care standards, it also provides the opportunity to create new methods to palliative care amongst a vulnerable population. Additional staff education on end-of-life care will not only meet the needs of palliative care in the Midwest veterans home but will also be a sustainable option for future practice.

In 2016, there were more than 19 million living United States (US) veterans, representing almost 10% of the total adult US population (Schaeffer, 2021). Years of US military service often come with a cost, resulting in unique physical, mental, emotional, and spiritual health issues that continue to manifest throughout veterans lives (Schaeffer, 2021). Veteran needs at end of life vary, as they may suffer from a spectrum of challenges related to their time in service (Schaeffer, 2021). Veterans challenges may relate to presumptive diseases from environmental exposures, or other debilitating emotional or spiritual issues (Shamas & Gillespie-Heyman, 2018). Quality healthcare for veterans is essential at all stages of life. It is important to recognize the difficulties veterans may face and to create a care team with the knowledge, skills, and confidence to properly care for veterans in all stages of life.

The current end of life care for veterans is done exceptionally well at this veterans home in the Midwest. It has been reported that nursing staff and bereaved family members feel veterans are being well taken care of at the end of their lives (S. Hogan, personal communication, June 2, 2021). For example, there is a final salute for the veteran as they are leaving the home for the last time. This ceremony is significant to the family, staff, and other veterans involved. It is special to have the opportunity to honor America's heroes until the very end. However, this care has changed within the past two years because of the COVID-19 pandemic and subsequent visitor restrictions in long term care (S. Hogan, personal communication, June 2, 2021).

The COVID-19 pandemic has put a strain on communication in long term and residential care to protect the residents. At the veterans home, a strict zero visitor policy except for imminent death was put in place to protect the vulnerable veteran population from COVID-19 (S. Hogan, personal communication, June 2, 2021). The new visitor policy poses a challenge to

inclusion of the family in end-of-life care. Many family members have reported feeling ignored, and that opportunities for communications have been missed (S. Hogan, personal communication, June 2, 2021). Military service has affected the individual resident, and the family and care team need to remain mindful of any special needs this requires. The question persists in how to properly educate, include, and communicate with family in end-of-life care, especially given the recent COVID-19 pandemic and visitor restrictions.

### **Background**

While the veterans home care revolves primarily around all care being palliative, there are always opportunities to engage and ensure care is comprehensive and serves the whole resident. A needs assessment at the organization of focus has uncovered that the biggest challenge is communication between the care team, family, and resident during end-of-life care. This communication pattern looks considerably different since the COVID-19 pandemic. During the height of the pandemic, a significant amount of communication was provided via a virtual method until the care team determined death was imminent (S. Hogan, personal communication, June 2, 2021). The end-of-life is a vulnerable time, and families were missing out on last moments with their loved ones. For this reason, quality improvement was focused on improving end-of-life care and communication in a period of limited in-person visitation.

In 2018, the Midwest veterans home introduced an initiative regarding end-of-life care, which included training of all direct care staff using the End of Life Nursing Education Consortium (ELNEC) course (C. Schauer, personal communication, June 2, 2021). The goal is that all nursing staff participate in the recommended eight-hour educational course, and as a result have the tools and knowledge to properly care for veterans in their end-of-life. The nursing staff's perception is that they have the proper knowledge to care for residents at the end of their

lives, but staff indicate that they would benefit from additional education tools or resources to help guide conversations and facilitate communication (C. Schauer, personal communication, June 8, 2021). Through the COVID-19 pandemic, staff have begun to lead visits with resident and family via a virtual connection. This transition to online social visits has created challenges with communication, technology, and overall staff comfort levels with the process (S. Hogan, personal communication, June 2, 2021). It is difficult to change the current workflow to have routine communication suddenly be delivered in a virtual method (Plunger et al., 2022). Virtual care can work as a supplement to face to face care, but it is essential the proper training is provided for the optimal virtual care experience (Hawkins et al., 2020).

During the planning stages of this project, one staff member at the veterans home shared a story. She was able to initiate a virtual connection between a veteran receiving end-of-life care and a family member who was unable to visit due to infection reasons. It turned out that the veteran passed away a few days later. The virtual connection was the last time the family member got to see their loved one. Staff shared that the family member reached out a few weeks later sharing how special the virtual connection was and how she was so thankful for one last time to talk to her loved one. This story is a reminder that the communication provided for veterans at the end-of-life is essential to the overall care experience.

### **Problem Statement**

Currently, there are approximately 800 residents across five veterans homes in a midwestern state. Each year, approximately 33% of these residents die (S. Hogan, personal communication, June 8, 2021). Over the past year, many of these residents have reached their end-of-life with decreased communication from the care team and family because of the



COVID-19 pandemic and visitor restrictions (S. Hogan, personal communication, June 2, 2021). The veterans home of focus was one in the Midwest with 270 residents.

In the planning stages of the project, it was decided that the veterans home end of life and hospice care approach would benefit from two different initiatives to ensure the whole person is served: 1) creating an educational resource for nursing staff to use with family to assist in conversations during the end-of-life process; and 2) increasing family inclusion via a virtual method. The educational resource encompassed family support, education, family inclusion, and techniques to improve communication in end-of-life care. These resources were evidence based and peer reviewed. The idea is that the additional educational resources will have helped staff supplement end-of-life care by improving the family knowledge and experience regardless of the delivery method. The organization requested the project leader to create teachings on end-of-life and place them in a central, online setting for staff to access for self-guided learning.

In addition to the educational resources, increasing communication with family will help continue conversations through the resident's end of life. Ideally, increasing communication would be done by providing staff with additional resources for conversation and encouraging staff to include family in a virtual method. Attention to communication at the end of life is imperative to improve medical, psychological, and relational outcomes for those dealing with the death and dying process (Keeley, 2017). With in-person visitor restrictions, it is important to include family in an alternate method. Interventions for increased communication continue to be at the forefront of the care team's concerns given the recent restrictions on visitors and can a sustainable option for future practice.

### **Purpose Statement**

The purpose of this proposed project is to develop, implement and evaluate an educational project to improve the frequency and quality of communication provided to families throughout the end-of-life care. The focus will be to provide staff with educational resources and tools to communicate with family via a virtual method.

### **Project Goals**

The ultimate vision for this project is to increase communication with family members during end-of-life care for residents in the veterans homes. To aid in achieving this vision, a staff education resource for end-of-life care will be created. The education will consist of visual and auditory teaching content through handouts and online learning. Each resource will be evidence-based and reviewed for quality. In addition, it is encouraged for staff to include family in a virtual method, when possible, to increase connection between the resident and their family members.

### **Improve Communication**

The first project goal is to improve communication while following a family centered model. For the purposes of this project, communication will be measured in an objective manner, through staff reports of communicating with family, and measurement of rates of connecting with family in a virtual method. This goal will be accomplished by meeting the following objectives:

- Evaluate staff requests for their education needs at end-of-life. The pre-intervention survey will be sent to staff by February 28.

- Identify appropriate communication tools. This will be an evidence based and peer reviewed tool that will be evaluated by the organization and project director by March 7, 2022.
- Create a staff education resource. Creation of an online guided education explaining end-of-life resources and education available for staff will be completed by March 7, 2022.

### **Increase Technology Use**

The second project goal is to use technology to broaden outreach and support to family during end-of-life care. This is an important goal for the organization with the changing visitor restrictions. This goal will be reached by achieving the following objectives:

- Identify appropriate technology use. Create an easily accessible and understandable guide for staff to use for virtual connection with family by March 7, 2022.
- Educate nursing staff on technology use. This will be an online guided education to be completed by March 7, 2022.
- Evaluate the effectiveness of given resources for increased communication. The post intervention survey will be sent to staff by April 18, 2022.

