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Preparation and Care at the Time of Death

Content of the ELNEC Curriculum and Teaching Strategies

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Nurses are exposed to death across the lifespan ranging from stillbirths to neonatal deaths to deaths of children, adolescents, or adults from trauma or various acute or chronic illnesses. To provide quality care at the end of life, nurses must not only possess the knowledge and skills to provide effective end-of-life care, but must also develop the attitudes and interpersonal competence to provide compassionate care. The purpose of this article is to present the key content and teaching strategies related to preparation and care at the time of death based on the End-of-Life Nursing Education Consortium (ELNEC) curriculum. As nurses are educated regarding end-of-life care in undergraduate nursing curriculums and through continuing education programs, the expectation is that quality care will be provided and the suffering of patients and families alleviated. Clearly, nurses play a key role in improving the care of the dying in America.

Nurses are exposed to death across the lifespan ranging from stillbirths to neonatal deaths to deaths of children, adolescents, or adults from trauma or various acute or chronic illnesses. The final hours to days before a patient dies may be the most significant for a patient and his or her family. Nurses are often the health professionals who facilitate a dignified, comfortable death that honors the patients' and families' wishes and preferences. Nurses do this through their roles as professional caregivers, advocates, educators, and supporters. To provide quality care at the end of life, nurses must not only possess the knowledge and skills to provide effective end-of-life care, but must also develop the attitudes and interpersonal competence to provide compassionate care. (Ferrell & Coyle, 2001; Matzo & Sherman, 2001). This involves empathy by putting oneself in another's place, genuineness expressed through openness, trustworthiness, unconditional positive regard with nonjudgmental acceptance, attention to critical thinking by providing informed choices, and understanding the challenges and opportunities of a situation (Berry & Griffie, 2001).

Nursing knowledge and skills regarding end-of-life care are essential in improving the care of the dying. Funded by the Robert Wood Foundation, the American Association of Colleges of Nursing joined forces with the City of Hope National Medical Center to begin a national educational initiative, entitled

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the "End-of-Life Nursing Education Consortium" (ELNEC) (http://www.aacn.nche.edu/elnec/), whose goal is to educate nurses in end-of-life care. ELNEC was launched in February 2000 and involved a consortium of many organizations represented through the ELNEC Advisory Board to ensure a collective professional approach to improve end-of-life care. ELNEC's "Train the Trainers" course was developed through the work of project consultants and with extensive input from the Advisory Board and expert reviewers.

The ELNEC curriculum provides essential content regarding end-of-life care, effective teaching strategies, and helpful resources for nurse educators and continuing education providers to teach end-of-life care competently and successfully integrate end-of-life content into existing nursing curriculums. Over a 3-day training program, nine modules related to end-of-life care are presented, which include didactic and experiential learning strategies (ELNEC, 2000):

- Module 1: Nursing Care at the End of Life
- Module 2: Pain Management
- Module 3: Symptom Management
- Module 4: Ethical/Legal Issues
- Module 5: Cultural Considerations
- Module 6: Communication
- Module 7: Grief, Loss, Bereavement
- Module 8: Achieving Quality Care at the End of Life
- Module 9: Preparation and Care for the Time of Death

As of January 2004, there have been 591 undergraduate nursing faculty participants and 716 continuing education faculty, for a total of 1,307, who have received ELNEC training during a total of 13 courses.

The purpose of this article is to present the key content and teaching strategies related to preparation and care at the time of death. Emphasized through each of the ELNEC modules are the curricular threads including the importance of providing care for the patient and family as the unit of care, the role of the nurse as advocate, the importance of cultural and spiritual considerations, and recognition of the value of an interdisciplinary team in addressing the holistic needs of patients and families. The key messages of the module on care at the time of death are that (1) the actual time of death creates unique issues beyond those encountered during the course of illness; (2) care at this time demands attention to physical, psychological, social, and spiritual needs of patients and families; and (3) assessment by professionals of their own experiences at the time of death is helpful to strengthen professional effectiveness. Upon completion of this module, participants are able to

- assess an imminently dying patient and list five physical signs and symptoms of the dying process and three signs of death;
- assess physical, psychological, social, and spiritual care needs and interventions for an imminently dying patient and his or her family;
- identify one culturally diverse population in the nurses' community and discuss death and dying belief systems for that population;
- discuss five responsibilities of the nurse following the death of a patient;
- identify personal experiences with death; and
- describe how the nurse can access resources when seeking support in the care of the dying patient and his or her family.

