

Role of Critical Care Nurses in End-of-Life Care

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INTRODUCTION

One of the most difficult realities that nurse face is that despite their best efforts, some of their patients die. Although nurses cannot change this fact, they can have a significant and lasting effect in which the patients live until they die the manner in which death occurs and the enduring memories of that death for the families. Indeed, providing care to the patients who are close to death and being present at the time of their death can be considered as one of the most rewarding experiences a nurse can have. Critically ill patients together with their families are understandably fearful of the unknown and may prompt new issues or previous concerns to resurface and both of them have needs that should be addressed in every dimension with the use of effective nursing care.

The Institute of Medicine (2004) defined optimum end-of-life (EOL) care as an experience that is free from avoidable distress and suffering for patients and their families, in accord with the patients' and families' wishes, and reasonably consistent with clinical, cultural, and ethical standards. Standards for a good death include symptom management, patient- and family-focused care, and spiritual well-being for both patients and families. The World Health Organization has defined quality EOL care as the "active total care of patients whose disease is not responsive to curative treatment." This definition includes meeting the psychological, social, and spiritual needs for both patients and families, as well as the definitions of quality care provided by the National Consensus Project and National Quality Forum summary.

The American Association of Critical-Care Nurses (AACN) has established nursing standards that provide a framework for critical care nurses. Nursing practice varies depending on the setting in which the nurse is employed and the patients cared for in that setting. The standards set forth by AACN in terms of Quality Nursing Care, Communication, Education, Collegiality, Ethics and Collaboration describe the practice of the nurse who cares for an acutely or critically ill patient in the health care environment. These standards are authoritative statements that describe the level of care and performance by which the quality of nursing care can be judged. They serve as descriptions of the expected roles and responsibilities.

Moreover, on the Mission-Vision Statement of the Critical Care Nurses Association of the Philippines (CCNAPI), the national organization of nurses interested in the field of critical care nursing, it stated that the association strives for a culture of quality and safety in all endeavors; believes in building competencies, career advancement and proactive evidenced

informed nursing practice and lastly, is committed in fostering the people's health, welfare and rehabilitation through community involvement and development. Its mission as cited also seeks to become the epitome of utmost standards in critical care nursing through demonstrating dedication in upgrading critical care nursing practice by responding with great compassion to the needs of their clientele.

Critical care nurses work in a wide variety of settings, filling many roles including bedside clinicians, nurse educators, nurse researchers, nurse managers, clinical nurse specialists, and nurse practitioners. With the onset of managed care and the resulting migration of patients to alternative settings, critical care nurses are caring for patients who are more ill than ever before. Managed care has also fuelled a growing demand for advanced practice nurses in the acute care setting. They provide direct patient care, including assessing, diagnosing, planning, and prescribing pharmacological and non-pharmacological treatment of health problems.

Having an inadequate exposure to the critical care unit, the researchers decided to come up with this study. It served as a great opportunity to give each and everyone the chance to have an idea about the real scenarios inside the ICU. The researchers viewed this as a means of learning and understanding how critical care nurses rendered their duties and how they complied with their roles among the dying patients.

The researchers firmly believe that the findings of this study would be a great help and value to the respondents. This study will make them well-oriented to the significant role of nurses in caring for a critically-ill client and providing peaceful and dignified death. To the student nurses and College of Nursing, the study will help them enhance their knowledge and increase their awareness on how to apply, respect and consider the different factors affecting the effectiveness of the care being rendered to patients at near death thus improving the quality of nursing care being delivered.

Objectives of the Study

The general purpose of this study was to ascertain the care rendered by the critical care nurses here in Batangas in providing compassionate care in a dying patient. Specifically, the purposes of this study were: a) to identify the profile of the respondents in terms of age, gender, educational attainment, and length of service; b) to determine the extent of nursing care rendered to a dying patient in terms of: quality of care, communication, education, collegiality and collaboration, ethico-moral and legal responsibility; c) to discover if there is a significant relationship between the profile variables and the extent of nursing care rendered to a dying patient; d) lastly, to propose measures to enhance the nursing care rendered by the respondents on the dying patient.

Theoretical Framework

The American Association of Critical Care Nurses (AACN) Synergy Model for Patient Care describes nursing practice based on the eight patient characteristics which span the health-illness continuum. The patient characteristics are resiliency, vulnerability, stability, complexity, resource availability, participation in care, participation in decision making, and predictability.

The synergy model also describes eight nurse competencies. These competencies consist of clinical judgment, advocacy and moral agency, caring practices, collaboration, systems thinking, response to diversity, facilitation of learning, and clinical inquiry. According to the synergy model, "nursing care reflects an integration of knowledge, skills, experience, and attitudes needed to meet the needs of patients and families. Thus, continuums are derived from patient needs".

The core concept of the model is that the needs or characteristics of patients and families influence and drive the characteristics or competencies of nurses. Synergy results when the needs and characteristics of a patient, clinical unit, or system are matched with a nurse's competencies (AACN, 2006). The underlying tenets of the synergy model are: (a) patients' characteristics are of concern to nurses; (b) nurses' competencies are important to patients; (c) patients' characteristics drive nurses' competencies; and (d) when patients' characteristics and nurses' competencies match and synergize, outcomes for the patient are optimal (Hardin & Kaplow, 2005).

The assumptions guiding the AACN Synergy Model for Patient Care are: Patients are biological, psychological, social, and spiritual entities who present at a particular developmental stage, thus the whole patient (body, mind, and spirit) must be considered ; the patient, family, and community all contribute to providing a context for the nurse-patient relationship ; patients can be described by a number of characteristics which are connected and contribute to each other and thus, cannot be looked at in isolation ; similarly, nurses can be described on a number of dimensions. The interrelated dimensions paint a profile of the nurse; the goal of nursing is to restore a patient to an optimal level of wellness as defined by the patient. Death can be an acceptable outcome, in which the goal of nursing care is to move a patient toward a peaceful death (AACN, 2006).

Since the study of the researchers focuses on the role of ICU Nurses in rendering end-of-life care among dying clients, the AACN Synergy Model perfectly explains how the nurse's competencies in different aspects like Quality of Care, Communication, Education, Collaboration and Collegiality and Legal and Ethico-Moral Responsibility directly affect the client and his family during the most critical stage of his life. It illustrates how nurses play the vital role in providing not only physical support to terminally ill clients but also spiritually and emotionally. Derived from the health-illness continuum the Synergy model further emphasizes that nurses and clients work together to help client achieve wellness or assist client towards a peaceful death.

METHOD

This presents the research design, subject or respondents of the study, data gathering instruments, data gathering procedure and statistical treatment of data.

Design

This research was conducted utilizing a descriptive correlational method in establishing the relationship between the profile of the respondents and their role in providing end-of-life care among dying patient in different hospitals in Batangas Province.

