The University of Manitoba

Assessing the Impact of Death Education on Nursing and Non-Nursing Staff in a Health Care Setting

by

Lila M. Larson

A Thesis Presented to
The Faculty of Graduate Studies
University of Manitoba

March, 1990

In Partial Fulfillment of the Requirements for a Masters Degree in Education

ISBN 0-315-63383-2

ASSESSING THE IMPACT OF DEATH EDUCATION ON NURSING AND NON-NURSING STAFF IN A HEALTH CARE SETTING

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ABSTRACT

Research into the area of long term care and the needs of the staff in such facilities gave rise to the problem for examination in this study (i.e. **What is the impact of a death education course on nursing and non-nursing staff in a health care setting?**)

A literature search indicated a quantity of readings in the area of Adult Education re development, implementation and evaluation of courses. In addition, there was a considerable number of readings in the Nursing Journals about the impact of death education. What seemed to be missing however, were references which examined both in a long term care setting. The other missing link dealt with how death education courses, programs etc. would impact on a mix of staff (i.e. both nursing and non-nursing staff). It appeared then, that the question of interest (i.e. **what was the impact of a death education program on nursing and non-nursing staff in a health care setting?)** was not included in any of the literature reviewed for this study.

The proposal for the study was that the subjects (i.e. a mix of the staff) who had participated in a ten session death education course and which might result in an altering of their attitudes towards life and death (Leviton and Fretz, 1978; Waldman and Davidshofer, 1984) be studied. This study is proposed as a pilot project. The basic design is analytical and falls into a category of being conducted after the completion of a death education course within the past two years. Of a possible 184 staff (nursing and non-nursing at Deer Lodge Centre) who completed an

"inhouse" death education program a random selection of those still on staff was made. In the first step, subjects who had completed the "inhouse" death education course (developed and offered according to the principles of adult education), and who had completed the Pre-test of Templer's Death Anxiety Scale were contacted to ask for their participation in this study. Those who agreed completed a copy of the DAS post-test and a demographic sheet (age group, sex, department, education grouping). Course evaluation forms on file in the Education Services Department were consulted to identify the adult education principles considered by the respondents to have been the most effective for learning in the specific death education course.

The respondents indicated that they experienced a beneficial effect from participating in a course which had a mix of nursing and non-nursing staff. There did not appear to be a noticeable difference in the responses given related to age, educational background or departmental affiliation. The majority of those participating were female and this accurately reflects the gender distribution within the facility. There was a statistical significance in the difference of anxiety level as measured on the pre-post test. Adult education principles which were most beneficial to learning were identified. This would seem to suggest that there was an impact from the death education course on the nursing and non-nursing staff in this health care setting.

ACKNOWLEDGEMENTS

This project could not have been realized without the help of a number of dedicated people to whom the author is forever indebted. Deepest thanks are expressed to each of them for making the process easier, thereby allowing me to learn and to gain satisfaction from the experience.

The author sincerely appreciates the direction and guidance received from the primary advisor, **Dr. Deo Poonwassie**, and the thesis committee members, **Dr. Janet Beaton**, **Dr. Hal May**, and **Dr. David Murray**. Their substantive comments, interest and positive encouragement in the study played a major part in the quality of the completed work.

The assistance provided by **Rob Balshaw**, of the Student Advisory Service, from the Statistical Department, at the University of Manitoba was critical to the interpretation of the data from the research instruments used in the study.

Thanks are given to the many **staff members at Deer Lodge Centre** who took the time and effort to complete and return the research instruments which were used as the basis of the analysis and interpretation of the data. Their many questions and encouraging interest were valuable. Appreciation is also expressed to the **Administration of Deer Lodge Centre** for allowing the study to be conducted within the facility and for the access to the Archive material about Deer Lodge Hospital. The assistance from the **Library staff** within the Education Services Department was

extremely valuable. The technical expertise in editing provided by **Eden Mah** was crucial to the quality of the final product. Thanks also to **Art Skoda** for his helpful suggestions and interest in the formatting of the document. Specific thanks to colleagues and friends, **Lynne Forbes, Trish Fox, Valerie Friesen, Marilyn Froment, Shelley Keast, Wally and Lynn MacMartin, Diana Pennington, Dot Smith** and **Beverley Wilden**, for their encouragement, sense of humor, support, but most of all for their willingness to critique and decipher the direction, content and substance of this study.

Finally, the author would like to express special thanks to her family, her **husband AL**, and **son John**, for their patience, understanding and good humour, while sharing the responsibilities for those tasks and activities which fell by the wayside while this study was being developed and completed. Without their loving support and inspiration, the project would not have been completed in a timely fashion. Support from her **parents, Bill and Florence Davis**; her **sister Sylvia, Greg and Rachel Anne**; her **brother Bill, and his family of Judy, Kelley and Kara; her brother Don, and his family of JoAnn, Kris and Andrew** was an ongoing source of motivation, as illness and a shortage of time became important to the completion of the project on schedule.

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An Introduction to the Problem

A. Rationale

During a period of five and half years of employment in a long term care centre in Winnipeg, staff members (nursing and non-nursing) expressed concerns about their ability to provide appropriate care for serving and assisting dying patients within the facility as part of their activities and responsibilities . Buckingham (1983) found that in long term care, skilled nursing facilities and staff are not necessarily properly prepared to provide the dimensions of care and sensitivity for the frail aged and incurably ill which would meet the needs of older persons. The staff in the main have been trained to function in a manner which is consistent with the requirements of an acute care hospital structure (Buckingham, 1983; Mount, 1985). This was also the background of the staff in the facility used in this study, which was in fact, an acute care military hospital from 1918 until 1983, at which time the transfer to a provincial geriatric centre occurred.

For the purposes of this study, an acute care setting is defined as a hospital where the focus is on the disease oriented concerns of the health care team in investigation and diagnosis, concern with the prolongation of life, and cure by means of surgery, active medicine and rehabilitation (Mount, 1985), versus a focus on the diffuse and global whole-person needs of patients/residents and their families in long term care facilities

(this includes those who are terminally ill), embracing the psycho-social, financial, spiritual and physical concerns (Mount, 1985) which are needed in a long term care institution.

The transition from an acute care setting to a provincial geriatric setting required a downsizing process of the staff, because of the reduction in the variety of acute medical services offered and the reduced number of available beds . The majority of the staff who remained were those who had been trained and worked in acute care facilities. It became increasingly evident (by the nature and number of requests for assistance from the Education Services Department) that staff were having difficulty in making the transition from the care required and given in the acute care setting to the long term care approach where less technology but more personal care was required than is usual on a busy hospital ward (Buckingham, 1983; Mount, 1985).

Research into the needs of the staff in long term care facilities and the care required, raised a question for the investigator of what the impact of a death education course would be in alleviating the anxiety and discomfort some staff were experiencing when dealing with the patients/residents and their families during the final days of illness. Buckingham (1983) reports that it is only recently (i.e. within the past ten to fifteen years) that help and training in caring for the critically or terminally ill patient has been available to staff in such facilities. It is not surprising then, that staff in long term care facilities are afraid of "getting too involved", while others

are shocked that staff should spend "undue time" with dying patients when they are so needed for patients who can get well (Buckingham, 1983). It has happened that the patient/resident may have died (often alone), and have been rushed out of the facility without allowing the staff and other patients/residents to grieve and mourn the loss of a "friend". Because the long term care facility has not prepared its staff for the impact of death in this environment,the institutionalized elderly and their families often do not experience compassionate and dignified support for the enhancement of the quality of their life and death.

Wilden (1988) reports that the care of the elderly in Western society has been depicted as discriminatory, rejecting and negative. As a result, the staff working with the elderly in long term care facilities, tend to provide care which is custodial and dependency fostering, rather than therapeutic (Armstrong-Esther, Sandilands and Brown, 1985; Baum, 1977; Vladeck, 1980). Since persons over the age of 65 account for approximately 70% of all deaths (Forbes, Jackson, Kraus, 1987), the place of death becomes a factor in the care provided. A recent study of personal care homes in the United States indicates that between 20-22% of all deaths (over the age of 65) occur in nursing homes or personal care home settings (Thoreen, 1983; Rosenberg and Short, 1983). Similar studies are not available in Canada, but by referring to the Canadian mortality statistics, there are 131,115 deaths per year of persons aged 65 and over in 2,543 Canadian nursing homes i.e. approximately 51.56 deaths per home per year or one death per week

(Forbes, Jackson and Kraus, 1987; Palliative Care Survey, 1983). These figures do not include the statistics from deaths occurring after a transfer to a hospital for the terminal stages of life. There appears to be a need to address the issues related to care of the dying in Canada's nursing homes (Skafte, 1988). It has been estimated that 1/5 to 1/4 of elderly people can expect to spend some time in a long term care facility since the focus of the health care system tends to be on providing institutional care versus community care (Chappell, Strain, Blanford, 1986). In view of these facts, it would seem relevant to examine the care provided to the elderly population in such care settings (Wilden, 1988). The role that death education could play in assisting the long term care staff to make the transition from their acute care training to the kind of care required, became the focus of a possible study. Death education (Benoliel, 1982; Bugen, 1980; Degner et al, 1980;) relates not merely to the moment of death itself, but that it encompasses the pattern of one's life, feelings about self... the world and how we relate with others. By being able to explore personal attitudes towards death as a natural part of the life cycle, situations of coping with death become less traumatic for the caregiver (Benoliel, 1982; Bugen, 1980).

As an adult educator, this was of interest, particularly after having received requests from nursing and non-nursing staff members to assist them with ways of coping with the demands of working within a long term care facility so that they were giving more appropriate care to the patients/residents within the facility.

This study was proposed as a means of providing the author with a framework for synthesizing the experiences resulting from the teaching of a particular death education course, as well as promoting interest for further research in this field.

There are numerous accounts in the literature of how death education affects nurses in their care of patients (Denton and Wisenbaker, 1977; Yarber, Gobel and Rublee, 1981; Laube, 1977; McCorkle, 1982), as well as some references to the effects of death education on medical school students (Dickinson, 1985; Goodell, Donohue and Benoliel, 1982), and on interdisciplinary students (Swain and Cowles, 1982). Existing studies dealing with death education have been done primarily with staff who are trained for acute care settings, specifically the nursing and medical staff, (Popoff, 1974; Denton and Wisenbaker, 1977; Yarber, Gobel and Rublee, 1981; Laube, 1977; Swain and Cowles, 1982; McCorkle, 1982), for students in educational institutions (Rublee and Yarber, 1983; Shneidman, 1970; Benoliel, 1982; Lanham, Speer and Fritz, 1980), or for nursing staff in nursing homes (Mullins and Merriam, 1983). Literature which integrated adult education, death education and the needs of nursing and non-nursing staff in long term care facilities, were not be found in the literature reviewed at the time of this study.

The purpose of this study, therefore, was to assess the impact of death education instruction on health care employees (i.e. the nursing and non-nursing staff) in a long term care facility.

B. Significance of the study

The literature search indicated a quantity of readings in the area of adult education as it related to the development, the implementation and the evaluation of courses and programs (Brookfield, 1986; Darkenwald, 1982; Knowles, 1980; Rogers, 1986;). In addition there were numerous readings in nursing journals about the impact of death education on nursing staff. What seemed to be missing however, were any references to an examination of the ways in which adult education, death education and long term care needs could be integrated and studied. An additional missing link was any reference to the impact of death education programs on a mix of staff (i.e. nursing and non-nursing). The question being proposed for investigation (i.e. What is the impact of a death education program on nursing and
non-nursing staff in a long term care facility?) was not dealt with in the literature surveyed for this study.

The research on education in health care, addresses such issues as being able to:

a) Alter the anxiety levels in the caregivers so that the needs of the patient/resident could be more appropriately met (Vargo and Batsel, 1984; Denton and Wisenbaker, 1977; Laube, 1977; Waldman and Davidshofer, 1984; Templer, 1971),

b) Assess the impact of death education on a staff person's locus of control, because research shows that persons with the greatest internal control have qualities which are desireable for working with the terminally ill (Yarber, Gobel and Rublee, 1981),

c) Determine whether avoidance of the patient is increased or decreased and how the fear of death is altered (Mount, 1983; Collett and Lester, 1969; Leviton and Fretz, 1979; Lanham, Speer and Fritz, 1980; Robinson and Wood, 1983),

4) Measure the effect of death education on the attitudes of the caregivers and how that would affect the care given to the long term care patient/resident (Nagi and Lazerine, 1982; Kalish, 1963).

In practice, the results of those receiving death education indicate that there is an accompanying reduction in contact avoidance with patients who are dying or who are recipients of long term care (Lanham, Speer, Fritz, 1980; Mullins and Merriam, 1983; Denton and Wisenbaker, 1977). The care and degree of comfort given to the patients improves when the staff are more comfortable with their own feelings about death and consequently are better able to assist the patients/residents/families to cope with the reality of the impending death of their family members
(Lanham, Speer, Fritz, 1980; Leviton and Fretz, 1978; Kalish, 1963; Laube, 1977; McCorkle, 1982; Robinson and Wood, 1983). Based on the lack of available research dealing with the effects of death education programs for nursing and non-nursing staff in Canada, the purpose of this study was to assess the impact of death education instruction on health care employees in long term care.