DEVELOPING COMPETENCE IN THE PREPARATION AND CARE AT THE TIME OF DEATH

Developing competence in end-of-life care requires nurses to become comfortable with their mortality so that they may compassionately prepare and care for patients and families approaching death. Nurse educators can assist nurses to being comfortable with "being with" the patient and family, which involves their presence during the dying process. By possessing knowledge, skills, and attitudes for effective and sensitive end-of-life care, nurses can "midwife" the patient and family in the transition of death. Through collaboration with members of the interdisciplinary team, the physical, emotional, cultural, and spiritual needs of patients and families can be met and provide an opportunity for personal growth for families and caregivers as they witness dying and death (Ferrell & Coyle, 2001; Matzo & Sherman, 2001). A nurse's competence in the preparation and care of patients and families at the time of death can be enhanced by gaining the following knowledge offered by the ELNEC curriculum.

First, it is understood that although dying and death are uniquely individual experiences, nurses can identify basic human needs at the end of life and promote the patients' vision of a "good death" by recognizing their values, beliefs, and preferences. With an awareness of impending death, patients are able to consider where they want to die, who they want to be with them, and how they want to die, and nurses can advocate for these preferences. Understanding patients' and families' choices may require multiple conversations with various members of the interdisciplinary team, including the social worker, chaplain, physician, and others. At the time nearing death, the interdisciplinary team serves as advocates for the patient and family and provides interventions directed at comfort, minimizing

physical, emotional, social, and spiritual pain and suffering and providing care that addresses and respects the patients' and families' wishes. Each discipline has expertise in specific areas and their combined expertise can allow for the highest quality care possible remembering that health professionals have only one chance to get it right (Emanuel, Von Gunten, & Ferris, 1999).

Dying is a time to reflect on the life lived, the relationships developed, and accomplishments achieved, as well as acknowledging unfulfilled hopes, dreams, or expectations. Nurses and other team members can assist patients, as well as family members, to process related thoughts and feelings, celebrate life achievements, and reframe missed opportunities or disappointments that can exacerbate suffering. This is often accomplished through a process of life review during which time the nurse communicates care and interest.

As death approaches, nurses can prepare the patient and family through advocacy, communication, education, and support. Nurses and other team members can advocate for patients' and families' choice of settings as death occurs in hospitals, homes, nursing homes, hospices, and other healthcare settings. However, no matter where death occurs, nurses have the responsibility to create a supportive, physical, emotional, social, and spiritual care environment (Lo, 2000). The creation of a supportive care setting can begin by encouraging the display of the patient's personal items, such as family pictures or a favorite blanket, allowing unrestricted visiting hours, and providing privacy for patient and family. Nurses should avoid a change of setting in the final stages of life such as transferring an imminently dying patient from the nursing home to the hospital, as this change can be very distressing. Changes in setting should only occur as a last measure and preferably only if the patient and family request the change.

In preparing the patient and family for dying and death, nurses need to communicate information in simple, uncomplicated terms without overloading or overwhelming the patient or family. At times, patients have a greater awareness that they are dying than those around them. If a patient asks if he or she is dying, the nurse should respond honestly. Nurses may ask patients "what are you thinking?" or "what are you feeling?" Nurses can assist patients to live as fully as possible until death by maintaining hope and providing companionship through their presence (Johnston-Taylor, 1999). It is important to understand that patients move back and forth between acceptance and denial of their illness and approaching death. Families frequently express fear about communicating prognosis or imminent death with the dying and these concerns should be discussed.