As one of the types of Descriptive Studies, the purpose of descriptive correlational research is primarily to observe, describe and document aspects of a situation as it naturally occurs and sometimes to serve as a starting point for hypothesis generation or theory development. Its aim as described by Polit and Beck (2008) is to describe relationships among variables rather than to infer cause and effect relationships.

Participants

The respondents of the study were composed of 50 ICU nurses from the different hospitals in Batangas Province. Convenience sampling was used by the researchers. The chosen respondents for the study are nurses working in the Intensive Care Unit. The different government and non-government hospitals where the respondents assigned in the ICU included Batangas Regional Hospital, Jesus of Nazareth, Our Lady of Caysasay Medical Center, Metro Lemery Medical Center, and Bauan Doctors General Hospital.

Instrument

A survey method of data collection through questionnaires was used. According to Polit and Beck (2008), the advantage of this method is that it is less expensive, permits anonymity, and may result in more honest responses. Another advantage is that the researcher does not have to be present thus, eliminating bias due to phrasing questions differently for different respondents.

In this study, the researchers used the Critical Care Nursing Standards in formulating the questionnaire. To effectively obtain the necessary data needed by the researchers, they made some modifications and devised a 30-item questionnaire formulated based from the standards established by the American Association of Critical-Care Nurses (AACN), as well as the respondents' demographic profile, which the researchers seek to determine the significant relationship to the role of Critical Care Nurses in End-of-Life Care.

The questionnaire was composed of 2 parts. The first part contained questions regarding the profile of the respondents, the ICU nurses. It included the gender, age, educational attainment and length of service as ICU nurse. The second part contained the American Association of Critical-Care Nurses (AACN) standards to determine the extent of nursing care rendered to a dying patient in terms of: quality of care, communication, education, collegiality and collaboration, ethico-moral and legal responsibility. They utilized a 4-point Likert Scale Survey to ascertain the Intensive Care Unit nurses' perception on providing compassionate death based on their practice in the clinical setting. It was validated by three expert clinical instructors, adviser and panellists and asked for approval for the distribution of the questionnaire.

Procedure

After browsing some books and other materials from the library, the researchers chose a topic and consulted the approval of the adviser. After the approval, the researchers made a thorough review of related literature and drafted the questionnaire which was validated by the

three expert clinical instructors, adviser and panellists. After the validation, the researchers submit letters to the authorities and seek for their approval for distribution of the questionnaire. The researchers distributed the questionnaire personally, attached with a letter to the respondents which were collected after a week.

Analysis

After the retrieval of the questionnaires, data were tallied, tabulated, analyzed, and interpreted by the researcher to see the results of the study. Frequency Distribution was used to determine the profile of the respondents in terms of gender, age, educational attainment, and length of service as Critical Care Nurse. Weighted Mean was used to identify the role of critical care nurses in end-of-life care among dying patient in terms of the extent of nursing care rendered to dying patient. ANOVA was used to test the relationship between the profile of the respondents and the scale of the role of critical care nurses in end-of-life care.

RESULTS AND DISCUSSION

This section presents the data generated from the questionnaire which were then interpreted and analyzed.

Table 1
Frequency Distribution of Respondents' Profile V

Profile Variable	Frequency	Percentage
Gender		
Male	19	38.0
Female	31	62.0
Age		
21-25	37	74.0
26-30	7	14.0
36-40	4	8.0
46 and above	2	4.0
Educational Attainment		
BSN, RN	41	82.0
MAN	8	16.0
Length of Service as Critical Care Nurse		
Below 3 years	34	68.0
3-5 years	15	30.9
12 and above	1	2.0

Table 1 presents the frequency distribution of the respondents' profile variable in terms of gender, age, educational attainment and length of service as ICU nurse.

As to gender, majority of the respondents are female with a frequency of 31 or 62.0%; 19 or 38.0% are male. Women dominate the nursing profession basically because women in nature are caring. Nursing is also considered as a suitable job for women because it is an extension of their familial roles. Aside from that, most of the students taking this course are females. There is also a stereotype belief that this profession belongs only to women rather than men. Roles like nurturing, dependency, caring, and submission are opposite from the ones attributed to men in society.

According to Casao (2003) female nurses are more sensitive to the needs of their patients because they are considered the surrogate mothers which are more inherent in female nurses to provide the so-called TLC or Tender Loving Care to patients. The fact remains that there are sex characteristics as to how females and males act, react, and perform in situations affecting every aspect of life. When it comes to human relationship, intuitively women tend to pick up subtle tones of voice and facial expressions, whereas men tend to be less sensitive to these communication cues. In navigation, women tend to have difficulty finding their way, while men seem to have a better sense of direction. The above results may be explained by Begany (2000) where he cited that because nursing have historically been viewed as women's works, men in nursing have been categorized as feminine and have subsequently been labelled homosexual, thus some men in nursing may already experience a form of gender discrimination with regards to the based role assumptions,.

In terms of age, majority of them were 21-25 years of age which obtained the highest percentage of 74.0. This is because they are the demographic profile of the freshly graduates and newly registered nurses. Nurses belonging to the age group of 21-25 are more physically fit to work in the critical care unit because they have the strength and vigour in rendering the care needed by the patients. Since most of the critically ill patients are debilitated and incapable, it is required that nurses are well- built to be able to perform necessary activities to improve the mobility of the patient and prevent complications. As explained by the [Institute of Medicine \(2004\)](#), as individual's age, most will experience a progressive decline in aerobic power, reaction speed, and acuity of senses. Aging decreases the speed of circadian adaptation to night work, increasing the risk of sleep disorders and therefore impaired job performance and other negative health effects.

In terms of educational attainment, most of the respondents are registered nurses only with a frequency distribution of 41 or 82.0%; and 8 or 16.0% have completed their master's degree. The age of the respondents influence their educational attainment. Since most of them are fresh graduates who belong to the age group of 21-25 they are expected to acquire only the degree of being a registered nurse. Only few of them will pursue immediately their Masteral degree, although some of them may decide to uplift their professional degree they cannot easily accomplish or complete it because it takes time and at the same time they also have their duties which they have to attend and requires high cost as mentioned by American Association of Colleges of Nursing (2009) where they cited several financial barriers preventing nurses from pursuing the advanced levels of education required to be a nurse educator

In terms of length of experience, most ICU Nurses have 3 years and below experiences as revealed by the frequency of 34 out of (68.0%). Similar to the result of educational attainment, the age of the respondents influence the length of service of the critical care nurses. Most of the respondents are fresh graduates thereby it is also anticipated that they are

serving as ICU nurses for a period of less than three years. It could also be assumed that there are nurses who only acquire experience for 2 years or less as preparation for bigger opportunities abroad because as Cueto (2007) stated, as more and more developed countries open their doors to migrant health workers, most of the new graduates made a beeline for jobs overseas. The graduate's fortunate enough to make the cut lost no time in applying for jobs abroad, most of them skipping the minimum one-year experience required by hospitals abroad.