There is a considerable bank of literature in the area of adult education and the teaching of adults (Brookfield, 1985, 1986, 1987, 1988; Brundage and Mackeracher, 1980; Cross, 1972, 1976, 1979, 1981; Davies, 1981; Dickinson, 1973; Draper and Barer-Stein,

1980; Draves, 1984; Kidd, 1973; Knowles, 1973, 1975, 1980, 1984, 1986, 1987; Knox, 1977; Mezirow, 1983; Tough, 1967, 1979; Ulmer, 1980). This literature will be referred to in an examination of the principles necessary to facilitate learning in a death education course.

In the literature reviewed for this study, there was none which linked the value of the integration of adult education principles with the assessment of the impact of death education programs. Adult educators (Andrews, 1981; Apps, 1973; Brookfield, 1985; Cross, 1972, 1976, 1979, 1981; Dickinson, 1973; Fielding, 1986; Fox, 1987; Godbey, 1978; Grabowski, 1981; and Tough, 1967, 1979) do suggest however, that unless the educational experiences provide a means for a linking of the adult's background with what is being presented in the course, there will be less likelihood of the participant being prepared to transfer the learnings outside of the classroom.

A search of the literature with reference to the varieties and formats of education or training activities offered to nursing home/personal care home staff has yielded little, other than some information about education/training conducted with the nursing staff (Degner and Gow, 1988; Denton and Wisenbaker, 1977; Yarber, Gobel and Rublee, 1981; Laube, 1977; and McCorkle, 1982).

The impact of death education as it has been presented in a variety of formats (i.e. university courses for credit, symposiums, workshops, seminars) has been explored in the literature by Waldman and Davidshofer, 1984; Bertman, 1979; Degner and Gow, 1988; Leviton

and Fretz, 1979; Kalish, 1963; and Cook, Oltjenbruns, Lagoni, 1984.

There appears to be a scarcity, however, of literature dealing with the impact of death education instruction which has been based on adult education principles and conducted within a long term care setting. This lack of research includes references to personnel from: the Dietetics, Health Information Services, Housekeeping, Laboratory Services, Nursing, Radiology, Recreation, Respiratory, Physiotherapy, Social Services, and Volunteer disciplines working in a long term care facility (Bertman, 1979).

Deer Lodge Centre has been selected as a site to assess the impact of a specific program (namely the Patient Relations and Communications Course) on a mix of disciplines (e.g. Dietetics, Health Information Services, Housekeeping, Laboratory, Nursing, Physiotherapy, Radiology, Recreation, Respiratory, Social Services, and Volunteer Services). For a brief history of this facility consult Appendix B. If staff from this cross-section of caregivers were to receive a death education program, it is likely that there would be changes, in that, the resulting care given by the trained staff would be expected to be more appropriate and compassionate for both the residents and the families concerned (Lanham, Speer, Fritz, 1980; and Kalish, 1963, 1985).

This study makes a contribution to the health care field and may assist practitioners in providing death education programs (to both nursing and non-nursing staff) as one means of addressing staff discomfort in dealing with the chronically/terminally ill

patients/residents in a long term care setting (Buckingham, 1983; Degner and Gow, 1988; Shedletsky and Fisher, 1986).

C. Statement of the Problem

Butterfield-Picard and Magno (1982) report that almost 70% of hospice/palliative care patients in the United States are over 65 years of age. For the purposes of this study, hospice/palliative care will be defined as the care given by those who work directly or indirectly with dying persons and their families (Wass, 1978). Reports of 51.56 deaths per nursing home each year (Palliative Care Foundation, 1983) suggest the need for an examination of the issues related to the care of the dying residents in Canadian long term care settings. As the number of the elderly increases in the general population and in care settings, implications for the provision of hospice/palliative care arise. Yokie (1981), the previous Executive Vice-president of the American College of Nursing Home Administrators, believes that there are not many formal programs which specifically address the needs of caring for the dying nursing home residents in the United States. Yokie(1981) suggests that the administrator (i.e. the person responsible for the operation of the facility) in most cases is in a position to identify the needs of the dying resident, and to recognize the ways in which the staff is already oriented towards these patients. He goes on to propose therefore, that the administrators can develop strategies to provide the hospice/palliative care for the patients if required. This operating premise is likely to depend on how

closely the administrator works with those who provide care to the residents in a facility. Where the administrator is closely aligned with the needs of the residents and the staff, Yokie's premise may hold true. If this close alignment does not exist, the administrator may not be in the best position to identify strategies which meet the needs of the residents and staff.

In 1983, the Canadian Palliative Care Foundation conducted a survey which demonstrated that 32 % of all hospice/palliative care programs are offered in chronic and extended care institutions. These programs are founded on the belief that dying residents and their families need the comfort, support, and relief that hospice-type care provides. Because the principles of hospice/palliative care are common to designated hospice beds and nursing homes, the elements of care are also common i.e. the availability of a multidisciplinary team, counselling for the residents, the need for the involvement of close friends and family members, the needs for bereavement, spiritual and religious support. In reality, however, individual nursing homes vary considerably in the quality of care and expertise they are able to bring to the bedside of a dying resident (Skafte, 1988).

Thoreen (1981) reports that a survey of staff working in nursing homes, indicated that 60% of the deaths within their facilities are preceded by a period of known terminal illness and that in 75% of the cases, the staff have difficulty in offering care to the dying residents in the areas of: 1) providing supportive care, 2) relieving the discomfort of the caregivers and,

3) communicating adequately with residents/families. They also expressed a belief that more than four hours of education/training per year on terminal care is needed in:
1) providing comfort care, 2) communicating with residents and families about death, 3) helping with grief and bereavement, and 4) relieving the symptoms of death and dying.

Approximately 46% of the staff indicated that they were already providing some aspects of hospice care, while 45% stated that most hospice principles could be implemented in long term care facilities and, in fact, needed to be offered (Thoreen, 1981).

In 1984, Gotay surveyed nursing home administrators and nursing directors in 83 of Alberta's extended care facilities. Most facilities did not have any specific policies about the care of dying residents, while a number reported being in the process of developing palliative care policies and hospice programs. Buckingham (1983) proposes that if the view that death is more comfortable in one's own bed, in one's own home, attended by familiar staff, then the obligation of the long term care facility to perform these final services must be identified and the facility and staff enabled to offer them. This is what is referred to as terminal care in this study since it is more distinct from acute care, in that it is "more individualized", requiring "one-to-one" care by providing increased attention to both physical and psychosocial needs. Each facility surveyed by Gotay (1984) expressed the belief that hospice/palliative care could enhance the care given to terminally ill patients in extended care institutions. The term

"hospice care" is drawn from the St. Christopher's Hospice in London, England, a pioneer and model service for the care of the dying. This term is used in the United States as a description of the philosophy, style and technique of caring for the terminally ill. In Canada, the term "palliative care" is used instead, drawn from the palliative care unit of the Royal Victoria Hospital in Montreal, a hospital inpatient unit, one of the first hospice services in Canada (Buckingham, 1983; Mount, 1985).

Van Bommel (1986) promotes the use of either hospice or palliative care since he suggests that this approach is as much a philosophy as it is a program or institution. He goes on to define hospice/palliative care as the active compassionate care of the terminally ill aimed at improving the quality of the patient's remaining life i.e. physically, emotionally and spiritually. This care is given at a time when the disease is no longer responsive to the traditional treatment which is aimed at cure or prolongation of life. A multidisciplinary approach is appropriate and includes the patient/family and community within its scope (Van Bommel, 1986). In this study,therefore, hospice
(which is the term utilized more widely in the United States and England) will be used, although in recent years it is becoming more commonly used in Canada.

The results of three surveys (Gotay, 1984; Owen, 1981; Thoreen, 1981) imply that the staff members of nursing homes, the residents, and their families benefit from increased attention to the needs of the dying as well as to the needs of the residents'

families. Therefore, in this study, a death education program which is inclusive of adult education principles, will be used as one means of providing that increased attention.

As the " baby boomer " generation matures and becomes the primary segment of the aging population, the number requiring care in an institutional setting will increase, given the present system of health care in Manitoba and Canada. The demands on the staff providing care will increase, and if current staff are ill prepared to cope with the needs of the dying residents (Owen, 1981), the staff in the future will certainly require more training to improve the quality of care given (Skafte, 1988).

Staff can receive training in a variety of program: i.e. nursing programs for the nurses (Denton and Wisenbaker, 1977; Yarber, Gobel and Rublee, 1981; Swain and Cowles, 1982; McCorkle, 1982), university programs for a mix of professional disciplines (Cook, Oltjenbruns and Lagoni, 1985; Shneidman, 1971; Benoliel, 1982; Leviton and Fretz, 1979; Robinson and Wood, 1983), medical schools for physicians (Dickinson, 1986; Goodell, Donohue and Benoliel, 1982), workshop participation for specific groups (Lanham, Speer, Fritz, 1980; Laube, 1977; Kalish, 1963), attendance at symposiums on the topic of death and dying
(Waldman and Davidshofer, 1984) or by receiving training specific to the needs of staff in nursing home settings (Mullins and Merriam, 1983; Bertman, 1979).

In summary, the problem encountered in reviewing the literature for this study was that there was a lack of research

dealing with the effects of death education programs for nursing and non-nursing staff in long term care in Canada. This suggests therefore, that the question addressed in this study, i.e. **"What is the impact of death education on nursing and non-nursing staff in a long term care setting?"**, would assist in addressing this lack of research.

The purpose of this study, therefore, was to assess the impact of death education instruction on health care employees in long term care.

D. Limitations

The limitations of this study include the following:

1) The amount of time available for instruction of the course. This was set by the institution, and may have an impact on the application to the general field of death education in long term care.

2) The number of staff available for participation in each course. This was due to the voluntary nature of enrollment and may be a factor in the results obtained from the measurement instruments selected.

3) The number of times the course was offered. This was determined by the institution where the research was conducted and may have been a limiting factor on the number of staff wanting to attend.

4) The use of one research instrument as a pre/post-test. One tool was selected by the institution (where the research was

conducted) at the time the death education course was being offered.

5) The lack of use of a research tool to measure the importance of the adult education principles in the course.

6) The lack of correlation between Templer's Death Anxiety Scale (pre/post-test) and others. This may limit the generalization of the results to the broader field of long term care.

E. Delimitations

This study deals with:

1) The selection of one institution from which subjects were obtained
2) The choice of a specific death education program and
3) The choice of addressing only those adult education variables identified by participating staff on their course evaluations.

It is hoped however, that this study will open the door to others in the field of death education and adult education within long term care facilities in Canada. The questions addressed in this study are limited to the field of long term care in that there is a description of the effects (positive or negative) on the staff in <u>one</u> institution; with voluntary staff participation throughout the ten weekly sessions.

Chapter II

Overview of Related Literature and Research

In this review of the literature there are three main emphases :a) death education, b) adult education, and c) care of the aging patient/resident in a long term care setting.

This review will not include literature in aging and death education as it applies to the home or community settings (other than the applications of hospice /palliative care).The literature which will be addressed is that which concerns the care given within institutional settings,i.e. hospitals, extended care facilities, nursing homes, personal care facilities, universities, training sessions, symposiums, and workshops.

A. Related literature on death and death education

Literature which examines the subject of death and death education programs is limited in that reports are segmented by discipline and may not be generally applicable across long term care institutions. In this study, death education may be defined as education/training which focuses on the ways and means of offering humane, dignified terminal care to the dying .The methods used to provide death education for staff in acute care settings are not readily transferable to long term care settings (Kane, 1982; Buckingham, 1983; Mount, 1985, Parry, 1989). The focus of the literature on acute care training/education concerns the nursing staff or the medical staff on ways of improving their care of the

patient (Dickinson, 1986; Goodell, Donohue, Benoliel, 1982; Denton and Wisenbaker, 1977; Yarber, Gobel and Rublee, 1981; Laube, 1977; Swain and Cowles, 1982; McCorkle, 1982; Degner and Gow, 1988). In long term care the health problems of the residents tend to be of a chronic nature since the patients often become lifetime residents within an institution (Wilden, 1988). This is supported by Brook and Williams (1975) who propose that the quality of care in chronic illness is the sum of the technical care provided, the art of the care provided, and the interaction between the two.

When reviewing the content of death education programs therefore, opinions differ, depending on the staff who are to receive the training (Degner and Gow, 1988; Denton and Wisenbaker, 1977; Yarber, Gobel and Rublee, 1981; Shneidman, 1971; Benoliel, 1982; Dickinson, 1986) the setting where the skills and learnings are to be applied, (Mullins and Merriam, 1983; Bertman, 1979; Lanham, Speer,Fritz, 1980; Laube, 1977; Kalish, 1963) and the methodologies used to present the education program (Waldman and Davidshofer, 1984; Cook, Oltjebruns and Lagoni, 1985; Leviton and Fretz, 1979; Robinson and Wood, 1983; Broadfield, 1983; Buckingham, 1983, Mount, 1985).

Abramovice (1988) contends that death education for staff in long term care needs to take a different form, one that emphasizes the psychosocial needs of the patient and the family by bringing into the training milieu the family, the management, the staff and the resident. He suggests that if these sensitizing forums are conducted with skilled facilitation, the problems of staff

attitudes and low staff self-esteem can be addressed first; so that once the attitudinal changes have taken place, the needed technology can be taught and will subsequently be learned and applied better, and retained longer. Abramovice (1988) expounds on the theory that once the long term care staff have an enhanced sense of self-value or self-esteem, they are better able to encourage the resident's self-esteem. He sees this approach as being closely related to a need for a personal approach to death education in long term care. His main concern centres around the fact that virtually all of the people involved in implementing the psychosocial model in a long term care setting, have been trained in an acute care facility where the primary service focuses on the use of medical technology and a low emphasis on the psychosocial needs (e.g. nurses, aides, orderlies, dieticians, pharmacists,occupational therapists and physiotherapists, physicians, respiratory ,social workers, laboratory and radiology technologists and health record technicians are being trained in acute care hospitals or in acute care hospital methodologies). In Abramovice's experience, unless and until the attitude and self-esteem of the caregiver is addressed and a commitment made by the administrator and staff to improve the quality of care in a long term care setting, the resident will <u>not</u> experience the psychosocial model which develops a truly positive environment where growth and independence are possible and where self-esteem and dignity are maintained. Kane and Kane (1987) state that long term care is not about placements, cases, and target groups, but about people, their

families, their communities and their lives. This would suggest then, that long term care staff could benefit from education/training which addresses the gap between the acute care training and that required for long term care.

