

**THE NURSE PRACTITIONER ROLE IS IDEALLY SUITED FOR PALLIATIVE
CARE PRACTICE: A QUALITATIVE DESCRIPTIVE STUDY**

By

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Abstract

Persons with progressive chronic diseases, such as cancer, heart disease, and chronic respiratory disease, among others, need palliative care for best quality of life as the conditions become life-threatening and deteriorate toward death. Chronic diseases are most common among older persons; therefore, with an ageing population nurse practitioners (NPs) in various areas of practice likely will encounter an increasing number of patients needing palliative care. The purpose of this study was to understand the role that NPs, who are not palliative specialists, play in providing palliative care. A qualitative descriptive design was used and 19 NPs were interviewed. The findings revealed a central and 5 other themes, indicating that the *nurse practitioner role is ideally suited for palliative care practice*. Their broad scope and autonomy, presence, and unique practice situations facilitate palliative practice. Impediments to such practice are having limited specialty palliative care knowledge and lacking emotional comfort with providing palliative care.

Keywords: nurse practitioner, palliative care, practice, role

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CHAPTER ONE: PROBLEM STATEMENT

Background

Chronic disease conditions, such as cancer, heart disease, cerebrovascular disease (stroke), chronic respiratory disease, diabetes, and Alzheimer's disease, are prevalent in Canada (Statistics Canada, 2014). Over half of Canadians are living with at least one chronic condition (Canadian Coalition for Public Health [CCPH], 2005). That figure is increased to 74% for Canadian seniors (Canadian Hospice Palliative Care Association [CHPCA], 2015). Canada has approximately 4.7 million persons age 65 and older and this number is expected to increase to more than 12 million in the next 50 years, thus making seniors the fastest growing segment of the Canadian population. With an aging population, chronic diseases will become even more prevalent (CHPCA, 2015).

Furthermore, chronic diseases are leading causes of death, accounting for about two-thirds of total deaths in this country (Chronic Disease Prevention Alliance of Canada [CDPAC], 2015; Statistics Canada, 2014). Cancer, at the top of the ranking, is responsible for about 30% of deaths (Statistics Canada, 2014). Almost 50% of Canadians will be diagnosed with cancer in their lifetime, with the majority of these people being over the age of 50 at time of diagnosis (Canadian Cancer Society [CCS], 2013). Although considered a chronic disease, for some individuals, having cancer may be relatively short-term, with rapid progression from diagnosis to death. The most common cancers are lung, breast, colorectal, and prostate, with lung cancer causing the most cancer deaths (CCS, 2013). Following cancer, the leading causes of death from chronic diseases are heart

disease, cerebrovascular disease, chronic lung disease, diabetes, and Alzheimer's disease in that order of ranking (Statistics Canada, 2015).

Persons with progressive chronic disease conditions need specialized care in the form of palliative care for best quality of life as such conditions become life-threatening and deteriorate toward death (Baxter et al., 2013). With chronic diseases being most common among older individuals and with the anticipated rapid increase in the number of Canadians 65 years of age and older, the need for palliative care is not only great now but will become even more so in the future (Barrett, Latham, & Levermore, 2007; Bennett, 2012; Deitrick et al., 2011; Witt Sherman & Cheon, 2012; Wu & Volker, 2011). However, despite the increasing need for palliative care, it is estimated that less than 30% of Canadians who die from progressive disease conditions have access to palliative care services (CHPCA, 2015). In Newfoundland and Labrador (NL) palliative care services are provided by the regional health authorities (RHAs). The RHAs cover large geographical areas of the province with many rural and remote communities. Patient access to palliative care services in the RHAs is variable depending on the availability of health care providers with palliative care knowledge to provide such care and the geographical location of the patient in relation to available palliative care services. As such, it is fair to say that palliative care services are less accessible in rural and remote areas of the province (S. MacDonald, personal communication, January 21, 2016).

Palliative Care

Palliative care is focused on optimizing quality of life for persons with any advanced stage life-threatening condition (e.g., cancer, heart disease, stroke, chronic

respiratory diseases, and dementia). Palliative care does not prolong suffering nor hasten death. It may be provided in addition to the usual medical treatment for a condition or it may be the primary focus of care (Baxter et al., 2013). Key aspects of palliative care are effective symptom management to address the physical manifestations of disease conditions and interventions to promote the social, spiritual, and emotional well-being of patients and their families (Baxter et al., 2013; Bennett, 2012; Brazil, Brink, Kaasalainen, Kelly, & McAiney, 2012; Deitrick et al., 2011; Demarest, 2004; Letizia & Jones, 2012; Lynch, Dahlin, Hultman, & Coakley, 2011; Meier & Beresford, 2006; Owens et al., 2011). Palliative care incorporates end-of-life (EOL) care, which is care required when a person's condition progresses so that death is imminent. Generally, EOL care is considered to be care provided just days and hours prior to a person's death (Baxter et al., 2013). The emphasis with EOL care is optimal care to support a person to die without suffering and with dignity (Baxter et al., 2013; Kaasalainen et al., 2013).

Care for persons with advanced stage life-threatening conditions may be provided by palliative care specialists or generalist clinicians. Palliative care specialists are physicians, nurses, nurse practitioners (NPs), and other health care professionals who work exclusively in palliative practice, have additional education specific to palliative care, and have clinical expertise in pain and symptom management. Educational qualifications for being considered a palliative care specialist vary, with clinicians becoming specialists through any one or a combination of the following: (a) completing continuing education courses in palliative care, (b) completing a certification examination in palliative care (e.g. Canadian Nurses Association [CNA] Hospice Palliative Care

Nursing certification), or (c) completing a medical fellowship in palliative care (S. MacDonald, personal communication, July 20, 2015). Besides providing direct patient care, palliative care specialists also may offer education and support to generalist clinicians (Skilbeck & Seymour, 2002). These are health professionals, such as nurses (e.g., community health nurses, NPs) and family physicians, who, in addition to other areas of practice and other patient populations, provide care to persons with advanced stage life-threatening conditions. Due to limited availability of and access to palliative care specialists, most persons with advanced stage life-threatening conditions rely on their generalist health care providers for ongoing pain and symptom management (Deitrick et al., 2011; Demarest, 2004; Lynch et al., 2011; Skilbeck & Seymour, 2002).

The Nurse Practitioner

NPs are registered nurses (RNs) “with additional educational preparation and experience”. They possess and demonstrate “the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within ... legislated scope of practice” (Canadian Nurse Practitioner Initiative [CNPI], 2006, p. iii). Traditionally, within Canada, standardized requirements for entry into NP education programs have been lacking, with programs across jurisdictions being offered at any of post-RN diploma, post-baccalaureate degree, or master’s degree level of preparation (Canadian Association of Schools of Nursing [CASN], 2011; CNPI, 2006). Thus, nurses practice as NPs with varying professional designations, such as RN NP, BN NP (i.e., bachelor of nursing), or MN NP (i.e., master of nursing) and this is the case in NL at present. However, there have been calls by

professional and academic organizations to establish graduate education as entry-to-practice for NPs (CASN, 2011; CNPI, 2006) and currently, the majority of NP programs within Canada are at the master's level (CASN, 2011). Newfoundland and Labrador recently moved to all master's level preparation for NPs. The standard for acceptance of nurses into NP programs is that they have a minimum of two years' experience in clinical nursing (CNPI, 2006).

Although there is some variation among provinces, generally, there are three streams of NP registration within Canada: Adult, Pediatric, and Family/All Ages (also referred to as Primary Health Care). This is the case in NL (Association of Registered Nurses of Newfoundland and Labrador [ARNNL], 2013). While disease management and holistic patient care are generic aspects of NP education, the specific content of NP education programs is particular to NP practice stream. Educational content for Adult stream NPs is focused on care for adult patients over the age of 18 years who have any of a variety of illness conditions that affect the adult population. Educational content for Pediatric stream NPs is focused on care for patients up to 18 years of age who have any of a variety of illness conditions, many of which are exclusive to childhood. Educational content for Family/All Ages stream NPs is focused on care for all populations across the lifespan, from birth to death, and on illness prevention in addition to treatment of illness conditions. Although there may be variation in educational curricula for NPs across programs within Canada (CNPI, 2006), national standards have been established for NP competencies (Canadian Nurses Association [CNA], 2010) and to guide curricular content (CASN, 2012). Nurse practitioner practice in Canada is regulated by legislation

in the provinces and territories. The nursing regulatory bodies in each jurisdiction are responsible for ensuring "... NPs meet the entry-level and continuing competency requirement for safe, ethical, quality care" (ARNNL, 2013, p. 1). To achieve this the nursing regulatory bodies have standards of practice and entry-level and continuing competencies for NP practice in that jurisdiction and approve the curriculum content of educational programs to ensure the standards of practice and competencies are adequately addressed (ARNNL, 2013; CASN, 2012; CNPI, 2006).

In Canada there were 2,777 practicing NPs in 2011; a ratio of 1 NP per 122,418 Canadians. Of those NPs 107 were practicing in NL; a ratio of 1 NP per 4,793 residents of the province (Canadian Nurses Association [CNA], 2013). NPs provide care for individuals and families in a variety of practice settings, including hospitals, community clinics, and long-term care (LTC) facilities. More than half of Canadian NPs were practicing in community and non-hospital practice settings in 2011 (Canadian Institute for Health Information [CIHI], 2013). As members of the interprofessional health care team, NPs work collaboratively with other health care professionals to provide optimal patient care (ARNNL, 2013; CNPI, 2006). It is suggested in the literature that the advanced practice role of NPs, created by an extended scope of practice and autonomy and entailing advanced practice competencies, puts them in a particularly good position to provide care for persons with advanced stage life-threatening conditions (Barrett et al., 2007; Bennett, 2012; Deitrick et al., 2011; Ferrell et al., 2005; Kuebler, 2003; Letizia & Jones, 2012; Meier & Beresford, 2006; Owens et al., 2011; Paice et al., 2006a, 2006b;

Shea, Grossman, Wallace, & Lange, 2010; Skalla, 2006); yet, little is known about NP practice in palliative care.

Rationale for Study

Despite the fact that many patients requiring palliative care may have care provided by non-palliative care specialist NPs in any of a variety of practice settings, little is known about NP educational preparation for such care. However, it has been documented in the literature that content relevant to palliative and EOL care is lacking in both undergraduate and graduate nursing curricula (Ferrell et al., 2005; Letizia & Jones, 2012; Paice et al., 2006a, 2006b). Supporting that contention are reports that nurses lack palliative care knowledge (Brazil et al., 2012; Shea et al., 2010; White, Coyne, & Patel; 2001). Although I was unable to find any literature regarding the prevalence of NP specialized practice in palliative care in Canada, less than one percent of NPs in NL specialize in palliative care practice (B. McIsaac, January 8, 2015).

The need for palliative care, the advanced practice role of NPs, the dearth of information on educational preparation of NPs for palliative practice, and the paucity of palliative care specialist NPs in NL prompted me to think about the role NPs who are not palliative care specialists, that is, NPs whose focus is other areas of practice, play in palliative care. A literature review revealed that little research has been conducted about NPs and palliative care practice. As a result, this study was designed to understand the role that non-palliative care specialist NPs, that is, NPs across various other areas of practice, play in providing palliative care. Knowing about the role these NPs play in palliative care could inform NP education and NP practice in this area of nursing.

Research Questions

The research questions for this study were as follows: (a) What role do non-palliative care specialist NPs play in providing palliative care? and (b) What factors influence NP practice in palliative care?

Outline of Thesis

This thesis consists of six chapters. The following is an outline of the specific topics addressed in each chapter. In the present chapter, Chapter 1, I provided background information on the need for palliative care, what constitutes palliative care, and what constitutes NP practice, culminating in the rationale for the study and the research questions. In Chapter 2, my literature search strategy and the findings from studies relevant to this research topic are discussed. In Chapter 3, an overview of the methodology used in this study is provided and participant recruitment, sampling and the sample, data collection, data analysis, study rigor, and ethical considerations are described. In Chapter 4, a description of the study participants and a detailed account of the study findings are presented. The findings are represented as themes derived from the data, including the central theme and associated categories (facilitators of NP practice in palliative care and impediments to NP practice in palliative care) and respective subthemes. In Chapter 5, a detailed discussion of my research findings in relation to other research about NP practice and palliative care and relevant nursing theory is provided. In Chapter 6, implications of this study for NP practice, NP education, health care policy, and future research are described and the strengths and limitations of this study are identified.

CHAPTER TWO: LITERATURE REVIEW

An extensive review of the literature was conducted to identify research studies relevant to the role of the NP in providing palliative care. In this chapter, my literature search strategy and the findings of the studies relevant to this research topic are discussed.

Search Strategy

The academic databases CINAHL and PubMed and the non-academic databases Google and Google Scholar were searched for relevant literature. The key words and phrases used were advanced practice nurse, attitudes, autonomous practice, autonomy, chronic disease, comfort, curricula, elderly, education, EOL care, hospice care, knowledge, learning, nurse practitioner, palliative care, perceptions, practice, RN extended practice, scope of practice, specialist, specialist practice, and terminal care. My search was confined to English language research articles from the year 2000, so as to access the most recent research. A large number of articles were retrieved and examined, with nine deemed appropriate to the topic of my study. A hand search of those articles resulted in one other relevant study, which was published in 1997. Of the ten relevant studies, including three which are applicable to more than one topic area of interest, five have findings about the role of the NP in palliative care practice (Deitrick et al., 2011; Kaasalainen et al., 2013; Osborn & Townsend, 1997; Tyree, Long, & Greenberg, 2005, Williams & Sidani, 2001), three have findings about the outcomes of NP practice in palliative care (Kaasalainen et al., 2013; Owens et al., 2011; Williams & Sidani, 2001), and five have findings about the need for education about palliative care (Letizia &

Jones, 2012; Paice et al. 2006a, 2006b; Sullivan et al., 2005; Tyree et al., 2005). Seven are quantitative studies (Letizia & Jones, 2012; Osborn & Townsend, 1997; Owens et al., 2011; Paice et al., 2006a, 2006b; Sullivan et al., 2005; Tyree et al., 2005), two are qualitative studies (Deitrick et al., 2011; Kaasalainen et al., 2013), and one is a mixed-method study (Williams & Sidani, 2001). Eight of these studies were conducted in the United States (Deitrick et al., 2011; Letizia & Jones, 2012; Osborn & Townsend, 1997; Owens et al., 2011; Paice et al., 2006a, 2006b; Sullivan et al., 2005; Tyree et al., 2005), and two were conducted in Canada (Kaasalainen et al., 2013; Williams & Sidani, 2001). I have provided a summary table of the ten relevant studies in Appendix A.

The Role of the NP in Palliative Care Practice

Research findings indicate that NPs have particular functions and perform particular activities that enable palliative care. In direct practice, they meet varied needs of palliative patients through providing comprehensive care. Williams and Sidani (2001) learned about the NP role in palliative care when they examined one NP's practice in a palliative ambulatory clinic at a cancer centre. Through a self-report questionnaire about her own role functions and activities and a self-completed clinical database about specific care she provided to patients, the researchers found that the NP was involved in providing direct patient care through assessing patients, diagnosing medical conditions, prescribing interventions, including medications as needed, and consulting with other health care team members about patient conditions. The NP coordinated patient care, including home care services to address patient health care needs in the home setting, and arranged follow-up NP visits for on-going care management. Additionally, the NP provided patient

and family education and counseling regarding the patient's medical condition and treatment plan.