Education can empower patients and family to make informed choices at the end of life and prepare them for the physical, emotional, social, or spiritual changes that may occur. Often, the question asked by patients and family members is "What do I need to do to prepare?" Nurses can help the patient and family understand what they may expect to happen during the dying process and what they can do to cope with the experience. Verbal and written materials can be shared with families and nurses' role modeling of supportive behaviors can be very helpful, such as the comfort measures of touch, massage, cooling wash cloth, and mouth care (Berry & Griffie, 2001). Families can be encouraged to listen attentively, include patients in conversations, and recognize that even silence can be healing (Matzo, 2001).

Often patients ask "When will I die?" yet no one can predict the exact time of death as prognosis is affected by the disease, patient's will to live, or desire to wait for a special event such as a birthday or holiday and/or completion of life closure goals (Emanuel et al., 1999). Over the course of a sixth-month period, there are many progressive changes that occur. During this time, the patient may change from being fully coherent and ambulatory 6 months before death, whereas in the final month may require total bedrest and physical care and the need for intense symptom management as death approaches (National Hospice Organization, 1996) (see Table 1).

Nurses can promise to do everything possible to make the patient comfortable and can educate families regarding the signs or symptoms of the dying process, which can occur weeks, days, or just hours before the death, such as confusion, disorientation, delirium, weakness, fatigue, increased drowsiness or sleeping, decreased intake, lack of swallowing, energy surges, restlessness, agitation, fever, or change in bowel function resulting in diarrhea or constipation and incontinence (Ferrell & Coyle, 2001; Matzo, 2001; Pickett & Yancey, 1998; Twycross & Lichter, 1998) (see Table 2). Nurses teach families comfort measures to address each of the symptoms such as giving the patient simple directions in the event of confusion, providing mouth care or sips of fluid, providing skin care in the face of incontinence, or administering medications to allay various symptoms such as respiratory congestion, agitation, pain, or dyspnea (Matzo, 2001). Nurses can also describe the universal symptoms of imminent death such as decreased urine output, cold and mottled extremities, respiratory congestion, and changes in vital signs such as a drop in blood pressure, with an increase in heart rate and respiratory rate (Ferrell & Coyle, 2001).

It is important to emphasize that not all patients experience all symptoms and that the signs and symptoms do not occur in a sequence. Furthermore, nurses should assess for other causes of symptoms

TABLE 1 Progressive Change in the Terminal Phase

Month 6	Generally, patient is ambulatory, coherent, with some side effects from curative measures/medications, initial stages of grief, anger, denial
Month 5	Some weight loss, weakness, symptoms manifested, showing signs of stress, growing acceptance of terminal state, fear, depression
Month 4	Continuing weight loss, decreasing appetite, physical manifestations, symptoms are more pronounced. Grief work, planning, resolving
Month 3	Physical deterioration apparent, symptomatology and pain increase, beginning of withdrawal, acceptance of terminal disease
Month 2	Progressive physical deterioration, symptoms increase, pain management primary, may be bedridden, increasing withdrawal, resolution, and closure
Final month	End stage—pronounced withdrawal, requires total care, intensive management of symptoms and pain, no appetite

Note. From *Time Line Phases of Terminal Care*, by the National Hospice and Palliative Care Organization (NHPCO), 1996, 37. Copyright 1996 by the NHPCO. Reprinted with permission.

beside than the dying process. For example, sedation or increased sleepiness may be from an increase in the serum concentration of opioids as the kidneys and liver functions decline at the end of life. Medications may, therefore, need to be reduced to determine whether the sedation is the effect of the medication or reflective of the dying process.

Patients and families may also need additional psychological and spiritual support as they may fear the dying process or fear abandonment. It is important for nurses and other team members to provide reassurance and consider the staffing of the unit to be able to provide ongoing support to the patient and family. Often patients and families express fear of the unknown. Nurses can ask them what they think will happen and what they would like done, offering additional support by visits from the clergy or others. As death nears, patients may have near-death experiences, during which time they see deceased loved ones or hear them calling. Nurses can emphasize to the family that it is important not to contradict patient's experience but rather affirm the experience. Dependent on the culture of the individual, some patients are most comfortable when the family is present; however, other patients turn inward, withdrawing from the family as often occurs in time of stress.