Table 2.1
Weighted Mean Distribution of the Respondents' Role for Dying Patient in terms of Quality of Care

Items	Weighted Mean	Verbal Interpretation	Rank
I...			
1. <u>assess</u> and monitor vital signs accurately and notify the physician if there are any deviations from the normal.	3.96	Great Extent	1
2. <u>assess</u> pain frequently and administer analgesics only or as prescribed.	3.80	Great Extent	4
3. <u>perform</u> infection control measures (e.g. <u>handwashing</u> , gloving and gowning) before having contact with the clients.	3.58	Great Extent	9.5
4. <u>instruct</u> relatives about infection control such as <u>handwashing</u> , and avoidance of relatives/visitors with infectious diseases.	3.80	Great Extent	4
5. <u>ensure</u> client's safety by raising side rails and not leaving the client unattended.	3.92	Great Extent	2
6. <u>provide</u> the client with means to call for assistance (i.e. call bell/light) within reach.	3.62	Great Extent	8

7. <u>perform</u> frequent turning and positioning of client to prevent formation of pressure sores.	3.70	Great Extent	7
8. <u>use</u> non pharmacologic measures (e.g. guided imagery, deep breathing exercises, music therapy,) to promote comfort for them.	3.58	Great Extent	9.5
9. <u>position</u> client to semi-Fowler's position to improve his/her breathing.	3.80	Great Extent	4
10. <u>ensure</u> adequate dietary intake without addressing any stress for the patient during meal time.	3.76	Great Extent	6
Composite Mean	3.79	Great Extent	

Table 2.1 presents the weighted mean distribution of the respondents' role for the dying patient in terms of providing quality care. It can be gleaned from this table that respondents generally perceive Quality of Care as Great Extent with a composite mean value of 3.79. This result only brings out the reason why Filipino nurses are perceived to be the best caregivers worldwide, being able to be competitive enough in their field because they perform their duties with heart and treat their patients as members of their own family (Silvestre, 2006). ICU is one of the most delicate areas in the hospital, that's why it is a necessity for critical care nurses to render a safe and effective nursing care to a great extent for it is not only an obligation, but rather a commitment. This area is a matter of life and death situations, wherein the survival of the critically ill patients lies on the hands of nurses and other members of the healthcare team.

ICU nurses assess and monitor vital signs accurately and notify the physician to a great extent, with the highest weighted mean of 3.96. They are aware that vital sign monitoring is a fundamental component of nursing care. Monitoring basic vital signs allows us to identify problems early and take measures to prevent them from becoming serious. It serves as the basis of the physician in determining whether there is a development or deterioration in the patient's condition. It also determines which treatment protocols to follow, provide critical information needed to make life-saving decisions, and confirm feedback on treatments performed. This critical role of nurses in an ICU setting is also based on what Bare (2010) stated that as death approaches and organ systems begin to fail, observable, expected changes in the body take place, that is why nurses should report and consult with the physician about the deviations in their client's vital signs. Monitoring of vital signs should not be an automatic or routine procedure; it should be a thoughtful, scientific assessment. It should be evaluated with reference to the client's present and prior health status and are compared to client's usual and accepted normal standards (Kozier, 2008).

Ensuring client's safety by raising side rails and not leaving the client unattended has been perceived by ICU nurses as to a great extent ($x = 3.92$). Ensuring patient safety has ranked second since it is a necessity for all health professionals especially to those belonging in the critical care unit. Patients in the ICU are afflicted with terminal illness that could predispose them to situations that could cause injury to them such as fall. Lack of a safe environment can

cause additional harm or burden to the patients' condition, which may then cause further deterioration regarding their status. According to McAdam (2006), patient safety has been described as an ethical imperative, and one that is implied in health care professionals' actions and interpersonal processes. Due to the hectic, complex environment in the critical care unit, patients are particularly vulnerable due to their compromised physiologic status, multiple technologic and pharmacologic interventions, and multiple care providers who frequently work at a fast pace

Assessing pain frequently and administering analgesics only or as prescribed; positioning client to semi-Fowler's position to improve his/her breathing and; instructing relatives about infection control such as hand washing, and avoidance of relatives/visitors with infectious diseases were all classified by ICU nurses as to a great extent ($x= 3.80$). Since the essence of end-of-life care is for patients to be free from avoidable distress and suffering, assessment of pain and administration of analgesics when needed is perceived to be one of the most important responsibilities of ICU nurses. Doing so may not totally alleviate the disease, yet may relieve the patient's suffering thereby increasing patient's comfort and enable clients to maintain some quality in their life and their daily activities, including eating, moving and sleeping(Kozier, 2008).

On the other hand, proper positioning during dyspnea aids in the maximal use of respiratory muscles thereby improving client's respiration. Patients with breathing problems were traditionally placed in semi-fowlers position because this is believed to relieve the patient's difficulty of breathing as well as prevent unnecessary secondary complications on the patient's respiratory status (Bare, 2010).

It is given that relative of the dying patients still want to let them feel loved and taken care of. It is also known that their presence is needed especially in pediatric ICUs for feeding purposes and strict aseptic technique should be observed. Before entering the critical care unit it is a must that they perform handwashing, donning cap and mask, and wearing of foot cover. Giving instructions among the relatives regarding infection control measures in the ICU is necessary to protect the patient from infections or microorganisms that could contribute to the aggravation of their condition. If relatives would be thought as to how they should avoid infectious diseases, then nurses could assure that their patients are protected enough. Interventions used in reducing infection includes the use of an antiseptic detergent or an alcohol based sanitizer, wearing protective clothing such as gowns and gloves and teaching nurses and families how they can help reduce the spread of infection(Willeke, 2006).

Ensuring adequate dietary intake without addressing any stress for the patient during meal time ranked 6th having a weighted mean of 3.76, verbally interpreted as great extent since adequate nutrition is crucial to the treatment of ICU patients. Accurately assessing nutritional requirements and monitoring the adequacy of nutritional intake in critically ill patients can help ensure that discomforts and complications associated with underfeeding or overfeeding are avoided. As Cline (2006) stated, patients, families, and caregivers struggle to continue providing food and fluids in the face of declining ability and interest. All caregivers should be reminded to encourage but never to force intake of any kind

Regular positioning of the critically ill patients gained a great extent ($x=3.70$) which ranked 7th among the variables under quality of care. It is necessary to prevent complications

such as atelectasis, constipation, and urolithiasis. Furthermore, it is important in maintaining the skin integrity of patients in the ICU and preventing the formation of pressure ulcers. It also promotes patient's mobility thereby improving circulation. This same rationale was mentioned by and Goldhill et. Al., (2007) where in many hospitalized clients in ICU cannot reposition themselves in their beds therefore, they are regularly turned by their nurses, primarily to prevent pressure ulcer formation and it has long been recognized that immobility is associated with complications involving many organ systems including the lungs, the cardiovascular system, skin, muscles and bone (American Society for Pain Management Nursing, 2010). The use of positioning therapy has been advocated for the prevention and treatment of many of these complications. It is also routine practice, unless contraindicated, to place patients in a head up position Positioning therapy is also used to improve oxygenation in patients with severe respiratory failure (Goldhill et. al., 2007).