Deitrick and colleagues (2011) found similar NP role functions when they examined a community based palliative care service. Using a grounded theory approach, six staff members of the palliative service, including the medical director, the program director, the clinical coordinator, and three NPs, were interviewed to determine the role of the NPs in a specialized palliative care house call service. A semi-structured interview was conducted with each participant about the specific daily activities of the NPs in the palliative care practice. The findings revealed several main functions of the NP role: (a) medical management, involving providing goal oriented, holistic patient care; (b) psychosocial support of the patient and family, involving developing relationships with the patient, the family, and the health care team members, providing supportive counseling, and advocating for the patient; (c) care management and coordination, involving coordinating an individualized plan of patient care and communicating that plan to other health care team members; and (d) education of patients and families, involving assisting patients and families to navigate through the health care system.

Kaasalainen and colleagues (2013) studied the NP role in providing palliative care in LTC facilities. Focus groups were conducted with 143 participants from five LTC homes. The participants included 14 LTC residents, 21 family members, and 108 health care providers, four of whom were NPs. Consistent with the findings when the NP role was examined in palliative services (Deitrick et al., 2011; Williams & Sidani, 2001), the NP role in LTC was found to involve (a) caring for residents with complex care needs

through assessing and managing their multiple co-morbidities and managing pain and pain medications; (b) supporting families by being available to them for assistance with medical care decision-making and when a resident dies; (c) working with other health care providers to collaboratively plan palliative care interventions for residents and to provide bereavement support for the LTC staff when a resident dies, and (d) working within the health care system to improve availability and timeliness of palliative care interventions in LTC.

Osborn and Townsend (1997) found that NPs also can function to provide palliative care support through telephone consultation. In one medical centre, five NPs had been assigned to provide medical management to hospice (palliative) patients through telephone consultations with RNs at the hospice agencies. A retrospective chart review of documented telephone discussions between the NPs and the hospice nurses revealed that the NP role involved addressing pain management; medication and supply needs; and admission, discharge, and placement concerns. As with NPs who were involved in direct palliative practice (Deitrick et al., 2011; Kaasalainen et al., 2013; Williams & Sidani, 2001), care coordination and medical management were key aspects of the NP role in providing consultation for palliative care.

Tyree, Long, and Greenberg (2005) examined the role of the NP in EOL care discussions. Although specific to EOL care and not palliative care more generally, the study sheds light on the role of the NP in this important patient care need. Of 607 NPs surveyed from a general population of NPs at a national NP conference, 82% indicated that they had initiated EOL care discussions with patients and families at some time in

their careers. The discussions involved providing education and psychosocial support for the patient and family and talking with the patient about his or her EOL care wishes.

Information about the patient's care wishes obtained from such discussions guided NP decision-making regarding the patient's care management.

Outcomes of NP Practice in Palliative Care

Although it seems that NPs are well positioned, in terms of their role functions, for palliative care practice (Deitrick et al., 2011; Kaasalainen et al., 2013; Osborn & Townsend, 1997; Tyree et al., 2005; Williams & Sidani, 2001), little is known about the effectiveness of NP practice in palliative care in terms of patient and health care system outcomes. Only three studies were found in which outcomes were investigated. Two are descriptive studies (Kaasalainen et al., 2013; Williams & Sidani, 2001) and the other is a non-experimental, correlational study (Owens et al., 2011).

Findings of the Kaasalainen and colleagues (2013) study were based on staff perceptions of NP contributions to patient and organizational outcomes in LTC homes. Staff thought that NPs had improved the availability and the timeliness of palliative care interventions for residents in LTC, with fewer resident transfers from LTC to hospital to receive such interventions. Williams and Sidani (2001) reported on a NP's qualitative evaluation of her palliative care practice. The NP had monitored and recorded on a clinical encounter form patient and other health care provider outcomes as a result of her direct care to patients and her leadership functions. Her self-assessment indicated that there had been improved patient knowledge about and coping with the illness and plan of care; increased patient comfort with and adherence to the prescribed plan of care;

improved patient satisfaction with care; improved patient quality of life; increased health care provider (e.g., physicians and home health nurses) knowledge of the patient's condition, needs, and plan of care; improved timeliness of care delivery; and improved continuity of patient care. Owens and colleagues (2011) sought to determine whether palliative care provided by a NP in a primary palliative care clinic would result in improved symptom management and decreased emergency department (ED) visits. Forty-nine patients receiving care by a single NP, who had palliative care specialty certification, over a three-month period had weekly symptom assessments performed during that period. Additionally, the patients' medical records were reviewed to gather data regarding the number of ED visits that had occurred in the previous year, prior to NP care, compared to the number of ED visits during the study period. Although the findings did not reveal a significant improvement in symptom control with NP management, there was a significant decrease in the number of ED visits by the patients when they were cared for by the NP.

The Need for Education about Palliative Care

Although NPs may make important contributions in palliative care practice, whether and to what extent they actually engage in palliative care may depend on their comfort level in that area of practice. In the study of 607 NPs by Tyree et al. (2005), 48% of the NPs reported being very comfortable with initiating EOL discussions and 44% were somewhat comfortable. Sixty-five percent of the NPs thought that having more education about EOL would assist them in communicating with patients and families about such an important and delicate matter. Seventy percent thought that more

experience would help them in talking with patients and families about EOL decisions and care. That NPs might need further education in order to be prepared for palliative care practice was also evidenced by Letizia and Jones (2012). In a study of 99 NPs working in LTC homes, 61% reported having little to no confidence in evaluating and managing palliative care patients. After completing an education program about palliative care, 84% felt confident in those areas. These findings, similar to those of Tyree and colleagues (2005), are indicative of the need for NP education about palliative care.

Yet, there is evidence in the literature that palliative care content is lacking in nursing graduate programs. In the study by Letizia and Jones (2012), only a minority of the NPs (14.9 – 38.3%) reported having been exposed to formal palliative care content and palliative clinical courses in their graduate-level education. Similarly, deficiencies in graduate level palliative care content have been reported by others. In particular, in a survey of 131 graduate programs within the United States, faculty thought that EOL education is very important within graduate level education but rated their programs as only moderately adequate (4.27 – 6.40/10) and effective (5.66/10) with respect to such content (Paice et al., 2006a). Similar findings were noted in a second study by Paice and colleagues (2006b), whereby faculty members from 60 graduate nursing programs across the United States were surveyed. Consistent with the findings in the first study (Paice et al., 2006a), the graduate faculty rated the adequacy (3.33-6.06/10) and effectiveness (4.37/10) of EOL content in their graduate programs as moderate, at best.

One factor that could impact the extent to which palliative care is covered in NP education and ultimately could affect NPs' knowledge of that practice is faculty

educational preparation in the field. In the studies by Paice and colleagues, faculty members rated themselves (Paice et al., 2006b) or other master's-level faculty (Paice et al., 2006a) as moderately effective in teaching EOL care content (6.34/10 and 6.01/10, respectively). Sullivan and colleagues (2005) noted similar findings. The 149 faculty members in that study, who were from various disciplines, of which 25% were RNs or NPs, had moderate scores on both feeling prepared to care for patients at EOL (3/5) and to teach EOL care (2.6/5). Interestingly, after attending continuing education programs about EOL care, faculty ratings of their overall preparation to care for patients at EOL and to teach EOL curriculum content (Sullivan, et al. 2005) and their overall effectiveness in teaching EOL care (Paice, et al., 2006b) were improved.

Conclusion

With the increased need for palliative care to manage life-threatening chronic illness, as a result of the aging population and increased prevalence of chronic conditions, and the appropriate role functions of the NP for the provision of such care, it is surprising that there are so few studies examining the NP role in palliative care, outcomes of NP practice in palliative care, and NP educational preparation for palliative care practice. This study was designed to add to the existing limited literature by examining the role of NPs, who are not palliative specialists, in providing palliative care across a variety of practice settings and factors that influence such NP care. Addressing these topics may inform NP practice in palliative care.

CHAPTER THREE: METHODOLOGY

The purpose of this chapter is to present the methodology and methods I used for this study, including an overview of qualitative description and detail about participant recruitment, sampling and the sample, data collection, data analysis, study rigor, and ethical considerations.

Methodology

Qualitative description as proposed by Sandelowski (2000) is the methodology that was applied to address the research questions in this study. Qualitative description is suitable for exploring a topic for which little is known and for which the researcher is seeking a thorough understanding. As little was known about the role of the NP in palliative care practice, qualitative description was an appropriate approach for this study. The goal of a qualitative descriptive research study is to compile a comprehensive and rich description of the topic of inquiry. Therefore, researchers carrying out qualitative descriptive studies need to collect as much data as necessary to capture all aspects of the entity (i.e., phenomenon, situation, or event) under study and to accurately describe it from the perspective of the study participants, including the meanings the participants ascribe to it (Maxwell, 1992). Researchers stay close to the data collected and the product of the study is a comprehensive summary of the entity under examination in the “everyday terms” (Sandelowski, 2000, p. 334) of it and in language denoting the study participants’ language (Neergaard, Olesen, Andersen, & Sondergaard, 2009). As indicated by Sandelowski (2000), researchers “seek descriptive validity” (p. 336), that is,

an accurate account that the research participants and others (e.g., other researchers observing the same entity) would agree is accurate and seek “interpretative validity” (p. 336), that is, an accurate account of the meanings that the participants ascribed to the entity and that the participants would recognize and agree is accurate.

Typically, the principles and procedures used in qualitative description are drawn from other qualitative methods, such as grounded theory, phenomenology, and ethnography, and are an eclectic combination from these qualitative traditions depending on the research question. For this study, I used a number of authoritative sources on qualitative research to support the method decisions I made regarding recruitment, sampling, data collection, and data analysis. Those sources are Graneheim and Lundman, 2003; Hancock, Ockleford, and Windridge, 2009; Hsieh and Shannon, 2005; Maxwell, 1992; Morse, 2000; Morse, Barrett, Mayan, Olson, and Spiers, 2002; Neergaard, Olesen, Andersen, and Sondergaard, 2009; Sandelowski, 2000; Sandelowski and Barroso, 2002; Streeton, Cooke, and Campbell, 2004; Streubert and Carpenter, 2011; Thorne, Reimer Kirkham, and MacDonald-Emes, 1997; and Thorne, Reimer Kirkham, and O’Flynn-Magee, 2004.

Recruitment

NPs for the study were recruited through two means: (a) information sent out to NPs through the provincial regulatory body for nursing (see Appendix B) and (b) snowball sampling. In the first instance, a letter of request for assistance with disseminating information about the study was sent to the consultant for advanced practice at the provincial regulatory body for nursing (see Appendix C). Subsequently,

the information about the study (see Appendix B) was sent by email through the third party contact to all NPs, within a defined geographic region, who were registered with the regulatory body. The region consists of a metropolitan setting and of rural settings where NPs practice. This approach yielded 11 participants.

The second recruitment strategy, snowball sampling, is sometimes referred to as nominated sampling. In that approach participants who are already in the study inform others, whom they know personally and who they think might be suitable participants, about the study. The intent is that those potential participants will contact the investigator if they are interested in the study (Streeton, Cooke & Campbell, 2004; Streubert & Carpenter, 2011). In this study, NPs who already were participants were asked if they knew other NPs who might also be interested in participating in the study. If so, the study participants were asked if they would consider contacting those NPs to inform them of the study and to provide them with my contact information. NPs accessed by the nominating participants contacted me directly, if they were interested in the study, to receive detailed information about it. Eight participants were recruited in this manner.

Sample and Sampling

The sample in this study was purposive, which means it consisted of individuals who had the information needed to answer the research questions. A purposive sample is useful when the researcher wants to obtain broad insight about the research topic (Hancock, Ockleford, & Windridge, 2009; Neergaard et al., 2009; Streubert & Carpenter, 2011). Since this study was about the non-palliative care specialist NP role in palliative care, those NPs had the information needed to address the research questions. Thus, the

participants were non-palliative care specialist NPs (i.e., NPs who were not working in palliative care settings but whose focus was in other areas of clinical practice) who volunteered to participate in the study and who were willing to share their views. The study sample consisted of 19 NPs who possessed a practicing NP license within NL. Of the 19 participants, 16 were from a metropolitan setting and 3 were from rural settings.

Data Collection

Consistent with qualitative research methods, my main source of data was semi-structured participant interviews. I also collected participant personal and sociodemographic information and wrote reflective journal notes as other sources of data.

Semi-Structured Participant Interviews

Semi-structured interviews are useful to gather rich and valid information about specific content areas relevant to the study topic (Sandelowski, 2000). Such interviews are conducted with the aid of an interview guide, which is composed of a specific set of questions. The interview guide may be altered during the course of data collection by adding or modifying questions to address gaps in information or expand on the subject matter should this need be determined during data analysis (Graneheim & Lundman, 2003; Hsieh & Shannon, 2005; Sandelowski, 2000). For this study, I had specific content areas concerning the research questions for which I was interested in gathering information and which I compiled into a comprehensive interview guide (see Appendix D). Since informed questioning is crucial to collecting relevant, rich, and valid data I conducted the interviews for this study using that guide. The interview guide was composed mostly of open-ended questions (e.g., What are your thoughts on the role of

the NP in palliative care practice? Would you please tell me about any involvement you have had as a NP in palliative care?), with specific prompting questions (e.g., Would patients be at home, in hospital, or in a palliative care unit? What diagnoses did the patients have? How were you involved? Your role?). As such the guide helped keep my conversation with participants going and on topic and helped me collect the in-depth information needed to address the research questions.

Each of the 19 participants was interviewed once. The interviews were digitally recorded and later transcribed into text for data analysis. Seventeen of the interviews occurred in-person and were conducted privately either at the workplace office of the respective NP (n= 14) or at my workplace office (n = 3). Two interviews were conducted by telephone, with each NP in a private workplace office and I in my private home office.

Personal and Sociodemographic Data Questionnaire

Personal and sociodemographic quantitative data were collected by questionnaire (see Appendix E). I administered the questionnaire to each participant just prior to the interview so that I was familiar with the characteristics of each participant and could then use the information to inform my questions during the interview. The characteristics for which data were gathered are (a) number of years as a RN, (b) number of years as a NP, (c) type of educational preparation, (d) practice designation (e.g., Adult stream NP, Family/All Ages stream NP), (e) courses completed in palliative care, (f) age, and (g) sex. Those data were grouped to describe the general characteristics of the sample and were used to inform the inductive reasoning process during data analysis, as appropriate.