### **Theoretical Framework**

Peplau's interpersonal relations theory allows use of problem-solving techniques for collaboration by nurse and patient to meet the patient's needs (Peplau, 1997). The four components of the theory are the following: 1) person, an individual that tries to meet needs; 2) environment, which consists of existing forces outside of the person and their culture; 3) health, which is symbol that implies a forward movement of personality; and 4) nursing, a therapeutic interpersonal process that makes health possible for individuals (Hagerty et al., 2018). Utilization of Peplau's theory gives purpose to providing staff with increased resources to supplement

current end-of-life care. By taking a step back to focus on the patient and their environment, the nurse can take a step back to recognize what the patient is needing.

When encountering change from the typical workflow, staff can utilize the education resource for appropriate resources and share these resources with family members. The current problem is the visitor restrictions and subsequent missed communication frequency and quality during end-of-life. By providing staff with appropriate resources, the goal is that staff will initiate communication and connection between resident and family while also considering the role of environment.

### **Search Strategy and Appraisal**

#### **PICO Question**

Exploring different methods of staff education surrounding hospice, palliative, and end of life care can serve as a key indicator for sustainability for the intervention and help determine if learning objectives have been met during the evaluation. The identified PICO question is, “Does providing staff education surrounding end of life care help increase communication between staff, family, and resident?”

#### **Methods**

##### ***Exploration of Search Strategy and Data Sources***

A comprehensive search strategy was conducted on veteran specific care, hospice, end-of-life, and family centered care. The CINAHL, PubMed, and Google Scholar databases were utilized, and search limits were *peer-reviewed journals, research articles, English language*, and a publication timeline between 2010 and 2022. Keywords and Boolean phrases included: ‘end of life’, ‘palliative care’, ‘death or dying’, ‘terminally ill’, AND ‘telehealth’, ‘telemedicine’, ‘virtual visit’, OR ‘veterans’, ‘military’, ‘soldiers’, or ‘service men’.

A total of 18 articles were included for review. Professional opinions were excluded. Studies that were included contain various interventions and insights for hospice care, palliative care, veteran specific end of life needs, family centered care, virtual visits or telehealth, staff education, and family education. The interventions of focus were communication with family, staff education surrounding hospice and palliative care, and improved communication across the care team. A variety of study designs were included to begin to comprehend the current research and recommendations for practice.

### **Data Appraisal**

The Johns Hopkins Nursing Evidence-Based Practice Appraisal Tool was utilized to evaluate the articles. This tool highlights relevant objectives and findings from the articles, including study design, findings, worth to practice and recommendations. The 18 articles consist of 'high' and 'good' ratings, providing a rich synopsis of the quality of evidence included. The evidence levels range from I-V and were graded A-B based on the depth, variety, and quality of data (Table 1).

### **Literature Review and Synthesis**

Included were multiple qualitative studies, quality improvement, and literature reviews. A variety of study designs allowed opportunity to begin to grasp the current evidence-based recommendations and interventions for end-of-life care. Common themes encountered throughout the literature included creating virtual visit protocols during a pandemic, how to increase communication, staff education recommendations, and veteran specific recommendations for general and end-of-life care.

There were no specific studies on virtual end-of-life care. Much of the literature surrounded generalized virtual visits, end-of-life, or veteran care. Additionally, the evidence was

mainly level II, III, and IV. This uncovered a need for additional high-quality research in virtual end-of-life care to be done. The challenge was finding the best way to incorporate the needs of the organization and the current evidence-based recommendations. The specific needs of the organization remained at the forefront of the literature review and assisted in creating an evidence-based intervention.

### **Creation of Virtual Visit Protocols During a Pandemic**

The traditional way of receiving healthcare transitioned to primarily online beginning in early 2020, and this has been challenging for all those involved (Hawkins et al., 2020). A focus of the literature reviewed was on virtual care and different ways organizations have been transitioning to virtual care during the COVID-19 pandemic. Various challenges have been encountered by organizations when transitioning to virtual care, including staff and family education on virtual visits, technology issues and lack of access to proper tools (Hawkins et al., 2020).

End-of-life communication between patient, families, and healthcare teams at the end of life remains critically important during times of pandemic related visitor restrictions (Feder et al., 2020). Limited literature exists surrounding palliative care specific virtual visits, but virtual care in the end-of-life has the potential to function as an effective model with supplementing face-to-face care (Dolan et al., 2021). It is difficult to suddenly change staff workflow, so that the new protocol needs to be easy to use and relevant for patient care (Hawkins et al., 2020). For a virtual visit protocol to be successful, there needs to be communication between policy makers and healthcare workers, proper education and training, support for patients and their families, and access to necessary support services (Mitchell et al., 2020).

### **Recommendations for Increasing Communication**

There is opportunity to improve end-of-life communication in patients with severe, or life limiting illness (Reinke et al., 2017). Family members have a wide spectrum of questions they want to ask but do not always feel comfortable due to the emotions surrounding losing a loved one (Hebert et al., 2008). Patient and family centered care in the end-of-life context should include the following: assigning a point of contact that follow up with the patient; educating the family on what to expect; ensuring the patient's changing needs are met; ensuring the family has appropriate support, and communicating updates to family (Agha et al., 2021).

In addition, the Bereaved Family survey (BFS), a survey given by the VA to bereaved family members one year after their family member passes away, uncovered three important needs expressed by family members: 1) respectful care and communication; 2) emotional and spiritual support; and 3) benefits (Smith et al., 2019). Communication is perceived to be high-quality when staff are available for remote communication and being kept informed of the patient condition and plan of care (Feder et al., 2020). Clear, honest, timely, and compassionate communication is important to the bereaved (Agha et al., 2020). When residents entering the end-of-life and their family have the opportunity and the openness to freely talk about what is on their minds, the result is an increased sense of wellbeing, peace, and greater readiness for death (Keeley, 2017).

### **Recommendations for Staff Education**

The End of Life Nursing Consortium (ELNEC) course for veterans has been extremely successful for nursing staff (Gabriel et al., 2015). The course has allowed nursing staff to play a vital role in caring for individuals with serious illness. It is recommended that additional care team staff would benefit from continuous education surrounding end of life care, or by

participating in the ELNEC course to learn to properly care for residents at end-of-life (Andersson et al., 2016).

The literature reviewed focused on a national initiative to educate nurses on end-of-life care. There was minimal attention paid to other care team staff such as social work, recreational therapy, or care assistants. Recommendations have been made to include additional care team staff in the education to enhance end-of-life care to all residents (Gabriel et al., 2015).

### **Veteran Specific Recommendations**

For veterans to receive individualized care, staff should be educated on the nuances of different military branches and how veteran needs vary from one era to the next (Shamas & Gillespie-Heyman, 2018). Veterans of the World War II and Korean War era may have complications related to radiation and cold injury exposures, Vietnam veterans may have agent orange exposures, and those who served before 1975 were at high risk of having been enrolled in medical experiments involving radioactive, chemical, and biological agents, all substances that may have created lingering health issues (Antoni et al., 2012).