Research reviewed for this study, however, on the effective application of death education in nursing homes/personal care homes has been extremely limited and research on death education based on adult education principles seemed to be nonexistent. The available studies have primarily centered around the role of the nurse in providing care to the long term care resident, with an absence of emphasis on the role that other members of the caregiving staff play in promoting or preventing increased anxiety in the resident who is experiencing chronic or terminal illness (Heidemann, 1986; Mullins and Merriam, 1983; Bertman, 1979, Broadfield, 1983; Parry, 1989).

There is a considerable amount of literature available on the topic of hospice or palliative care for the dying person in both community and institutional settings (Shedletsky and Fisher, 1986; Holden, 1976; Degner, Chekryn, Gow, Koop, Mills, Reid, 1982; O'Connor, Burge, King and Fisher, 1986; Roy, 1986, 1989; Heidemann, 1986; Bertman, Greene and Wyatt, 1982; Kristjanson, 1989; and Munley, Powers, Williamson, 1982).

This literature does <u>not</u> however deal with the topic of death education specifically developed on the basis of the principles of adult education and which is subsequently offered to a cross-section of staff working in a long term care institution. This lack

of research includes any reference to the personnel from the departments of Dietetics, Health Information Services, Housekeeping, Laboratory Services, Nursing, Physiotherapy,Radiology, Recreation, Respiratory, Social Services, and Volunteer disciplines working in long term care facilities (Bertman, 1979). If staff from such a cross-section of caregivers were to receive death education it is possible that there would be changes in the staff anxiety levels (Denton and Wisenbaker, 1977; Laube, 1977; Waldman and Davidshofer, 1984, Templer, 1971). Changes in their patient avoidance behavior and in their attitudes about caring for the elderly may be experienced as anxiety levels decrease (Buckingham, 1983). Denton and Wisenbaker(1977) argue that <u>any</u> form of anxiety reduces the ability of an individual to perform tasks in a setting where anxiety is aroused. It could be expected therefore, that the care given by staff trained in the area of death education would be more comforting for the residents <u>and</u> the families concerned
(Lanham, Speer, Fritz, 1980; Kalish, 1963;and Laube, 1977). There are some existing studies dealing with death education programs which have been conducted with staff trained for acute care settings, specifically the nursing and medical staff
(Degner and Gow, 1988; Popoff, 1974; Denton and Wisenbaker, 1977; Yarber, Gobel and Rublee, 1981; Laube, 1977; Swain and Cowles, 1982; and McCorkle, 1982), with students enrolled in educational institutions (Rublee and Yarber, 1983; Shneidman, 1970; Benoliel, 1982; Degner and Gow, 1988; and Lanham, Speer and Fritz, 1980) and

with some nursing staff employed in nursing homes (Mullins and Merriam, 1983).

Degner and Gow (1988) conducted a critical evaluation of fifteen studies of death education in nursing and reported that although most of the studies demonstrated that death education reduces the level of death anxiety or improves death attitudes in nurses, others found no such effect or had nondefinitive results. They report that nurses need to receive education on the nursing models of comfort-oriented care, and that in their review of the fifteen studies of death education, three approaches to teaching this content have been:

1. integrating specific learning experiences on death and dying into a pre-existing curriculum

2. Offering an elective course e.g. where the teaching - learning strategies used in the integrated program have been supplemented by the addition of role playing and the use of sensitivity exercises.

3. Altering the curriculum to include a required course. e.g. where the emphasis was on the use of supervised assignments with dying patients and their families.

Nurse educators in hospital or baccalaureate programs have adopted either of the first two approaches, while continuing education and graduate programs use the second alternative. Most frequently, basic nursing programs have integrated this education into the general curriculum at various levels of the nursing program. The content includes lectures, seminars, on the topics of

communications skills, grief and mourning, personal feelings about death and dying, readings, videotapes and audiovisual materials on the care of the dying, exposure to the care of the dying/families in clinical practice, conferences to analyze these situations, and faculty counselling of students as required. An important factor in the teaching of a death education course is the degree of comfort experienced by the faculty responsible for the course.

Buckingham (1983) firmly states that living patients identify with the dying because they know that the care given to the dying patient will be the same for them. This means, he continues, that the way in which the dying patients and their memories are treated, become an indicator of the quality of life remaining to the patients themselves and unless ongoing inservice, training and education are provided for the long term care staff, the ability to communicate feelings, ideas and needs with the patients/residents cannot be developed and offered.

Lanham, Speer and Fritz (1980); Mullins and Merriam (1983); and Denton and Wisenbaker (1977) further report that in their experience, the results of death education programs/courses indicate that there is an accompanying reduction in contact avoidance with patients who are dying or who are the recipients of long term care, when care is given by the staff who have been trained in the area of death education. The frequency and quality of communication of feelings, ideas and needs given to these patients rise (Broadfield, 1988; Buckingham, 1983; Henteleff, 1987;Mount, 1986) when the staff are more comfortable with their

own feelings about death and subsequently are better able to assist the families in coping with the reality of their family member's impending death (Lanham, Speer, Fritz, 1980; Leviton and Fretz, 1978; Kalish, 1963; Laube, 1977; McCorkle, 1982; and Robinson and Wood, 1983).

B. Related literature on Adult Education

Adult educators (Andrews, Houston and Bryant, 1981; Brookfield, 1986; Brundage and Mackeracher, 1980; Godbey, 1978; Knowles, 1986; and Merriam and Simpson, 1984) support the view that the area of adult education is far reaching and can encompass a multitude of learning environments and methodologies. If Godbey's definition of adult education, as being "all forms of learning opportunities provided for adults", is used in this study, the conducting of a death education course within a specific health care setting certainly falls within the parameters of an adult education opportunity. Fox (1987) suggests that the necessity for the implementation of adult education principles is warranted because these principles are beneficial in guiding the education of the staff in providing care to the adult patient/residents in a long term care facility.

Brookfield (1986) proposes that there are six central principles which create a conducive learning environment and allow for effective practice and facilitation of learning:

1) Participation in learning is voluntary.i.e. adults engage in learning as a result of their own volition, 2) Effective practice

is characterized by a respect among participants for each other's self-worth, 3) Facilitation is collaborative....leadership and facilitation roles will be assumed by different group members, 4) Learners and facilitators are involved in a continual process of activity, reflection upon activity, collaborative analysis of activity, new activity, further reflection and collaborative analysis....., 5) Facilitation aims to foster in adults a spirit of critical reflection, and 6) The nurturing of self-directed empowered adults. These six principles of facilitation have numerous implications for practice and are observed in many different settings, e.g. adult education, continuing education, networks, self-directed learning, community action, university courses, seminars, workshops, professional development sessions and training courses. These principles formed the basis of the philosophy behind the research, development, implementation and evaluation of the specific death education course referred to in this study.

If the adult learning opportunities are structured in their development process so that the following are observed, the educator can be assured that opportunities for the learner to experience self-directed learning have been provided.

Each adult:

1) Progressively decreases their dependence on the educator
2) Understands and learns to use resources (material and human) as a way of sharing their experiences with others (i.e. with other learners and with the educator)
3) Defines their own learning needs e.g. physical, emotional, psychological, cultural, religious
4) Develops responsibility for setting the learning objectives, plans their programs, and evaluates their progress
5) Organizes the learning to make linkages with their own experiences and needs
6) Improves their decision making, and consequently increases their tolerance for alternative ways of understanding
7) Develops criteria to judge what is relevant/irrelevant to their learning
8) Develops skills of problem posing/ solving as it relates to their own personal problems or public issues
9) Provides a supportive feedback learning climate, avoiding competitive judgement

10) Participates in experiential instructional methods.

Rogers (1986) reports that there was a remarkable degree of agreement by 147 members of the American Commission of Professors of Adult Education that these practices are positive indicators that adult education principles are being practiced. Griffin (1983) and Langenbach (1988) have written about curriculum in adult education. However, because methods and content are integral to curriculum, it is possible to refer to what is known about curriculum in schools, as another source of reference when developing courses based on adult education principles. If we accept Rogers premise that curriculum is "all the planned experiences which the learner may be exposed to in order to achieve the learning goals" then an adult education curriculum should contain the five elements of addressing the:

1) philosophical framework - i.e. the attitudes and assumptions of the educator and which subsequently underlie the teaching
2) context
   a) setting - room, furniture, lighting, heating, noise levels, formal/informal, location, social environment
   b) climate- i.e. the atmosphere between the educator and the learners, amongst the learners themselves, or the stability of the timetable

3) content - i.e. the material to be covered in the course, the sequence of the content and the conditions attached to the learning

4) events - i.e. the planned activities and how the learner will participate, the sequencing of these activities, plans for the handling of unplanned activities, and preparation for ways in which the educator can redirect distractions back to the learners' goals

5) evaluation process - i.e. the ways in which the educator and the learners can use the planned evaluation processes to express their satisfaction/dissatisfaction by completing feedback activities, critiquing instruments, assessment forms.

Once the curriculum consists of these five elements the sequence of experiences and the underlying philosophy make up the learning.The role of the educator/instructor however, is the key in how the teaching style, methods, the instructor perceptions, and the content of the teaching/learning encounter are linked. Rogers(1986) matrix of methods/content in the adult learning process could be considered as a model for adult educators to follow in the course of the development and teaching of any course.

Teacher centered

Content oriented <- - | - -> Process oriented

Learner centered

The educator's choice of approach in the development and teaching of a course will be dependent upon their personal attitudes about the balance needed between content and methodology (Rogers, 1986). The emphasis needs to be on the sharing of the learning process between the instructor and the learner for maximum benefit from the learning activities.

Andrews, Houston and Bryant (1981) have prepared charts/exhibits delineating:

a) what a skillful moderator should do,

b) what the learning process should include, and

c) what the content of learning should cover.

Their report and exhibits are in agreement with the writings of other adult educators (Brookfield, 1986; Brundage and Mackeracher, 1980; Godbey, 1978; Knowles, 1986; Merriam and Simpson, 1984) as to the philosophy, content and sequencing of learning activities which maximize the learners' opportunities for self-directed learning. Knowles(1986) recommended that instead of the educator planning for and hoping that the learner will be self-directed as a result of the planning process, that a learning contract be set up with the adult learners so that they are in agreement from the outset with the objectives and activities required to fulfill their identified needs. Other adult educators suggest that there are many methods which could be employed to assist the learner with the development of skills for achieving their identified goals (Andrews, Houston and Bryant, 1981; Brundage and Mackeracher, 1980; Rogers, 1986) without specifically using learning contracts. There is agreement

nonetheless by all of these adult educators on the need to involve the learner in the learning process. The choice of content, methodology and evaluation process selected is simply one of choosing what is needed to complete the experience as designed and intended.

It would seem therefore, that if an educator was to include the methods and processes recommended by this body of adult educators, that the learning for participants in any course would be enhanced. However, as stated in the review of the literature for this study, there was a lack of research integrating adult education, death education and the field of long term care for nursing and non-nursing staff.

Given the work reviewed by Abramovice (1988) and the critical review of death education in nursing by Degner and Gow (1988), there seems to be support for the integration of adult education, death education and the needs of long term care staff,as taken in this study. Abramovice suggests that the format for a death education course in a long term care setting should be different from that experienced by staff working in an acute care hospital. The staff in the long term care setting would benefit from a focus on developing and understanding their own self-esteem, before any issues related to the care they offer in a long term care setting are considered. With reference to the Degner and Gow (1988) research, the content of the death education course(i.e. grief and mourning; care of the dying; exposure to the care of the dying and their families); and some of the methodologies (i.e. lectures,

seminars, assigned readings, the use of audiovisual materials, as well as the inclusion of one to one counselling,) have been incorporated into the course design and implementation. The methodology has been expanded to include a journal type assignment in addition to the lectures, seminars, group discussions, application and self assessment activities, combined with the use of audiovisual materials.

The question in this study (i.e. **What is the impact of death education instruction on nursing and non-nursing staff in long term care?)** provided some interesting results.

Chapter III

Methodology and Research Procedures

A. Sources of data

In the previous section (i.e. the literature review) the sources consulted were: Deer Lodge Centre Library, Deer Lodge Centre Health Information Services Department, the Human Resources Department, the Education Services Department; the University of Manitoba Dafoe and Woods Libraries; The Winnipeg Public Library, a research project conducted by Rudolph Moos from the Stanford University Medical Center, California, and the Manitoba Hospice Foundation Library.

The major purpose of this study was to identify the effect (positive or negative) which a specific course (namely the Patient Relations and Communications Course) had on the nursing and non-nursing staff in a long term care facility.