Providing the client with means to call for assistance ranked lower compared to other items under quality of care since call bell/light are not always readily available at the critical care unit, and nurses usually stay close to the client so that they can easily attend to their needs. Though it is interpreted as great extent ($x=3.62$), it is not considered a necessity because nurses themselves are aware of the client's needs for they are very focused about the assessment of their condition.

Tzeng (2010) proposed that an effective way to decrease call light frequency is to remove the reason for call lights in the first place. Hourly nursing rounds to ascertain and meet patients' needs are an evidence-based strategy that reduces dependence on call lights. Rounding not only fulfils the more mundane requests that are usually made via call lights but also demonstrates the nurse's availability to the patient and her readiness to anticipate the patient's needs. Rounding is about building relationships and trust as much as it is about meeting physical needs. Patients like to know someone is watching over them.

The use of non pharmacologic measures to alleviate pain is one of the least aspects under quality of care, having a weighted mean of 3.58 verbally interpreted as great extent. Since patients in the critical care unit need immediate means of relieving their pain, most of the times, they are managed through medications. Their pain may be so severe that guided imagery, music therapy, or deep breathing exercises cannot relieve. Most of the patients are unconscious or lethargic that's why non pharmacologic measures may not be so useful and applicable.

In a descriptive, exploratory study, 54 pediatric ICU nurses responded to a questionnaire that elicited self-report of their use of five nonpharmacologic techniques: distraction, focusing on breathing, focusing on relaxing, imagery, and changing perceptions of painful stimuli. Content analysis indicated that (a) nurses' lack of time and heavy workload impede their use of nonpharmacologic techniques; (b) nurses' most frequent use of nonpharmacologic techniques is with children undergoing painful procedures; and (c) nurses perceive parents as helpful in implementing nonpharmacologic techniques with children (Pederson and Harbaugh, 2010).

The environment in the critical care setting is highly controlled, and strict aseptic technique should be observed. Patients in this area are considered vulnerable since their immune system is compromised. Nurses may not guarantee the total elimination of infection however their occurrence can be minimal through strict aseptic technique.

Eventhough infection control was perceived by the ICU nurses to have a great extent (x=3.58), it is quite bothering that nurses give least attention with this measure. Infection control is considered to be a means of promoting safety for the client and preventing unnecessary secondary complications like the development of nosocomial infection. The researchers strongly believe that infection control measures among ICU nurses should be one of their top priorities that they must consider at all times because according to Bihari (2005),the highest rates of nosocomial infections are observed in intensive care units (ICUs), because of their underlying diseases or conditions associated with impaired immunity , several violations of their immune system or risks of aseptic mistakes in patient management during invasive monitoring, exposure to multiple invasive devices and procedures; increased patient contact with health-care personnel; a longer ICU stay which prolongs the risk of exposure; and space limitations that increase the risk of contaminating equipment(Zaki,2010).

Table 2.2
Weighted Mean Distribution of the Respondents' Role for Dying Patient in terms of Communication

Items	Weighted Mean	Verbal Interpretation	Rank
1. encourage the sharing of feelings of both the client and his/her family about death and provide emotional support by listening attentively to what they have to say.	3.58	Great Extent	5
2. discuss about patient's plan of care, provide accurate information and tell the family what to expect during conferences.	3.72	Great Extent	2
3. explore patient's wishes and encourage realistic goals.	3.70	Great Extent	3
4. talk and address with the patient's family their spiritual/ religious and cultural needs.	3.66	Great Extent	4
5. use simple and lay terms instead of complex medical language when talking to the relatives of the patient on matters regarding his/her condition.	3.92	Great Extent	1
Composite Mean	3.72	Great Extent	

Table 2.2 presents the weighted mean distribution of the respondents' role for dying patient in terms of communication with a composite mean value of 3.72 verbally interpreted as great extent. From the start, nurses are trained how to communicate effectively to various groups of people, that's why it is anticipated to be practiced at all times. The use of therapeutic communication enables nurses to establish rapport with their patient thereby providing them the opportunity to deliver the most efficient and effective care their patients needed.

Communication among healthcare providers, patients, and their families regarding end-of-life (EOL) care is an important determinant in providing quality care in the setting of choice for patients with terminal illnesses. Communication used therapeutically enables us to build rapport with our patient thereby providing us the opportunity to deliver the most efficient and effective care our patients needed. Communication in a critically ill patient is very tough process. We must be ready to accept how the client grieves, or how the client went through the process of it (Campbell, 2009).

Communication with the patient and family is a standard of professional nursing practice (Brener, 2007). When a patient is dying, compassionate communication becomes a clinical skill as important as assessment, drug administration, and physical intervention. The fact is that nurses are in the best position to help dying patients communicate about their wishes, help families understand the course of the patient's transition, ease conflicts and difficulties that are sure to arise, and facilitate interactions with physicians and other members of the palliative care team (Campbell, 2009).

The use of simple and lay terms instead of complex medical language when talking to the relatives of the patient on matters regarding his/her condition gained the highest weighted mean of 3.92, verbally interpreted as great extent. Since it is a must for nurses to make the family members of the dying patient understand the progress of the patient's condition and the treatment being rendered to them, the use of medical terminologies will not be helpful on the part of the client's significant others because not all of them are knowledgeable of the medical language.

End-of-life decisions commonly include what treatments to elect, which to decline and when. When talking with the patient about the treatments, nurses must help him and his family understands the topic being discussed. When communicating with the patient or family members, it is essential to reduce the language to the eloquence of simplicity. Be matter-of-fact and empathetic. Give accurate information. Listen actively and, if appropriate, use gentle touch to show your care and concern (Ufema, 2001).

When communicating with a patient and family members, nurses must always take care to convert medical language into lay language, not only to increase the patient's and family understands but also to better invite them into the conversation. Also, they should keep in mind that many families have varying educational levels, reading abilities, and language preferences. To communicate effectively with patients and their families, make sure nurses are communicating with cultural sensitivity, building rapps, using empathy, participating as needed in important end- of-life decisions, and continuously assessing thyself and their effectiveness (Adams et al, 2005).

Discussing about patient's plan of care, providing accurate information and telling the family what to expect during conferences were considered by ICU nurses as to a great extent

($x= 3.72$). End-of-life care is not just focused on alleviating the suffering on part of the patient but also to the family members. Discussing the patient's plan of care will help establish a trusting relationship between nurses and relatives. Telling the family members what to expect will not just provide them information regarding the development of the patient's condition but will also prepare them about the possible complications that may arise.

Scott (2010) proposed that nurses should always keep the family informed of every action that are being taken, but avoid allowing different specialists to deliver conflicting information and recommend taking advantage of any opportunity to clarify information and to allow people time to express concerns or feelings. All questions needs to be addressed until family members feel assured they are making the right decisions under the circumstances.