Veterans often encounter civilian healthcare professionals who are unaware of the demands and sacrifices it takes to be a soldier (Antoni et al., 2012). Challenges that persist include 1) ongoing support, comfort, honor, and validation; 2) helping the family understand how military experience has impacted the veteran ability to cope with illness; and 3) consideration of life-limiting illness caused directly or indirectly by being in the service (Agha et al., 2020). Proper staff education allows for comfort and confidence in communicating with each other, residents, and their families (Boomer et al., 2019).



## **Research Methods**

### **Project Design**

This project was developed with an emphasis towards quality improvement, or the framework used to systematically improve care. Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations (Centers for Medicare & Medicaid Services, 2021). Successful quality improvement focuses on evaluating the performance of systems and processes, patients, being part of the team, and use of the data (U.S. Department of Health and Human Services, 2011). These principles are vital to success in the development, design, and implementation of the project. In this project, the initial needs assessment, survey development, and education were done with the goal of increasing communication in end-of-life care. The generated outcome data was essential to determine the effectiveness of the quality improvement and areas for future improvement.

The educational resource consisted of psychosocial support, symptom management, veteran specific considerations, how to talk with family, how to answer difficult questions, ideas for furthering professional education, and technology troubleshooting. The idea requested by the organization was to have teaching pearls in a central location that is accessible online by staff. In addition, there was a 10-minute pre-recorded video showcasing the education and how to access the online resources.

To ensure the project reached the vision of improved communication, staff education was used to showcase evidence-based communication tools available for residents and their families during end-of-life care. By providing staff with the proper tools to communicate with family,

then communication should increase. The added challenge was to create excitement for staff to access and use the online learning.

The project relied on staff feedback regarding the education intervention and the quantity of virtual connections with family. To help guide the project, the plan, do, study, act (PDSA) cycle was utilized. The PDSA cycle provides structure for testing changes to help improve quality (Taylor et al., 2014). The continuous actions of the PDSA cycle allow the project to adapt and change throughout to better help fit the needs of the staff and the organization (Taylor et al., 2014). For example, the pre-intervention survey provided insight into current staff comfort and knowledge, and qualitative feedback. This allowed the educational resource to be created with staff interests and requests in mind.

Data was collected using two 10-questions surveys with five-point Likert scale responses. The target population included nursing, social work, and support staff working at a Midwest veterans home who are caring for residents receiving end of life care over a four-week period in the spring of 2022. The surveys were administered through email and the education was self-guided.

### **Outcome Measures**

Outcome measures seek to capture and evaluate staff satisfaction towards an online educational resource for end-of-life care and communication. By focusing on staff comfort and knowledge in end-of-life care, use of the education resources, and rate of virtual connections, the effectiveness of the quality improvement project was evaluated for usefulness among staff. The educational resource was created and placed in a central online location for staff to access and learn about specific end-of-life components of their interest. The educational resource included teachings on psychosocial support, symptom management, how to talk to family, how to answer

difficult questions, veteran specific considerations, ideas for furthering professional education, and technology troubleshooting. The measures were as follows:

- 1) Overall staff comfort and understanding of end-of-life care.
- 2) Effectiveness of an online, education resources surrounding end-of-life care and communication for staff.
- 3) Change in number of virtual visit connections.

### **Project Implementation**

#### **Project Vetting & Institutional Review Board**

An extensive project creation and vetting process was completed within the organization of focus prior to submitting a project proposal to the Institutional Review Board (IRB). This was a requirement to ensure the proposed quality improvement protected patients, healthcare information, and staff from harm. This quality improvement project was approved for implementation by the IRB at a private, liberal arts university in the Midwest. The Midwest veterans home did not have their own IRB and therefore did not require additional approval prior to beginning the quality improvement.

#### **Scope & Boundaries**

All survey respondents were employed at the organization of focus, a veterans home in the Midwest. Inclusion criteria were staff deemed to be critical in providing end-of-life care for residents and their families. This included registered nurses, licensed practical nurses, care assistants, licensed social workers, and recreational therapists. There were no identified risks or compensation for participation. Decision to participate in the survey was voluntary and did not impact employee status. Staff were notified about the project during weekly staff update emails and encouraged to participate as able.

### ***Sample Size***

This project examined the responses of staff working in a veterans home. A sample size of 142 participants were invited to complete the online survey. The veterans home requested all staff be able to participate and a flyer was sent by email to create awareness and excitement. Staff included registered nurses, licensed practical nurses, nursing assistants, recreational therapists, and social workers. A total of 24 respondents completed the initial pre-intervention survey, and eight completed the post-intervention survey.

### **Staff Participation**

Implementation of this quality improvement project occurred in three phases. First, the project director obtained staff input of recommendations for what they would like to see in end-of-life education with a pre-intervention survey. Second, an online education resource was created that was easily accessible for staff. Third, a post-intervention survey was developed and administered to assess staff perception of the intervention.

There was a 66% decrease in respondents from the pre- to post-intervention survey. This is thought to be related to the organizations challenges in staffing the homes, and challenges in creating awareness and excitement about the project. Throughout the project, there were staffing issues encountered and an undetermined number of staff ended up being independent contractors, or only working at the homes temporarily. In addition, creating excitement was challenging because the entirety of the project took place online. During process implementation, various reminders were given by the organization's stakeholders via email and verbally. Of further interest, the stakeholders reported hearing numerous accounts of positive feedback and participation in the education via word of mouth, but this unfortunately did not follow through to ensure sufficient survey respondents.

## **Data Collection**

Initial pre-intervention data was collected over a one-week period from February 28 to March 7. The survey was administered online via Microsoft SharePoint and accessible to staff through their work email. All correspondence was done virtually. The educational resource, with directions on how to access it, was released to staff on March 16. After a four-week implementation time, a similar Microsoft SharePoint post survey was sent by email, and post intervention data was collected beginning April 18 through April 25.

## ***Implied Consent***

An overview of the project, participant expectations, and use of data were provided prior to administration of the survey. This is in Appendix A and is titled, *Bridging Communication in End-of-Life Care*. This was distributed to staff via email with further explanation on how to access the survey. Following review of this document, implied consent to use survey responses was assumed.

## ***Data Storage***

Surveys were completed via online platform and saved in a secure drive of a personal computer. The survey did not collect any identifying information that could breach confidentiality. All participant identifying information and response data remained anonymous, as there was no way of finding out who completed the surveys. Data was only shared in aggregate form with this author's site supervisor to further disseminate project findings. Data will be destroyed one year after completion of this project. This timeframe was decided upon so that the organization has time to bring results forward to leadership and determine further actions.

## **Ethical and Social Justice Considerations**

It was important to consider the role of the multiple hospice agencies coming into the nursing home during the development, and implementation of this quality improvement project. The veterans home wants to ensure they are providing the best possible care to their veterans and families while not impeding the work of the hospice agencies (S. Hogan, personal communication, June 21, 2021). It was challenging to create a balance in adding to the care that the hospice agency provides to the residents. Visiting hospice staff were not invited to participate in the education at the time as they are employed by a different organization. In addition, not all veterans have a hospice agency on their care team. With not all residents receiving outside hospice care, this impacts fairness. Not all residents on hospice are receiving the same number of visits or care daily and have missed opportunities for communication or virtual connection. It is important for the veterans home to uphold the role of justice by distributing their care fairly and equally (Haddad & Geiger, 2021). Having more staff educated in end-of-life care will help ensure veterans are receiving the care they deserve.

This project focuses on staff education via an electronic method. Transformation of health systems into the digital world leads to various health inequities such as access, support, and representation (Brall et al., 2019). Resident family members may not have access or knowledge to use technology for virtual connection. To help close the gap in health inequities, an additional education method could be considered. Pamphlets, handouts, or telephone calls are some alternate options. This could be added in additional stages of the project, as the need and desire for education and virtual connection are uncovered.