Buckingham (1983) states that the staff in a long term care facility need unique kinds of support in that they care for the dying patients and offer help to the families. They must deal with their own feelings about dying and death and unless they are in touch with their own feelings they cannot be open to the feelings of others, because the depth of feelings they are exposed to opens within them the same fears, desolation and depression they would experience in a personal grief and loss situation.

This study reports the results of the nursing and non-nursing staff who participated in a ten session course which dealt with communication skills and topic areas related to death and dying.

The question being examined in the study is: **What is the impact of this course on the nursing and non-nursing staff in long term care?** (Leviton and Fretz, 1978; Waldman and Davidshofer, 1984). Denton and Wisenbaker (1977) propose that staff working in health care face the spectre of death more often and more consistently than any other group of professionals, and that the reaction of such personnel to death is an extremely important variable in the care given to the dying patient. Their premise is that any form of anxiety experienced by staff reduces their ability to perform well in their jobs and raises two questions based on such a premise:

1) How and why do staff react to death (both professionally and personally) and

2) What programs are available to assist the staff to understand and cope more effectively with their feelings and reactions toward death?

Denton and Wisenbaker's suggestion that staff exhibiting any form of anxiety which thereby reduces their ability to perform well in their job is in contrast to the commonly understood premise behind any reference to the normal curve, which is a symmetrical bell-shaped curve. When a bell shaped curve is used as a basis for the measurement of a variable (i.e. anxiety), there is an assumption that 99.74% of all scores will fall between +3 and -3 in the distribution of scores (Moore, 1983; Borg and Gall, 1971). If the bell shaped curve, accounting for 99.74% of the range of scores, was the measurement used to assess the anxiety experienced by staff (as Denton and Wisenbaker suggest), then <u>all</u> staff

exhibiting anxiety would be considered to be unable to do their jobs well. If the bell-shaped curve, however, was used as it is proposed by Moore (1983) and Borg and Gall (1971),then only those staff exhibiting anxiety levels exceeding +2 or -2 on the distribution curve would be considered as being unable to perform their jobs well, since there is a range of scores on the curve which are considered to be "normal"
(accounting for 68.26%). In their study, Denton and Wisenbaker consider any anxiety shown by the staff as being a negative factor in the performance of their work.

When bringing the staff into contact with the topic and experience of death, Denton and Wisenbaker (1977) identified a dilemma faced by the caregivers. The caregivers must work with the dying, so adequate education would seem to require being brought into contact with death and dying experiences. On the other hand, such contact could increase the anxiety, with the consequence being that there could be a reduction in the effectiveness of the care given the dying patient.

Broadfield (1988) states that the issue of education for the staff who care for the dying must be addressed twofold: 1)to help caregivers develop their technical skills in the care of dying patients, and 2) to include education which will enhance the staff's comfort in giving a humane approach to dying patients.

The research surveyed is inconclusive as to whether the anxiety level of the staff giving care to the dying is lowered by exposure to death and dying education. This study examines the question of whether there is a change in the death anxiety level from the time the pre test was conducted, a course was offered dealing with death and dying, to the time the post test was completed.

B. Design

This study is a pilot project. The basic design is analytical and was conducted after the completion of a course within the past two years. In the first step, a random selection of 100 subjects who were still on staff and who had completed an "inhouse" course on death education (developed and offered according to the principles of adult education), and who had completed the pre-test of Templer's Death Anxiety Scale (or DAS) were contacted to ask for their participation in this study. They were asked to sign a consent form (see Appendix G) and to return it to the investigator. The second step involved sending each consenting staff member a copy of the DAS post test (Appendix D.i), a demographic sheet (age grouping, sex, department, educational grouping) as in Appendix D.ii. Permission to use the comments from their completed course evaluations (already on their training files within the institution) was requested in the consent form. This meant that the data relating to the specific parts of the death education "inhouse" course which enhanced their learning was accessible as an

aid to identifying the adult education principles which were considered by the respondents to be most effective in the teaching of this death education course (Appendix D.iii).

C. Research Instruments

1. Templer's Death Anxiety Scale

The Templer (1970) instrument consists of 15 True-False items describing personal reactions to death related statements. Templer designed the instrument as a means of assessing the relative anxiety produced by reading and completing the statements. The scale can be self administered and requires little or no specific skills or provisions for completion beyond an introductory paragraph to provide a frame of reference. Directions precede the actual scale. Templer reports that the test-retest reliability and consistency were determined and the validity of the scale was established by two measures:

a) Presumable high death anxiety in psychiatric patients was found to be significantly higher than in the control patients and

b) DAS scores correlated significantly with the Fear of Death Scale or FODS Scale (another death anxiety questionnaire), and with a sequential word association task. The chief limitation of this scale (Templer, 1970) is that norms have not been established, although means and standard deviations for a number of subject categories have been identified. An advantage of this scale is the fact that it is worded simply and devised to allow people to rate the statements quickly. Phi coefficients were computed to determine

relative independence of items and the coefficients of correlation did not exceed 0.65, therefore the inference is that there is not excessive interitem redundancy.

In a project where 2500 subjects from 19 to over 85 years of age were examined, there was no relationship between age and DAS scores (Templer, 1971). Females consistently have higher DAS scores than males. The scale scores range from 0 to 15 with the means of normal subjects being roughly 4.5 to 7.0, and the standard deviations a little over 3.0. Therefore this scale offers a simple means of measuring death anxiety. It is however a pilot use for the scale in a long term care setting for the measurement of death anxiety in nursing and non-nursing staff (Appendix D.i).

The scoring of responses for each of the fifteen True-False items for each of the respondents was based on a "correct versus an "incorrect" answer key developed by Templer. "Correct" in this sense, means that the person feels a high level of anxiety when answering the question. Templer posits that anxiety is considered to have been reduced if the number of correct responses decreases from the pre-test to the post-test. This is the premise which was used in determining the mean difference on each item for each person surveyed.

2. Demographic Sheet

This sheet is designed to provide information on the background of the staff who consented to participate in the study for analysis purposes only (Appendix D.ii). It was adapted from a

demographic sheet developed by Rudolph Moos (1984). The adaptation was necessary so that only those areas directly relating to the research question in this study were asked.

3. Course Evaluation

The comments on this form were used to identify the particular methodologies which most enhanced the staff's learnings from the death education course. The evaluation form itself was structured according to the adult education principles of evaluation and provided an opportunity for open and close ended responses about the content/methods which the staff considered to be significant to their learning. Subjects were advised (at the time of the completion of the evaluation form (during the tenth session) that they were not required to answer all questions if they did not choose to do so. (Appendix D.iii).

D. Subjects

Of a possible 184 long term care staff (nursing and non-nursing) at Deer Lodge Centre who participated in an "inhouse" death education program developed according to adult education principles, a random selection of 100 from those still employed in the institution was made. Each person received a letter explaining the purpose of the study and asked for their participation in the study. Each person who responded positively received a copy of the DAS Post test and the demographic sheet (Appendices D.i and D.ii) for completion and return to the investigator.

Deer Lodge Centre was selected as it offered a large number of potential staff who had completed an inhouse death education program (184 out of 550, or 33.4%) designed according to the principles proposed in adult education and conducted by the investigator. A further brief history of this facility can be referred to in Appendix B. Since it is currently a provincial health care institution, it does not have a specific ethnic or religious affiliation. Because both personal and extended care of a geriatric population of patients/residents is offered, the staff providing the care are exposed to multiple deaths during their caregiving. It is important then that the staff receive education which would aid them in reducing their anxiety about dealing with death and dying as one means of improving the quality of care given to the patients/residents and their families.

Those not wanting to participate had their decision honored without any fear of a negative impact on their job security. A return of 75% of the 100 subjects sampled was required for the purposes of this study. If less than 75% had responded from the 100 sampled, a sample would have been drawn from the balance of the names of the remaining staff (who had completed the inhouse death education course), or until the 75% return had been achieved. This latter procedure was unnecessary because the actual rate of return from the 100 sampled was 91%.

All answers remained confidential. After the letters of consent and the research instruments were returned, the list of participants was destroyed by the researcher. Upon completion of

the analysis of the data on the pre/post tests and the demographic sheets (Appendices D.i and D.ii), those sheets were also destroyed by the researcher. The course evaluation forms were returned to the individual training files by the researcher (Appendix D.iii).

During the period of this study, all data relating to the participants was kept in a locked drawer by the researcher. The analysis of the results was considered as part of the data relating to participants and was also kept in a locked drawer.

E. Accessing subjects

Since all the staff who had completed the death education course were employed or were volunteers within the institution, the administration of the Centre was contacted to ask for written approval for the study. The initial contact was verbal, giving a brief description of the study and its background. A written proposal followed and included an explanation of the study, the criteria for the selection of subjects, the expected time requirements for the staff who participated in completing the research forms and the measures which were to be taken to ensure anonymity and confidentiality for all staff and their responses.

Any other clarifications required by the administration were provided. A summarized final report was offered to the institution and to the subjects.

A written response giving permission to conduct the study at Deer Lodge Centre was received (see Appendix F).

F. Protocol for selection of subjects

From class lists (computer generated by Deer Lodge Centre) of the names of staff members who had completed the Patient Relations and Communications Course, a systematic random sampling of names was made by selecting every fifth name on the list until the total of 100 had been prepared. Each name was assigned a code for identification purposes and the list of names was locked away until permission had been granted by the administration of Deer Lodge Centre allowing the study to take place. Upon receiving permission to conduct the study, a copy of the consent form (Appendix G) was sent to each of the selected subjects. A self addressed envelope and a red confidential sticker was included to facilitate the return of the consent form.

Upon receiving the signed consent form, each subject was sent a copy of the Templer's Death Anxiety Scale Post-Test (Appendix D.i) and the Demographic Sheet (Appendix D.ii) for completion, along with a self addressed envelope and a red Confidential sticker for the return of the instruments to the investigator.

The investigator then destroyed the list of subjects (by name and identifying number). As the results of the Pre/Post tests were compiled, the tests themselves were destroyed by the investigator. Following the data analysis and the compilation of the demographic sheets, the original sheets were destroyed by the investigator.

The data analysis consisted of computing a "z " score for each of the fifteen True-False items on the Templar's Death Anxiety Scale and a "t" score to calculate the overall change in proportion

of the anxiety level for the group from the pre to post test on the Death Anxiety Scale. This analysis will provide indicators of" change" or" no change" in anxiety level, given the pre-test, intervention of instruction, post-test measurement methodology.

Chapter IV

Analyses and Discussion of Data

The analyses and discussion of the data are presented based on the classification of topics versus a numerical sequence on the research instruments. The initial section outlines the return rate for the demographic sheet, followed by the data related to the course evaluation and the pre-post test data complete with the hypotheses and supporting data. The final section provides the data analyses and discussion related to the adult education questions as drawn from the course evaluation. **The data analysis for <u>all</u> tables is based on 100 nursing and non-nursing staff having been surveyed, with 91 responding.**

A. Return Rates for the Demographic Sheet

(Appendix D.ii)

Tables 1-9 present the data related to the demography of those surveyed. Each of the tables has the corresponding question number from the Demographic sheet indicated.

Table 1.0. Age groupings

	Frequency of response	% of response
15-19	02	02.2%
20-24	05	05.5%
25-29	20	22.0%
30-34	15	16.5%
35-39	12	13.2%
40-44	07	07.7%
45-49	16	17.6%
50-54	07	07.7%
55-59	03	03.3%
60-64	01	01.1%
65 +	03	03.3%
Totals	91	91.0%

In Table 1, it can be noted that the largest group of those attending the classes are between the ages of 25 and 34 (38.5%), with another 20.9% of the staff in the age group from 35-44 years of age, and 25.3% in the age group from 45-54. The mean age of those surveyed (n = 91) was calculated to be 37.7 years. This must be interpreted cautiously since the change in anxiety level may have been the result of the life experiences of those attending more than by the death education instruction.

Table 2.0. Department, Mean Age, Gender

Department	Mean Age	Gender Female	Male
Day Hospital	39.3	04	00
Dietetics Department	29.0	01	00
Health Information	37.3	03	00
Housekeeping	28.5	00	02
Lab Services	35.5	02	00
Materiels Management	55.0	00	01
Nursing Department			
a) R.N.	38.6	16	00
b) L. P. N.	38.6	10	00
c) Nursing Aide	30.8	12	00
d) Nursing Orderly	40.3	00	06
e) Ward clerk	31.0	03	01
Physiotherapy	41.0	02	00
Prosthetics	36.0	01	00
Radiology	34.5	02	00
Recreation	35.3	08	02
Respiratory	50.0	01	01
SociaL services	34.0	01	00
Volunteers	43.4	09	03
Mean	37.7	N = 75	N = 16

Table 3.0. Gender Distribution

	Frequency of response	% of response
Female	75/81	92.6%
Male	16/19	84.3%
Totals	91/100	

In Table 3, it can be noted that the majority of the nursing and non-nursing staff who agreed to participate were female. This is an accurate reflection of the attendance in classes since the majority of staff who attended the course were female. This is also a reflection of the reality in health care where 90% of the employees are female (Center for Women in Government, 1988).

Table 4.0. Educational Background

	Frequency of response	% of response
High school/GED	19	20.9%
Trade school/diploma	04	04.4%
Nursing Department		
a) Registered Nurse	16	17.6%
b) Licensed Practical	10	11.0%
c) Nursing Aide	12	13.2%
d) Nursing Orderly	06	06.6%
e) Ward clerk	03	03.3%
Community College	12	13.2%
University degree	08	08.8%
Graduate degree	01	01.1%
Totals	91	100.0%

Table 4 indicates that the majority of those responding (59.4%) have received post-secondary training from a trade school, community college or nursing training (i.e. Registered Nurse, Licensed Practical Nurse, Nursing Aide) and that 9.9% have a university education. The factor which is unknown to the investigator is whether the nursing orderlies have post-secondary training since those who responded (six males) did not indicate whether they had any post-secondary training; while the nursing aides who replied did indicate that they had completed a nursing aide course after completing high school.