In the care of the dying child, nurses need to address the needs of the child, parents, siblings, and extended family. Children often know they have a terminal illness even if it is not directly communicated to them. They detect subtle changes in the way family and staff respond to them. Some family prefer not to tell the pediatric patient that he or she has a terminal illness, and it is important for nurses to respect the parent's choices and decision making while assessing for opportunities to encourage open communication between parents and child. Some children do not want to talk about their illness but want to know that there is someone available if they choose to talk. Art therapy and play therapy are useful ways to help children express their feelings and fears. It is important for nurses to communicate with children at the appropriate developmental level, and presence is often one of the most therapeutic interventions. Nurses can encourage parents, siblings, and other family members to participate in the child's care, as well as helping siblings interact at a level that they feel comfortable such as holding their brother or sister. Siblings should be assessed for fears, concerns, and ability to cope. Siblings of the dying child may feel neglected and may act out or attempt to be the perfect child. Helping them to continue their extracurricular activities is important. Children should be encouraged to verbalize their feelings in a safe place without them feeling as though they are making their parents feel worse. Grandparents and extended family are also in need of support.

During the death vigil, family may want to remain constantly at the bedside, whereas others may be uncomfortable. It is valuable to explore families' preferences and provide support. Families may express fears of being alone with the dying patient, fear that death will be painful, fear of not knowing how to react when death occurs, fear that they will not know that the patient is dead, or fear administering the last dose of pain medication and causing death. Reassurance is needed that adequate pain management is a priority so that the patient does not suffer. Memories of a painful death may actually increase distress. To calm family fears, close collaboration should occur with members of the interdisciplinary team and with increased support by the presence of family, friends, or church members.

Physical Signs, Symptoms, and Interventions of the Actively Dying

Signs and Symptoms	Cause/Etiology	Interventions
Confusion, disori[illegible] (conf[illegible] ab[illegible] time, [illegible]ce, and identi[illegible] [illegible]ple), deliri[illegible] (reaction to [illegible]iologic change, drug re[illegible] [illegible]nd may go away with tre[illegible]tment • May be one of the patient' greatest fears	Disease progression Opioids Pain Full bladder Constipation Side effects medications (possible reversible) Hypoxemia Metabolic imbalances, acidosis Toxin accumulation due to liver and renal failure Disease-related factors (nonreversible)	Differentiate among nearing death awareness, confusion, disorientation, and delirium. Assess cause and treat as appropriate. Implement safety measures including 24-hour supervision. Speak clearly and truthfully with the patient when something needs to be communicated to the patient. Do not patronize. In home care setting, provide respite for the caregiver as needed because of increased patient care needs and caregiver fatigue. Professional caregiver/volunteer support.
Weakness and fatigue • Increases as patient gets closer to death. Increased weakness may trigger any of the following: • Patient anticipatory grief because of loss of independence, loss of functionality, and/or awareness of weakness as a result of disease progression • Family/caregiver fatigue in home care setting because of patient's increased care needs • Patient questions the meaning of weakness in relation to disease, dying, death	Disease progression	Offer and provide increased assistance with activities of daily living, such as bathing, grooming, feeding, mobility with increased support from nurse, nurses aides, volunteers, family. Provide assistive equipment as needed such as shower stool, hospital bed, wheelchair, walker as needed. If bed bound, passive range of motion, turn and position, draw sheet, check for skin breakdown including air mattress as appropriate, rubbing in circular motion over bony prominences to improve circulation and shift edema. In home care setting, educate family on patient's needs and care. Provide respite for family caregiver in home care setting as needed. Social work, pastoral care support for anticipatory grief as needed. Increase patient care support including hospice, family, friends. Answer patient questions about disease progression openly, honestly.
Change in character and intensity of pain Actively dying patient's family, nurse, and/or other healthcare workers may have concerns about giving the "last dose" of pain medication for fear the dose will cause or hasten the death	Disease progression	Assess pain frequently. Adjust medications, dosages based on principles of pain management. Refer to Pain module If pain-control principles are followed, the disease and not the medication will cause the death. Listen to family/caregiver concerns, educate regarding principles of pain management, and explore choices regarding dying in pain and extending suffering versus comfortable death (refer to Ethics module).