Apart from assessment and management of pain, in which the nurse's key role has been clearly recognized, no palliative care process is more important in the ICU than the family meeting to establish goals of care. It is in this process that families are helped to understand the patient's condition and prognosis, can share their knowledge of the patient's values and preferences along with their own concerns and questions, and receive emotional and practical support. Thus, the family meeting is the backbone of informed, patient-focused, decision making about appropriate care goals and the corresponding treatment plan. Nurses can contribute to these meetings in many important ways. The ICU bedside nurse has the latest information about the patient's condition. Usually, this nurse is also the clinician with the best knowledge of and strongest relationship with the family. The nurse at the bedside often has extensive discussions with family members before the family conference, including discussions of the patient's values and treatment preferences(Cortez et. al., 2011).

ICU nurses consider exploring patient's wishes and encouraging realistic goals as great extent ($x=3.70$) in the aspect of communication, however it is not perceived as a top priority. Being aware of the various wishes of the critically ill patients will enable us to relate this to their family thereby giving patient's a sense of satisfaction whenever these wishes are met. Setting realistic goals will provide direction that will guide nurses in rendering the care needed by their patients. It will also prevent unnecessary expectations because the goals being set are realistic and attainable. The nurse may be in a position to understand and interpret patient wishes based on his or her intense contact with the patient. The nurse may also be able to reiterate messages about prognosis and answer patient and family questions based on his or her involvement in the discussions (Miller, 2001).

Talking and addressing with the patient's family their spiritual/ religious and cultural needs were interpreted as to great extent ($x=3.66$). Critical care nurses perceive this aspect as important, yet there are certain issues that they prioritize to attend and communicate rather than the religious, spiritual, and cultural needs. Nurses assume that their patients belong to the same religion and culture as they are since majority of the patients they are handling are Roman Catholics and belonging to the same ethnic affiliation.

Campbell (2009) mentioned that when communicating about end-of-life issues, many cultural variables come into play, including respect, causing harm, provoking anxiety or depression, and self-fulfilling prophecy. One common pitfall to avoid in becoming culturally competent is unintentionally stereotyping a patient into a particular culture or ethnic group on the basis of characteristics such as outward appearance, race, country of origin, or stated

religious preference. Stereotyping is defined as an oversimplified conception, opinion, or belief about some aspect of an individual or group of people (Flowers, 2004).

Moreover, Smith (2006) stated that it is not expected that every nurse is or should be a spiritual nurse. Specialized education in spirituality can help ensure that nurses are aware that spiritual care is within the purview of nursing and can prepare all nurses to deliver an appropriate level of spiritual care to patients.

ICU nurses encourage the sharing of feelings of both the client and his/her family about death and provide emotional support by listening attentively to what they have to say with a weighed mean of 3.58 verbally interpreted as great extent. Discussion of feeling is a form of providing empathy towards the patient and his family. It is interpreted to be great extent since ICU nurses still find time to communicate, discuss, and listen to the concerns of the patient's significant others, but it is not accomplished at all times. Critical care unit is known to be an area wherein every second counts and every situation creates pressure among health care providers, so instead of providing comfort to the relatives, nurses tend to focus more on performing their duties and giving appropriate interventions to their patients. In a study, American Journal of Critical Care (2005) cited that the most prominent cluster of needs that family members felt were least satisfactorily cared for just after admission were related to medical information: the clarity of explanations given, family representatives' knowledge of equipment being used, and the representatives' understanding of the patients' treatment. These findings are generally consistent with those of the many previous studies conducted with families of critical care patients.

Although receipt of clear information about patients has been identified as a primary need of patients' families, the specific aspects of the hospital staff's communication process most important to the family members was addressed in only one study, Jurkovich et. al. (2000) found that along with the clarity of the communication, the most important feature in the process of receiving bad news was the attitude of the news giver. This feature was even more important than the news giver's knowledge or ability to answer questions (American Journal of Critical Care, 2005).

Table 2.3
Weighted Mean Distribution of the Respondents' Role for Dying Patient in terms of Education

Items	Weighted Mean	Verbal Interpretation	Rank
1. take advantage of educational programs and mentoring opportunities that will provide me the knowledge and skills needed to implement critical care standards	3.88	Great Extent	1
2. constantly attend trainings and seminar that may enhance and develop my knowledge, skills and competency in terms of critical care nursing.	3.68	Great Extent	3
3. apply the theories and concepts learned in providing end-of-life care in the clinical setting.	3.74	Great Extent	2
4. keep myself updated/abreast with the current trends regarding end-of-life care practices.	3.62	Great Extent	4
5. actively involve myself in on-going research studies on critical care nursing and apply the significant findings of which in my practice as nurse.	3.43	Moderate Extent	5
Composite Mean	3.67	Great Extent	

Education is one of the vital components in rendering quality care to every patient. Through it, nurses obtained various knowledge and skills that are necessary in the survival of every patient. It continuously strengthens nurses' confidence when they are guided with the things they have learned. Table 2.3 presents the weighted mean distribution of the respondents' role for dying patient in terms of Education which illustrates that ICU nurses value education of high importance with a composite mean value of 3.67 verbally interpreted as great extent.

Among the 5 items under Education, taking advantage of educational programs and mentoring opportunities that will provide them the knowledge and skills needed to implement critical care standards got the highest weighted mean of 3.88, verbally interpreted as to a great extent. It goes to show that ICU nurses continually search for the enhancement of their knowledge and skills even if they have already obtained their baccalaureate degrees. This is explicitly cited by AACN (2008) where nurses must seek learning opportunities that reflect evidence-based practice in order to maintain clinical skills and competencies needed to care for

acutely and critically ill patients and families and participates in ongoing learning activities related to professional practice and maintains professional records that provide evidence of competency and lifelong learning.

ICU nurses constantly view applying the theories and concepts learned in providing end-of-life care in the clinical setting to a great extent having a weighted mean of 3.74. This means that they utilize the different nursing theories and concepts learned in their nursing education as basis in identifying what appropriate action need to be applied to client care by reviewing, reflecting, critically analyzing , questioning specially in times of doubt or uncertainty about their actions.

Because nurses and nursing practice are often subordinate to powerful institutional forces and traditions, the introduction of any framework that encourages nurses to reflect on, question and think about what they do provides an invaluable service. Evidence- based practice involves the recognition of which knowledge is appropriate for application to health care. Practice theories, those that describe the relationships, among variables as applied to specific clinical situations are important contributors to effective evidence-based practice (Campbell, 2005).

Education is a dynamic process. Nurses constantly attend trainings and seminar that may enhance and develop their knowledge, skills and competency in terms of critical care nursing to a great extent ($x= 3.68$). This means they are aware that as part of their personal and professional growth as nurses, learning is continuous and attending conferences and seminars will constantly brush up their knowledge and skills to keep up with the rapid advancement of technology. AACN (2008) cited that nurses should participate in ongoing learning activities to acquire and refine the knowledge and skills needed to care for acutely and critically ill patients and their families.