Table 5.0. Response Rate by Shift Worked

	Frequency of response	% of response
Days	81/ 88	92.1%
Evenings	08/ 09	88.9%
Nights	02/ 03	66.7%
Totals	91/100	

There seemed to have been more participation by staff on days.

This may have been because it was easier to accommodate their attendance because more staff are on days and the absence of a staff member was easier to oblige. The classes were held during the working day.

Table 6.0. Classification of positions

	Frequency of response	% of response
Full-time staff	**62/ 68**	**91.2%**
Part-time staff	**19/ 20**	**95.0%**
Volunteers	**12/ 12**	**100.0%**
Totals	**91/100**	

In Table 6, it can be noted that when those participating in the study were asked to indicate the classification of their position, they were not requested to differentiate between part-time and casual status. Therefore the number of casual employees within the part-time classification is unknown and subsequently it is not possible to differentiate between a position which is 0.2 of a full-time position and a 0.8 of a full-time position, versus a casual employee working shifts whenever they are called. This may or may not be a significant factor in the ratings given. It is interesting to note that the volunteers attended all classes on their own time.

In Table 7, a summary has been drawn from the comments of those surveyed, about the ways in which they have made applications of the skills, behaviors and information from the course in a personal or professional situation.

Table 7.0. Specific applications on your job

1. I realize the importance of the nonverbal and verbal communications with the residents/families/co-workers more.
2. I listen to the residents/patients more than I did before the course
3. My self confidence has increased
4. I find it easier to talk to co-workers, patients/residents and families about death
5. I can sit with a dying patient now and be comfortable in doing so

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Table 8.0. Return Rate - Nursing and Non-nursing Staff

	Frequency of response	% of response
Day Hospital	04/ 04	100.0%
Dietetics Department	01/ 04	25.0%
Health Information Services	03/ 03	100.0%
Housekeeping Department	02/ 05	40.0%
Lab Services Department	02/ 02	100.0%
Materiels Management	01/ 01	100.0%
Nursing Department	48/ 52	92.3%
PhysioTherapy Department	02/ 02	100.0%
Prosthetics Department	01/ 01	100.0%
Radiology Department	02/ 02	100.0%
Recreation Department	10/ 10	100.0%
Respiratory Department	02/ 02	100.0%
Social Services Department	01/ 01	100.0%
Volunteer Department	12/ 12	100.0%
Total	91/100	

Table 8 presents the return rates for the staff/volunteers. The rates range from 25% in the Dietetics Department to 100% in

nine departments. An unknown factor is why the return rates for the Dietetics Department was at the 25% range. It is possible that the specific dynamics within the department at the time the survey was conducted, played a role in the response rate.

Table 25, presents some generalizations drawn from the comments made by those surveyed in Question 7 as part of the adult education data analysis and discussion portion of this chapter. A detailed list of verbatim comments can be found in Appendix K.

Table 9.0. Other Comments

I'll miss the classes.

Learning about ourselves was helpful personally and professionally.

Other co-workers have commented on how my approach to residents is different than before the course.

Library readings were helpful but difficult to make use of because there was no Xerox machine available.

B. Analysis and Discussion from the Course Evaluation (Appendix Diii)

Tables 10-17 present the data from the Course Evaluation completed by those who were surveyed.

The data analyses and discussion which follows in Tables 10.1-

10.10 are based on the course evaluations which were completed during the last session of the death education instruction. The data are reported with respect to each of the topic areas presented in the course. These topic areas include: Introductory Session, Looking at Self; Attitude Cycle; Understanding the impact of institutionalization; Nonverbal communication; Listening, giving and getting information; Calming hostile people; Assertiveness; Terminal Illness, a personal perspective; Terminal Illness, a professional perspective; and the Course Summary. A description of each of the sessions and information about the format of the course can be found in Appendix C. A 5 point Likert scale was given as the means of rating each session and those surveyed were asked to rate each session somewhere between the "not helpful" to "some help" to "very helpful". Some of those surveyed did not rate a particular session, hence the additional heading of " No Rating Given" for each of the sessions.

Table 10.1. Session 1. Introduction and Looking at Self

	(Question 1a) Frequency of response	% of response
No rating given	05	05.5
1 Not helpful	01	01.1%
2	01	01.1%
3	15	16.4%
4	38	41.8%
5 Very helpful	31	34.1%
Total	91	100.0%

Table 10.1 indicates that 75.9% of those surveyed found the introductory session to have been helpful (referring to #4 and #5 on the ratings scale).

Table 10.2. Session 2. Attitude Cycle

	(Question 1b) Frequency of response	% of response
No rating given	00	0.00%
1 Not helpful	00	00.0%
2	00	00.0%
3	08	08.8%
4	29	31.8%
5 Very helpful	54	59.4%
	91	100.0%

Table 10.2 indicates that 91.2% of those surveyed found the session on attitudes to have been very helpful (drawn from the #4 and #5 on the ratings scale).

Table 10.3. Session 2. The Impact of Institutionalization

(Question 1c)

	Frequency of response	% of response
No rating given	01	01.1%
1 Least helpful	01	01.1%
2	00	00.0%
3	06	06.5%
4	30	33.0%
5 Very helpful	53	58.3%
Total	91	100.0%

Table 10.3 presents data indicating that 91.3% of those surveyed found the session on understanding the impact of institutionalization to have been significantly helpful to them (drawn from the #4 and #5 ratings scale).

Table 10.4. Session 4. Nonverbal Communication

(Question 1d)

	Frequency of response	% of response
No rating given	02	02.2%
1 Least helpful	00	00.0%
2	00	00.0%
3	14	15.3%
4	24	26.4%
5 Very helpful	51	56.1%
Totals	91	100.0%

Table 10.4 indicates that 82.5% of those surveyed found the session on nonverbal communication to have been very helpful (drawn from the #4 and #5 on the ratings scale).

Table 10.5. Session 5. Listening

(Getting and Giving Information)

	Frequency of response	% of response
No rating given	02	02.2%
1 Least helpful	01	01.1%
2	00	00.0%
3	11	12.1%
4	28	30.8%
5 Very helpful	49	53.8%
Total	91	100.0%

Table 10.5 was rated by those surveyed as being very helpful (84.6%, drawn from the #4 and #5 on the ratings scale).

Table 10.6. Session 6. Calming Hostile People

(Question 1f)

	Frequency of response	% of response
No rating given	01	00.0%
1 Least helpful	00	00.0%
2	01	01.1%
3	18	19.8%
4	35	38.5%
5	36	39.6%
Total	91	100.0%

Table 10.6 indicates that 78.1% of those surveyed found this session to have been very helpful (referring to #4 and #5 on the ratings scale).

Table 10.7. Session 7. Assertiveness

(Question 1g)

	Frequency of response	% of response
No rating given	00	00.0%
1 Least helpful	00	00.0%
2	00	00.0%
3	08	08.7%
4	28	30.8%
5 Very helpful	55	60.5%
Totals	91	100.0%

Table 10.7 indicates that 91.3% of those surveyed found that this session on assertiveness was very helpful (drawn from the #4 and #5 on the ratings scale).

Table 10.8. Session 8. Terminal illness, a personal perspective

(Question 1h)

	Frequency of response	% of response
No rating given	01	01.1%
1 Least helpful	00	00.0%
2	01	01.1%
3	05	05.5%
4	39	42.8%
5 Very helpful	45	49.5%
Totals	91	100.0%

Table 10.8 indicates that 92.3% of those surveyed found this session on the personal perspective of dealing with terminal illness to have been very helpful (drawn from the #4 and #5 on the ratings scale).

Table 10.9. Session 9. Terminal Illness, Professional Perspective(Question 1i)

	Frequency of response	% of response
No rating given	01	01.1%
1 Least helpful	00	00.0%
2	00	00.0%
3	07	07.6%
4	43	47.3%
5 Very helpful	40	44.0%
Totals	91	100.0%

Table 10.9 indicates that 91.3% of those surveyed fond this session on the professional perspective of dealing with terminal illness, to have been very helpful (drawn from the #4 and #5 on the ratings scale).

Table 10.10. Session 10. Course Summary (Question 1j)

	Frequency of response	% of response
No rating given	**03**	**03.3%**
1 least helpful	**00**	**00.0%**
2	**00**	**00.0%**
3	**10**	**11.0%**
4	**23**	**25.2%**
5 Very helpful	**55**	**60.5%**
Totals	**91**	**100.0%**

Table 10.10 presents data indicating that 85.7% of those surveyed found this session which summarized the entire ten weeks of the course to have been helpful (drawn from the #4 and #5 on the ratings scale).

It would appear that those surveyed considered the sessions to have been of value to them. In the case of the "no response" category, no rating was given for that specific session. The sessions which were ranked highest (i.e. over 90% positive response - using the categories of #4 and #5 on the Likert scale as the indicators of a positive response for each session), were: Session 2, The Attitude Cycle, 91.3% ; Session 3, Understanding the Impact of Institutionalization, 91.3% ; Session 7, Assertiveness, 91.3%; Session 8, Terminal Illness, a Personal Perspective, 92.4% ; and Session 9, Terminal Illness, a Professional Perspective, 91.3%. It is possible that these sessions were ranked high because the largest percentage of class time in these sessions was spent on role plays, group discussions and self assessment activities, which were ranked as valuable methodologies by those surveyed, and acted as reinforcements of the specific application assignments.

The sessions which were ranked next highest (i.e. between 80-89% positive response were: Session 4, Nonverbal Communication, 82.5% ; Session 5, Listening, Giving and Getting Information, 84.7% ; and Session 10, Course Summary, 85.8% . These sessions contained less time on role plays and more on the practice of specific skills during class time, with emphasis on application and practice outside of the class time. To some degree, these sessions were more theoretical than the sessions which were ranked over 90 % .

The sessions which were ranked the lowest (i.e. between 75-79%) were Session 1, Introduction and looking at self, 75.9% and Session 6, Calming hostile people, 78.1% . In the rating of Session

1, it is not known why five respondents placed no ranking on this item. This rating may be lower because more of the class time is spent on introductory activities, e.g. meeting each other, having the course outline and assignment structure explained, an explanation of where the reference materials could be found and how to access them, where counselling assistance could be found if required, and the importance of the confidentiality of the class activities and comments. A considerable amount of time was spent in a discussion of what voluntary versus mandatory attendance means and each person was encouraged to discuss this with their supervisor before deciding to return to Session 2 voluntarily . Therefore the bulk of the class time was more information oriented and appears to have been less positively rated than the subsequent sessions which were more experiential in nature. The lower rating for Session 6 may have been related to a reluctance on the part of the staff to have conducted an indepth examination of their own feelings about anger and frustration during that class. The class which followed, Session 7 on Assertiveness, was really an integration of all the skills and behaviors which had been practiced and learned until that session. During session 7, there was considerable discussion and practice on how to say things and how to handle very specific situations which were raised during the class. It is possible that the content of Session 6 required more analysis and synthesis that could be dealt with individually during a two-hour class.

The results of the overall rating of the ten sessions

indicate that eight out of the ten were considered to have a positive benefit ranging between 80 and 95%. The participative structure and design of the course seem to have been rated as positive by those who were surveyed.

Question 2 on the Course Evaluation pertains to the methodology used in the instruction of the course. Therefore the analysis and discussion of this question will be found in the Adult Education part of this chapter.

Table 11 indicates a range of expectations from those who were initially sent to the course by their supervisor, to some who wanted to learn more effective caregiving skills with their patients/residents, to those who were there for personal skill improvement. These expectation sheets were completed and brought to the first class. A factor to note at this point is, that during the first class, each person was explicitly given the option to withdraw without any repercussions from their supervisor. Staff were requested to make their attendance on a voluntary basis versus a mandatory referral basis. Of the 184 staff/volunteers who participated in the complete course, not one person withdrew.

The expectation sheets were returned to the attendees at the time that they were requested to complete their course evaluations, thereby allowing each person to assess whether their expectations had been met or not.

Table 11.0. Expectations of the Course

1. Learn to cope more effectively with the feelings and needs of the families/patients/ visitors
2. Learn better coping skills for my personal life
3. Improve communication skills and awareness of the nonverbal messages
4. Peace and quiet from the boss who sent staff to the course
5. Improve skills in coping with dying patients/residents and their families

---

Table 12 indicates that those attending and completing the course found it to have been helpful and useful in more than a satisfactory manner (i.e. the categories of "met the expectations very well" and" exceeded expectations " accounted for 67.1% of the responses from those surveyed).

Table 12.0. Expectations met?

Rating given	Frequency of response	% of response
Met my expectations fairly well	07	07.7%
Met my expectations	15	16.5%
Met my expectations very well	27	29.6%
Exceeded my expectations	34	37.4%
No response on this question	08	08.8%
Did not meet my expectations	00	00.0%
Totals	91	100.0%

It is possible that where there is a "no response" that it is a negative response.

In Table 13, it can be noted that the expectations which were stated prior to the first class were met or exceeded by the conclusion of the ten sessions. The level of comfort and freedom in expressing opinions and feelings on the evaluation seem to have increased over the ten weeks as well.

Table 13.0. How were your expectations met?