## Results

Implementation of this online educational resource allowed opportunities to evaluate staff input surrounding end-of-life care and communication with family. The survey questions provided insight into the effectiveness of the intervention. Each response helped to generate quantitative data and provided an opportunity for the identified outcome measures to be analyzed. The staff that responded to the surveys gave valuable insight in the current trends surrounding end-of-life care and communication in the veterans home.

Qualitative data received showed appreciation for the given resources, and the educational materials were felt to be relevant, useful, and easily accessible. Respondents also felt empowered to use the new resources to create virtual connections between resident and family but requested clarity in which discipline should be doing so. It was also noted that the educational resource was difficult to share with family and suggested that family members have an avenue to access the educational resource.

### **Pre- and Post-intervention**

Twenty-four employees responded to the pre-intervention survey. Appendix B reflects the responses of the 10 survey statements. With 142 employees receiving the survey and 24 responses, this was approximately a 17% response rate. Eight employees responded to the post-intervention survey; this was approximately a 6% response rate. Appendix D reflects the responses of the 10 survey statements. From pre- to post-intervention, there were slight increases in overall staff comfort and knowledge in end-of-life and varying results for communication and initiated virtual connection. Data was statistically not significant, but generalized trends were analyzed.

## **Interpretation**

### ***Outcome Measures***

Three outcome measures were evaluated in this project. Due to the low rate of respondents from the pre- to post-intervention survey, statistical analysis was not of the greatest importance, but rather defining the clinical significance and recommendations for further study and practice.

#### **1) Determine overall staff comfort and knowledge of end-of-life care.**

There was a significant level of improvement in staff who report they “agree,” they have the comfort (25% increase) and knowledge (16% increase) for end-of-life care post intervention. Staff who utilized the education gained further confidence and knowledge of end-of-life care. It is important to recall that this was self-guided learning, and it can be inferred that staff who participated and responded to the surveys were wanting to learn and grow in the end-of-life care they provide to residents. It is also possible that not all respondents to the pre-survey viewed the educational resource, but only respondents to the post-survey. Further breakdown of results can be found in Appendix B and C.

#### **2) Evaluate the effectiveness of an online, educational toolkit surrounding end-of-life care and communication for staff.**

There was a 19% increase in respondents reporting they “agree,” they have the proper tools and resources to care for end-of-life residents after the intervention. This result is reassuring that staff are utilizing the educational tools available and utilizing them for end-of-life care. Further breakdown of results can be found in Appendices B and C.



### **3) Determine if virtual visit connections increased.**

There was an 18.5% decrease in respondents reporting they “agree,” they will continue to utilize virtual visit connections after the intervention. This could be related to the improvements in the pandemic, or the lack of excitement and engagement surrounding the project. In addition, qualitative feedback provided by respondents requested further guidance on which discipline should be initiating the virtual connections and a specific protocol to follow for initiating these visits. Further breakdown of the results can be found in Appendices B and C.

### **Interpretation of Results**

While this quality improvement project had a small sample of participants, broad themes emerged. Many healthcare professionals recognize the value of continuing education and deem it necessary to provide safe, up-to-date patient care (Schneider & Good, 2018). The problem persists in finding an appropriate and adaptable way to educate a range of staff members in the everchanging field of healthcare. Survey results are the beginning effort to comprehend comfort and knowledge levels of the current staff, and to discover staff ability to learn in a virtual way. Due to the poor response rates and lack of statistical significance, there is room for improvement and further education on end-of-life.

A total of 24 staff responded to the pre-intervention survey and eight responded to the post-intervention survey. Mean confidence scores and the non-paired t-test were used for data analysis because there was a 66% decrease in response rates between pre- and post-intervention. The level of significance of .05% was used as a standard in the project. In addition, it was not possible to track if all staff who responded to the pre-survey responded to the post-survey, and vice versa. It is suspected the difference in response rates came from difficult online communication and limited staff excitement and awareness of the project. This also created a

high nonresponse bias when respondents were unwilling or unable to respond. To help mitigate this, in-person education and survey administration would likely have been of benefit to ensure participation.

### **Staff Comfort & Knowledge**

Staff reported comfort with end-of-life care in the “agree” category increased from 50% to 62.5% over the month-long project. In the “strongly agree” category, staff reported comfort decreased from 41.7% to 37.5% over the four-week period. With a p-value of 0.05, this data is statistically significant. It is possible that participants recognized how much information was available and uncovered areas for improvement in the end-of-life care they provide.

Staff reported knowledge in understanding the death and dying process in the “agree” category increased from 54% to 62.5%, and in the “strongly agree” category, it decreased from 41.7% to 37.5% over the month-long project. With a p-value of 0.06, this data was not statistically significant, but was approaching significance.

### **Adequate Tools and Resources**

When asked about having the adequate tools and resources, staff reports in the “agree” category increased from 42% to 50% post-intervention. In the “strongly agree” category, it decreased from 16.67% to zero over four weeks. With a p-value of 0.3, this data was not statistically significant. With an increased number of educational resources available, respondents still did not feel they had everything they needed for tools and resources to provide end-of-life care.

### **Communication**

For staff communication with family regarding death and dying, staff reports in the “agree” category decreased from 37.5% to 25% over the one-month period. This may have been

because not all staff cared for an end-of-life resident in the four-week implementation period, or the difference in response rates from pre- to post-intervention surveys. In the “strongly agree” category, staff reports of communication comfort increased from 29.2% pre-intervention to 37.5% post-intervention. With a p-value of 0.07, the data was not statistically significant. This result is likely related to the short implementation period.

### **Virtual Connections**

Staff reported ability to utilize video chat technology in the “agree” category decreased from 46% to 37.5% over the four-week period. In the “strongly agree” category, staff reports increased from 29% to 37.5% over the four weeks. These results are based on a poor turnout of the post-survey and the data is not statistically significant with a p-value of 0.5. This result is likely related to the short implementation period and that not all staff had cared for a resident in end-of-life during the implementation period.

### **Limitations**

#### **Sample Size**

Results reviewed were from 24 and eight respondents respectively. This author suspects the difference in response rates comes from difficult online communication and limited staff excitement and awareness about the project. Modifying the project to in-person and a larger sample size would enrich findings and provide conclusive results towards staff satisfaction with end-of-life care, education tools, and communication. To enlarge the sample size, consideration of surveying staff across the five veterans homes in the Midwest state would be of benefit.

#### **Survey Style**

The Likert scale survey provides ordinal data, and it is controversial whether parametric tests are beneficial for analysis (Sullivan & Artino, 2013). Responses are rated or rank, and the

distance between responses is not measurable. The difference in responses from the pre- to post-intervention survey creates even greater difficulty in comparing data and determining the effectiveness of the intervention. When using randomization of means, it makes the data appear as if there were similar rates of respondents, when there was a 66% decrease from pre- to post-intervention. This causes the data to be not statistically significant or reliable and the data presentation to be difficult to interpret. Further survey analysis and a greater sample size would be of benefit.

### **Online Resources**

Access to the educational resource is available to employees through an online, password protected website. While the links are all active and available for employee use, there were reported issues in sharing the resources with family, including how to share with family, how to talk them through accessing the resource, and what to do if the family did not have the technology to access it. With further use of this process, it may be of benefit to have resources available in a different method (printed fliers or handouts) to promote ease of access.