ICU nurses keep themselves updated/abreast with the current trends regarding end-of-life care practices to a great extent ($x= 3.62$). This proves that as health care practitioners, nurses value constant updating about the scientific and technological change and changes within the nursing profession to improve the quality of care being rendered to their clients. This is the same with what Bare (2010) mentioned in her book, nurses must continually be aware of studies that are directly related to their own area of clinical practice and critically analyze those studies to determine the applicability of their implications for specific patient populations.

On the other hand, Critical Care Nurses perceive actively involving themselves in ongoing research studies on critical care nursing and applying the significant findings of which in nursing practice into a moderate extent only, with a weighted mean of $x= 3.43$. This means that only a few ICU nurses actively participate in research studies which may be brought by lack of time in conducting and implementing research, lack of interest in reading current research findings, lack of understanding about the importance of research to name a few as cited by Voda (2003) in a study where he identified these constraints to impinge upon the successful initiation conduct and application of research to the clinical setting.

Table 2.4
Weighted Mean Distribution of the Respondent's Role for Dying Patient in
terms of Collaboration and Collegiality

Items	Weighted Mean	Verbal Interpretation	Rank
I...			
1. <u>establish</u> a good-working relationship with the members of the health care team in planning and delivering quality care.	3.94	Great Extent	1
2. <u>involve</u> myself in the personal and professional development of my colleagues by imparting knowledge to them.	3.88	Great Extent	3.5
3. <u>join</u> and actively participate in different organizations involving advanced nursing practices.	3.74	Great Extent	5
4. <u>consult</u> and collaborate with my co-health workers whenever I am in doubt especially on certain matters concerning the health status of my patient.	3.92	Great Extent	2
5. <u>honor</u> and humbly accept my colleagues' criticisms as a means of developing and enhancing my performance in the ICU.	3.88	Great Extent	3.5
Composite Mean	3.87	Great Extent	

It can be gleaned from Table 2.4 that ICU nurses perceive Collaboration and Collegiality as an essential component in the delivery of the best end-of-life care to terminally ill patients with a composite mean value of 3.87 verbally interpreted as to great extent. Collaboration among healthcare team is vital to facilitate better patient outcome. The health care team works as a group utilizing individual skills and talents to reach the highest patient care standard. Collegial relationship between nurses and other health workers are vital to achieving the goal of clinically integrated care. A more collegial unified relationship between nurses, physicians, and hospital administrators leads to improved patient care and increases the power of nurses and physicians to protect the best interest of patients

An advanced practice nurse to pull together interdisciplinary teams early in the admission to develop a consistent plan of care focusing on the family spokesperson, identification of decision makers (family), identification of primary physician spokesperson (may not be the primary doctor), and identification of a primary nurse (caregiver or advanced practice nurse). This team would identify the patient's predicted quality of life and prognosis (American Journal of Critical Care, 2006).

ICU nurses establish a good-working relationship with the members of the health care team in planning and delivering quality care to a great extent having the highest weighted mean of 3.94. Collaboration and collegiality involves all members of the health care team and establishing rapport with co-workers aids in rendering efficient and quality nursing care. Individuals must be willing to work together, have the same objectives and goals, and provide a plan of care which is individualized to the patient's needs. A health care team which works well together, has mutual respect for everyone's contributions and communicates effectively can make all the difference in the patient's outcome.

The health of people depends on what happens in organizations and what they do. Cultivating good team work and nurses' cohesion will establish harmony working condition, enhance quality of patient care and increase patient satisfaction (Heap, 2001).

The patient is the most important part of the team, and through a collaborative team based approach, patients can receive the highest quality of care. The medical team of doctors, nurses and other medical professionals that engage and respect each other will create a positive working environment and perform at an elevated level which can produce quality patient care with exceptional patient outcomes. And like any team, the medical team needs to work together respectfully and thoughtfully. The medical team needs to listen attentively to each other and communicate and problem solve together. Each member of the team supports and respects one another. The synergy of collaboration will greatly benefit the patient (Ficara, 2010).

Consultation and collaboration with co-health workers whenever in doubt especially on certain matters concerning the health status of patient gained the second rank having a great extent ($x = 3.92$) in the respondents' nursing practice. One way to ensure client safety is through collaboration and consultation. Nurses should not perform any procedure whenever they are in doubt. They must learn how to consult with other members of the health team to prevent errors that may harm the patient. Nurses at all times must keep in their minds that they are handling lives of dying patients, it is a must that every assessment, deterioration, or changes should be relayed accurately to other members of the health care team. It is the same with what Lenz (2010) mentioned that protecting the rights of subjects is a basic consideration in planning and undertaking any measurement activity. Since many ethical issues related to nursing measurement remain open to considerable controversy, the nurse who is unsure of the ethical and risk-related consequences of a given activity is well-advised to consult others before proceeding.

Honoring and humbly accepting their colleagues' criticisms as a means of developing and enhancing their performance in the ICU was perceived to a great extent, having a weighted mean of 3.88. Learning how to accept people's criticisms will improve the quality of care being rendered by nurses, especially when it comes from those people who had a lot of experiences and expertise on the field of critical care nursing. Since patients in the ICU are at delicate conditions, it is imperative for them to accept those mistakes that they have made and to be open with the new learning. This aids to the development of nurses' personally and professionally as well as the assurance of patient's safety. Venzon (2005) even cited that constructive criticism is always welcome but not fault-finding. Fault-finders, gossipers and those

who are fond of intrigues will surely resent it too if they become the target of their own practices.

Establishing bonds of trust and cooperation requires helping one another achieve a common goal. Nurses establish good working relationships with other health care workers by involving themselves in the personal and professional development of their colleagues by imparting knowledge to them and had interpreted it as to a great extent ($x= 3.88$). Sharing knowledge with colleagues allows for sharing others ideas and experience. It is crucial to the development of skills and competencies. Through sharing of learnings, nurses and other members of the health care team were given the opportunity to learn from each other. This knowledge helps them to develop personally and professionally. This also facilitates evaluation of one's perception regarding the performance of their colleagues, therefore correcting misconceptions (Venzon, 2005).

Respondents join and actively participate in different organizations involving advanced nursing practices to a great extent ($x= 3.74$). Learning and developing are life-long processes. It provides a means of staying current in their field. Organizations provide trainings, seminars, and programs that will enhance their competencies. It also offers opportunities to lead and relate to others. Through membership from different organizations, nurses receive valuable information concerning a variety of topics. However, nurses viewed joining organizations as a less important thing to accomplish. Nurses do not regard this matter as one of their top priorities because most of them believe that joining organizations may be time consuming and they do not recognize the benefits it offers. Compared with foreign countries, different nursing associations are not known to Filipino nurses, they are not well aware that there are existing organizations that can contribute to their professional development. Ellis and Hartley (2004) cited reasons for the low level of membership in nursing organizations; these are the high cost of membership and the lack of time participating in the activities. Others also have the dual responsibilities of job and home and feel that they have no time left for involvement in professional organization. Some just do not see how the benefits available through membership in the association are personally valuable and explain that they are not just interested with the issues and concerns of the organization.