Reflective Journal

Often in qualitative research, journaling is used to document observations made during each interview and to reflect on the information obtained from each participant. The contents of a reflective journal can inform subsequent data collection and provide important contextual information for the researcher during data analysis (Banks-Wallace, 2008; Streubert & Carpenter, 2011). Immediately after completing each NP interview I recorded in an electronic journal my observations about the interview setting and the participant, including the way comments were verbalized and any facial expressions or actions made by the participant during the interview, and my thoughts about the content of the interview. I recorded any questions that occurred to me as I reflected on the interview and the information I had gathered from the participant. For instance, when a participant spoke of palliative care as being synonymous with EOL care, I asked myself why that might be so and made a note to probe it further in interviews with other participants. I also noted things such as whether a participant seemed comfortable and confident in discussing palliative care and I reflected on such observations later as I analyzed the respective participant's interview and other interviews as a whole. Hence, my reflective journal served to enhance both data gathering and data analysis.

Data Analysis

The interview data from this study were analyzed using qualitative content analysis, a systematic approach to examining qualitative data. With content analysis, the data from each interview text is coded and categorized and resulting themes are synthesized across interviews to produce a comprehensive description of the entity under

study that reflects meanings, as revealed by the participants, and the overall message conveyed in the data (Neergaard et al., 2009).

For qualitative research, it is recommended that data collection and data analysis occur concurrently. “Collecting and analyzing data concurrently forms the mutual interaction between what is known and what one needs to know ... the iterative interaction between data and data analysis ...” (Morse, Barrett, Mayan, Olson, & Spiers, 2002, p. 18) ensures complete data for a thorough description of the subject under study. When no new information is forthcoming from the participants in the study and the description is complete, saturation is said to have been achieved and there is no need for further data collection (Morse et al., 2002; Streubert & Carpenter, 2011). Consistent with that approach, data collection and analysis occurred simultaneously in this study. This means that data analysis began as soon as the first interview transcript was ready and continued with and informed each subsequent interview. Saturation was considered to have been achieved in this study when 19 participants had been interviewed.

I began data analysis with each interview by first listening to the digital recording as I read the transcription to ensure that it had been accurately transcribed. If errors were identified, changes were made to correct the transcription to reflect the interview accurately. I then proceeded to work with this cleaned copy of the interview. As I listened to each recording I also made notes regarding what I was hearing such as key words and phrases used by the participants during the interview (e.g., “specialty”, “broad scope of NP practice”, “not familiar enough”). I then reread the interview transcript time and again to become thoroughly familiar with the data. As more interviews were completed,

reading each one allowed me to think about how the content was similar to or different from that of other interviews completed to that point. After becoming familiar with each interview transcript, I began to analyze it using the process of qualitative content analysis. The analytic procedures involved coding, constant comparison, and memo writing. Each interview was my unit of data for analysis (Graneheim & Lundman, 2003); although, as I was working with the interview, I also was reviewing my reflective journal, as an additional source of information about the interview, and thinking about the personal and sociodemographic characteristics of the respective participant.

Each interview transcript was divided into two columns with the interview text in the left column and the right column used to document my coding. To code, I examined each interview line by line and sentence by sentence to identify key words and phrases revealed by the participant. These were highlighted in the interview text. In the corresponding space in the right column, I applied a code or label to accurately represent each key word or phrase. Using the process of constant comparative analysis, I then examined the codes for similarities and differences both within each interview and across all interviews as they were completed. Subsequently, like codes were grouped into categories and themes. To complete the analysis, the themes were examined for any relationships among them that explained the NP role in palliative care. The codes applied and themes inductively abstracted from the data were *in vivo* as possible. This means that participant language was used. For example, key words and phrases such as “I don’t feel comfortable”, “not feeling comfortable”, “not for everybody”, and “very depressing” were coded as not comfortable or feeling uncomfortable and synthesized into the theme

lacking emotional comfort with palliative care practice. Otherwise the themes were worded on the basis of my interpretation of the data. For example, the theme *being uniquely situated* was derived from such participant phrases as “in rural areas where there is no team... you are the team”, “you are the care provider”, NPs “support that person [patient] in the home”, and “in long-term care, nurse practitioners are basically first call.... before a physician”.

Throughout the data analysis process, I used analytic memos to assist and record my thinking. Analytic memos are simply notes of the researcher’s ideas and insights about the data as he or she works with it (Birks, Chapman, & Francis, 2008). As I worked with the data, I recorded my thoughts about codes, categories, and themes. These memos were written in point form and brief notes in an electronic Word document and illustrate my thinking about the data and how some of my thoughts changed as the analysis progressed and as I consulted with my thesis supervisor. In effect, the memos helped me think through the data. For example, in several memos I had commented on the importance of the NP role in developing therapeutic relationships with patients and families, the importance of listening to patients, and the importance of being supportive of patients through a holistic approach to patient care. As a result of reviewing these memos, as well as codes from the transcript text and my reflective journal entries, I identified the theme *being present*. Furthermore, the analytic memos helped me identify relationships among themes. For example, NPs *having broad scope and autonomous practice* was about NPs possessing the needed scope of practice and advanced competencies for palliative care practice. In reflecting on my analytic memos along with

the interview transcripts it was evident that *having broad scope and autonomous practice* was related to *being present* and *being ideally situated* as having a broad scope and autonomy of practice provide opportunities for presence and situatedness. I developed diagrams to help me sort out my thoughts about the themes, which resulted in Figure 1 (Chapter 4), a diagram illustrating the study findings. The product of the data analysis for this study is a comprehensive description of the non-palliative care specialist NP role in palliative care practice.

Rigor

“Without rigor, research is worthless...and loses its utility” (Morse et al., 2002, p.14). Morse and colleagues (2002) contended that rigor in qualitative research can be attained through implementing strategies during the research process to achieve validity and reliability of study findings. Recognizing the importance of rigor, I employed a number of strategies in this study to optimize the quality of the findings. The strategies are as outlined by Morse et al. (2002): attaining methodological coherence, endeavoring to bracket presuppositions, carrying out appropriate and adequate sampling, being responsive, and thinking theoretically. These strategies assisted me to obtain complete data and ensure that the research findings are a true representation of the data collected, thus supporting the validity and the reliability of the findings. In qualitative research, it also is important for the researcher to be able to show how data collection and analysis decisions were made, that is, to provide an audit trail. In this study, my coded interviews, analytic memos, and reflective journal provide an audit trail.

Methodological Coherence

Methodological coherence is achieved by the selection of and adherence to a research methodology suitable for collecting information to answer the research question (Morse et al., 2002; Sandelowski, 2000). Qualitative description was an appropriate choice for my research study as I wanted to provide a comprehensive description of a situation, that is, the role of non-palliative care specialist NPs in palliative care practice. The research questions, data collection methods (i.e., semi-structured interviews, journaling), and data analysis method (i.e., content analysis) fit with qualitative description methodology.

Bracketing Presuppositions

Bracketing is a technique to identify one's presuppositions about the study topic and one's prior knowledge from the literature and to keep such pre-understanding from influencing the study findings. Bracketing increases the researcher's openness to learn from the data. Reflective journaling is a method that may be employed to make bracketing explicit (Streubert & Carpenter, 2011). As I am a palliative care NP with a specialized body of knowledge and extensive practice experience and had completed a literature review before the study, it was important for me to acknowledge my presuppositions and knowledge regarding the role of the NP in palliative care practice. Therefore, using reflective journaling, I documented my attitudes, beliefs, and knowledge in relation to the NP role in palliative care practice before the interviews began so that I might approach the study openly, thus minimizing the potential for intrusion of my pre-understandings into the study findings. I frequently reflected upon my journal entry as I

gathered the data and analyzed it in an effort to not prejudge or force interpretation of what the participants were telling me and to keep bias at bay.

Appropriate and Adequate Sampling

Purposive sampling is used to ensure data collection is from individuals who are knowledgeable about the topic of interest (Graneheim & Lundman, 2003; Morse et al., 2002). I used purposive sampling in this study. The NPs who volunteered for the study (all non-palliative care specialist) were appropriate as it is the non-palliative care specialist NP role in palliative practice that I wanted to learn about. To obtain a complete understanding of the NP role in palliative care, I carried out in-depth interviews using an interview guide. I also analyzed the interviews as they were completed. This concurrent data collection and analysis allowed me to see what was in the data to date and to consider what I still needed to learn from NPs or have them elaborate on. Although no modifications were made to the interview guide as the study progressed, I used prompting questions to probe participant responses to encourage them to elaborate on their comments. This ensured the information provided by the participants was rich in detail.

In qualitative research, the focus is on thoroughly describing the topic of interest and a general principle is that participants are recruited into the study until data saturation. Although there is no suggested sample size in the literature for qualitative description methodology, suggested sample sizes for the main qualitative research traditions range from 6-10 participants for phenomenology to 20-50 for grounded theory and ethnography (Morse, 2000; Polit & Beck, 2012). For this study, I continued to seek NP participants until no new themes were being revealed in the NP interviews and I was

able to fully describe each theme. I was confident that theoretical saturation had been achieved in this study at 19 participants.

Being Responsive

During data analysis it is important for the researcher to be responsive to the data (Morse et al., 2002). To achieve this, I read and reread the participant interview transcripts. I carefully examined the words of the participants and reflected on my journal notes to ensure that I remained open to the data. As data collection and analysis progressed I relinquished initial ideas that were not well supported in the participants' narratives. For example, early in data collection and analysis, I was thinking that non-palliative care specialist NPs would identify palliative care as not being relevant to their practice. However, as data collection progressed, I recognized that the relevance of palliative care in NP practice depended on the context of the practice, that is, location (e.g., community primary health care clinic vs acute care inpatient unit) and population served (e.g., progressive chronic conditions vs specialty non-palliative conditions). Thus, I determined that NP practice in palliative care is context dependent. My intent in asking the NPs the initial interview question "Would you please tell me about your NP practice?" was to gather basic descriptive information about the participants' practice settings and their patient populations. My reflection on the responses to that question coupled with the information gathered from NP responses to later interview questions gave me an appreciation of the importance of context to NP palliative care practice. By staying focused on the data I was able to make informed observations about the study topic that were true to what the participants had told me (e.g., NPs practicing in LTC and

primary health care provided palliative care while those practicing in specialty disease clinics did not because of the non-palliative populations they served).

Thinking Theoretically

Morse and colleagues (2002) contended that “ideas emerging from the data are reconfirmed in new data; this gives rise to new ideas that, in turn, must be verified in data already collected” (p. 18). Through using constant comparative analysis, when I thought I had identified a particular theme I checked all interviews to date for the presence of the specific theme. As new interviews were conducted I examined them to confirm or disconfirm the theme. I consulted with my thesis supervisor and she guided me in thinking about the themes and how themes were connected. Her questioning of my thinking ensured that I abstracted the data to the level of descriptive theory. When I felt confident that the findings were complete and represented the participants’ narratives, I returned to the nursing literature to see if the findings were supported or refuted by existing knowledge about NP practice in palliative care. Thus, I was able to explain the findings of this study within the context of what was already known about NP practice in palliative care (see Chapters 5 and 6).

Audit Trail

An audit trail refers to the information the researcher has recorded with respect to data collection and analysis. Typically, this information is captured in a reflective journal, in the coding on interview transcripts, and in analytic memos. Such information is important as it provides the history of the researcher’s decision-making such that an external reviewer would be able to understand how the researcher arrived at the study

findings (Banks-Wallace, 2008; Birks et al., 2008; Graneheim & Lundman, 2003; Hancock et al., 2009). The entries in my reflective journal reveal my presuppositions about the research topic and my thoughts about each interview. The interview transcripts reveal my coding and the transcripts and analytic memos reveal how the codes evolved into potential and final themes. The analytic memos also reveal my ideas and decisions regarding data collection to ensure theoretical saturation.

Ethical Considerations

This study was approved by a research ethics committee as required by Memorial University of Newfoundland. According to the Tri-Council Policy Statement (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014), when conducting research respect for persons and concern for welfare are of paramount importance. Throughout this study I was guided by these core ethical principles.

Respect for Persons

Abiding by this core ethical principle requires researchers to respect the autonomy of research participants. Obtaining free and informed consent is an action that reflects respect for such autonomy (Canadian Institutes of Health Research et al., 2014). To obtain free and informed consent, during recruitment researchers discuss study details with potential participants, including the purpose of the study, what is involved in participation, any anticipated risks and benefits, and the voluntary nature of participation with the provision that withdrawal from the study can occur at any time and without consequences (Canadian Institutes of Health Research et al., 2014).

In this study, as the researcher, I had no direct contact with the NPs who participated until they contacted me to inquire about the study. The initial contact with NPs was through a third party, that is, either a consultant with the provincial nursing regulatory body, who had access to email contact information for NPs in the province, or a participant who already was in the study (nominated sampling) and agreed to pass on information about the study to other NPs. It was up to NPs who received the information about the study to contact me should they be interested in participating in the study or in learning more about it. When initially contacted by a potential participant I explained the study in detail, including its purpose, what would be involved in participating, the anticipated time commitment, risks and benefits, and the voluntary nature of participation. When a NP decided to participate in the study, we made arrangements for an interview. So that potential participants could review the consent information beforehand, I forwarded the consent document (see Appendix F) by email to each NP prior to the scheduled interview. The NPs were instructed to read the consent information and be prepared to ask me, at the appointed interview, any questions they might have about the study. At the beginning of the interview I again reviewed in detail with the NP the consent information and provided an opportunity for the NP to ask questions. All NPs interviewed in-person were asked to provide a written consent, while the two NPs interviewed by telephone were asked for verbal consent. I documented verbal consent on a consent page designated for each of those two participants.

Concern for Welfare

Concern for welfare is about maintaining the privacy of participants and minimizing inconvenience, discomfort, and risks associated with study participation (Canadian Institutes of Health Research et al., 2014). Any benefits of participating in the study are also addressed under this ethical principle.

Privacy. I had a number of measures in place to protect participant privacy. I assigned a unique participant code to each NP when consent for study participation was obtained. The code was recorded by me on the consent form and it was used in place of the participant's name on all data and study documents. The digitally recorded interviews were conducted in private with only the participant and I present both when the interviews were conducted in-person and when they were conducted by telephone. During the interviews, I was sensitive to information that could identify the participant and tried to avoid having such information recorded. However, where identifying or potentially identifying information was inadvertently recorded it was removed from the interview text by the transcriptionist at the time of transcription or by me when I reviewed the electronic transcripts for completeness and accuracy. Such information was replaced with neutral or anonymous wording. Personal and sociodemographic information collected across participants have been aggregated, thus eliminating the potential identification of specific participants. When using examples or quotations to illustrate my results, I have ensured any possibly identifying information is not disclosed. All such illustrations have been made fully anonymous. Additionally, prior to working on

this study I took an oath of confidentiality, as did the transcriptionist, who is a research assistant at Memorial University of Newfoundland, and my supervisor, Dr. Sandra Small.

During the study, the transcriptionist had access to the digitally recorded interviews for the purpose of transcribing them into text. Otherwise, access to study information (i.e., consent forms, interviews, reflective journal, analytic memos, and personal and sociodemographic questionnaires) was limited to me and my supervisor, Dr. Sandra Small. Each NP interview was recorded on an encrypted and password protected USB flash drive. I promptly delivered the flash drive to the transcriptionist at her Memorial University of Newfoundland office for her to transcribe the interview and save it onto the same flash drive, which I subsequently retrieved from her. No data were retained by the transcriptionist. The details of the NP interviews that I recorded in my electronic reflective journal, the analytic memos I created, and all my work related to the analysis of the data were saved in Word documents on the encrypted and password protected USB flash drive. When I was not using the USB drive, I stored it in a locked cabinet in my workplace office.