This is a summary of the responses to this question:

1. Increased personal self-understanding
2. Learned from the point of view of others in the class because it was a mixed class and not all from the Nursing Department
3. Improved listening skills and recognition of the nonverbal messages
4. Became aware that personal rights and choices exist which helped in choosing what to do with co-workers, patients/residents and families
5. Learned to apply the principles learned at work and at home
6. Became more comfortable in giving care to the dying residents/patients and their families/visitors

---

In Table 14, it can be noted that more than two-thirds (i.e. 71.5%) of the nursing and non-nursing staff reported that they were able to make applications on the job (drawn from the categories of #4 and #5 on the Likert scale). If the category of "Some" was to

be included, the total for the applications on the job would rise to 90.2%. This would seem to be an enthusiastic response of learnings from the sessions in the course.

Table 14.0. Application of course material on the job.

	Frequency of response	% of response
Very little (1)	00	00.0%
A little (2)	02	02.2%
Some (3)	17	18.6%
Some + (4)	34	37.4%
Considerable(5)	38	41.8%
Totals	91	100.0%

Table 15.0. Recommend this course to others?

	Surveyed	Response
Yes	81/100	89.1%
No answer given	10/100	10.9%
	91/100	100.0%

Table 15 would seem to indicate that those who were surveyed and responded, considered the course to be of value to them and would therefore recommend that others attend as well. In this instance, the "no answer" might be construed as a negative response. It is possible that those surveyed did not intend it to be a negative response, but in this instance, it appears to be.

Table 16.0. Who would benefit from the course?

Day Hospital
Dietetics
Health Information Services
Housekeeping
Laboratory Services
Nursing (all staff)
PhysioTherapy
Recreation
Respiratory
Social Services
Volunteers
X-Ray (Radiology)

At the end of each course, lists of specific departments were identified for inclusion in future offerings of this course, by those completing the course. The responses indicate that all of the departments listed in Table 16 would benefit from the course. They also added the following departments (Table 17) to the list of those who would benefit.

Table 17.0. Additional departments who would benefit

Occupational Therapy
Clerical staff
Physicians
Pastoral Care
Evening and Night Nursing Coordinators
Directors of all departments
Administration of the facility
Unit CoordinatorsCafeteriaPersonal Care and Extended

Table 17 would seem to indicate that in the opinion of the respondents, all staff employed in this long term care centre would benefit from attending this particular course.

Staff in Occupational Therapy, in various clerical positions,representatives from the Pastoral Care, and a representative from the Evening/night nursing coordinators did attend the course during later offerings and therefore could be accounted for on the list of those who should attend. It is possible that the Physicians, Department Directors, Unit Coordinators of the Personal Care and Extended Care Floors, and Administration were added to the list of those who would benefit from the course because they are the decision making groups within this specific facility. There were occasions during classes when the staff expressed frustration, annoyance and at times, anger, with their own inability to make the changes they thought would improve the quality of care they were providing to the patients, residents,and families.

Questions 7 and 8 from the Demographic sheet have been included as part of the data dealing with the adult education analysis and discussion portion of this chapter.

Tables 20-28 also provide adult education data which indicates the responses to Questions 7-10 from the Course Evaluation.

C. Pre-Post Test Data and Analyses

One of the means of measuring the impact of the death education instruction on the nursing and non-nursing staff was to ask those attending the classes to complete the Templar's Death Anxiety Scale in the first session of the Patient Relations and Communications Course; and again when they agreed to participate in the study (which was conducted two years after the completion of the course). Two sets of measurements were used:1) the measurement of overall anxiety level, person by person (i.e. the and "t" test) and 2) an item by item analysis of the number "correct" (i.e. the "z" score). The Death Anxiety Scale (DAS) is described in more detail in Chapter 3. Basically the DAS consists of a 15 item True-False questionnaire. EAch item has a "correct" answer which indicates that a high level of anxiety is being experienced when answering the questions. For each respondent a total anxiety rating was calculated as a number of "correct" responses over the 15 items. The scoring of this pre-post test is described in more detail.

For each of the fifteen True-False items in the Death Anxiety Scale the following scores were calculated:

X pre = the number of "correct" responses over the 15 items before the instruction

X post = the number of "correct" responses over the 15 items after the instruction

The difference between each response (pre and post test scores) gives a general indication of a change in overall anxiety.

i.e. D= X pre - X post.

P pre = the average of the X pre scores

P post = the average of the X post scores

D. Discussion of Hypotheses

The hypothesis used to examine the impact of death education instruction and to measure change which may have occurred from the pre test to the post test was:

1) No change in overall average anxiety level

i.e. μ pre = μ post

or μ Diff = 0

1) **The Null Hypothesis: There will be no difference in anxiety level as measured on the Templar Death Anxiety Scale from the pre test to the post test. (D = X pre- X post)**

Ho: μ pre = μ post

or " no change" from μ pre - μ post = 0

μ Diff = 0

where: 1) μ pre = the mean of the pre-test anxiety score.

2) μ post = the mean of the post-test anxiety score

3) μ D = the mean of the changes in anxiety scores

2) **The Nondirectional Research Hypothesis: There will be change in the anxiety level as measured on the Templar Death Anxiety Scale from the pre test to the post test.**

Ha: μ pre $\neq$ μ post

or "change" from μ pre - μ post =/= 0

Diff =/= 0

E. Analysis of the pre-post test results

1. Overall anxiety level analysis or Paired t test for related groups to test Hypothesis #1.

The t test for related groups was used to determine whether there was a statistically significant difference between the two scores on the variable of anxiety level. This formula takes into account the interrelationship between the two variables (i.e. the Xpre and the Xpost scores) with the difference between each pair of scores being computed and compared against the standard error of difference.

For each of the fifteen True-False items in the Death Anxiety Scale the following scores were calculated:

X pre = the number of correct responses before the instruction

X post = the number of correct responses after the instruction

P pre = the average of the X pre scores

P post = the average of the X post scores

The "correct" response in this test means that the person felt a high level of anxiety when answering the question. The scoring of this pre-post test is described in more detail in Chapter 3.

The formula used to calculate the "t" score is:

$Di = X\ pre\ i - X\ post\ i$

$N = 91$

$$s = \sqrt{\frac{(\sum D\ i)\ 2}{N} - (\bar{D})\ 2}$$

$$\bar{D} = \sum D\ i\ /\ N$$

$$= 1.066$$

$$t = \frac{\bar{D} - 0}{s\ /\sqrt{N}}$$

$$= 4.387$$

The details for the calculation of the "t" score are in Appendix I.

The significance probability of the observed "t" value (4.387) is less than 0.05, so the null hypothesis Ho: is rejected (i.e. $D =/= 0$).

THE "t" VALUE INDICATES THAT THERE WAS A CHANGE IN OVERALL ANXIETY LEVEL.

2. Item by item analysis of the change in anxiety level

A "z" score was calculated to assess the significance of the change. This "z" score is used as a means of conceptualizing the group change but it is not as sensitive in measuring changes in individual scores as is the overall anxiety measure.

Measurement of change = P pre - P post

results in the measurement of the significance of change from P pre to P post by calculating the "z" score, given that:

P pre = # of "correct" responses by 91 before the instruction

# of respondents = 91

P post = # of "correct" responses by 91 after the instruction

# of respondents = 91

F. Discussion of the hypothesis

In addition, each of the fifteen True-False items on Templar's Death Anxiety Scale was tested for a change in proportion from the pre to post test by testing against a null hypothesis:

Ho: P pre = P post or "no change"

versus a nondirectional research hypothesis of:

Ha: P pre =/= P post or "change"

Assessing the change using "z" scores

A "z" score was calculated to assess the significance of the change. **This "z" score is used as a means of conceptualizing the group change but it is not as sensitive in measuring changes in individual scores as is the overall anxiety measure.**

$$z = \frac{\hat{p}\ \text{pre} - \hat{p}\ \text{post}}{\sqrt{\hat{p}\ (1 - \hat{p})}\ \sqrt{1/n\ \text{pre} + 1/n\ \text{post}}}$$

where:

$$p = \frac{n\ \text{pre} + P\ \text{pre} + n\ \text{post} + P\ \text{post}}{n\ \text{pre} + n\ \text{post}}$$

A chart showing the values of the calculation of the "z" scores is included in Appendix H.

Table 18 indicates a "z" score for each of the fifteen True-False items on Templer's Death Anxiety Scale.

Table 18.0. "z" scores

(For the 15 item Death Anxiety Scale as reported by those surveyed)

Item #	Description	Ppre	Ppost	zscore	Legend
1.	I am very much afraid to die	.386	.217	2.400	*
2.	The thought of death seldom enters my mind.	.337	.460	1.685	#
3.	It doesn't make me nervous when people talk about death.	.483	.781	1.347	~
4.	I dread to think about having to have an operation.	.483	.422	0.808	~
5.	I am not at all afraid to die	.258	.264	0.092	~
6.	I am not particularly afraid of getting cancer.	.258	.368	1.599	~
7.	The thought of death never bothers me.	.067	.115	1.125	~
8.	I am often distressed by the way time flies so very rapidly	.562	.540	0.298	~
9.	I fear dying a painful death	.798	.747	0.820	~
10.	The subject of life after death troubles me greatly	.461	.253	2.930	*
11.	I am really scared of having a heart attack.	.236	.138	1.691	#

12.	I often think about how short life really is.	.708	.907	2.785	*
13.	I shudder when I hear people talking about a World War III	.427	.425	0.027	~
14.	The sight of a dead body is horrifying to me.	.250	.141	1.807	#
15.	I feel that the future holds nothing for me to fear	.213	.430	3.067	*

Legend: * P<.05, z.025 = 1.96; # P<.10, z.05 = 1.64;
~ P >.1 (no statistical significance)

G. Adult Education Data Analyses and Discussion

Those surveyed were asked to evaluate their experiences with some specific dimensions in the area of adult education within death education instruction, e.g. Teaching methods, Handouts, Instructor, Classroom, Length and schedule of the course, Group feeling, Changes in the course, Additional topics, and Other comments. The corresponding question number on the Course evaluation is indicated beside each Table Number for Tables 19-28. For the dimension of Teaching methods, (Tables 19.1 to 19.8), the range of the ratings between the methods which were ranked the lowest and those which were ranked the highest (on a 5 point Likert scale), is presented for each item.

Table 19.1. Use of films

Rating	Frequency of response	% of response
No rating given	06	06.6%
Least effective (1)	00	00.0%
(2)	00	00.0%
(3)	09	09.9%
(4)	35	38.5%
Most effective (5)	41	45.0%
Total	91	100.0%

In Table 19.1, it can be noted that 83.6% (drawn from #4 and #5 on the rating scale) found the use of films to have been particularly effective. The use of visual techniques and skill applications displayed in the selected films seem to have been helpful in making the transition from the class to either work or personal settings.

Table 19.2. Use of role plays

Rating	Frequency of response	% Returned
No rating given	05	05.5%
Least effective (1)	00	00.0%
(2)	00	00.0%
(3)	11	12.0%
(4)	16	17.6%
Most effective (5)	59	64.9%
Total	91	100.0%

In Table 19.2, it can be noted that 82.5% of those responding found the role plays to be a valuable teaching method for them. In the class where the role plays were first introduced, there was

considerable reluctance to participate, yet those who participated once, were not as reluctant to do so in subsequent classes, because their emotional experience of being in that role left an indelible memory of how it felt to be treated as they were. One of the responses in Table 27 (Question 9) suggested that a change for future courses would be to have more role plays.

Table 19.3. Use of behavior rehearsal

Rating	Frequency of response	# Returned
No rating given	00	00.0%
Least effective (1)	02	02.2%
(2)	00	00.0%
(3)	11	12.1%
(4)	25	27.4%
Most effective (5)	53	58.3%
Total	91	100.0%

In Table 19.3, it can be noted that behavior rehearsal was rated as being very valuable, i.e. 85.7%, (drawn from the #4 and #5 on the rating scale) in learning how to do or say things differently.

Table 19.4. Use of mini-lectures

Rating	Frequency of response	% of response
No rating given	02	02.2%
Least effective (1)	00	00.0%
(2)	03	03.3%
(3)	12	13.2%
(4)	35	38.4
Most effective (5)	39	42.9%
Total	91	100.0%

In Table 19.4, it can be noted that the use of mini-lectures was found to be an effective learning method by 81.3 of those surveyed. The accompanying handouts and readings in the library may also have assisted with the rating of this method since the mini-lectures were directly tied to the use of the examples and readings made available as reference materials.

Table 19.5. Use of small/large group discussions

Rating	Frequency of response	% of response
No rating given	00	00.0%
Least effective (1)	01	01.1%
(2)	01	01.1%
(3)	05	05.5%
(4)	37	40.6
Most effective (5)	47	51.7%
Total	91	100.0%

In Table 19.5, it can be noted that 90.6 (drawn from the #4 and #5 on the rating scale) of those surveyed found the use of small and large group discussions to have been a very important factor in their learning within the class. Being able to hear

others' opinions was stated as being a valuable learning experience and the discussions also served as a means of confirming their own opinions/experiences, thereby building support among the group members.

Table 19.6. Use of Feeling Reaction Sheet

Rating	Frequency of response	% of response
No rating given	02	02.2%
Least effective (1)	00	00.0%
(2)	01	01.1%
(3)	13	14.3%
(4)	29	31.8
Most effective (5)	46	50.6%
Total	91	100.0%

In Table 19.6, it can be noted that the specific assignment sheet, titled the Feeling Reaction Sheet was found to be effective as a self-learning device by 82.4 of those surveyed (drawn from the #4 and #5 on the rating scale).