Source: The Hospice Institute of the Florida Suncoast, 1999. Reprinted with permission.

In addition to reassurance, education, role modeling, and providing physical comfort, nurses can maintain an awareness of the cultural and spiritual needs of the patient and family (Doka & Morgan, 1993; Sherman, 2001). For example, if a patient is Catholic, the nurse may ask if a visit from the priest would provide comfort or if the patient would like to receive the sacrament Anointing of the Sick. If the patient is Jewish, ask if there are prayers that would be comforting. It is important to ask patients and families what would be helpful given their faith or spirituality. The role of the nurse can, therefore, be to assist patients and families in carrying out rituals and practices that provide solace and support within the context of their religion and culture.

Even when death is anticipated, it is often overwhelming and even shocking to the family. Nurses should know if the family wishes to be called when death is imminent and whom in the family should be notified. Telling the family that the patient has died requires sensitivity, while providing open and honest information at the family's level of understanding. Families often have many questions if they are not present at the time of death and information often needs to be repeated.

If the family is at the bedside, nurses can prepare them for the signs of death, such as no response, absence of heartbeat and respirations, release of stool or urine, fixed or dilated pupils, eyes slightly open, jaw falling open, pale body color, and purplish discoloration of the skin, known as liver mortis (Emanuel et al., 1999). In many states, nurses can pronounce death and sign the death certificate if death occurs in the hospital, nursing home, or at home if hospice is involved. The death pronouncement procedures involves identifying the patient, noting the general appearance of the body and signs of death and documenting the patient's name, time of call, who was present at the time of death, detailed findings of the physical examination, who was consulted or notified and if the coroner was notified, plans for the disposition of the body according to religious or cultural tradition, and if there is to be organ donation or an autopsy performed (Berry & Griffie, 2001). Once the death certificate is signed, the funeral director may be contacted to transport the body to the funeral home or crematorium. If the death was sudden or unexpected, the coroner must be called and must assume responsibility for the body and decide if an autopsy needs to be performed.

In the care of the physical body, nurses need to have a general understanding of cultural beliefs and death rites and rituals of the major cultures in their practice area (Lipson, Dibble, & Minarik, 1996). Following death, tubes, medical supplies, and equipment should be removed from the room immediately except if the coroner has been called to evaluate a suspicious circumstance of death (Berry & Griffie, 2001; Matzo, 2001). The goal is provide a personal closure experience for the family, leaving family with memories of the deceased as a loved one rather than as a patient.

Following the death, family members may feel numb and confused about what to do next. The nurse should explain the process and procedures for the care of the body immediately following death. In bathing and dressing the body, respect and dignity should be shown. Family members may be invited to assist in the physical care of the deceased, because this may be their last opportunity to touch their family member or be with the deceased privately. Nurses should place dressings on leaking wounds and apply diapers as needed for incontinence. The body of the deceased should be placed in proper alignment and dentures placed the mouth. The head of the bed should be elevated so that blood does not drain into the head and discolor the face. The hair should be combed and clean clothing placed on the deceased to provide a clean and peaceful impression of the deceased for the family. Family members should be allowed as much time as needed to say goodbye. Because rigor mortis occurs within 2–4 hours of death, family should be informed of the natural stiffening of the body and be informed that air may escape the lungs and sound like breathing. During the physical removal of the body, all body parts should be covered and the body treated with respect. Covering or uncovering face during removal should be based on family choice. The physical removal of the body may also be dictated by cultural considerations. In most settings, the funeral home will require a time of death, the social security number, diagnosis, name of physician, and information regarding survivor contact (Lo, 1996).