In addition, the educational resource required self-guided learning by staff and the education was not a requirement of their job. This likely contributed to the low response rate. It would be important to consider the addition of in-service training or additional access education to promote participation and mastery of the content.

### **Length of Time**

The implementation phase of the project lasted four weeks. This is a significant limitation because staff reported needing more time to implement the education. Not all staff had cared for a resident at the end of life during this period. For the education to be successful, a four-to-six-month implementation time is recommended. In addition, tracking of the number of visits to the

education site would be a necessary tool to measure the success. This would give key information on how often staff are utilizing the education and to determine if it is relevant to their daily work. Respondents requested further guidance on which discipline is initiating visits, and it is important to ensure it can be added with ease to their job duties and daily workflows. Creating a concrete method to track use of the educational resource will provide more reliable data than self-reported rates of use.

### **Results from One Setting**

This project evaluated responses from one nursing home in the upper Midwest. Within the healthcare organization of focus, there are five homes situated around the state. Surveying additional nursing homes would be of benefit to ensure the exact preferences and needs of staff are being comprehensively uncovered. Doing so would allow for future iterations of the project to move forward.

At this point, the veterans home has released the educational resource to all staff across their five homes. While this was done prior to receiving results from the pre- and post-surveys, stakeholders have been receiving positive feedback. To ensure the intervention is successful, it would be important to consider alternate forms of surveying and analysis, such as chart audits and visit tracking. The more staff surveyed with increased data obtained, will improve the evaluation and usefulness of the intervention.

### **Project Communication**

Additional challenges were encountered throughout the process. First, it was difficult to create an intervention that met all of the requests of the veterans home. Throughout the course of the project, new ideas and innovations were continually being brought forward by key stakeholders. Due to this, it was difficult to create excitement and engagement for the planned

intervention as there was always a desire for more to be done at the organization. Second, communication was a major challenge between the project leader and stakeholders. There were numerous missed communications and deficient feedback on scheduled project deliverables leading to many delays. Ultimately, communication between the project leader and stakeholders was improved with biweekly emails and once weekly virtual meetings. The challenges created difficulty in creating excitement and awareness for the project and likely contributed to small survey response rates.

### **Project Review and Critiques**

Creating a doctor of nursing practice project within an organization provides opportunity to improve staff, patient, and organizational outcomes. Students are expected to take the role of project director and align with the vision of their organization of choice and add value through process and quality improvement from an alternate perspective.

Beginning this project during the COVID-19 pandemic created many unexpected challenges for both the project director and organization. This project was given priority within the organization due to the need for virtual visit education and increased communication among staff, residents, and family throughout the pandemic. There were unforeseen challenges in creating staff education due to pandemic related changes in care, staffing shortages and time. In addition, it was difficult to alter the project along the way to fit the changing needs of the organization.

A major challenge was completing the entirety of the project using a virtual method. All meetings, surveys, education, and evaluations were done online. This created a disequilibrium in the project development, planning, and implementation due to differing expectations from academic course work and organizational requirements. The inability to meet face-to-face led to

missed communications, which delayed project implementation. Additionally, the online format contributed to low rates of respondents in the pre- and post-intervention surveys. With additional time, this project could have been done face-to-face. Opportunities for further in-person communication, collaboration and education would be of benefit.

### **Practice Recommendations & Nursing Implications**

There is ample literature relating to staff education on end-of-life (Hawkins et al., 2020; Reinke et al., 2017; Shamas et al., 2018). The question that was to be answered is how to create an easily accessible, understandable, and relevant end-of-life education resource for staff to increase care and communication. The project laid a foundation for staff to participate in self-guided online learning and implement it in their daily work. Findings of this quality improvement project show the need for more staff to be educated, the creation of a virtual visit protocol, and further data collection to support the intervention.

#### **Adequate Training**

It is the recommendation of this author to consider the addition of in-service training to enhance participation. For education to be applicable and increase quality of outcomes, empowering education is recommended (Schneider & Good, 2018). Depending on the organizations' goals, this may include fostering of searching skills, clinical performance monitoring, developing motivational factors, and including staff in the designing, implementing, and problem solving (Chaghari et al., 2017). Creating empowerment and staff involvement may facilitate greater mastery of the education and excitement for the intervention.

#### **Virtual Connection Protocol**

The COVID-19 pandemic created a need for evaluating traditional care standards and creating online or virtual standards. The Centers for Medicare & Medicaid Services (CMS)

released various guidelines throughout the course of the COVID-19 public health emergency outlining rules and regulations for visiting those in a nursing home (Centers for Medicare & Medicaid Services, 2020). While protocols were available for outdoor visitation, indoor visitation, virtual visits with providers, and compassionate care exceptions, there was nothing created about virtual connection with other healthcare staff.

With the shift to virtual care and visitor restrictions because of the COVID-19 pandemic, it is important to create alternate ways for residents to connect with their family. It is recommended that staff at the forefront of patient care are included in creating this protocol to ensure it is adaptable and fits within their current workflow (Plunger et al., 2022). Creating an organization specific virtual connection protocol to meet the facility specific needs would further the success of this quality improvement process. With clear guidance and expectations, it may lead to greater use and mastery of the educational resources.

### **Chart Audits for End-of-Life Care**

To enhance project results, it would be beneficial to create two separate chart audit functions: 1) to determine the number of residents receiving end-of-life care; and 2) to determine the rate of staff-initiated virtual connections. At the time of the project, the organization did not have a way to decipher how many residents were receiving hospice, palliative, comfort, or end-of-life care. Having a quantifiable number will help justify the significance and recommendations for furthering use of the educational resource. Obtaining further data would allow the organization to uncover whether the staff education is still relevant, and if it helps achieve the intended outcome of increased virtual connection in end-of-life.



## **Annual Review of Content**

Healthcare dynamics are always changing and creates a challenge of clinical information to change rapidly (Schneider & Good, 2018). It is essential that staff education aligns with the current, evidence-based standards and recommendations of end-of-life care. Routine review of education content will ensure that quality and current information is available. To assist with this, creating staff empowerment and in person participation will likely help create excitement for the educational resource. Further staff participation will help ensure education is up to date so residents and their families are receiving current evidence-based recommendations.

## **Conclusion**

This quality improvement project worked to develop, support, and disseminate professional practice innovation. Several challenges were uncovered throughout the process, while the organization's commitment to staff education and quality outcomes helped propel the project forward. Overall, the education resource was intended to supplement current learning and promote family centered care and communication despite current care challenges presented by the COVID-19 pandemic.

While the initial results did not show great statistical significance, it serves as a reminder that staff are willing to implement change and grow in the care they provide to veterans at the end-of-life. Clinical significance in end-of-life care was difficult to determine with poor statistical significance, but generalized themes were uncovered. Ideally, improved staff education will help improve end-of-life care. Revisions should be made to the current intervention to increase staff involvement and create excitement for the educational resource and virtual connections with families. There is still important work to be done and improvements to be made

to ensure veterans and their families are receiving the best possible end-of-life care and communication among their loved ones and healthcare providers.