All study data on that USB drive was promptly copied, as it was added, to another encrypted and password protected USB flash drive as a backup data source and that drive was stored in my workplace office in a different locked cabinet from the source USB drive. Printed working copies of the interviews and the personal and sociodemographic data questionnaires also were secured in a locked cabinet in my workplace office. All data were stored separate from the signed participant consents, which were also secured in a locked filing cabinet. My supervisor, Dr. Sandra Small, was provided with printed

copies of the interviews and stored them in a locked cabinet in her Memorial University of Newfoundland office. Since completion of the study, I have transported all study materials to Dr. Sandra Small to be securely stored at Memorial University of Newfoundland. Dr. Small will be the only individual with access to the study materials, which will be kept for five years in accordance with the requirements of the research ethics committee. After five years all information on the USB flash drives will be deleted and all paper documentation related to the study will be securely disposed of according to Memorial University of Newfoundland's policy for secure disposal of confidential material.

Convenience and comfort. To minimize inconvenience related to participating in the study I conducted the NP interviews at a date, time, and location selected by the NPs. I assured the NPs that should they wish to not answer any question(s) during the course of the interview, they were entirely free to decline answering.

Risks and benefit. There were no anticipated risks associated with participating in this study. The only known benefit was that NPs received a complimentary copy of "A Caregiver's Guide: A Handbook about End-of-Life Care," published by The Military and Hospitaller Order of Saint Lazarus and the Canadian Hospice Palliative Care Association, as a thank you from me for participating in the study. This book is a clinical resource manual addressing the practical aspects of providing EOL care and is suitable for use by health care professionals as well as family caregivers.

Conclusion

This study was conducted to describe the NP role in palliative care, a topic for which few studies have been conducted. Qualitative descriptive research methodology was selected for the study and was found to be suitable for examining the research questions: (a) What role do non-palliative care specialist NPs play in providing palliative care? and (b) What factors influence NP practice in palliative care? Methodological coherence and adherence to strategies for scientific rigor throughout the research process enabled me to gather complete data and derive themes that reflect the participants' narratives, with theoretical saturation occurring at 19 participants. In addition to high regard for scientific rigor, enabling the best quality findings, this study was conducted with the highest regard for the ethical principles of respect for persons and concern for welfare.

CHAPTER FOUR: FINDINGS

In this chapter I present a description of the study participants and the themes derived from the interview data, which consist of the central theme labeled as *the nurse practitioner role is ideally suited for palliative care practice* and five other themes subsumed under the broader categories of facilitating factors of and impeding factors to NP practice in palliative care.

Participants

Information about the study and an invitation to participate in the study were emailed to 52 licensed NPs. This email recruitment strategy, coupled with nominated sampling, resulted in a total of 19 NPs being interviewed for the study. One NP was a man and 18 were women. The NPs ranged in age from 32 to 62 years with a mean age of 48.5 years. They had been RNs from 7 to 41 years with a mean of 26.1 years. They had been NPs from 4 months to 18 years with a mean of 9.4 years (see Table 1).

Seventeen NPs were educated in the Family/All Ages stream and 2 were educated in the Adult stream. A breakdown of the NPs academic credentials revealed that 5 had RN diplomas only prior to their NP preparation, 7 had BN degrees prior to their NP preparation, and 7 had MN degrees specific for NP practice. See Table 2 for an illustration of the NPs practice stream preparation in relation to their academic credentials.

Table 1

Participant Age and Professional Experience

Characteristic	Range (years)	Mean (years)
Age	32-62	48.5
RN experience	7-41	26.1
NP experience	0.3-18	9.4

Table 2

Participant Practice Stream by Sex and Academic Credentials

NP (N=19)	NP Practice Stream	
	Family/All Ages (n)	Adult (n)
Total	17	2
Women	16	2
Men	1	-
RN NP	5	-
BN NP	7	-
MN NP	5	2

The NPs were employed in a variety of settings: primary health care clinics, LTC geriatric facilities, a hospital ED, an acute care hospital inpatient non-palliative specialty unit, non-palliative specialty clinics, and educational institutions. Those NPs employed as educators also maintained a part-time clinical practice in one of the aforementioned practice settings. In this study there were two distinct groups of NPs identified. Six NPs did not and 13 NPs did provide palliative care in their NP practices. The 6 NPs who did not provide palliative care practiced either in an acute care hospital inpatient non-palliative specialty unit or non-palliative specialty clinics. The NPs who provided palliative care practiced either in primary health care clinics, LTC geriatric facilities, or a hospital ED (see Table 3).

Table 3

Participant Practice Settings

Practice Setting	NP (n)
Primary health care clinics	8
LTC geriatric facilities	4
Hospital ED	1
Acute care hospital inpatient non-palliative specialty unit	1
Non-palliative specialty clinics	5

The participants in this study are represented in the findings by use of direct quotations. However, to protect their identities I have applied pseudonyms to their voice where quotations are more than two words. For simplification, quotations of one or two words are acknowledged by quotation marks alone. Although the NPs used various terms, including patient, client, and resident, when referring to individuals under their care, for consistency I have chosen to use patient, exclusively, in my description of the findings.

The Role of NPs in Palliative Care

NPs work in a variety of practice settings, from primary care in the community, to specialty care in clinics, to emergency and acute care in hospitals, to LTC in geriatric facilities. For NPs who do not work in a specialty palliative setting, whether and to what extent they are involved in palliative care, then, depends largely on the patient population in their practice settings. The NP role is “very job specific depending on where you are located and what your population is.” (Sarah) This study was about the role NPs, who are not palliative care specialists, play in palliative care, and the NPs in this study practiced in a variety of clinical settings (i.e., primary health care clinics, LTC geriatric facilities, a hospital ED, an acute care hospital inpatient non-palliative specialty unit, and non-palliative specialty clinics), except palliative care specialty settings. Because of the nature of their practice settings, 6 of the NPs did not have any contact with patients requiring palliative care. Those NPs were practicing in non-palliative care specialty settings (i.e., an inpatient acute care hospital specialty unit and specialty clinics) where they were providing care to patients with particular conditions such as might be the case in a clinic

dealing with patients with dermatological problems. The other 13 NPs in this study practiced in community primary health care clinics or an ED, providing care to a variety of patients, including patients with chronic diseases and patients with life-threatening conditions, or practiced in LTC facilities, providing care to geriatric patients. These 13 NPs had varied opportunity for palliative care practice, from minimal to frequent.

Regardless of whether or not they were exposed to palliative patients in their practice and the extent of their experience in palliative care, all the NPs in this study thought the NP role is ideally suited for palliative care practice. The role is ideally suited for palliative care practice because of NPs' "broad scope" and "autonomous" practice, "presence" with patients, and unique practice situations. As one NP said palliative care practice is "the perfect place for a nurse practitioner." (Bertha) However, the NPs also thought that there are other factors that impact the NP role in palliative care practice and ultimately affect whether individual NPs are ideally suited in their role for palliative practice. These are NP knowledge of palliative care and NP emotional comfort with palliative care practice.

Hence, the central theme in the findings of this study is *the nurse practitioner role is ideally suited for palliative care practice* as it is the focus that brings together the other five themes derived from the data. These other themes are represented by two categories: (a) facilitators of NP practice in palliative care, which is composed of *having broad scope and autonomous practice, being present, and being uniquely situated*; and (b) impediments to NP practice in palliative care, which is composed of *having limited knowledge about palliative care and lacking emotional comfort with palliative care*

practice. The themes, including their grouping as either facilitators of or impediments to NP practice in palliative care, and their connection to the central theme are illustrated in Figure 1.

The NP Role is Ideally Suited for Palliative Care Practice

None of the NPs in this study were in a palliative care specialty practice; however, many of them had encountered palliative patients in their practice and some of those had provided palliative care for those patients. Interestingly, regardless of their practice settings, all the NPs thought the NP role is ideally suited for palliative care practice. *Ideal* means “exactly right for a particular purpose” (Ideal, n.d.). *Ideally* means capable of producing “the best results; perfectly” (Ideally, n.d.). Hence, it may be said that the NP role is exactly right to produce the best patient outcomes in palliative care, or as one NP said “a perfect fit.” (Bertha) For some NPs, their view was based on their personal experience of having cared for palliative patients in their NP practice; for others, it was based on their knowledge of “the nature of the nurse practitioner” (Bertha) by virtue of being NPs themselves. As purported by the NPs, there are factors that facilitate the NP role being ideally suited to palliative care practice and factors that impede NPs from practicing in palliative care. In other words, although the NP role is ideally suited to palliative care practice because of inherent characteristics of the NP role, characteristics of individual NPs detract from the NP role being ideally suited to such practice.

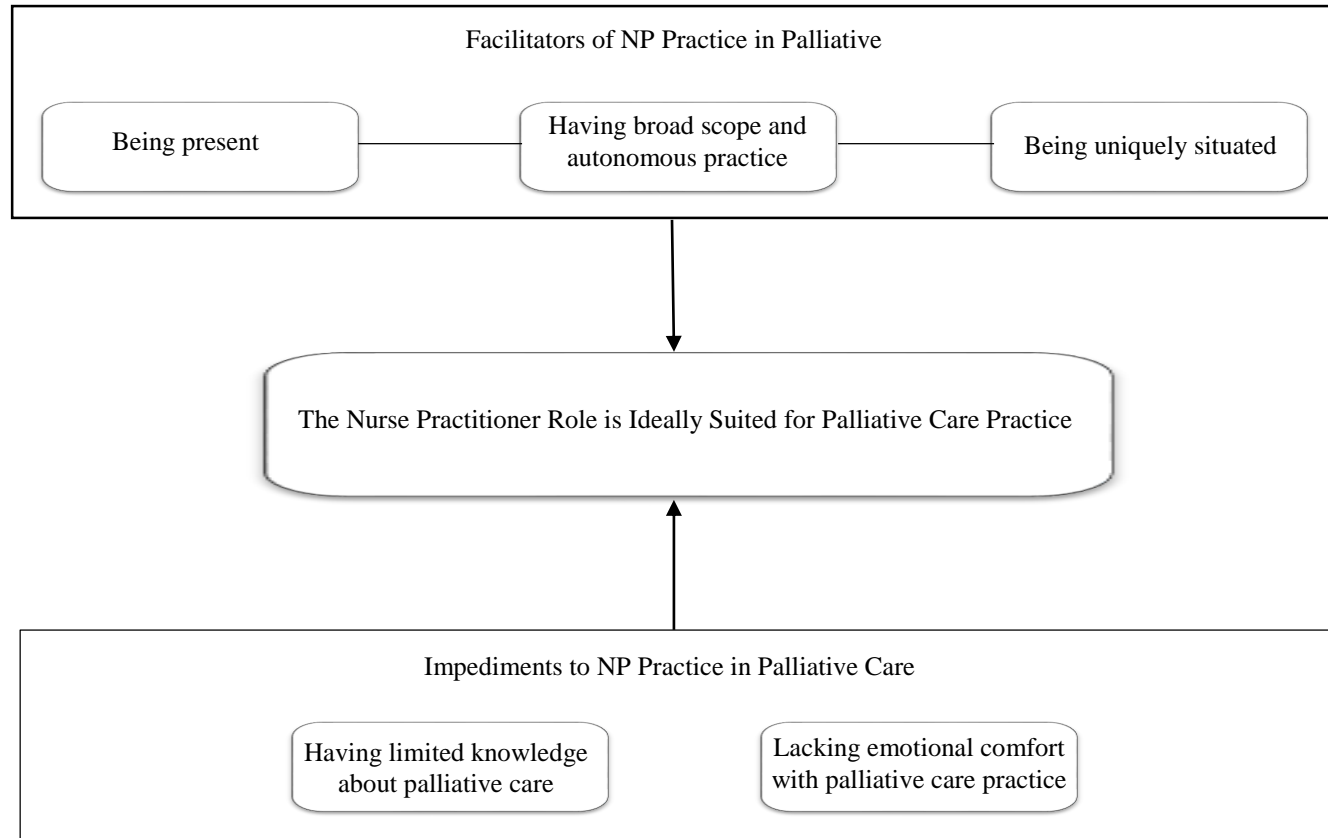


Figure 1. Thematic representation of the facilitators of and the impediments to the NP role being ideally suited for palliative care practice. NP role attributes of being present, having a broad scope and autonomous practice, and being uniquely situated facilitate palliative care practice. Having broad scope and autonomous practice provide opportunities for presence and being situated. Having limited knowledge about palliative care and lacking emotional comfort with palliative care practice are impediments to NP practice in palliative care.

Facilitators of NP practice in palliative care. Facilitators are defined as factors that “help to bring about an outcome” (Facilitator, n.d.). In this study facilitators refer to attributes of the NP role that make it ideally suited for palliative care practice and are represented by three themes: *having broad scope and autonomous practice*, *being present*, and *being uniquely situated*. Although presented linearly as discrete themes, it may be inferred that relationships exist among them. Having a broad scope and autonomous practice provides opportunities for presence, as a result of the requisite provision of comprehensive and ongoing care, and for situatedness, as a result of the types of practice available to NPs and the varied patient conditions they encounter.

Having broad scope and autonomous practice. NPs are advanced practice nurses whose educational preparation includes knowledge and skills from the discipline of medicine integrated with the philosophy of holistic nursing care. This education affords NPs a broad scope of practice from having the knowledge and the skills to assess, diagnose, treat, evaluate, and follow-up as needed in the clinical management of patient conditions. NPs work independently within their broad scope of practice; thus, they have autonomy to determine and implement the patient’s plan of care.

NPs in this study believed NP broad “scope of practice” coupled with practice “autonomy” contributes to making NPs ideally suited for palliative practice. The NPs talked about how NP scope of practice and autonomy go well beyond that of RNs to include medication prescription and treatment of illness. They spoke of NPs having the necessary advanced knowledge of medical conditions and advanced skills and autonomy to assess patients, plan care, implement interventions, and provide ongoing care. In

particular, they spoke of NPs being able to prescribe medications, including controlled drugs such as opioids. The NPs were aware of the importance of “comfort measures ... and pain control” (Emma) in palliative care and thought that prescribing privileges and autonomy to treat and manage patient conditions enable NPs to provide optimal care to palliative patients for “best quality of life.” (Kate)

Being present. *Present* may be defined as “available”, “in attendance”, or “attentive” (Present, n.d.). In nursing, being present is about not only physical attendance but also the nature of that attendance. In being present the nurse interacts with the patient such that he or she is attentive and receptive to the patient’s physical, social, emotional, and spiritual needs. This attentiveness facilitates the development of a trust relationship between the nurse and the patient. Thus, being present with the patient is an essential aspect of providing holistic nursing care to address the whole person needs of the patient so as to optimize the patient’s well-being (Easter, 2000; Zybblock, 2010).