Following the death of the patient, nurses can provide the family assistance with making telephone calls as the family may need time to adjust to the immediate loss. Nurses should also notify the physician or other involved professionals. In the home setting, medications should be destroyed according to local or state laws. Nurses may also be asked by the family to assist with funeral arrangements or memorial services. These arrangements are best completed before death but that option is not always available. Nurses can provide options regarding burial plans or refer the family to other members of the interdisciplinary team who can assist with such plans. Following the death, the nurse should initiate bereavement support by providing compassion, active listening, and meaningful presence. In addition, the nurse should assess grief reactions and assess bereavement risk factors (Corless, 2001). Follow-up bereavement support through telephone calls, cards, or attending funeral or memorial

services are helpful to the family and for nurses' closure with the deceased. For family members in need of continued bereavement support, nurses can refer them to bereavement support services, including hospice support groups. Family members may need to know that they are not alone and that they will not be abandoned to cope with their grief alone. In the death of children, parents should be encouraged to hold their child and to allow siblings to participate in rituals and traditions. Family members can be encouraged to speak about the deceased and reminisce (Corless, 2001; Matzo & Sherman, 2001).

In the care of the dying and their families, nurses may also experience feelings of anxiety and may grieve the loss of the patient (Vachon, 2001). Nurses need to ask for help and seek the assistance of the social worker, chaplain, pastoral care providers, or physicians. Nurses may feel support by verbalizing their feelings with each other as staff or with nursing instructors. Such debriefing is important in avoiding cumulative grief. Care of the patient and family during the dying process and at the time of death entails unique dimensions of care. The goal of postdeath nursing is to promote support of the family with the tasks of bereavement to enhance the adjustment. Nurses strive to provide interventions that offer an opportunity for growth throughout the illness and dying experience and into the bereavement period.

TEACHING STRATEGIES FOR CARE AT THE TIME OF DEATH

Quality care at the end of the life requires knowledge regarding the physical, emotional, social, and spiritual changes experienced along the illness/dying trajectory. Written materials, slides, and story telling were teaching strategies used by nurse educators in presenting the didactic content of the module regarding end-of-life care. However, nurse educators also assisted participants to identify their personal and professional experiences with death. One teaching strategy involved eliciting components of a good death experience, while helping to neutralize bad experiences. During group discussion, nurses were asked to identify personal belief systems and traditions about dying, death, and an afterlife and their relation to their culture, race, religion, spirituality, gender, education level, and work experiences. Further discussion involved the populations of patients in the nurse's practice setting with a focus on their belief systems and their rituals or traditions with regard to illness, dying, and death.

Participants were also asked to write a letter to "Dear Death" to further reflect on each nurse's thoughts and feelings regarding death. During this final ELNEC module, nurse participants were invited to read their letters. This proved to be not only an insightful and powerful exercise conveying fears related to dying and death, but also source of strength in coping with the end of life. Through death awareness, nurses were able to recognize their own attitudes and experience validation and support of nursing colleagues. Another learning activity was called the "Room, Hat, and Panic Button." During this activity, participants were asked to draw a picture of the room where they would want to die (e.g., in their home, hospital, a cabin) and what they wanted to be surrounded by (flowers, a window view, books). For

"There is nothing beneficial in a clinically correct death filled with super technology and proficiency.
All people want is to be treated with respect and kindness.
Talk with them.
Ask them how they feel about things.
Don't ever make anyone feel they're facing this alone.
Stay with them and hold their hands.
Cherish their lives.
Let them know how special they are.
Ease their fears and make them comfortable.
Discuss their last wishes and ask them the hard questions about what they would want done if they stopped breathing or their heart stops.
Allow them to grieve leaving this life and all that they have known.
Help them be in touch with their physical and spiritual and emotional selves.
And listen and love them."

From Caring for Mo [Video], by New Hampshire Breast Coalition, 1998, Exter, NH: JBC Communications [Producer]. Copyright 1998 by New Hampshire Breast Cancer Coalition. Reprinted with permission.