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Table 1: Evidence Appraisal Summary

Citation: author/date of publication and title	Purpose of study	Design/ method & Sample/setti ng	Major variables, definitions, and measurements	Study findings	Worth to practice: LOE/quality/stability/co nclusions/recommendati ons	Level of evidence and quality
Feder, S., Smith, D., Griffin, H., Shreve, S. T., Kinder, D., Kutney-Lee, A., & Ersek, M. (2020). "Why Couldn't I Go to See Him?" Bereaved Families' Perceptions of End-of-Life Communications during COVID-19.	To examine bereaved families' understanding of the quality of end-of-life communication among Veterans, families, and staff in Veterans Affairs (VA) medical centers during the COVID-19 pandemic.	Design: qualitative  Sample: Next-of-kin of 328 Veterans who died in one of 37 VA medical centers.  Setting: VA medical centers with the highest number of COVID-19 cases during the study period.	Open-ended survey questions about family member's perception of: (1) communication with the healthcare team about the patient, (2) communication with the patient, and (3) use of remote communication technology.	Bereaved family members reported factors perceived to impact communication quality: having family at the bedside when death is imminent, fears that the patient died alone, and overall care perceptions.  Poor communication was perceived to be from lack of access to staff, insufficient updates regarding patient condition, and not contacting family about care decisions.  Communication with the patient was facilitated or impeded by the availability of video technology.	End of life communication has increased importance during periods of limited in person visitation.  Poor communication causes distress that affects the quality of the dying and bereaved family members.  New strategies are requested to overcome communication difficulties during pandemic visitation restrictions.	Level II, quality A
Andersson, E, Salickiene, Z., & Rosengren, K. (2016). To be involved – A	The aim of this study was to describe nurses' experiences >2 years of caring for	Design: qualitative	One category: caring and three subcategories: being supportive,	Nurses were personally affected and felt unprepared to care for dying patients due to a lack of	Supervision is a valuable tool for during the transition from novice to expert nurse.	Level II, quality B



<p>qualitative study of nurses' experiences of caring for dying patients.</p>	<p>dying patient in surgical wards.</p>	<p>Sample: six registered nurses.  Setting: two surgical wards in the southern part of Sweden.</p>	<p>being frustrated, and being sensitive in the caring process.</p>	<p>knowledge about the palliative care.</p>		
<p>Gabriel, M. S., Malloy, P., Wilson, L. R., Virani, R., Jones, D. H., Luhrs, C. A., &amp; Shreve, S. T. (2015). End-of-life nursing education consortium (ELNEC) for veterans.</p>	<p>An educational project to improve care for all veterans with serious, complex illness. The purpose of the article is to share evaluation data from training.</p>	<p>Design: qualitative  Methods: The ELNEC-for Veterans Project was developed as a partnership between the VA, City of Hope, and the American Association of Colleges of Nursing (AACN) to prepare nurses in any setting to support veterans palliative and end-of-life care needs.</p>	<p>Five major components: infrastructure, access, quality, expertise dissemination, and program evaluation and support.  Data was collected six months after completion of the course using a survey.</p>	<p>The overall cumulative score of the course was 4.86 (1 = poor, 5 = excellent).  Informative and thought provoking regarding palliative care score was 4.85.  The course met the objectives and their expectations 4.77.  Barriers included high acuity patient assignments, lack of administrative support, and difficulty in applying for continuing education credits.</p>	<p>The ELNEC-For Veterans has been extremely successful. Trainers continue to hold courses across the country.</p>	<p>Level II, quality B</p>

		Sample: 730 nurses representing all 50 states over a six-month period.				
Smith, D., Thorpe, J. M., Ersek, M., & Kutney-Lee, A. (2019). Identifying optimal factor scores on the bereaved family survey: Implications for practice and policy.	To identify target scores on each Bereaved Family Survey (BFS) factor that are most strongly related to a rating of “excellent” on the Bereaved Family Survey Performance Measure (BFS-PM).	Design: quantitative, cross-sectional analysis of BFS and Veteran clinical data from January 2012 to January 2016.  Sample: 40,180 Veterans whose next-of-kin completed a BFS.	The primary outcome of interest was the BFS-PM. For analysis the BFS-PM was categorized into excellent, very good, good, fair, and poor.  Independent variables included: respectful care and communication, emotional and spiritual support, and benefits.  Variables were measured using a four-point Likert scale or yes/no scale.	61.4 percent of respondents rated the quality of care received during the last month of life as excellent.  The mean factor scores: respectful care and communication: 13.2 (SD 2.5), emotional and spiritual support 7.2 (SD 2.4), and benefits 1.7 (SD 1.2).	Findings show benefit in developing clinically relevant tools for performance measurement and quality improvement surrounding end-of-life care for veterans.	Level III, quality B

<p>Reinke, L. F., Feemster, L. C., McDowell, J., Gunnink, E., Tartaglione, E. V., Udris, E., Curtis, J. R., &amp; Au, D. H. (2017). The long term impact of an end-of-life communication intervention among veterans with COPD.</p>	<p>To assess if an end-of-life communication intervention with patients with COPD led to increased documentation of advance care planning discussions.</p>	<p>Design: randomized controlled trial</p> <p>Sample: 376 patients</p> <p>Setting: VA Puget Sound Health Care System</p>	<p>Intervention to promote discussions about advance care planning with patient and caregiver.</p> <p>The form included patient preferences regarding discussing advance care planning, patient-specific barriers, and facilitators to communication about end-of-life care, patient preferences for CPR and mechanical ventilation, and severity of their airflow limitation.</p> <p>Followed over an average of 3.6 years.</p>	<p>A one-time intervention did not result in more frequent documentation of advance care planning over several years.</p> <p>Patient characteristics did not predict documentation of subsequent end-of-life discussions.</p>	<p>There is room to improve end-of-life conversations with patients who have severe COPD.</p>	<p>Level I, quality B</p>
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<p>Wachterman, M. W., Lipsitz, S. R., Simon, S. R., Lorenz, K. A., &amp; Keating, N. L. (2014). Patterns of hospice care among military veterans and non-veterans</p>	<p>To determine whether veteran and non-veteran hospice users differ by demographics, primary diagnosis, location of care, and service utilization.</p>	<p>Design: quantitative  Methods: using the 2007 National Home and Hospice Care Survey to assess for differences in hospice care.</p>	<p>Hospice diagnosis, hospice location, primary caregiver, and service utilization, or length of stay (LOS).</p>	<p>Veteran hospice users were older than non-veterans (77.0 versus 74.3 years, <math>p = 0.02</math>) but did not differ by other demographics.  A higher proportion of veteran hospice users had a primary hospice diagnosis of cancer, lived at home while receiving hospice, and received fewer home health aide visits compared to nonveterans.</p>	<p>Provides nationally representative data contrasting veteran and nonveteran hospice users.</p>	<p>Level II, quality B</p>
<p>Agha, A., Kutney-Lee, A., Kinder, D., Shreve, S., &amp; Keddem, S. (2021). "That is care that you just can't fake!": Identifying best practices for the care of Vietnam veterans at end of life.</p>	<p>To identify: recommendations for improved EOL care for older veterans, model best practice in EOL care for veterans, and any relevant differences in best practices between Vietnam and prior war eras.</p>	<p>Design: quasi experimental  Method: Five years of Bereaved Family Survey (BFS) collected between 2013 and 2017.  Sample: 25,157 BFS surveys from next of kin.</p>	<p>The BFS asks the respondent to evaluate care received by the Veteran during the last month of life and contains 18 close-ended questions and 2 open-ended questions.</p>	<p>14 themes were identified: pain management, environment and surroundings, staff demeanor, staff availability, communication efforts with both Veterans or family and between staff, EOL dignity and respect, after passing, Vietnam-specific content, and recommendations.  Further classified into four themes: support,</p>	<p>Findings indicate that a patient-centered approach to EOL care is essential to a positive experience.  Patient-centered care in the EOL context, should include the following: assigning a point of contact that follows up the patient, educating the family on what to expect, ensuring the patient's changing needs are met, ensuring the family has appropriate support, and communicating updates to family throughout the</p>	<p>Level II, quality A</p>