The NPs in this study believed that nursing “presence” with patients and their families is essential in palliative care and NPs have the opportunity and competencies for it and their holistic approach to care embodies it. For the NPs, being present is about “being there, just absolutely being there.” (Lynn) They believed that being there demonstrates caring and permits patients to reveal their needs. They thought that of particular importance in palliative care is development of a “trust” relationship between the NP and the patient and family to permit open and honest conversations about the patient’s diagnosis, prognosis, and future care wishes. Being present in every sense of the word enables such conversations. In relating her personal experience, Mary commented,

“I’m able to talk to them [patients] about it [palliative care] in a more open way because I’ve already established a trust with them.” As the NPs noted, NPs are physically present with patients because of their direct contact for comprehensive and ongoing care and NPs’ holistic approach goes beyond patients’ physical needs. As Sally related, it involves discussing with patients their “spirituality, their faith, their family support.... Have they accomplished what they needed to accomplish in this life? Do they feel that they’re missing something ... or are they just sick of being sick and they want it over?” It is about helping patients find “a place of comfort.” (Mary) The NPs believed that NPs have the “psychosocial skills”, the “advanced communication”, the “active listening” and the “empathy” needed for providing palliative care. In essence, having the availability for and capability of being present with the patient and family and enacting presence through a focus on holistic care contribute to NPs being ideally “suited” for palliative care practice.

Being uniquely situated. *Uniquely* is “used to say that something or someone is unlike anything or anyone else” (Uniquely, n.d.). In other words, it is about being distinctive. *Situated* is defined as “located” or “placed” (Situated, n.d.). As indicated by the NPs in this study, NPs are uniquely situated in that by virtue of their distinctive practice (i.e., broad scope, autonomous, interdisciplinary, and collaborative) and places of work they are afforded opportunities to encounter patients who require palliative care. In addition to specialty palliative care settings, such as palliative care units and specialty palliative oncology clinics, palliative care patients also are encountered in a variety of other practice settings where NPs work, whether inpatient or outpatient services.

As noted by the NPs, rural primary health care and LTC are two types of settings where NPs are especially likely to encounter patients requiring palliative care. For example, in rural areas, specialty palliative care services generally are not available, a NP may be the sole health care provider, and caseloads involve diverse patient conditions. Such circumstances mean that primary health care NPs may be particularly exposed to patients who require palliative care. Sarah described the unique situation of NPs in rural primary health care,

Especially in the rural areas where there is no team.... You [the NP] are the team.... You are the care provider.... [You] put the plans in place.... Follow them [palliative patients] through all the stages ... titrations of medications....

Providing the education and the psychosocial support.

Similarly, palliative patients, that is, elderly or disabled persons with progressive and life-threatening conditions, are routinely encountered in LTC geriatric facilities and often NPs are the primary health care providers in such settings. Some NPs spoke of the fact that many patients already are “palliative when they arrive” (Lynn) to LTC geriatric facilities, being placed there because of their worsening conditions or need for extensive care. In effect, then, such NP exposure to palliative patients as a result of their situatedness, resulting from their distinctive practice and opportune work settings, contributes to them being ideally suited for palliative care practice.

Impediments to NP practice in palliative care. While contending that the NP role is ideally suited for palliative practice and thus advocating for NP palliative practice, the NPs in this study thought that there are impediments to such practice. *Impediment* is

defined as “something that makes it difficult to do ... something” (Impediment, n.d.). In other words, it is a “hindrance or obstruction” (Impediment, n.d.). In this study, impediments refer to personal attributes of NPs that hinder them from practicing in palliative care. These attributes, which are *having limited knowledge about palliative care* and *lacking emotional comfort with palliative care practice*, affect whether individual NPs are ideally suited for palliative practice. Thus, particular NP personal attributes interfere with the NP role being ideally suited to palliative care practice.

Having limited knowledge about palliative care. The NPs in this study readily recognized that limited knowledge about palliative care is an impediment to NP practice with palliative care patients. By limited knowledge the NPs meant not having “specialty” knowledge about this area of nursing. They considered that such specialty knowledge is acquired from formal academic and continuing education in the subject matter and from working in the field. Interestingly, all of the NPs indicated that their formal academic NP education either lacked palliative care content or did not have sufficient emphasis on NP “management ... of a palliative care patient” (Emma). They thought that “what you’ve learned in your [NP] program is not enough” (Kate) to feel knowledgeable about providing palliative care. “As a new NP you really have no concept of ... how to truly care for someone in palliative care and you’re nervous” (Kate) about providing such care.

Not surprising, NPs whose practice did not involve palliative care patients had limited knowledge about palliative care practice. Since their patient populations did not require such care this was not affecting their NP practice. Of the NPs who encountered palliative patients in their practice, some revealed a good knowledge base with respect to

palliative care despite feeling that their formal academic NP education “certainly didn’t prepare you for caring for palliative care patients.” (Tina) Their knowledge was derived from their experience in caring for palliative patients over time, from working with or consulting with other professionals in their collaborative practice or with specialists in the field, and for some, availing of continuing education opportunities such as palliative care conferences. NPs spoke of how they valued being able to “talk to somebody from the palliative care team or the collaborating physician” (Mary) for support in palliative care decision-making because “palliative care patients are ... complicated.” (Tina) They felt “confident” in their ability to “access avenues to get what was needed” (Tina) for their best provision of palliative care. Knowledge gained from experiences of caring for palliative patients was considered “vital” for NPs in palliative care practice.

The remaining NPs, although encountering palliative patients in their practice, had limited “experience as a nurse practitioner” (Sally) in working with palliative care patients and demonstrated limited knowledge about palliative care. They spoke of needing “a lot more information and knowledge” (Marie) about this area of nursing, especially with respect to “protocols and clinical guidelines and evidence-based practice.” (Sally) These NPs had not participated in continuing palliative care education; however, several expressed interest in learning about best practice for “opioid prescribing”, for providing “end-of-life care”, and for discussing “end-of-life decision-making” (Sally) with patients and families. Although the NPs viewed consulting with experts in the field as important to feeling confident and certain in palliative practice, some indicated that they did not have access to such specialty support or they were

uncertain “where to go for help” (Marie) if they wanted to discuss care related to a palliative patient.

Whether or not the NPs’ practice involved palliative patients and whether or not they had access to continuing education and experts in the field for palliative information, NPs in this study talked about the importance of such education and access to expert knowledge. Yet, most NPs who provided palliative care, whether occasionally or more regularly, thought that there was little support in the health care system for continuing education in general, in terms of financial support for conference registration fees or time off from work to attend educational events. For instance, they noted that NPs who are interested in attending continuing education events might have to “use annual leave” (Meg) to attend “lectures” or “conferences.” NPs voiced concern that “ongoing education is something ... that has been “got[ten] away from” (Pat) in the health care system as a result of budget restraints. Because of the limited support in the system, some NPs thought that their only means of palliative care education was to be “motivated enough to find other resources” (Tina), such as journal “articles” and “online” education. The few NPs who had received employer-supported educational leave to attend palliative care conferences valued the learning experience and described it as being a “very good” opportunity to learn from “good speakers” about palliative care. Some NPs thought that having access specifically to “a specialty [palliative care] nurse practitioner” (Tina) would be particularly helpful for information about palliative care and for mentoring and guidance in palliative care NP practice.

Thus, while all NPs have the needed scope of practice, autonomy, and advanced competencies for palliative care, without “specialty” and ongoing continuing palliative care education and informational support from palliative experts, NP suitability for palliative practice may well be impeded by limited palliative care knowledge.

Lacking emotional comfort with palliative care practice. The NPs in this study thought that lacking emotional comfort with palliative care practice is an impediment to the NP role in palliative care. Comfort means feeling at “ease”, “not having unpleasant feelings” (Comfort, n.d.). By lacking emotional comfort the NPs meant not being at ease with providing palliative care.

NPs thought that lacking emotional comfort with palliative care may have to do with the specific NP being a particular type of person. The consensus was that palliative care requires a particular kind of person, that is, one who has the emotional fortitude needed to work with patients and families who are facing progressive life-threatening conditions that lead to death. The NPs believed that palliative care practice is “not for everybody” (Paula) and that “because they’re not comfortable” (Sally) with palliative care some NPs might choose to practice in an area of nursing with a patient population not needing such care. Or, “because they’re not comfortable” (Kate) with palliative care practice it is simply “not an area of interest for them.” (Paula) In this study, some NPs who were not involved in palliative care practice revealed that the very nature of palliative care was uncomfortable for them as they thought it “very sad” and “really challenging,” emotionally.

Conversely, NPs in this study who were involved in palliative care practice spoke of how “dying is a part of living” (Joan) and death is a “normal” part of life. Some of those NPs were more comfortable emotionally with palliative care practice, as a result of their experience in palliative care, than were others. Those NPs with more palliative care experience described how being able to “support a person ... through a difficult time” (Tina) felt “empowering” for them. They perceived their involvement in caring for a palliative patient as a “privileged position.” NPs who were more routinely involved with providing palliative care in their practice revealed an affinity for it. They were comfortable with that type of care and were deriving satisfaction from their NP practice in that area of nursing. Rita commented,

When you know that you can help somebody have a better experience, it makes a difference.... It makes you feel good about yourself if you can ... help somebody and make life easier for somebody else; then you know you’ve done your job.

Without that type of personal affinity for and emotional comfort with palliative practice then it goes without saying that the NP would not be most suited for palliative care practice.

Conclusion

Qualitative descriptive methodology was suitable for compiling a comprehensive and rich description of the non-palliative care specialist NP role in palliative care practice. Whether the NPs in this study were involved in palliative care practice depended on the needs of their patient population. Therefore, some non-palliative care specialist NPs practice palliative care while others do not. Whether or not their practice involved

palliative care patients, all the NPs in this study thought *the NP role is ideally suited for palliative care practice*. This is the central theme of the study as it is the focus that brings together the other five themes generated from the data. The NPs believed *having a broad scope and autonomous practice, being present with patients and families, and being uniquely situated in the health care system to encounter palliative patients* are facilitators of the NP role being ideally suited for palliative care practice. They described *having limited education about palliative care and lacking emotional comfort with palliative care practice* as impeding the NP role in this area of nursing.

It can be concluded that NPs have the needed scope of practice, autonomy, and advanced competencies for palliative care practice. However, being suited for palliative practice requires more. It requires specialty palliative care knowledge and personal emotional comfort with palliative care. This has implications for NP preparation for practice.

CHAPTER FIVE: DISCUSSION OF STUDY FINDINGS

In this chapter, I discuss the themes identified in this study in relation to what is already known in the literature about the NP role in palliative care practice.

The NP Role is Ideally Suited for Palliative Care Practice

The purpose of this study was to provide a description of the non-palliative care specialist NP role in palliative care practice and to identify factors that influence NP practice in this area of nursing. None of the NPs in this study worked in a palliative care specialty practice; however, approximately two-thirds of the NPs had provided palliative care in their practices. Whether the NPs were involved in palliative care depended on the patient population in their practice settings. Regardless of whether or not they had provided palliative care, all the NPs in this study thought the NP role is ideally suited for palliative care practice. Thus, the central theme in the findings of this study is *the nurse practitioner role is ideally suited for palliative care practice*. That perception of the NP role is consistent with findings in other studies whereby NPs (Osborn & Townsend, 1997; Owens et al., 2011; Williams & Sidani, 2001), other health care professionals (Deitrick et al., 2011; Kaasalainen et al., 2013), and patients and families (Kaasalainen et al., 2013) identified the important role of NPs in palliative practice. The findings of this study also revealed attributes of the NP role that facilitate it being ideally suited to palliative care and personal characteristics of NPs that impede practicing in palliative care. The facilitators are *having a broad scope and autonomous practice, being present, and being uniquely situated*, and the impediments are *having limited knowledge about palliative care and lacking emotional comfort with palliative care practice*.

Having a Broad Scope and Autonomous Practice

The NPs in this study were aware of the complex and comprehensive care needs of palliative patients, such as symptom management, psychosocial support, and care coordination. They thought that NP broad scope of practice and autonomy, with the capability to assess, diagnose, treat, evaluate, and follow patients as needed help make the NP role ideally suited for such practice. Their view is consistent with those of the participants in studies by Deitrick and colleagues (2011), Kaasalainen and colleagues (2013), Osborn and Townsend (1997), and Williams and Sidani (2001). Although the terms broad scope and autonomy of NP practice generally were not used in the findings of those studies, the participants described NPs' ability to provide the medical management and the care management and care coordination to meet the complex medical and nursing care requirements of palliative patients.

Being Present

NPs in this study believed that nursing presence, that is, being in full attendance with the patient and attentive to the holistic needs (i.e., physical, social, emotional, and spiritual) of the patient, is essential in palliative care to address the complex medical and psychosocial needs of patients. They further believed that NPs have the opportunity (i.e., direct contact for comprehensive and ongoing care) and competencies (e.g., advanced communication skills) for true presence, which contributes to them being ideally suited to palliative care practice. Nursing presence is a fundamental concept in nursing practice that has been discussed extensively in the nursing literature (Easter, 2000; Parse, 1992; Paterson & Zderad, 2007; Zybblock, 2010). For example, Paterson and Zderad (2007) in

their Humanistic Nursing Theory described the relationship between nurse and patient as being an existential experience. The nurse must be open to knowing the holistic care needs of the patient and aim to provide patient-centered care based on the patient's unique life experience. To do so the nurse must be available to, and develop a relationship with, the patient; the nurse must exhibit nursing presence (Easter, 2000; Paterson & Zderad, 2007; Zybblock, 2010).

In this study the NPs drew attention to the importance of nursing presence to demonstrating caring for and to establishing a trust relationship with the patient and family in order that there are open and honest conversations in relation to their psychosocial needs. As noted by Easter (2000) and Zybblock (2010) being present is necessary for patients and their families to have a meaningful relationship with the nurse and for the development of a sense of trust between them. The concept of nursing presence was not addressed, per se, in the prior research reviewed in relation to NP practice. However, descriptions of NP role functions, such as provision of emotional support, counseling, and holistic care (Deitrick et al., 2011; Kaasalainen et al., 2013; Owens et al., 2011; Williams & Sidani, 2001) suggest that nursing presence is inherent in NP practice.

Being Uniquely Situated

The NPs in this study thought that because of NPs' distinctive practice, which is characterized by such features as broad scope, autonomy, collaboration, and varied work settings, NPs are uniquely situated to encounter patients who require palliative care. Such situatedness supports their claim that NPs are ideally suited for palliative care practice.

Indeed, not only do NPs work in specialty palliative care settings, such as inpatient and outpatient palliative oncology services, but they work in a variety of other settings, such as EDs, primary health care centres, and geriatric LTC facilities (ARNNL, 2013). As noted by the NPs in this study, and consistent with findings of other studies, NPs may be the primary health care providers for palliative patients encountered in such settings, including patients with advanced cancer (Deitrick et al., 2011; Owens et al., 2011; Williams & Sidani, 2001), advanced dementia (Kaasalainen et al., 2013; Owens et al., 2011), and end-stage chronic illness (Deitrick et al., 2011; Kaasalainen et al., 2013; Owens et al., 2011). The value of NP palliative care practice in primary health care (Deitrick et al., 2011; Owens et al., 2011) and LTC settings (Kaasalainen et al., 2013), as well as in specialty palliative oncology clinics (Williams & Sidani, 2001) has been acknowledged.