FIGURE 1 Last letter from Mo (written in Mo's words as read by a nurse).

the hat picture, the participants were asked what hats they would want people (e.g., family member, nurse, friend) around them to wear. For the panic-button picture, the participants were asked what would make them push the panic button (e.g., pain, dyspnea, fear). All answers were acknowledged, and it was emphasized that participants have different values, beliefs, and ideas about how they would want to die, where they would want to die, and who they would like present. It was reinforced that it is the nurse's responsibility to facilitate patient choices (Lo, 1996).

Critical analysis of case studies enabled participants to determine patient/family needs and potential interventions in providing effective and compassionate care. One case study presented an 86-year-old woman diagnosed with dementia and colon cancer. The following questions were discussed in relation to this case: (1) What signs/symptoms of approaching death were present during this case? (2) What additional information might have been helpful in planning her care? (3) What are the aspects of her care that the nurse might seek collaboration with the physician? (4) What care should be provided at this time?

During the experiential component of this module, a film entitled *Caring for Mo* was also shown regarding the life and death of a young nurse diagnosed with breast cancer. The film illustrated the physical, emotional, social, and spiritual needs of Mo and her family across the illness/dying trajectory and the response of her professional caregivers. Participants then read "The Last Letter from Mo," which offers Mo's suggestions in the care of dying (see Figure 1). The identification of nurses with a dying colleague emphasized that efforts at improving the care of the dying will, ultimately, promote the quality of one's own death as well.

CONCLUSION

The didactic content of this ELNEC module and the experiential learning exercises enhanced nurses' knowledge regarding preparation and care at the time of death and awakened nurses to their own perspectives, feelings, and concerns regarding the end of life. Through reflection and discussion, nurses were able to process their thoughts and feelings, while learning about the needs of the dying patient and their families and ways to promote their quality of life as death approaches. As nurses are educated regarding end-of-life care in undergraduate nursing curriculums and through continuing education programs, the expectation is that quality care will be provided and the suffering of patients and families alleviated. Clearly, nurses play a key role in improving the care of the dying in America.

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Preparation and Care at the Time of Death: Content of the ELNEC Curriculum and Teaching Strategies

Instructions:
- Read the article page 93.
- Take the test, recording your answers in the test answers section (Section B) of the CE enrollment form. Each question has only one correct answer.
- Complete registration information (Section A) and course evaluation (Section C).
- Mail completed test with registration fee to: Lippincott Williams & Wilkins, CE Depart., 333 7th Avenue, 19th Floor, New York, NY 10001.
- Within 4-6 weeks after your CE enrollment form is received, you will be notified of your test results.
- If you pass, you will receive a certificate of earned contact hours and answer key. If you fail, you have the option of taking the test again at no additional cost.
- A passing score for this test is 11 correct answers.
- Need CE STAT? Visit www.nursingcenter.com for immediate results, other CE activities, and your personalized CE planner tool.
- No Internet access? Call 800-933-6525 x6617 or x6621 for other rush service options.
- Questions? Contact Lippincott Williams & Wilkins: 646-674-6617 or 646-674-6621.

Registration Deadline: June 30, 2007

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CE TEST QUESTIONS

GENERAL PURPOSE: To acquaint the registered professional nurse with the key content and teaching strategies related to preparation and care at the time of death based on the End-of-Life Nursing Education Consortium (ELNEC) curriculum.

LEARNING OBJECTIVES: After reading this article and taking this test, the nurse will be able to:

1. Explain how nurses can develop confidence in the preparation and care at the time of death.
2. Describe teaching strategies for care at the time of death.

1. Which of the following best describes the goal of the End-of-Life Nursing Education Consortium (ELNEC)?
a. to advise nurse educators regarding effective end-of-life care teaching strategies
b. to provide helpful resources for nurse educators
c. to provide essential end-of-life care content to educators
d. to educate nurses in end-of-life care

2. According to this article, developing competence in end-of-life care requires nurses to
a. become comfortable with their mortality.
b. be familiar with local community resources for end-of-life care.
c. always support the dying patient's wishes.
d. collaborate with interdisciplinary team members.