		Setting: VA medical centers		comfort, honor, and validation.	patient's continuum of care.	
Shamas, T. & Gillespie-Heyman, S. (2018). Specialized palliative and hospice care and the importance of mourning our nation's veterans.	To explore the perspective of veterans either facing critical life-limiting illness or at the end of life.	Design: personal narrative  Sample: two veterans in hospice care at a VA hospital.	N/A	Lack of social support, challenges with substance use disorders, and combat trauma impeding appropriate interventions for distressing symptoms are some limitations for end-of-life care.	Challenges include helping the family to understand how military experience might impact the veteran's ability to cope with illness, and the consideration of the life-limiting illness that occurs might have been caused by time in service.	Level V, quality B
Terrill, A. L., Ellington, L., John, K. K., Latimer, S., Xu, J., Reblin, M., & Clayton, M. F. (2018). Positive emotion communication: Fostering well-being at end of life.	To define hospice care team members communication strategies that strengthen relationships with family.	Design: large prospective observational project.  Sample: Hospice nurses and family caregivers of hospice cancer patients at seven home hospice agencies located in two different geographic locations in the U.S.	Case characteristics: research staff documented the number of nurse home visits and length of home hospice care.  Coding positive emotion communication using Roter Interactional analysis System (RIAS) and secondary coding of PEC to create positive	Across all visits, PEC represents a median 5.87% of the total visit utterances.  Positive emotions are a mechanism to enhance resilience and foster connections with people, they help promote well-being at the end-of-life.	Focusing on PEC offers a way to bring strength-based approaches into end-of-life communication research. Further prospective studies need to be conducted to better understand potential benefits of positive emotion, especially in the face of variable symptoms at end of life.	Level II, quality B

		Setting: home hospice cases with a minimum of four recorded home visits.	emotion categories.			
Hawkins, J. P., Gannon, C., & Palfrey, J. (2020). Virtual visits in palliative care: About time or against the grain?	The numerous issues around how to decide between face-to-face and virtual visits and how to set up such provision within an organization.	Design: qualitative study meta-analysis  Method: Systematic review  Setting: palliative care in the UK.	Focused on the following: clinical, ethical and logistics domains; identifying areas of benefit as well as drawbacks, and some specific to rushed implementation because of COVID-19's infective risks and the 'rules' of lockdown.	Explored a multitude of themes surrounding virtual visits: theoretical issues, first-hand feedback, COVID-19 specific reasons for virtual visits, the merits/risks of virtual visits, the now 'known' short-term successes, longer term drawbacks, the conflicting patient/family/staff/organizational/societal agendas, and the differing starting premises behind the observed support for virtual visits.	Creating virtual visit protocols is complex. Recommend taking a balanced and cautious approach to allow staff to adjust.  Different modes of assessment need to be better evaluated in the palliative care setting.  There needs to be a range of approaches for assessment, treatment, and support.	Level III, quality B
Dolan, H., Eggett, C., Holliday, L., Delves, S., Parkes, D., & Sutherland, K. (2021). Virtual care in end of life and palliative	To identify virtual care modalities that are safe and effective in the delivery of end of life and palliative care.	Design: literature review  Method: question refinement, defining	N/A	Quality of life: similar or favorable quality of life outcomes to face-to-face palliative care were reported across the studies, especially when virtual care was used as a supplement.	Virtual care in end of life when used correctly can be an effective model of care.	Level V, quality B

care: A rapid evidence check.		inclusion criteria, search strategy and study selection, data screening, extraction, and narrative synthesis.  Sample: 33 peer reviewed articles (19 reviews and 14 qualitative studies).		Participation in care planning: video visits enabled patient participation in interdisciplinary hospice team meetings.  Healthcare provider outcomes: positive attitudes for usefulness and feasibility were reported across systematic reviews, in addition to increased communication, including improved contact with care givers and patients.		
Antoni, C., Silverman, M. A., Nasr, S. Z., Mandi, D., & Golden, A. G. (2012). Providing support through life's final chapter for those who made it home.	To highlight the efforts of the Department of Veterans Affairs to provide exceptional end-of-life care.	Design: position statement from VA	N/A	The special needs of those who served: because of their service to our nation, many veterans have been functionally and/or cognitively impaired for years preceding their terminal diagnosis.  Role of VA hospice and palliative care remains committed to integrate palliative	The VA continues to invest time and resources into developing exceptional hospice and palliative care. Future studies are needed to compare the quality and costs of care for veterans provided by the VA versus that provided through contracted community services.	Level IV, quality B

				care across the health care continuum.		
Keeley, M. P. (2017). Family communication at end of life.	To highlight the role of family interactions in the death and dying process.	Design: meta synthesis  Methods: focus on communication, families, and the end of life.	N/A	Five major themes: 1) approaches for beginning the conversation about death and dying earlier rather than later, 2) who is making decisions and how they are made, 3) how aging and disease require changes in family communication, 4) the importance of good communication between family and care team members, and 5) the importance of exploring, acknowledging, and valuing the perspective of family members' experiences at the end of life.	When the dying person and their family can talk about what is on their minds at the end of life, the result is often the relief of stress, peaceful interaction, and greater readiness for the impending death.  Proper communication allows for a "good death," because wishes are heard, understood, and followed.	Level III, quality B
Hebert, R. S., Schulz, R., Copeland, V., & Arnold, R. M. (2008). What questions do family caregivers	To determine what questions family caregivers, want to discuss with health care providers to prepare for the	Design: mixed methods  Methods: interviews and focus	Ethnographic interview lasting one hour with three questions.	Findings show that the multidimensional nature of the questions asked are consistent with previous findings that preparing for death has medical,	Family caregivers consistently report that end-of-life communication is often inadequate. There is little information available about what caregivers	Level II, quality A



<p>want to discuss with health care providers in order to prepare for the death of a loved one? An ethnographic study of caregivers of patients at end of life.</p>	<p>death of a loved one.</p>	<p>groups containing 6-8 participants held at a location of the caregivers' preference.</p> <p>Sample: 33 caregivers of terminally ill patients with a life expectancy of less than 6 months.</p> <p>Setting: Inpatient palliative care consult service</p>	<p>The following questions: 1) the questions they believe are important to discuss with healthcare providers to prepare for the death of their loved one, 2) which of these questions they asked health care providers, and 3) which questions they did not discuss with health care providers.</p>	<p>practical, psychosocial, and religious/spiritual dimensions.</p>	<p>need from health care providers to prepare for the death of a loved one, this study works to characterize the questions they want to discuss.</p> <p>Future work should focus on helping caregivers ask questions and explore whether answering these questions results in better mental health. Also, the questions generated by these participants could be used to create a question prompt sheet, or a list of questions that caregivers can refer to when talking to health care providers.</p>	
<p>Boomer, C., Ross, M., &amp; Dillon, D. (2019). Improving caregivers experience: Enhancing end-of-life care for residents.</p>	<p>To develop and evaluate participant's palliative and end-of-life care knowledge.</p>	<p>Design: Quasi experimental</p> <p>Method: a practice development program</p> <p>Sample: registered nurses and care</p>	<p>The program included the following topics: principles of palliative care, communication, holistic assessment, advanced care planning, symptom management,</p>	<p>The findings confirm the strength of adopting a practice development approach for staff education. Integrating registered nurses and care assistants in the learning environment enhanced working relationships and enhanced person-</p>	<p>Integrating practice development into staff education for nursing home staff is an effective means of developing their knowledge and skills and seeing this integrated into practice. A more systematic approach to the development of nursing home staff is required to enhance</p>	<p>Level II, quality B</p>