Table 19.7. Use of self-assessment activities

Rating	Frequency of response	% of response
No rating given	01	01.1%
Least effective (1)	01	01.1%
(2)	01	01.1%
(3)	17	18.6%
(4)	38	41.8%
Most effective (5)	33	36.3%
Total	91	100.0%

In Table 19.7, it can be noted that the use of self assessment activities was found to be an effective teaching method for 78.1% of those surveyed (as drawn from the #4 and #5 on the rating scale).

Table 19.8. Use of This is My Week sheets

Rating	Frequency of response	% of response
No rating given	00	00.0%
Least effective(1)	00	00.0%
(2)	03	03.3%
(3)	23	25.2%
(4)	27	29.7%
Most effective (5)	38	41.8%
Totals	91	100.0%

In Table 19.8, it can be noted that the use of This is my week sheets was found to have been an effective teaching method of 93.5% of those surveyed (as drawn from the #4 and #5 on the rating scale).

The next question which dealt with the area of adult education on the Course Evaluation was Question 7a). The results are presented in Table 20.

For the comments on the dimension of Handouts, the range of comments has been presented as seven generalizations in Table 20. The comments seem to indicate that the handouts were considered to be valuable to the staff for reference and to assist them in understanding more about themselves and their own feelings.

Table 20.0. Comments about the Handouts

1.	Some were unnecessary
2.	Didn't like This is my Week handouts
3.	Good
4.	Helpful in understanding the topics presented
5.	This is my Week was the best assignment, helped me learn more about myself and how others see me, liked the comments you put on them each week
6.	Learned more about myself after reading and applying the content from the handouts
7.	Very useful as reference. I shared them with my co-workers and family

For the dimension of Instructor, there are six generalizations drawn from the survey responses and presented in Table 21. There was a high degree of positive regard for the instructor, which may in itself have had an impact on the way in which the course material on death education was received by the staff.

Table 21.0. Comments pertaining to the Instructor

1. Pleasant and trustworthy
2. Enthusiastic and bubbly
3. Good sense of humour
4. Very relaxed and knowledgeable in presentation of course material
5. Used everyday examples which helped in application
6. Excellent all round

For the dimension of Classroom, the range of comments has been presented as five themes in Table 22. There is a range of responses about the classroom used and this reflects the conditions of the classrooms used for instruction. Not all of the classes were conducted in the same classroom and therefore different staff/volunteers experienced different physical learning atmospheres.

Table 22.0. Comments pertaining to the Classroom

1. Chilly and uncomfortable
2. Hot, stuffy and overcrowded
3. OK
4. Needed soundproofing to keep out the construction noise
5. Comfortable, cheery, relaxed, the right size, well equipped and bright

Table 23 indicates a trend to agreeing with the set schedule of ten weekly sessions of two hours per session.

Table 23.0. Comments re: length/schedule of classes

1. Each session could be shorter if more classes were added beyond the ten weeks
2. Twice a week would keep the flow of the course going
3. Just right
4. At times too short because it was so interesting
5. Could be longer to allow for more discussion

Table 24 presents a range of comments, with the majority indicating that there was a positive bond experienced by those in the classes.

Table 24.0. Comments re: group feeling

1. None
2. Fair
3. Conducive to sharing
4. Pulled together as a group
5. A special bond was formed
6. Helpful, supportive and positive

Table 25 indicates that the majority of those attending the course found the present structure and content to be satisfactory.

Table 25.0. Additional topics to be included

1. None at all
2. Staff burnout
3. More on death and dying with role plays of specific situations

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Table 26 offers the comments which were made concerning changes in future courses.

Table 26.0. Comments re: changes in the course

1. None at all
2. Bigger classroom so that it would not be so stuffy with poor circulation
3. Longer classes each session
4. Turn off the music when the groups are discussing, otherwise it was nice to have it on in the background
5. Staff attending classes should be scheduled for day shift and not have to attend on their own time
6. More role plays with one-half of the class being residents and the other one-half being caregivers from all departments (i.e. not just from the Nursing Department)

A selection of verbatim comments which were given in response to the dimension of Other Comments (Question 10)has been included as Appendix J. Some generalizations from the comments are presented here in Table 27.

Table 27.0. Other Comments

- **I'll miss the classes**
- **There should be more courses set up this way**
- **I learned more about myself and others**
- **I feel better able to cope with those who are ill**
- **This should have been part of my original training (community college and/or university)**
- **My experience was so positive that my co-workers and even some of my family want to attend when it is offered again**

The dimension of Significant Learnings from the Course,(drawn from Question 7 on the Demographic Sheet), can be referred to in Table 28, which contains a sampling of generalized comments made by those surveyed. A more detailed list of some of the verbatim comments can be found in Appendix K.

Table 28.0. Significant learnings

- Increased awareness of my own and others feelings and needs
- Increased self-confidence which helps me to give better care
- Dealing with the terminally ill is no longer so fearful to me
- Have been able to sit with, talk with and be with dying residents/families , which I could not have done before the course
- Learned to live each day to the fullest, reaching one small goal at a time

The dimension of dealing with death since the course ended (Demographic sheet, Question 8) can be found in verbatim form in Appendix L. A decision was made by the investigator to maintain the verbatim comments in Appendix L, to preserve the accuracy of the experiences reported by those surveyed

Chapter V

Summary, Conclusions, Recommendations

A. Summary

This study was concerned with an investigation of the impact (positive or negative) that a death education course would have on the anxiety levels of the nursing and non-nursing staff in a long term care facility. This study began with concerns being expressed by nursing and non-nursing staff about their required transition from working in an acute care military hospital to a geriatric long term care facility. Specific concerns were expressed related to ways of caring for and providing assistance to the long term patients/residents and in particular those who were dying. Buckingham (1983) suggests that because dying is part of the fabric of life in a long term care facility, the death of fellow patients/residents has special meaning and impact on all patients/residents, families and the staff providing care. He further proposes that the experience of death in a long term care institution is therefore uniquely different from death at home or in a hospital and subsequently the staff of a long term care facility need unique kinds of support; because they too, must deal with their own feelings about death and dying before they can be open to dealing with the feelings of the other patients/residents, families and co-workers. Shedletsky and Fisher (1986) found in their study within both acute care hospitals and long term care facilities that a considerable number of staff admitted to having difficulty talking with patients about their impending death and

in addition felt that the facility (whether it was an acute care hospital or a long term care facility), was obligated to meet the emotional needs of the dying patients. In contrast, when these staff were asked if these needs were being met, they indicated that such needs are either never met or infrequently met. A further finding in the Shedletsky and Fisher study was that although the staff in long term care believed it appropriate for terminally ill patients to be treated on their units, the acute care staff were not in favour of this practice. In reality, the practice within the acute care hospital is to transfer dying patients to long term care facilities. This could suggest that because the placement is of a more permanent nature, that the long term care staff feel that death is more likely. Consequently the long term care staff tend to develop a long term relationship with the patient/resident and therefore find it easier to discuss death and dying with the resident than the acute care staff do (Shedletsky and Fisher, 1986). This could be a reason that a number of the acute care staff avoided discussions of death and dying with the patients more frequently than did the staff in long term care .

The research into the needs of the staff employed in a long term care facility and the impact that a death education course would have on the anxiety and discomfort levels of the nursing and non-nursing staff, became the focus for this study. The transition from an acute care military hospital (Deer Lodge Veterans Hospital) to a geriatric long term care facility (Deer Lodge Centre) in 1983, resulted in a considerable number of requests for assistance being

forwarded to the Education Services Department. This was done as one means of offering the staff support in making the transition from their initial training in an acute care facility to the care they were now required to provide in this long term care facility, i.e. focusing on the whole-person needs of patients/residents and their families (Mount, 1985).

Given that 20-25% of the elderly can expect to spend some time in a long term care facility due to the focus of the health care system at the present time, being that of providing institutional care versus community care (Chappel, Strain, Blanford, 1986), the care in such settings would seem relevant to examine (Wilden, 1988). For the purposes of this study , the investigator has chosen a definition of death education which includes the moment of death, the lifestyle and pattern of living, feelings about self/others, and relationships to the world at large. It is important therefore, that the staff, patients/residents'/families' attitudes toward death be seen as a natural part of the life cycle, thereby decreasing the trauma and anxiety of caregiving (Benoliel, 1982; Bugen, 1980),in the nursing and non-nursing staff.

1. Literature review on death education

In the literature search it became evident that the elements which were to be a part of this study, had not been integrated in this way before. There was a considerable amount of information on studies and research in the area of death education (Shneidman, 1970; Popoff, 1974; Denton and Wisenbaker, 1977; Laube, 1977;

Lanham, Speer and Fritz, 1980; Yarber, Gobel and Rublee, 1981; Laube, 1977; Benoliel, 1982; Degner, Chekryn, Deegan, Gow, Koop, Mills, Reid, 1982; Goodell, Donohue,and Benoliel, 1982; McCorkle, 1982; Swain and Cowles, 1982; Buckingham, 1983; Mullins and Merriam, 1983; Rublee and Yarber, 1983; Mount, 1985; Kane and Kane, 1987; Broadfield, 1988; Degner and Gow, 1988; Parry, 1989).

Literature which specifically dealt with the anxiety levels in staff and the impact of death education on staff (albeit the majority of the references were in the field of nursing training and the method of delivery of nursing care) had been done by Kalish, 1963; Collett and Lester, 1969; Templer, 1971; Denton and Wisenbaker, 1977; Laube, 1977; Leviton and Fretz, 1979; Lanham, Speer and Fritz, 1980; Yarber, Gobel and Rublee, 1981; Nagi and Lazerine, 1982; Mount, 1983; Robinson and Wood, 1983; Vargo and Batsel, 1984; Waldman and Davidshofer, 1984.

2. Literature review in long term care

Abramovice (1988) by his work in the field of long term care, provided the basic premise for this study, in that he believes that when the long term care staff have an enhanced sense of self-value, they are better able to communicate while maintaining a sense of dignity and to encourage the resident's self-esteem. He suggests that death education for these long term care staff if done in a facilitative style (i.e. an emphasis on the psychosocial needs of the patient, the family, the management and the staff) will result in more comfort being displayed by the staff, than if the tradi-

tional acute care style (which focuses on medical technology and methodologies which promote cure and rehabilitation) are used. If the facilitative model is utilized, he advocates that when a management structure which supports the development and maintenance of the caregiver's self-esteem is in place, that patients/residents will experience an environment where growth and independence are not only possible, but are actively fostered and sustained as the self-esteem and dignity of the resident visibly increases.

3. Literature review on adult education

In the research and development of the death education course the facilitative style of implementation drew on the field of adult education. A considerable bank of literature dealing with the assessment of needs, development of materials, possible methodologies and styles of learning, implementation strategies and evaluation of courses was reviewed and utilized (Brookfield, 1985, 1986, 1987, 1988; Brundage and Mackeracher, 1980, Cross, 1972, 1976, 1979, 1981; Kidd, 1973; Knowles, 3, 1975, 1980, 1984, 1986, 1987; Knox, 1977) to design a death education course which would exemplify the format proposed by Abramovice (1988).

4. Significance of this study

THE PURPOSE OF THIS STUDY WAS TO ASSESS THE IMPACT OF A DEATH EDUCATION COURSE ON NURSING AND NON-NURSING STAFF IN A HEALTH CARE SETTING. There was a vacuum however, in the literature reviewed for this study, i.e. literature which dealt with the integration of

adult education principles with a means to measure the impact of nursing and non-nursing staff in a long term care facility. Missing in the research were any references to staff from the Day Hospital, Dietetics, Health Information Services, Housekeeping, Lab Services, Nursing, Radiology, Recreation Services, Respiratory, Physiotherapy, Social Services and Volunteer departments within a long term care centre. In addition to the stated purpose of this study, this study integrates death education, adult education and the needs of long term care staff who work in a cross-section of departments.

Deer Lodge Centre was selected as the site for the study which would attempt to measure the impact of a specific death education course (Patient Relations and Communications Course) on the anxiety level of the nursing and non-nursing staff. Lanham, Speer and Fritz (1980) and Kalish (1963, 1985) found that caregivers (after participation in a death education course), were more likely to provide more appropriate and compassionate care for the residents and their families than before participating in such a course and this supported the approach developed and used in this study.

5. Methodology

As part of this study, a list of the staff (nursing and non-nursing) and volunteers who had completed the course (a total of 184) was drawn up alphabetically. A consultation with the Human Resources Department resulted in the elimination of the names of thirty people who were no longer employed at the Centre. A selection of every fifth name was made until a total of 100 names

resulted from the remaining 154 names. This was the list which was used when letters went out requesting participation in the study (See Appendix G). Those who agreed to participate returned a signed consent form and received by return mail, a copy of the Demographic Sheet (Appendix D.ii),and the Death Anxiety Scale Post-Test (Appendix D.i). The signing of the consent form also gave permission to access the completed Course Evaluation forms which were on individual training files within the Education Services Department.

6. Demographic information

The random sample of 100 names was drawn from a possible of 154 nursing and non-nursing staff names who were still employed at Deer Lodge Centre at the time the study was conducted.