Table 2.5
Weighted Mean Distribution of the Respondents' Role for Dying Patient in terms of
Ethico-Moral and Legal Responsibility

Items	Weighted Mean	Verbal Interpretation	Rank
I...			
1. facilitate in decision-making for patients when making choices about end-of-life care.	3.64	Great Extent	5
2. ensure client's privacy by pulling curtains around the bed, closing the door and making sure that he/she is adequately covered when doing certain procedures.	3.90	Great Extent	2
3. always tell the truth when talking with the family regarding the client's condition.	3.82	Great Extent	4
4. take affirmative action responsive to the client's condition and document what was done to protect the client.	3.84	Great Extent	3
5. am responsible and accountable for individual nursing practice as well as in preserving the client's integrity and safety.	3.98	Great Extent	1
Composite Mean	3.84	Great Extent	

Ethical dilemmas are encountered daily in the practice of critical care. The critical nature of the situation and the speed that is required to make decisions, often prevent practitioners from gaining insight into the desires, values, and feeling of patients. Table 2.5 presents the weighted mean distribution of the respondents' role for dying patient in terms of Ethico-Moral and Legal Responsibility with a composite mean value of 3.84 verbally interpreted as to great extent.

Among the 5 items under Ethico-Moral and Legal responsibility, Being aware that they are responsible and accountable for individual nursing practice as well as in preserving the client's integrity and safety got the highest weighted mean of 3.98, verbally interpreted as to a great extent. This shows that as ICU nurses and acting as client advocates, part of their duties is to promote and protect the health, safety and rights of their clients. They know that they are held responsible and accountable for their actions, consistent with the nurses' obligation to provide optimum patient care (Brenner, 2007).

Verbally interpreted as to a great extent with a weighted mean of weighted mean of 3.90, ICU nurses always follow the principles of Confidentiality and Privacy by ensuring client's privacy by pulling curtains around the bed, closing the door and making sure that he/she is adequately covered when doing certain procedures. This attests that nurses protect the rights of their clients and ensure that their client's dignity is preserved in their actual practice. According to Brener (2007), Confidentiality and Privacy are two vital elements of fidelity or faithfulness that is based on traditional health care professional ethics. Regardless of the amount of autonomy that patients have in the critical care areas, they still depend on the nurse for a multitude of types of physical care and emotional support.

ICU nurses answered taking affirmative action responsive to the client's condition and documenting what was done to protect the client to a great extent with a weighted mean of 3.84. It clearly indicates that in their everyday encounter with critically-ill clients, ICU nurses always keep in mind that as healthcare practitioners, they are legally responsible for their obligations and actions. Documentation is important and not just for legal purposes but is necessary and it is a way of giving high-quality care (Berman, 2008).

The cornerstone of the nurse-patient relationship is trust, especially in keeping the philosophy of family-centred care. Veracity, or truth-telling, is an important ethical principle that underlies this relationship. ICU nurses always tell the truth when talking with the family regarding the client's condition to a great extent ($x= 3.82$). However, according to Daniels (2004), though truth-telling is essential in establishing a nurse-patient relationship, it is often difficult to achieve. It may not be hard to tell the truth, but it can be very hard to decide how much truth to tell.

Among the 5 items, facilitating informed decision-making for patients making choices about end-of-life care had the least weighted mean of 3.64, but verbally interpreted as to a great extent. This means that although it is part of the responsibility of the nurses as advocates to be involved in making decisions about patient care, not all ICU nurses perceived themselves as being held accountable in facilitating decision-making with regards to client's plan of care. In a study conducted by Brenner (2007), only 8% of physicians recognize nurses as part of the decision-making team. Other research reports that a majority of nurses feel relatively powerless to change things they dislike in their work environment. This autonomy-accountability gap interferes with nurses' ability to optimize their essential contribution and fulfil their obligations to the public as licensed professionals.

Table 2.6
Summary of the Weighted Mean Distribution of the Respondents' Role for the Dying Patient

Extent of Nursing Care rendered to a Dying Patient in terms of:	Composite Mean	Verbal Interpretation	Rank
Quality of Care	3.79	Great Extent	3
Communication	3.72	Great Extent	4
Education	3.67	Great Extent	5
Collaboration and Collegiality	3.87	Great Extent	1
Ethico-Moral and Legal Responsibility	3.84	Great Extent	2

Table 2.6 presents the composite means of all the variables in respondent's role to a dying patient. Collaboration and collegiality got the highest rank with the composite mean of 3.87, verbally interpreted as great extent. ICU nurses have given the above results because basically, nurses do not only perform independent interventions but as well as dependent and interdependent functions, that is why it becomes an imperative in the critical care unit for ICU nurses and other health care teams to communicate assessment, findings, or changes about the health status of the patient to facilitate better outcomes. As Heap (2001) pointed out, the health of people depends on what happens in organizations and what they do. Furthermore, cultivating good team work and nurses' cohesion will establish harmony working condition, enhance quality of patient care and increase patient satisfaction.

Education got the lowest rank with a composite mean of 3.67, verbally interpreted as great extent. Among the variables about the respondent's role to a dying patient, the researchers agree that this is the least priority since the educational aspect of the nurses' role will enhance the nurses' personal and professional development rather than the patient's progress. Quality of care, Communication, Collaboration and collegiality, and Ethico-Moral and Legal Responsibility are more client-centered and has a direct impact on patient outcome compared to Education. Though education may somehow aid in the enhancement of the patient's prognosis, it is viewed to have an indirect effect, because as nurses gain additional knowledge, they become more competent in rendering the needs of their patients in terms of Quality of care, Communication, Collaboration and collegiality, and Ethico-Moral and Legal responsibility. As Boyle (2001) mentioned, although nurses take pride in the expert care they provide, they often feel frustrated with the lack of knowledge, support, and training they have for care at the end-of-life. The above results also agree to what Research suggests that there are persistent deficiencies in end-of-life nursing care practice and the education to support that care (Schlairet 2009).

Table 3
Relationship between the Respondents' Profile Variables and their Role among Dying Patients

Preparation in terms of: Profile Variable	Quality of Care	Communication	Education	Collaboration and Collegiality	Ethico-Moral and Legal Responsibility
Age	0.287	0.527	*0.037	0.860	0.540
Gender	0.942	0.428	0.697	0.250	0.424
Educational Attainment	0.367	0.901	0.065	0.092	0.330
Length of Service	*0.026	0.199	0.384	0.836	0.329

Legend: $p\text{-value} < 0.05 = \text{*Significant}$

$p\text{-value} > 0.05 = \text{Not Significant}$

Table 3 presents the relationship between the respondents' profile variables and their role among dying patients based on the table, the computed p-value of age in relation to education and length of service to quality of care, was less than 0.05 level of significance; thus the hypothesis of significant relationship between the profile variables (age and length of service) and the extent of role rendered to dying patient (education and quality of care) is accepted.