3. Which of the following nursing interventions is aimed at creating a supportive care setting for the dying patient?
a. transferring the patient from the nursing home to the hospital
b. restricting visiting hours for nonfamily members
c. removing personal items from the room to ensure infection control
d. covering the patient with his or her favorite blanket

4. Nurses can assist patients to live as fully as possible until death by
a. maintaining hope and providing companionship.
b. limiting interactions between patients and staff.
c. not telling them that they are dying.
d. encouraging family and friends to visit.

5. Universal symptoms of imminent death include
a. an increase in urine output.
b. agitation.
c. a drop in blood pressure with an increase in heart rate and respiratory rate.
d. an energy surge.

6. Dying patients and their families often express fear of
a. pain.
b. the unknown.
c. dying alone.
d. mental disorientation and confusion.

7. Which of the following techniques are useful in helping dying children express their feelings and fears?
a. physical exercise
b. direct, honest communication with the child
c. family counseling
d. art therapy and play therapy.

8. Siblings of a dying child may
a. mimic symptoms.
b. become quiet and introverted.
c. attempt to be the perfect child.
d. avoid their friends and normal activities.

9. The funeral director can be contacted to transport the body
a. when the patient dies
b. once the death certificate is signed
c. after the family has viewed the body
d. after the physician has pronounced the death

10. When must the coroner be called?
a. if no physician was present at the time of death
b. if the death was due to a traumatic injury
c. if the death was suspicious in nature
d. if the death was sudden or unexpected

11. Rigor mortis occurs within
a. 2–4 hours after death.
b. 4–6 hours after death.
c. 6–8 hours after death.
d. 8–12 hours after death.

12. In the care of the dying and their families, debriefing is important in helping nurses
a. identify their personal beliefs.
b. avoid burnout.
c. avoid cumulative grief.
d. reflect on their feelings of dying and death.

13. **The "Dear Death" letter writing exercise**
    a. provided a source of strength in coping with the end of life.
    b. elicited components of a good death experience.
    c. helped to neutralize bad death experiences.
    d. provided knowledge about the spiritual changes experienced along the illness/dying trajectory.
14. **The "Room, Hat, and Panic Button" activity**
    a. helps improve the care of the dying.
    b. illustrates the physical and emotional needs of the patient who is dying.
    c. analyzes the patient's values and beliefs about death and dying.
    d. reinforces that is it is the nurse's responsibility to facilitate patient choices.
15. **According to this article, which of the following teaching strategies can help determine patient/family needs and potential interventions in providing effective and compassionate care?**
    a. story telling
    b. group discussions
    c. critical analysis of case studies
    d. role playing

CE Enrollment Form

Journal for Nurses In Staff Development, May/June 2005: Preparation and Care at the Time of Death: Content of the ELNEC Curriculum and Teaching Strategies

A **Registration Information:**

Last name_____ First name_____ MI____

Address_____

City_____State_____Zip_____

Telephone_____Fax_____email_____

Registration Deadline: June 30, 2007

Contact Hours: 3.0

Fee: $22.95

☐ LPN ☐ RN ☐ CNS ☐ NP ☐ CRNA ☐ CNM ☐ other_____

Job Title_____Specialty_____

Type of facility _____

Are you certified? ☐ Yes ☐ No

Certified by _____

State of License (1)_____License #_____

State of License (2)_____License #_____

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B **Test Answers:** Darken one for your answer to each question.

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	○	○	○	○	5.	○	○	○	○	9.	○	○	○	○	13.	○	○	○	○
2.	○	○	○	○	6.	○	○	○	○	10.	○	○	○	○	14.	○	○	○	○
3.	○	○	○	○	7.	○	○	○	○	11.	○	○	○	○	15.	○	○	○	○
4.	○	○	○	○	8.	○	○	○	○	12.	○	○	○	○					

C **Course Evaluation***

	A	B
1. Did this CE activity's learning objectives relate to its general purpose?	☐ Yes	☐ No
2. Was the journal home study format an effective way to present the material?	☐ Yes	☐ No
3. Was the content relevant to your nursing practice?	☐ Yes	☐ No

4. How long did it take you to complete this CE activity?____ hours____minutes

5. Suggestion for future topics_____

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