Having Limited Knowledge about Palliative Care

The NPs in this study thought that specialty palliative knowledge is required for NP palliative care practice and not having such knowledge is a definite impediment to suitability for palliative practice. However, all the NPs reported having had little, if any, palliative care content in their formal academic NP education such that they had not received what is needed to feel knowledgeable in providing palliative care. That was the case regardless of the NPs' level of nursing academic education as some had been prepared as NPs on a RN diploma or BN degree foundation and others had been prepared as NPs at the MN degree level. That NPs may be lacking formal palliative care content was also noted by Letizia and Jones (2012) who completed a study on master's or

doctoral prepared NPs who worked in nursing home settings. Only small percentages of NPs reported receiving any graduate level palliative education in the form of theory content and clinical course experience. Many of the NPs had not received any palliative care content in their undergraduate programs, either. Similarly, other investigators have found that palliative and EOL content are lacking in nursing curricula (Ferrell et al., 2005; Paice et al., 2006a, 2006b). For instance, Ferrell and colleagues (2005) discussed the lack of palliative care content in undergraduate nursing education. They contended that more palliative and EOL content in undergraduate nursing programs is needed to improve nurses' ability to care for patients who have progressive life-threatening conditions. Paice and colleagues (2006a, 2006b) described faculty perceptions of the adequacy of palliative care content in graduate nursing programs. Although faculty thought EOL education is very important in graduate level nursing education, they rated the EOL content of their graduate nursing programs as being only moderately adequate.

Despite inadequate palliative care content in their formal academic education, some NPs in this study had good knowledge of palliative care as a result of having experience in caring for palliative patients over time, working with or consulting with knowledgeable professionals about palliative care, and for some, participating in continuing professional education opportunities. However, other NPs, although encountering palliative patients in their practice, had limited knowledge about palliative care, especially with respect to evidence-based clinical practice protocols and guidelines. That NPs might not have good knowledge of palliative care is consistent with results of other studies. In the study by Letizia and Jones (2012), many of the NPs who worked in

nursing home settings reported needing to know more about palliative care and many reported having little or no confidence in providing palliative care, in terms of evaluation of patients and management of their conditions. Similarly, in a study of NPs' provision of EOL care, many of the NPs reported that having more education about EOL would assist them in communicating with patients and families about this important aspect of palliative care (Tyree et al., 2005).

NPs in this study talked about the importance of clinical experience with palliative patients, continuing professional education in palliative care, and mentoring by and collaborative practice with experts in the field to gaining good knowledge for palliative care practice. This has also been noted in other studies about NPs (Letizia & Jones, 2012; Tyree et al., 2005). In the study by Tyree and colleagues (2005), NPs thought that having more experience would enable them to talk with their patients and families about EOL. Those who had participated in a continuing education course or seminar had a greater level of comfort with initiating EOL discussions with patients and families. Similarly, Letizia and Jones (2012) found that NPs who participated in a palliative care continuing education program had improved palliative care knowledge, and those who had little to no confidence in their palliative patient assessment and management capability prior to the continuing education program had improved confidence in their capability after the program. Although not about NPs in palliative practice, study findings have been reported about the valuable learning gained through clinical experience and clinical mentoring for NPs generally (Gardner, Gardner, & Proctor; 2004).

Lacking Emotional Comfort with Palliative Care Practice

The NPs in this study thought that lacking emotional comfort with palliative care is an impediment to the NP role in this area of nursing. NPs who were involved in providing palliative care in their practices varied in their level of emotional comfort with this type of practice. Some were more emotionally comfortable than were others. The NPs with the greatest emotional comfort had more regular encounters with palliative patients and therefore greater experience in caring for palliative patients. They described an affinity for palliative care practice and derived great satisfaction from it. On the other hand, NPs who were not involved in palliative care practice at all indicated that they were not comfortable with palliative care practice as a result of the very nature of palliative care. However, regardless of their own experience and emotional fit with palliative care practice, the NPs in this study thought that palliative care requires a particular type of person: someone who is emotionally comfortable with caring for patients and their families as they face death.

No studies were found in which NP emotional comfort with palliative care practice was examined specifically. However, there are studies in the literature in which it was revealed that providing care for terminally ill patients was stressful and emotionally upsetting for generalist nurses in acute care hospital settings (McCourt, Power, & Glackin, 2013; Sasahara, Miyashita, Kawa, & Kazuma, 2003; Terakado & Matsushima, 2014). Consistent with those findings and as suggested by the NPs in this study, palliative care practice may not be for everyone. It seems natural that nurses would choose to practice in areas that appeal to them and in which they are emotionally

comfortable. Therefore, it is not surprising that nurses who have not chosen to practice in palliative care experience personal stress when palliative patients are encountered (McCourt et al., 2013; Sasahara et al., 2003). Nurses who work in palliative care are viewed as being unique in that they choose to, and are thought to be more prepared to, work with dying and death (Johnston, 2002).

There were few studies found in the literature about the personal attributes of nurses who choose palliative practice and there were no such studies regarding NPs specifically. What is known is that nurses choosing to practice palliative care have a caring nature (Cameron & Johnston, 2015; Johnston, 2002; Richardson, 2002), have an interest in and are accepting of the holistic needs of the dying patient, and have an emotional comfort with dying and death (Johnston, 2002; Thompson, McClement, & Daeninck, 2006). As indicated by the NPs in this study, then, it seems reasonable that lacking emotional comfort interferes with the NP role being ideally suited for palliative care practice. Having emotional comfort with dying and death is essential for nurses, including NPs, if they are to provide the best care for palliative patients and their families (Thompson et al., 2006).

Conclusion

The central theme of this study, *the nurse practitioner role is ideally suited for palliative care practice*, is supported by past studies in which it was found that NPs play an important role in palliative practice. Being ideally suited for palliative care is a function of having (a) the capability to assess, diagnose, treat, evaluate, and follow patients, which is afforded to NPs by the broad scope and autonomy of NP practice; (b)

the opportunity and competencies for nursing presence, such that NPs are attentive to the holistic care needs of the patient; and (c) the opportunity to encounter palliative patients because of their distinctive practice and work settings. These findings are consistent with descriptions of the NP role and role functions in palliative care as reported in prior studies.

However, just as there are facilitators of palliative care practice, there also are impediments. One such impediment is inadequate specialty palliative care knowledge. The NPs in this study reported that their formal NP education was lacking in palliative care content. That palliative care content may be lacking in graduate-level education has been reported by NPs and educators in other studies, as well. NPs in this study thought that clinical experience, continuing professional education, and mentoring by knowledgeable palliative care professionals are important for gaining good knowledge for palliative care practice. The value of such learning opportunities has also been noted by others. Another impediment to palliative care practice is lacking emotional comfort with caring for patients who will die from their condition. There were no prior studies found in which NP emotional comfort with palliative practice was examined specifically. Findings of studies examining generalist nurses and palliative practice are consistent with the findings of this study that palliative care practice requires an emotional comfort with dying and death and may not be suitable for all nurses.

Based on the findings of this study and past studies it may be concluded that the NP role is ideally suited for palliative care practice, but NPs who work in palliative

practice need to have specialty palliative care knowledge and have emotional comfort with providing care for patients who have conditions that will lead to death.

CHAPTER SIX: NURSING IMPLICATIONS, STUDY STRENGTHS, AND STUDY LIMITATIONS

In this chapter I present the implications the findings from this study have for NP practice, NP education, health care policy, and future research. I also discuss the strengths and limitations of this study.

Implications for NP Practice

The NPs in this study thought the NP role is ideally suited for palliative care practice because of the role's broad scope and autonomy, the opportunities and competencies of NPs for nursing presence, and the unique practice situations of NPs to encounter palliative patients. However, as would be expected, whether NPs practice palliative care is dependent on the needs of the patient populations they serve. Given that persons aged 65 and older are the fastest growing segment of the population and that many older persons have chronic progressive conditions leading to death (CHPCA, 2015), it is likely that the need for palliative care will continue to grow (Barrett, Latham, & Levermore, 2007; Bennett, 2012; Deitrick et al., 2011; Witt Sherman & Cheon, 2012; Wu & Volker, 2011) and that NPs will encounter an increasing number of patients needing palliative care. NPs, particularly those practicing in LTC geriatric facilities, primary health care clinics, and palliative care in-patient units and clinics, are in prime positions to provide palliative care to help manage the increasing need for such care.

However, the NPs in this study thought that whether individual NPs are suited for palliative care practice depends on their emotional comfort with such practice. Being comfortable caring for patients in EOL situations is essential for the provision of best

palliative care (Thompson et al., 2006). Hence, NPs who exhibit an interest in and emotional comfort with palliative care would be considered best suited for palliative practice and should be encouraged to practice in this area of nursing.

Implications for NP Education

The NPs in this study described having limited palliative care content in their formal academic NP education but thought that NP practice requires specialty palliative care knowledge. Paice and colleagues (2006a, 2006b) and Letizia and Jones (2012) also found that there was limited palliative care content in formal academic nursing education. While it may be unrealistic to expect extensive in-depth specialty palliative care education in NP education programs because of the large volume of content that needs to be addressed, content about fundamental best practices in palliative care seems essential. Furthermore, for NPs who likely will routinely encounter palliative patients in their NP practice, such as NPs who plan to work in LTC, primary care, and palliative care inpatient units or clinics, it seems prudent that they receive more in-depth palliative education. In addition to the current NP practice streams in educational programs (i.e., Adult, Pediatric, Family/All Ages), educational institutions could consider introducing a palliative care specialist stream.

Consistent with findings in other studies (Letizia & Jones, 2012; Tyree et al., 2005), NPs in this study discussed the importance of continuing education to enhance knowledge for palliative practice. Congruent with such thinking is the fact that some NPs in this study were engaged in continuing palliative care education; although, other NPs were not. Continuing education programs have been found to be effective for improved

palliative care competency. For instance, Paice and colleagues (2006b) used the End-of-Life Nursing Education Consortium (ELNEC)-Graduate education program (nursing care at EOL, pain management, symptom management, ethical and legal issues, communication, grief and loss, preparation for time of death, and quality of care at EOL) as an educational intervention for graduate nursing faculty. After completing the education program, the faculty members reported greater effectiveness in teaching EOL care. Sullivan and colleagues (2005) revealed similar findings. Study participants, who were faculty members across various disciplines, including nursing, were better prepared to provide EOL care after attending a continuing education program about EOL care. Letizia and Jones (2012) selected and adapted content from the ELNEC-Graduate program to develop a three module online learning program (quality care at EOL, pain management and symptom management, communication and ethical issues) as an educational intervention for NPs working in LTC. The NP participants reported improved confidence in providing palliative care after completing the education program.

Based on the findings of this study and those of past studies, it is suggested that NPs pursue professional development, in an ongoing manner, to support palliative practice. This can be done through formal approaches, such as participating in palliative care conferences and palliative care continuing education programs, or informally through independent learning, such as accessing academic journals and other online literature. Those who are engaged in regular palliative practice should consider writing the CNA hospice palliative care nursing certification examination. Achieving this CNA

specialty practice designation is suggested as it is a nationally recognized acknowledgement of palliative care competence.

Implications for Health Care Policy

Consistent with findings in other studies (Deitrick et al., 2011; Kaasalainen et al., 2013; Osborn & Townsend, 1997; Owens et al., 2011; Williams & Sidani, 2001), the NPs in this study thought that NPs are ideally suited to providing palliative care. With the anticipated growth in the need for palliative care services (Barrett, Latham, & Levermore, 2007; Bennett, 2012; Deitrick et al., 2011; Witt Sherman & Cheon, 2012; Wu & Volker, 2011) more human and fiscal resources will be required. NPs are one group of health care providers who could assist in addressing this increasing demand. Governments, health care institutions, and educational institutions need policies and programs such that optimal palliative care services are available and provided by highly qualified NPs.

In this study, NPs indicated that they valued continuing education but were financially unsupported in the health care system to attend educational events. NPs also valued consultation with palliative care experts for confidence in palliative practice. Yet, some NPs indicated that they did not have access to or know how to contact palliative care experts. This is a situation where governments and health care institutions can make an immediate difference, that is, through financial support for continuing palliative care education (e.g., attendance at conferences, provision of workplace in-services), and access to expert palliative consultants for NPs who have palliative patients. Several NPs in this study suggested that having a palliative care specialist NP role that is dedicated exclusively to palliative practice would be a valuable resource with whom to consult,

collaborate, and mentor regarding complex palliative care conditions. Health care and educational institutions are encouraged to make such expert consultants available to practicing NPs.

Implications for Future Research

As the participants in this study were non-palliative care specialist NPs within a specific regional health authority of one Canadian province, it would be beneficial to conduct a larger study of NPs throughout Canada to determine support for the findings of this study.

The NPs in this study thought that having emotional comfort with palliative care is important to NP practice in this area of nursing. Although not about NPs, Thompson and colleagues (2006) revealed that to be present to provide holistic care for palliative patients and their families it is essential for nurses themselves to have personal emotional comfort with dying and death. There were few studies found in the nursing literature in which the personal characteristics of nurses who practiced palliative care were examined and no such studies regarding NPs. Research is needed to examine characteristics of NPs who choose palliative care practice and to determine how best to encourage NPs with such characteristics to participate in palliative practice.

All the NPs in this study identified having little, if any, palliative care content in their formal academic NP curriculum. They believed limited palliative care knowledge impedes the NP role in palliative practice. There is little information available as to palliative care content in formal academic NP curricula. Hence, research about palliative care content in formal academic NP curriculum is warranted. It would be beneficial to

conduct a study to determine how and to what extent palliative care content is addressed in NP educational programs across Canada in order to identify deficiencies and how the deficiencies might be addressed.

Past studies have examined faculty perceptions as to their effectiveness (Paice et al., 2006a, 2006b) and preparedness (Sullivan et al., 2005) to teach palliative care content in graduate nursing education. In those studies, faculty rated themselves (Paice et al., 2006b) or other master's program faculty (Paice et al., 2006a) as moderately effective in teaching palliative care content in their graduate nursing curricula. After participating in palliative care education, faculty perceived they had improved effectiveness or improved preparedness to teach palliative care. As neither study focused on NP graduate nursing education specifically, and given the increasing need for palliative content in NP programs, it would be appropriate to conduct more research to examine faculty preparedness to teach palliative care and what they might need to enhance their effectiveness to teach such curricula.

Many NPs in this study thought that having access to a palliative care specialist NP would be valuable for non-palliative care specialist NPs to consult and collaborate with when they have patients with complex palliative conditions. Little is known about palliative care specialist NP practice in Canada. Based on a thorough literature search and consultation with experts in the field, no information was found on the extent to which there are palliative care specialist NPs within Canada, their formal academic educational preparation for such practice, their practice settings, and their particular role functions.

Research should be conducted to establish details about palliative care specialist NP practice in Canada.

The NPs in this study thought that the NP role is ideally suited to palliative practice. Although others, including NPs (Osborn & Townsend, 1997; Owens et al., 2011; Williams & Sidani, 2001), other health care professionals (Deitrick et al., 2011; Kaasalainen et al., 2013), and patients and families (Kaasalainen et al., 2013), have also noted the important value of NPs in palliative practice, little research has been conducted to examine effectiveness of the role. In one study researchers sought to determine whether palliative care provided by a NP in a primary palliative care clinic would result in improved symptom management and decreased ED visits (Owens et al., 2011). The findings did not reveal a significant improvement in palliative patients' symptom control with NP management; however, there was a significant decrease in the number of ED visits by the patients when they were cared for by the NP. Hence, more research is needed to determine the effectiveness of NPs, both non-palliative care specialist and palliative care specialist roles, in palliative practice for patient and health care system outcomes.