		assistants, 16 total participants	end-of-life, and bereavement care.	centered end-of-life care.	person centered end-of-life care.	
		Setting: two nursing homes	Data was gathered via a range of methods: focus groups, self-assessment, residents' note reviews, one-to-one interviews, and reflective diaries.			
Di Guilo, P., Finetti, S., Giunco, F., Basso, I., Rosa, D., Pettenati, F., Bussotti, A., Villani, D., Gentile, S., Boncinelli, L., Monti, M., Spinsanti, S., Piazza, M., Charrier, L., & Toscani, F. (2019). The impact of nursing homes staff education on end-of-life care in residents with	To compare end-of-life care in nursing home residents with advanced dementia before and after an educational intervention aimed to improving palliative care.	Design: quality improvement  Method: seven-hour lecture, followed by two 3-hour meetings consisting of case discussion.  Sample: nursing home staff and 245 nursing	Information on sex, age, FAST stage, date of admission, date and cause of death, major comorbidities, and DNR orders were taken from records. Specific information on nutrition/hydration, pain, number of prescriptions, tests and interventions administered	An overall trend towards a more palliative approach and a significant decrease in the rate of residents exposed to CPR.	Results are promising, showing an improvement in resident quality of life with increased staff education. Consider combining with other studies that provide support.	Level V, quality A

advanced dementia: A quality improvement study.		home residents.  Setting: 29 different nursing homes in Lombardy, Italy.	was also collected for the time periods of 60 and seven days before death.			
Jack, B. A., Kinloch, K., & O'Brien, M. R. (2019). Teaching nurses to teach: A qualitative study of nurses' perceptions of the impact of education and skills training to prepare them to teach end-of-life care.	To explore nurses' perceptions of the impact of a program designed to train them to teach end-of-life care.	Design: qualitative  Method: data collected through focus groups.  Sample: 20 participants  Setting: three hospice education centers in Northwest England.	The training program included three objectives: knowledge, skills, and support for development.	Participants strongly valued the program providing an education overview combined with real world application of basic adult educational theory to guide their teaching.  All participants reported increased enthusiasm, feeling more energized, and were more confident in their ability to teach.	Appropriately trained, specialist staff are better able to teach others how to deliver good quality end-of-life care. Staff should engage in continuous professional development to develop their skills and improve their efficacy when teaching.	Level II, quality B
Mitchell, S., Maynard, V., Lyons, V., Jones, N., & Gardiner, C. (2020). The role and response of primary healthcare services in the delivery of palliative care in	To synthesize existing evidence related to the delivery of palliative and end-of-life care by primary healthcare professionals in epidemic and pandemics.	Design: systematic review  Sample: 552 articles identified; five articles met the	The review showed that lack of attention to palliative care was noted in pandemic planning and service modelling.	Reveals a concerning lack of evidence from previous pandemics related to primary healthcare services in palliative care provision within a pandemic.	Important factors in a successful response to pandemics should include timely and consistent communication between policy makers and healthcare providers; education, training and debrief for the workforce; support for family	Level II, quality B

<p>epidemics and pandemics: A rapid review to inform practice and service delivery during the COVID-19 pandemic.</p>		<p>inclusion criteria.</p>			<p>caregivers; and continued delivery of equipment and access to necessary support services, such as diagnostic tests.</p> <p>There is insufficient evidence to support the development of a framework to either improve the understanding of the role or enabling response of primary care services in palliative care during pandemic.</p>	
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## Appendices

### Appendix A: Implied Consent

#### *Bridging Communication in End-of-Life Care*

You are invited to participate in this quality improvement project as you are identified to be a critical clinician working with our residents and families that are end-of-life residents at {Midwest veterans home}. This project is being conducted by Taylor Karrow, DNP student at St. Catherine University. The purpose of this survey is to assess staff comfort level with end-of-life care and communication, as well as to identify areas for improvement. The data that we collect from this survey will be used for quality improvement. It will take approximately 5-10 minutes to complete.

Your responses to this survey will be confidential and the results will be presented in a way that no one will be identifiable. Your participation is voluntary and your decision whether to participate will not affect your relationships with your employer, coworkers, or researcher. If you decide to stop at any time, you may do so. You may also skip any item that you do not want to answer. If you have any questions about this project, please contact Taylor Karrow at [tkkarrow748@stkate.edu](mailto:tkkarrow748@stkate.edu).

By responding to this survey, you are giving us your consent to allow us to use your responses for educational purposes.

You may keep a copy of this form for your records.

## Appendix B: Results of Pre-Intervention Survey

<b>I have been a Midwest veterans home employee for...</b>	<b>Responses</b>
Less than one year	1
One to three years	5
Three to five years	3
Five to ten years	5
Greater than 10 years	10

<b>My role is...</b>	<b>Responses</b>
Social work	2
Human services technician	0
Licensed practical nurse	1
Registered nurse	12
Recreational therapist	9

<b>I have attended the End-of-Life Nursing Education Consortium (ELNEC) course...</b>	<b>Responses</b>
Yes	12
No	12

<b>If yes, I feel my comfort with end-of-life care after attending the ELNEC course has improved...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	3
Agree	4
Strongly agree	5

<b>I am comfortable providing end-of-life care to residents...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	2
Agree	12
Strongly agree	10

<b>I am confident in my understanding of the death and dying process...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	1
Agree	13
Strongly agree	10

<b>I feel comfortable talking to resident family members regarding death and dying...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	8
Agree	9
Strongly agree	7

<b>How many times have you helped a resident and family with a virtual visit during end of life?</b>	<b>Responses</b>
Less than one times	10
One to three times	8
Three to five times	2
Five to 10 times	2
Greater than 10 times	2

<b>I am able and confident in using video chat technology...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	1
Neutral	5
Agree	11
Strongly agree	7

### Appendix C: Results of Post-Intervention Survey

<b>My role is...</b>	<b>Responses</b>
Social work	1
Human services technician	0
Licensed practical nurse	0
Registered nurse	4
Recreational therapist	3

<b>I am comfortable providing end of life care to residents...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	0
Agree	5
Strongly agree	3

<b>I am confident in my understanding of the death and dying process...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	0
Agree	5
Strongly agree	3

<b>I feel comfortable talking to resident family members regarding death and dying...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	3
Agree	2
Strongly agree	3

<b>I feel I have the adequate tools and resources to use for teaching and supporting family members during their loved one's end-of-life...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	1
Neutral	3
Agree	4
Strongly agree	0



<b>I have accessed the end-of-life resources on SharePoint...</b>	<b>Responses</b>
Yes	3
No	4
I don't know what this is	1

<b>How many times have you helped a resident and family with a virtual visit during end-of-life?</b>	<b>Responses</b>
Less than one	2
One to three	3
Three to five	0
Five to ten	1
Greater than ten	2

<b>I am able and confident in using video chat technology...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	2
Agree	3
Strongly agree	3

<b>I feel comfortable including family via technology during vital times of care...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	0
Agree	5
Strongly agree	3

<b>I will continue to include family via technology in my care...</b>	<b>Responses</b>
Strongly disagree	0
Disagree	0
Neutral	0
Agree	4
Strongly agree	4