The age of respondents affect the educational aspect of their role as critical care nurses. Since most of them belong to the age group of 21-25, they are more open to accept new trends and attend different seminars. Nurses belonging to this age group are highly flexible compared to those nurses who are older and resistant to changes. Younger nurses have more time to attend seminars and trainings because they are not yet committed to a profound responsibility. They also view themselves as novice and they still lack knowledge that's why they are pushed to strive and achieve higher learning.

Highly complex and technologically rich work settings could be a contributing factor for the professional nurses seeking further education. Murray (2005) noted that learning to be an information management specialist with increased problem solving skills has become a necessity for RNs to survive and thrive in many positions. Additionally, aggressive marketing by nursing programs, combined with pressures to obtain advanced degrees with the enticement of increased salary as a result have also been found as a major factor in attracting younger RNs back into the academic world (HRSA, 2002).

Furthermore the quality of care improves as the length of service increases. This means that as one nurse serves as an ICU Nurse for a greater time, she develops her potentials to the fullest, enabling her to provide a good quality of care to a dying patient. ICU nurses serving for long period of time acquire different experiences that open avenues for them to learn and develop professionally. They are able to identify which things must be prioritized regarding patient care. And they become used to the routines being observed inside the critical care unit, they can easily determine what interventions to render even without the physician's order and easily recognize inaccuracy of the patient's treatment regimen.

ICU nurses view their work as once in a lifetime chance to prove to themselves they can do something for the betterment of the profession. Advanced beginners demonstrated marginally acceptable performance, because they had coped with enough real situations or had mentors who previously identify correct clinical decisions while competent practitioners who had worked 3 years and above could relate their immediate actions to a along range of goals or plans. Proficient nurses perceive a situation as a whole and limited their number of reasonable options and experts had an intuitive grasp of situations and zeroed in on accurate data and were therefore able to provide care accurately and quickly; and they analyzed data without delay when novel situations occurred and events and behaviours did not respond as expected (Martin, 2005).

In adjunct with this, Dunton et. al. (2007) mentioned that a research compiled National Database Nursing Quality Indicators which looked at the nursing environment and characteristics in relation to patient outcomes. This research concluded that multiple factors, including nurse staffing, percentage of RN staff, and RN years of experience, impact patient’s safety and nurse-sensitive outcomes.

Gender and Educational attainment does not have a significant effect on any variables under the respondent’s role among the dying patient. In terms of gender, the researchers ascertained that the quality of care being rendered is not determined by the masculinity or femininity of a nurse. Males can do what females can and vice versa. Even though males are known to have a strong personality; they are still capable of being compassionate, empathic, and submissive.

Moreover, education does not also directly affect the extent of nursing care rendered by ICU nurses to their dying patient. The degree of educational attainment does not justify the service that ICU nurses can offer. Though higher education can enhance the knowledge of nurses, it does not follow that the caring attitude of the nurse will also be moulded since it is a personal attribute. Sometimes those nurses who are just recognized as RNs can work as competent as those having the Masteral degree.

Table 4
Proposed Measures to Enhance Nursing Care rendered on the Dying Patient

General Objective: To enhance the nursing care rendered by ICU Nurses on dying patient in terms of quality of care, communication, education, collaboration and collegiality and ethico-moral and legal responsibility.

Specific Objective	Area of Responsibility	Program and Activities	Persons Responsible	Expected Outcome
ICU Nurses will be able to: to develop interest in conducting research, be	1. Research will be enhanced	Seminars regarding the current trends in Research, latest evidence-based	ICU Nurses	The ICU Nurses will: actively participate in on-going research studies

<p>knowledgeable of the important role of Research in Nursing and integrate findings into practice. raise and maintain the highest standard and quality of nursing practice through attending trainings and seminars</p> <p>keep abreast with the latest trends in end-of-life care</p>	<p>through dissemination and application of research findings in nursing practice</p> <p>2.The personal and professional development must be expanded through the pursuing continuing education</p> <p>3.The personal and professional development will be developed through continuing education. Research will be expanded through application of findings and trends from studies in the clinical</p>	<p>practices and the comparative effectiveness of different treatments and clinical practices.</p> <p>a.Seminars/ Conferences about the current nursing practices in critical care setting.</p> <p>b. Staff training that will enhance the skills of nurses in applying evidence-based practices in ICU</p> <p>3.regular subscription and habitual reading of nursing journals, magazines, books and others resources for updates about critical care nursing</p>	<p>2.ICU Nurses and Hospital Managers</p> <p>3.ICU Nurses</p>	<p>and apply findings to improve client care.</p> <p>participate in formal and non-formal education and gain adequate knowledge, skills and attitude and applies learned information for the improvement of care. Utilize available resources such as internet, magazines, TV and others to acquire latest updates on critical care nursing and apply these into practice.</p>
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CONCLUSIONS

Based on the aforementioned findings, the researchers came up with the following conclusions:

Nursing has been historically viewed as an extension of women’s familial roles, and young nurses have a greater capability of caring for people who are critically ill since they are more physically fit and in their productive stage in life.

ICU Nurses generally are competent in rendering end-of-life care to terminally ill clients. Among the five standards established by the AACN in Critical Care nursing, Education had the least priority since it is more focused on the nurses’ personal and professional development and is believed to have an indirect effect to the patients’ prognosis.

Age and length of service are significant predictors of nurses’ role in critical care setting. The quality of critical care rendered depends largely on these profile characteristics.

The proposed enhancement program in Table 4, if utilized, will improve the roles of ICU nurses in providing end-of-life care to critically ill patients in terms of key themes of comfort, attachment and worth.

RECOMMENDATIONS

Based on the findings and conclusions of this study the researchers highly recommend the following:

1. The proposed measures may be utilized by the health care institutions to enhance the nursing care rendered to dying patients.

2. The ICU Nurses and all members of the health care team shall provide the best quality of care to their patients, family, and significant others. And continuously prepare patients on what to expect, provide information to alleviate uncertainty and facilitate therapeutic communication at all times.

3. Healthcare institutions should continuously improve their service and have adequate resources to enhance the quality of care provided to their client. They should implement a strict policy and carefully evaluate ICU Nurses in order to assure the safety of critically ill patients.

4. The College of Nursing shall provide student nurses the needed knowledge to improve the skills required in the intensive care unit and carefully evaluate student’s performance.

5. The student nurses should maintain and enhance the quality of care they are providing. They should also be guided to be more compassionate and caring to their patients as well as to the family members. Student nurses should also apply different nursing care strategies to help them cope with their fears.

6. For future researchers, they may work on a similar topic but need to evaluate the ICU Nurses’ performance in a broader perspective.

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