Study Strengths

This study has several strengths. Firstly, it was designed to include NPs from any practice setting within the designated regional health authority in which the study took place. NPs from a variety of practice and educational backgrounds and from rural and urban settings participated, thus providing a diverse sample of non-palliative care specialist NPs, some of whom practiced palliative care and some of whom did not. This

variation permitted a good understanding of the role of non-palliative care specialist NPs in palliative care and of factors that influence NP practice in palliative care. Secondly, to my knowledge and based on a review of the literature, this is the only Canadian study in which the role of non-palliative care specialist NPs in palliative practice has been examined. Thirdly, this study adds to the body of nursing knowledge about the NP role in palliative care in terms of identifying facilitating and inhibiting factors to the role. Fourthly, this research was conducted with strict adherence to qualitative descriptive methodology and as such the findings may be considered to be rigorous.

Study Limitations

This study has the following limitations. Firstly, the study was confined to a single regional health authority within one Canadian province. The study participants from that regional health authority were NPs practicing in urban and in rural areas. None of the NPs were practicing in remote areas of the province. A larger sample from diverse settings within Canada might have produced different results. Secondly, the study sample consisted of 19 participants who self-selected for the study. Other NPs might have views different from the NPs who participated in this study.

Conclusion

The qualitative descriptive methodology and research methods selected for this study were suitable for compiling a comprehensive description of the non-palliative care specialist NP role in palliative practice. The NPs in this study thought that the NP role is ideally suited for palliative care practice because of attributes inherent to the NP role. However, they also thought that there are personal factors that may impede NP palliative

practice. While the broad scope and autonomous practice of NPs, their presence, and their practice situations, which enable opportunities to encounter palliative patients, facilitate the NP role in palliative practice, it can be concluded that to be ideally suited for palliative care practice NPs also need to have specialty palliative care education and to be emotionally comfortable with such care. These findings have implications for NP practice in palliative care, NP education with respect to practice in palliative care, as well as implications for health care policy to support NP practice in palliative care.

With the growing need for palliative care, NPs could help manage the increasing demand for such care. However, attention needs to be paid to their formal academic education and to supporting their continuing education. NPs are encouraged to pursue independent learning and access experts in the field, as possible. Research is needed to determine the current palliative care content in formal academic NP curricula so that attention may be focused on making necessary changes to address deficiencies.

This study was conducted with attention to methodological coherence and rigor. The study findings are consistent with findings from past studies and add to the body of nursing knowledge about NP practice in palliative care. However, more research is warranted to examine on a larger scale both the non-palliative care specialist and the palliative care specialist NP roles in palliative practice and to determine the effectiveness of NP practice for patient and health care outcomes.

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Appendix A: Literature Review Table

Study author, date, title, country, design, and topic	Purpose and Research Questions	Sample and Instruments	Findings and Limitations
<p>Deitrick et al. (2011). Delivering specialized palliative care in the community: A new role for nurse practitioners.</p> <p>United States</p> <p>Qualitative study using grounded theory method.</p> <p>Topic: NP role in Palliative Care (PC) practice.</p>	<p>Purpose:</p> <ul style="list-style-type: none"> To describe the daily nursing activities of three NPs working within a community-based palliative medicine service in Pennsylvania. <p>Research question(s):</p> <ul style="list-style-type: none"> What is the role of NP providers in a specialized palliative medicine house call service? 	<p>Sample:</p> <ul style="list-style-type: none"> Staff working in the community-based palliative medicine service (medical director, program director, clinical coordinator, and three NPs). No comment regarding the NPs' palliative care educational preparation. <p>Instruments:</p> <ul style="list-style-type: none"> Ten question semi-structured, in-depth interviews conducted with each participant. 	<p>Findings: Four interconnected constituent elements of the NP role in that palliative medicine practice emerged:</p> <p><i>Care management and coordination</i></p> <ul style="list-style-type: none"> Looking at the bigger picture. Coordinating client care. Communicating with physician to plan client care. Developing relationships with client, family, and health care team members. <p><i>Medical management</i></p> <ul style="list-style-type: none"> Providing goal oriented, holistic care. <p><i>Psychosocial support of client and family</i></p> <ul style="list-style-type: none"> Developing relationships with client, family, and health care team members (counseling and being client advocate). <p><i>Education</i></p> <ul style="list-style-type: none"> Assisting clients and families to navigate through the health care system. <p>Limitations: NP perspectives were not specifically identified from those of the other participants. Only 3 NPs involved.</p>

<p>Kaasalainen et al. (2013). Role of the nurse practitioner in providing palliative care in LTC homes.</p> <p>Canada</p> <p>This qualitative study was part of a larger mixed-methods study. This component involved an exploratory descriptive design.</p> <p>Topic: The role of the NP in PC practice and outcomes of NP practice in PC.</p>	<p>Purpose:</p> <ul style="list-style-type: none"> To explore the NP role in providing PC in LTC <p>Research question(s):</p> <ul style="list-style-type: none"> What are the perceptions of the NP role and role activities in LTC? 	<p>Sample:</p> <ul style="list-style-type: none"> 143 participants from 5 LTC homes across Canada (108 LTC health care providers including 4 NPs), 14 LTC residents, and 21 family members. <p>Instruments:</p> <ul style="list-style-type: none"> 35 focus groups and 25 individual interviews (including the 4 NPs). An interview guide was used and it was tailored slightly to reflect the unique perspectives of those being interviewed. 	<p>Findings:</p> <p>Participants perceived NPs in LTC to be: <i>Caring for residents with complex issues and their family members</i></p> <ul style="list-style-type: none"> Managing multiple co-morbidities. Managing pain and pain medications. Needing extensive knowledge and assessment skills. Being there through relationship development and physical presence and accessibility (counseling support and resident advocate). Pronouncing death and supporting staff and family with timely responsiveness. <p><i>Working with other health care providers</i></p> <ul style="list-style-type: none"> Supporting staff and residents through collaborative PC decision-making and providing bereavement support for staff. <p><i>Working within the organization/system</i></p> <ul style="list-style-type: none"> Improving accessibility and timeliness of care for improved care coordination and fewer hospital admissions. <p>Limitations:</p> <ul style="list-style-type: none"> No information about NP educational background and PC experience. Findings not specific to participant groups (i.e., NP, nurses, family, etc.).
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<p>Letizia & Jones (2012). An educational intervention for nurse practitioners providing palliative care in nursing homes.</p> <p>United States</p> <p>Quantitative exploratory descriptive design.</p> <p>Topic: The need for education about PC.</p>	<p>Purpose:</p> <ul style="list-style-type: none"> To evaluate an online educational program designed to improve palliative care knowledge of NPs working in nursing home facilities across the US. 	<p>Sample:</p> <ul style="list-style-type: none"> Non-probability convenience sample: 99 NPs working in nursing homes across the US; NPs had graduate level education and averaged 9 years NP experience. 3 NPs had national PC certification. Some NPs had formal PC education. All NPs had informal PC education. 85% reported interest in participating due to relevance to their NP practice. <p>Instruments:</p> <ul style="list-style-type: none"> Questionnaire for demographic and professional characteristics. End-of-Life Nursing Education Consortium (ELNEC) program adapted 50 item pre- and post-test. 	<p>Findings:</p> <ul style="list-style-type: none"> Sixty-one of the 99 NPs began the program with little to no confidence in evaluating and managing PC patients. After completing the program 83.6% of those NPs felt confident in evaluating and managing palliative care patients. Statistically significant changes between pre- and post-test scores (mean pre-test score 62.26; mean post-test score 83.39) representing significant learning gains by participants. Participants reported increased confidence in providing PC from beginning to end of learning program with ~ 93% reporting practice change as result of program learning. Findings indicate limited knowledge and little confidence about the provision of palliative care prior to the educational program. <p>Limitations:</p> <ul style="list-style-type: none"> No information regarding the extent to which the NPs were providing palliative care in their practice settings.
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<p>Osborn & Townsend (1997). Analysis of telephone communication between hospice nurses and a nurse practitioner group.</p> <p>United States</p> <p>Quantitative study.</p> <p>Topic: The role of the NP in PC practice.</p>	<p>Purpose: To describe the content of telephone calls made by hospice RNs to NPs at a medical center regarding the medical care of hospice patients.</p> <p>Research question:</p> <ul style="list-style-type: none"> • Is providing medical management to hospice patients by telephone an appropriate role for NPs? 	<p>Sample:</p> <ul style="list-style-type: none"> • A group of NPs (2 adult and 3 geriatric) with home care experience who were assigned to coordinate communication between the medical center employing them and hospice agencies and to provide medical management by telephone. <p>Instruments:</p> <ul style="list-style-type: none"> • Retrospective, exploratory chart review and card-sort methods were used to identify and analyze themes for NP responses. • Documentation of 114 telephone discussions between the NPs and hospice RNs discussing care issues of 57 hospice patients were reviewed. 	<p>Findings:</p> <ul style="list-style-type: none"> • NPs intervened to manage clinical problems concerning pain management, medication and supply needs, and admission, discharge, and placement problems. <p>Limitations:</p> <ul style="list-style-type: none"> • A retrospective chart review. All NP actions and interventions might not have been recorded. Therefore findings might not be a complete description of the role. • Lack of information as to the level of NP PC education and PC expertise.
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<p>Owens et al. (2011). Primary palliative care clinic pilot project demonstrates benefits of a nurse practitioner-directed clinic providing primary and palliative care.</p> <p>United States</p> <p>Quantitative study.</p> <p>Topic: Outcomes of NP practice in PC.</p>	<p>Purpose:</p> <ul style="list-style-type: none"> To determine if patients with a life-limiting illness receiving primary care and palliative care from a consistent NP care provider would have improved symptom management and decreased ED utilization over time. 	<p>Sample:</p> <ul style="list-style-type: none"> 49 patients followed in a specific primary palliative care clinic. Care was provided by clinic NP who had sub-specialty certification in hospice palliative care. <p>Instruments:</p> <ul style="list-style-type: none"> Patient medical records used for gathering demographic information, number ED visits in previous year. Interviews with patients (n = 49). Weekly assessment by care provider using a numeric symptom assessment scale to assess 8 symptoms from Edmonton Symptom Assessment System (ESAS) scale. 	<p>Findings:</p> <ul style="list-style-type: none"> There was no change over time on symptom assessment scores (i.e., NP practice was not related to symptom scores). Mean number of ED visits decreased significantly compared to the previous year (i.e., NP practice was associated with fewer patient visits to the ED). <p>Limitations:</p> <ul style="list-style-type: none"> Involved one NP in one clinic. Only the number of ED visits and pain scores were assessed for over 1/3 of the participants due to their cognitive impairment.
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<p>Paice et al. (2006a) Graduate nursing education regarding EOL care.</p> <p>United States</p> <p>Quantitative study.</p> <p>Topic: The need for education about PC.</p>	<p>Purpose:</p> <ul style="list-style-type: none"> To determine the existing state of PC content within the curricula of 382 graduate nursing programs prior to adapting ELNEC-Core curriculum suitable for graduate nursing education. 	<p>Sample:</p> <ul style="list-style-type: none"> Faculty representing 131 graduate nursing programs from 40 states participated. <p>Instruments:</p> <ul style="list-style-type: none"> Nursing curriculum survey of master's-level programs regarding EOL care content, perceived importance of the topic, and efficacy of existing program. Rating scale of 0-10 was used with a score of 10 representing highest effectiveness. 	<p>Findings:</p> <ul style="list-style-type: none"> Faculty thought that EOL education is very important within graduate level nursing education. Faculty rated their graduate programs as only moderately adequate (4.27-6.40/10) and effective (5.66/10) with respect to EOL content. Faculty rated master's-level faculty as moderately effective in teaching EOL care content (score 6.01/10). <p>Limitations:</p> <ul style="list-style-type: none"> No description was provided regarding the practice designations of the faculty (i.e., unknown if any faculty were NPs, if faculty had any PC or EOL care expertise).
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<p>Paice et al. (2006b) Appraisal of the graduate end-of-life nursing education consortium training program.</p> <p>United States</p> <p>Quantitative study.</p> <p>Topic: The need for education about PC.</p>	<p>Purpose:</p> <ul style="list-style-type: none"> To appraise the effectiveness of providing nursing faculty in graduate nursing programs with ELNEC-Graduate education. <p>Research question:</p> <ul style="list-style-type: none"> Did the amount of time teaching EOL content in participating graduate programs increase after faculty exposure to ELNEC-Graduate curriculum? 	<p>Sample:</p> <ul style="list-style-type: none"> Sixty graduate nursing faculty from different programs across 34 states. Mean number years was 16.6 with an average of 65% of time teaching in graduate nursing program. 82.8% of faculty (n=48) identified NP as their graduate program specialty. <p>Instruments:</p> <ul style="list-style-type: none"> Faculty completed surveys (prior to receiving ELNEC-Graduate education and 6 and 12 months post) regarding the adequacy of EOL content in their curriculum. As part of the 6 and 12 month follow-up, faculty reported on the number of graduate nursing students taught ELNEC modules. 	<p>Findings:</p> <ul style="list-style-type: none"> In the pre-survey results faculty rated the adequacy (3.33-6.06/10) and effectiveness (4.37/10) of EOL content in their graduate programs as moderate, at best, and themselves as moderately effective in teaching EOL care content (6.34/10) In the 12 month post-survey faculty reported significant improvements in PC content in the graduate nursing curriculum. Faculty perceived an increased ability to teach EOL curriculum as reported in the 12 months post-survey. Significant improvement in perceived status of EOL education and the need for, and benefit of having, more EOL education in graduate nursing curriculum. The mean number of hours for EOL education increased by 18.4 hours. <p>Limitations:</p> <ul style="list-style-type: none"> Unknown if any of faculty were NPs. No information regarding faculty's baseline level of PC knowledge prior to ELNEC-Graduate learning. No breakdown was provided regarding the number of NP students in the graduate programs.
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<p>Sullivan et al (2005). Teaching and learning EOL care: Evaluation of a faculty development program in palliative care.</p> <p>United States</p> <p>Mixed methods study.</p> <p>Topic: The need for education about PC.</p>	<p>Purpose:</p> <ul style="list-style-type: none"> To evaluate the effectiveness of the Palliative Care Education and Practice (PCEP) program, an intensive faculty development program at a US university. <p>Research question(s):</p> <ul style="list-style-type: none"> Compared with pre-program assessments, did faculty who completed both sessions in the program report improved: <ul style="list-style-type: none"> preparation to provide, teach, and lead initiatives in EOL care; attitudes related to providing or teaching EOL; patient care practices and teaching behaviors? 	<p>Sample:</p> <ul style="list-style-type: none"> Faculty who participated in PCEP: 66% physicians, 25% nurses (n=38), and 9% other health care disciplines. All participants reported having at least 25% clinical practice in PC. More than 50% had PC training but there were no details provided about such training or which participants had the training. <p>Instruments:</p> <p>Self-assessment questionnaires were completed immediately prior to and after Session 1 and on last day of Session 2. Information gathered at those time points was about participant training and practice characteristics, preparation to provide and teach key aspects of PC, preparation to develop and lead PC clinical services and educational programs, and attitudes about EOL care.</p>	<p>Findings:</p> <ul style="list-style-type: none"> Faculty had limited palliative care knowledge and were not well-prepared to teach palliative care without the continuing education program (i.e., pre-program ratings for preparation to teach EOL care [2.6/5] were consistently lower than ratings to provide EOL care [3/5], preparation to provide EOL care improved from moderate [3/5] to well [4.2/5] rating post-program participation, and preparation for teaching EOL care improved from moderate [2.6/5] to well [4.3/5] rating post-program participation). <p>Limitations:</p> <ul style="list-style-type: none"> 25% of participants were nurses (RN and NP) but there was no breakdown of results specific to practice designation. Nursing faculty were not identified as undergraduate or graduate faculty.
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<p>Tyree et al. (2005). Nurse practitioners and EOL care: Beliefs, practices, and perceptions.</p> <p>United States</p> <p>Quantitative non-experimental descriptive research design.</p> <p>Topic: The role of the NP in PC practice and the need for education about PC.</p>	<p>Purpose:</p> <ul style="list-style-type: none"> To explore how NPs approach EOL care. <p>Research question(s):</p> <ul style="list-style-type: none"> Do NPs participate in EOL care? Do NPs feel that EOL education would enhance their own personal beliefs, practices, and perceptions of EOL care? Do NPs feel that beliefs, practices, and perceptions of EOL care evolve with experience? 	<p>Sample:</p> <ul style="list-style-type: none"> A convenience sample of NPs attending a national NP conference (607 volunteered to participate). No details were provided as to the conference focus, the palliative care experience of the NP participants, or the NPs' practice areas. <p>Instruments:</p> <ul style="list-style-type: none"> Modified version of the End-of-Life Care Decision Questionnaire II (EOLCDQII). 	<p>Findings:</p> <ul style="list-style-type: none"> 82% had initiated EOL care discussions with patients and families. 48% of participants reported feeling very comfortable and 44% somewhat comfortable with initiating EOL care discussions. 7.6% of NPs did not feel at all comfortable with initiating EOL care discussions. NPs' attributed their comfort level to two factors: <ul style="list-style-type: none"> 87% identified their work experience 74% identified their nursing education. NPs who had participated in EOL care education were more comfortable with having such discussions with clients. 65% of NPs thought increased education and 70% thought increased clinical experience in EOL care are important for enhancing NP practice in this area. <p>Limitations:</p> <ul style="list-style-type: none"> The results are confined to the views of NPs who were attending a national conference and who volunteered to complete the questionnaire.
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<p>Williams & Sidani (2001). An analysis of the nurse practitioner role in palliative care.</p> <p>Canada</p> <p>A case study mixed-methods design. (This method was chosen as only 1 NP was found to be assigned to an oncology palliative clinic.)</p> <p>Topics: The role of the NP in PC practice and outcomes of NP practice in PC practice.</p>	<p>Purpose:</p> <ul style="list-style-type: none"> To examine the nature and the contribution of the NP role in an oncology palliative clinic. 	<p>Sample:</p> <ul style="list-style-type: none"> One NP who had been employed 1 year in a palliative ambulatory clinic at a cancer center in a large city in Southern Ontario. The NP's area of specialization was adult oncology-palliative care. <p>Instruments:</p> <ul style="list-style-type: none"> Quantitative data about the extent the NP was able to implement a specific list of activities expected of the NP role were collected from the information provided in a validated self-report questionnaire. The NP completed a clinical encounter form to record each patient's problems, interventions provided, and outcomes achieved. This formed a clinical database (maintained by the NP) that provided qualitative data for the study. 	<p>Findings:</p> <p><i>Role functions</i></p> <ul style="list-style-type: none"> NP time: 28.3% diagnosing patient problems, 23.5% coordinating patient care, 37.5% providing patient and family education and counseling, and 1.7% providing formal education for students and colleagues. <p><i>Practice pattern</i></p> <ul style="list-style-type: none"> Collaboration, referral, and direct care. <p><i>Outcomes</i></p> <ul style="list-style-type: none"> Improved patient outcomes (e.g., improved knowledge about their illness and plan of care, feeling comfortable with prescribed therapy and plan of care, adherence to treatment and follow-up appointments, ability to cope with their illness and treatment plan, symptom control, prevention of complications, satisfaction with care and quality of life) and outcomes for other health care providers including physicians and home care RNs (e.g., increased knowledge of patient condition, needs, and plan of care, timeliness of care delivery, and continuity of patient care). <p>Limitations:</p> <ul style="list-style-type: none"> Sample of one NP in one clinical setting.
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Appendix B: Study Recruitment Information Letter

*A research study on “The Nurse Practitioner Role in Palliative Care”*

I am a nurse practitioner [REDACTED]. As part of my Master of Nursing program at Memorial University I am conducting a research study about the NP role in palliative care.

Cancer it is the leading cause of death in Canada, with 25% of Canadians expected to die of the disease. Further, in Canada, the most rapid rate of population growth is for persons over the age of 60 and many seniors are living with two or more chronic health conditions (e.g., heart disease, lung disease, dementia). Persons with life-limiting conditions need care that is focused on palliation of symptoms. Despite the increasing need for palliative care, only a small proportion of Canadians have access to palliative care services.

I am interested in understanding the NP role in providing palliative care in a variety of practice settings. I believe this is best achieved by talking with nurse practitioners themselves. I would like to hear your ideas and insights about the role of the NP in palliative care practice and about palliative care in your practice. All information you provide in a 45-60 minute interview will be kept confidential, and you can opt not to share an opinion or comment on a specific question if you choose. Interviews will be scheduled for a time that is convenient for you and will take place in-person, by telephone, or by Skype. You will be provided with a copy of the clinical resource manual, “A Caregiver’s Guide: A Handbook about End-of-Life Care”, for your participation in the study. Information from this study might help in planning palliative care programs. It also might help in planning palliative care education for NPs.

If you are interested in participating in this study please contact

[REDACTED]

[REDACTED].ca or [REDACTED]

Appendix C: Letter to Consultant Provincial Regulatory Body

September 1, 2014

[REDACTED]
Nursing Consultant Regulatory Services/Advanced Practice
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

As you are aware, I am the nurse practitioner [REDACTED]
[REDACTED]. In addition to my clinical practice I also am enrolled in a Master of Nursing program at Memorial University of Newfoundland. My research, *The Nurse Practitioner Role in Palliative Care*, involves interviewing nurse practitioners to understand the NP role in palliative care practice.

Palliative care is the care of persons living with life-threatening conditions to improve quality of life. This is achieved by addressing the physical manifestations of illness and the social, spiritual, and emotional well-being of patients and their families. Palliative care is an approach to caring for patients which includes, but is not limited to, end-of-life care. The nurse practitioner scope of practice to address both the medical management of illness and the holistic approach to nursing care of patients and their families uniquely qualifies NPs to provide palliative care.

Recently I conducted a review of the literature and found that very little has been written about the NP role in palliative care, and whether and to what extent NPs engage in palliative care practice. I believe this to be an important topic to examine as many Canadians are living longer with life-threatening chronic illnesses and advanced

malignancies. Health care focused on improving quality-of-life is an important consideration in the care of these persons.

I am attaching an invitation for NPs to participate in my study and I thank you for having agreed to email it to NPs from the eastern region of our province who are currently registered with the ARNNL. This invitation includes information about the study and how to contact me to discuss the study in more detail. Participation in this study is completely voluntary and there is no cost associated with it for the NPs. The anonymity of participants will be protected. The study proposal has been approved by the Health Research Ethics Authority.

Understanding the NP role in palliative care is the initial step in identifying information to enhance NP practice in palliative care. Your support in this research endeavor is appreciated. I am available to answer any questions you may have.

Kind regards,

[REDACTED]

Master of Nursing student

Memorial University of Newfoundland

[REDACTED].ca

Home: [REDACTED]

Cell: [REDACTED]

Appendix D: Interview Guide

Preamble:

Thank you for choosing to participate in this study.

As you know, I am interested in learning about the NP role in palliative care. I believe that this is best achieved by talking with NPs. I would like to talk with you about the role of the NP in palliative care practice and about palliative care in your NP practice.

I would like to start by asking you some general questions about your background.

Interviewer to administer personal/sociodemographic data questionnaire (Appendix D).

Interview questions (questions may or may not be asked depending on the participant's circumstances):

1. Would you please tell me about your NP practice?

Prompts

- Your role?
- Type of clients?
- Activities in which you are involved?
- Roles of other team members?

2. What are your thoughts on the role of the NP in palliative care practice?

3. Would you please tell me about any involvement you have had as a NP in palliative care?

Prompts

- What types of situations?
 - What diagnoses?
 - At home, hospital, palliative care unit?
- Your role? How were you involved? Were other health care providers involved? How so?
- How often have you been involved with palliative care patients?
- Has the way you provide palliative care changed or remained the same over the course of your NP practice? Explain.
- What is most helpful to you in providing care for palliative patients?

- Resources? Supports?
 - What restricts or prevents you from providing palliative care in your NP practice?
4. When I say a patient has been “diagnosed with a palliative condition” what are your thoughts about that person’s diagnosis? Situation? *For you, what diagnosis come to mind that require palliative care?*
5. When I say “palliative care” what comes to your mind? What about when I say “end-of-life care”?
- Prompts
- How comfortable do you feel initiating end-of-life care discussions with patients and families?
 - Is this different when the patient or family initiates end-of-life conversations with you?
 - *When do you think is an appropriate time to initiate a conversation about palliative care with a patient and family? (i.e. When do you know a patient is palliative and when to start the discussions about palliative care?)*
 - *Do you believe initiating these discussions is part of the NP role?*
 - *Do you talk with these patients and/or families about grief and bereavement services?*
6. Would you please tell me how you feel about providing palliative care?
- How comfortable do you feel prescribing opioid medications for palliative patients? Why do you think that is so?
 - How comfortable are you in providing care for other symptom management? For example, shortness of breath, emotional distress, poor appetite, fatigue, constipation?
7. Was palliative care taught in your NP education?
- Prompts
- What topics were discussed?
 - Were you taught about pain and symptom management?
 - How prepared did you feel to provide palliative care after completing your NP education?
 - What additional comments or suggestions do you have about NP education and palliative care?
8. What suggestions would you offer NPs regarding providing palliative care?
9. Is there anything else you would like to share with me regarding palliative care? What about with respect to the role of the NP in palliative care? What about your own role in palliative care? *Other than within the specialist palliative care NP role, what do*

you see as the general NP role in providing palliative care for patients/clients/residents?

Appendix E: Personal and Sociodemographic Questionnaire

Unique participant code: _____

1. How many years have you practiced as a registered nurse? _____

2. How many years have you practiced as a nurse practitioner? _____

3. How old are you? _____

4. Sex? Female _____ Male _____

5. What is your area of NP practice?

- Family and All Ages NP _____
- Adult NP _____ Practice area _____
- Other (specify) _____

6. What is your highest level of nursing education?

RN _____ BN _____ MN _____ PhD _____ other (specify) _____

7. Do you have Canadian Nurses Association (CNA) speciality certification? ___

If yes, in what specialty area? _____

8. Have you participated in any form of palliative care education or professional development? _____

If yes,

- University or college palliative care specialty course (specify) _____
- Employer in-services (specify) _____
- Professional development sessions (specify) _____
- Palliative care conferences (specify) _____

Other (specify) _____

Appendix F: Study Consent



Consent to Take Part in Research

TITLE: The Nurse Practitioner Role in Palliative Care

INVESTIGATOR(S):

[REDACTED], Master of Nursing student, School of Nursing, Memorial University, [REDACTED]

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

1. Introduction/Background:

- Palliative care is control of pain and other symptoms caused by illness.
- Many people are living longer with serious illnesses.
- These people need health care to treat their illness and to improve their quality of life. Therefore, there is an increasing need for palliative care.
- Nurse practitioners (NPs) provide care for people with serious illnesses, but little is known about the NP role in palliative care.

2. Purpose of study:

The purpose of this study is to understand the NP role in palliative care. Information from this study might be helpful in planning palliative care programs. It might also be helpful in planning palliative care education for NPs.

3. Description of the study procedures:

- You will be interviewed either in-person, by telephone, or Skype.
- You will be asked questions about the NP role in palliative care and about your role in palliative care practice.
- To help me describe the group of NPs in the study group I will be asking about
 - how long you have been a registered nurse,
 - how long you have been a NP,
 - your NP practice area,
 - your education,
 - any professional development in which you have been involved, and
 - your age and sex,
- I may contact you for a short follow-up interview if I need to ask you more questions to get more detail or clarify points.
- If you agree, I will audio-record the interviews so it is easier for me to remember what we talked about.

4. Length of time:

You will be interviewed for 45-60 minutes. A follow-up interview will take 15-30 minutes, if needed.

4. Possible risks and discomforts:

No risks and discomforts are expected with taking part in this study.

6. Benefits:

It is not known whether this study will benefit you. You will be given a copy of “A Caregiver’s Guide: A Handbook about End-of-Life Care” as a thank you for taking part in the study.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However it cannot be guaranteed. For example we may be required by law to allow access to research records.

When you sign this consent form you give us permission to

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records

The members of the research team will see study records that identify you by name. Other people may need to look at the study records that identify you by name. This might include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

Use of your study information

The research team will collect and use only the information they need for this research study.

This information will consist of your answers to my interview questions.

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will be kept for five years.

If you decide to withdraw from the study, the information collected up to that time will be destroyed.

Information collected and used by the research team will be:

- kept on a secure USB drive, and
- stored in locked filing cabinets in my office [REDACTED] during the study.

██████████ is the person responsible for keeping it secure during the study. After the study is completed, all study information will be stored at Memorial University and will be securely disposed of after five years.

Your access to records

You may ask ██████████ to see the information that has been collected about you.

9. Questions or problems:

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is:

██████████ ██████████

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:
Ethics Office

Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

After signing this consent you will be given a copy.

Signature Page

Study title: The Nurse Practitioner Role in Palliative Care

Name of principal investigator:

_____, Master of Nursing student,
School of Nursing, Memorial
University

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent.	Yes { }	No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { }	No { }
I have received satisfactory answers to all of my questions.	Yes { }	No { }
I have received enough information about the study.	Yes { }	No { }
I have spoken to _____ and she has answered my questions	Yes { }	No { }
I understand that I am free to withdraw from the study	Yes { }	No { }
• at any time		
• without having to give a reason		
I understand that it is my choice to be in the study and that I may not benefit.	Yes { }	No { }
I understand how my privacy is protected and my records kept confidential	Yes { }	No { }
I agree that the researcher may audio-record our interview(s)	Yes { }	No { }
I agree to take part in this study.	Yes { }	No { }

Signature of participant

Name printed

Year Month Day

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of investigator

Name printed

Year Month Day

Telephone number: _____