The findings indicated that 91.5% of those surveyed were female, with the largest group of staff surveyed being in the 25-34 age group (38.5%), with another 20.9% of the staff in the age group from 35-44, and 25.3% in the 45-54 age group. The mean age was calculated to be 37.7 years of age. This was indicative of the reality of the distribution of gender employed within the facility and in health care in general. In a study conducted by the Centre for Women in Government, State University of New York for pay equity in health care in Manitoba (1988), the results indicated that 90% of the employees in health care were females.

In a review of the departments surveyed, it can be noted that there were only two females (2.2%) from a middle management level (i.e. one Evening/Night Coordinator, one Department Director) with

the balance of the 89.3% representing the line level of functioning. In this study, therefore, there was a large representation from the females who provide care to the patients/residents; but there was almost no representation at a decision making level where changes can be made directly.

The educational backgrounds of those surveyed ranged from those with high school/GED (20.9%), to some with a trade school/diploma training (4.4%), to those with nursing and community college training (64.9%), to those requiring a university degree for their profession (8.8%) to one person with a graduate degree (1.1%). The unknown in the nursing department is the number of the male orderlies who have completed some form of post-secondary training, since they (the six males) did not indicate whether they had such training, while the nursing aides indicated that they had completed a course after high school.

There was no one in the Occupational Therapy Department surveyed, as a result of the random sampling procedure used. Staff from other departments were sampled. It is noteworthy that of the 12 volunteers surveyed, 100% responded and that they attended all classes on their own time without any expectation of credit for the use of their personal time.

7. Findings of the Pre-Post test

The analyses of the pre-post test examined a hypothesis for:

i. the overall anxiety level where no change occurs

ii. an item by item analysis where no change occurs

As the completed forms were returned, the results were tabulated and analyzed as described in Chapter IV.

i. The overall anxiety level

Measurement of the overall anxiety level by using the paired "t" test for related groups

The "t" test for related groups was used to determine whether there was a statistically significant difference between two scores on the variable of death anxiety. The interrelationship between the two variables (i.e. X pre and X post scores) was compared with the difference between each pair of computed scores and measured against the standard error of difference.

The resulting "t" score indicates that there was a change in the "t" score indicated that Ho: hypothesis should be rejected at the 5% level, indicating that there WAS a change in the overall anxiety level of anxiety experienced in the area of death and dying as measured on Templer's Death Anxiety Scale pre-post test. The null hypothesis was rejected. Appendix I provides the calculations used in determining the "t" score.

ii. an item by item analysis of anxiety by calculating the "z" scores

"z" scores were calculated for each of the fifteen True-False items on the DAS to determine a change in proportion of"correct" i.e. the anxious responses from the pre-to-post test (Table 18). A statistical significance was found on Items # 1,10,12,15 at p

<.05, Z.025 = 1.96 level. Three other items (# 2, 11, 14)were found to be statistically significant at $p < .1$, z.50 = 1.64 level. The null hypothesis was rejected for these two groups, indicating that a change in proportion of "correct" responses did occur from the pre-to-post test.

The remaining eight items (#3, 4, 5, 6, 7, 8, 9, 13) were found to have no significant statistical change in proportion from the pre-to-post test scores. The null hypothesis was accepted on these items indicating that no significant change in proportion occurred from the pre-to-post test of the Death Anxiety Scale.

8. Findings on the Course Evaluation

Each of the sessions were rated by those surveyed as to the value they attached to the content. The most helpful sessions according to the ratings (90-95% as drawn from the #4 and #5 on the rating scale) were: Session 2. The Attitude Cycle (91.3% as drawn from the #4 and #5 on the rating scale); Session 3. Understanding the impact of institutionalization (91.3% as drawn from the #4 and #5 on the rating scale); Session 7. Assertiveness (91.3% as drawn from the #4 and #5 on the rating scale); Session 8. Terminal illness, a personal perspective (92.4% as drawn from the #4 and #5 on the rating scale); and Session 9. Terminal illness, a professional perspective (91.3% as drawn from the #4 and #5 on the rating scale). It is possible that these sessions were ranked highest due to the largest percentage of class time in those sessions was spent on role plays, group discussions and self assessment activities.

The sessions which were rated the next highest (80-89% as drawn from the #4 and #5 on the rating scale), were: Session 4. Nonverbal communication (82.5% as drawn from the #4 and #5 on the rating scale); Session 5. Listening, getting and giving information (84.7% as drawn from the #4 and #5 on the rating scale); and Session 10. Summary (85.8% as drawn from the #4 and #5 on the rating scale). These sessions contained less time spent on role plays, and more on the practice of specific skills during class time with emphasis on application and practice outside of the class. To some degree, these sessions were more theoretical than those sessions which were rated as being over 90%.

The sessions which were rated as the lowest (75-79% as drawn from the #4 and #5 on the rating scale), were: Session 1. Introduction and Looking at self (75.9% as drawn from the #4 and #5 on the rating scale) and Session 6. Calming hostile people (78.1% as drawn from the #4 and #5 on the rating scale). Session 1 may have received a lower rating because five people did not rate the session at all. In addition, a good portion of the class time in Session 1 was spent on providing an overview of the course content, methodologies to be used, the assignments, and most importantly, the voluntary attendance factor. Therefore, there was not as much interaction in this session as in the later ones. Session 6 may have been rated lower since more of the class time was spent in examining a theoretical model and not as much time on practice activities or on self assessment activities. There may have been an integration of Session 6 with the content of the

previous five sessions because session 7 was a compilation of everything which had been learned to that time and that was highly valued by those surveyed (Tables 10.1 to 10.10).

The overall rating of the ten sessions indicated that eight out of ten session were rated positively (i.e. over 80% as drawn from the #4 and #5 on the rating scale) which would seem to indicate that the participative nature of the design and implementation supports what Abramovice (1988) believed and espoused from his work in long term care.

When the expectations were listed, they ranged from learning to cope more effectively with the feelings and needs of the patients/residents, to better personal coping skills, to improved communication and nonverbal awareness of messages, to peace and quiet from the boss who sent the staff, to improved awareness and skills in dealing with the dying and their families (Table 11).

When the course evaluations were completed during the last session, the expectation sheets were returned to the staff for a comparison of the achievement of their expectations. The overall rating was that the expectations had been met or exceeded for 83.6% of those surveyed. This would support the use of the facilitative model proposed by Abramovice (1987) in that once the long term care staff have quieted their anxiety, they are able to transfer these learnings to giving better and more appropriate care to the patients/residents.

The explanations as to why and how the expectations had been met included increased personal self-understanding, learning from

the points of view of others (i.e. from the mix of departments), improved listening skills, awareness of personal rights and choices which helped in decision making with patients/residents and co-workers, applications at work and at home, and finally being more comfortable in giving care to the dying and their families (Table 13). The ability to apply the learnings at home and at work was reported by 90.2% as having been possible and achieved. This would seem to support the view that once the personal self-confidence is established, the willingness to transfer the learnings outside of self rises (Table 14).

There seemed to be a unilateral recommendation that everyone employed in the facility should attend the course (as shown by the list of departments which were recommended to take the course). Some frustration was indicated because the desired change for the inclusion of the administration, the physicians, the Unit coordinators and the department directors, did not occur (Tables 15 - 17).

The teaching methods which were rated as being most effective were: the use of the weekly "This is my week" sheets(where staff commented on their learning/application and the instructor made a comment and returned them the next week) at 93.4% as drawn from the #4 and #5 on the rating scale; small and large group discussions at 90.7% as drawn from the #4 and #5 on the rating scale; the use of behavior rehearsal at 85.8% as drawn from the #4 and #5 on the rating scale; the use of films at 83.6% as drawn from the #4 and #5 on the rating scale; the use of role plays at 82.5% as drawn

from the #4 and #5 on the rating scale, and the use of the Feeling Reaction Sheet at 82.5% as drawn from the #4 and #5 on the rating scale ; the use of mini-lectures at 81.4% as drawn from the #4 and #5 on the rating scale and the use of the self assessment activities at 78.4% as drawn from the #4 and #5 on the rating scale. It would seem that the methods which dealt with interactions with others (This is my week, discussion groups, behavior rehearsal, films, role plays, and the Feeling reaction sheet) received higher ratings than those which were done on an individual basis (mini-lectures and self assessment activities) (Tables 19.1-19.8).

The handouts were seen as being useful reference material and for sharing with co-workers and family members (Table 20). The rating on the instructor was highly positive and may have had an impact on the way that the course material was received by the class (Table 21). Both of these factors were seen as an important part of the adult education part of the course, which assisted the staff in learning more about themselves.

The classroom comments ranged from being chilly and uncomfortable to being hot, stuffy and overcrowded to the other extreme of being comfortable, bright, cheery, relaxed, the right size, and well equipped. This in reality reflects what the various classes experienced as different rooms were used throughout the facility (Table 22). Adult education principles which are concerned with the physical setting and learning environment seemed to have been a factor in how people were able to concentrate and

participate in the course activities. Because of the comments made by the staff about the room being hot, stuffy and crowded, the classroom was changed as soon as it was possible so that the climate was more conducive to positive learning.

The general timing and scheduling of classes seems to have been considered to be satisfactory by those who were surveyed (Table 23). There was a range of comments on the sense of group feeling from none to helpful, supportive and positive (Table 24).

Significant learnings were identified by those attending the course and are reflected in the detailed verbatim comments in Appendix K. The comments ranged from increased awareness of feelings and needs, to improved self-confidence which allows better care to be given, to dealings with the terminally ill are no longer fearful, to being able to sit and talk with the dying patients/residents which could not have been done before the course, to learning to live each day to the fullest (Table 28).

The question dealing with Other comments ranged from the classes being missed, to the need for more courses set up in the same way, to learning more about self and being better prepared to cope with the ill, to wishing this type of course had been part of the original professional training, to being ecstatic about the experience and promoting it with co-workers and family members (Table 30).

The final question on the Demographic sheet which actually is part of the adult education analysis, is found verbatim in Appendix L. The comments are found in brief form in Table 28.

B. Conclusions

The question examined in this study (i.e.**WHAT IS THE IMPACT OF A DEATH EDUCATION COURSE ON NURSING AND NON-NURSING STAFF IN A HEALTH CARE SETTING?**) has been answered to some degree by the respondents on the research instruments. The conclusion are based on this data. The overall conclusions are presented in this order: 1) demographic conclusions, 2) conclusions about death education, and 3) conclusions about the use of adult education as a framework for the design, implementation and evaluation of education/training courses.

1. Demographic conclusions

It appeared that the mix of nursing and non-nursing staff from the cross-section of departments had a beneficial effect in terms of the learnings which resulted from the exposure to others' opinions and the sense of group support for similar experiences.

There did not seem to be a noticeable difference in how staff responded on questions related to age, educational background or departmental affiliation. There was an overwhelming majority of female participation in the course, but as was mentioned in the Summary, this was indicative of the reality of the gender distribution within the facility.

2. Death education conclusions

It appeared that: 1) there was a difference (increase or decrease was not measured) in overall anxiety level from the pre-to-post test scores as measured either by the use of the paired "t" scores for related groups; 2) by the use of the "z" scores for each of the fifteen True-False items on the Death Anxiety Scale.

This change requires a cautious interpretation however, since there was a two year gap in time between the time of the pre test to the time of the post test. This time interval alone, may in fact have had some influence on the resulting change in anxiety level.

The use of a facilitative model as recommended by Abramovice (1988) seems to have been an important factor in the ability of the staff to deal with personal issues related to death and dying first, and then to be able to examine the professional issues of caring for the patients/residents in a long term care facility where the incidence of death has a more global psychosocial impact than death in an acute care hospital where cure and prolongation of life are the primary foci. Death education as it was provided in the Patient Relations and Communications Course seems to have been a positive and valuable experience for those who were surveyed in this study(i.e. They believe that they can deal with the long term care patient/resident more effectively and that they are more comfortable in talking about dying with the patient/resident/families who wish to do so).

3. Conclusions about adult education as a process and framework for course development and implementation

The implementation of Rogers' (1986) philosophical framework where the attitudes and assumptions of the instructor were part of the teaching; the context of the climate and setting for the course were important in the eyes of those surveyed; the content, i.e. the material, sequencing and learning conditions were considered to be of prime importance to the instructor in the development of the course; the planned activities, along with the sequencing and handling of interruptions was an ongoing shared responsibility between the instructor and the class members; and the evaluation process used by the instructor and the staff attending provided a vehicle for the expression of satisfaction and dissatisfaction with the course on a week by week basis.

Brookfield (1986) believes that voluntary attendance; respect for each other in class and opportunities to practice new skills; the vacillating role of leadership from instructor to class members; the development of critical thinking about how and why events and situations affect each person; and the nurturing of self-directed adults in the course are the central principles for effective and facilitative learning.

There was a continuing fluctuation from teacher centered to learner centered activities and from content oriented to process oriented learning in this course. This flow seemed to be what those surveyed, were reporting and rating as highly positive experiences in the course. It would appear that a large number of adult

educators place a high degree of confidence in the principle that the learner must be involved in the learning process (Andrews, Houston and Bryant, 1981; Brundage and Mackeracher, 1980; Rogers, 1986; Brookfield, 1988). This was certainly the situation in the death education course offered under the title of Patient Relations and Communications course.

C. Recommendations for future study

This study asked the question:

What is the impact of a death education course on nursing and non-nursing staff in a health care setting?

From the research conducted under the limitations discussed, it may be cautiously concluded that:

1. The specification of the category of staff i.e. full time, part-time, casual or volunteer status may assist in identifying trends in the views and experiences of staff based on their exposure to the care of the patients/residents.
2. The use of a control group in the same facility or in another long term care facility with a similar composition of staff according to age, gender, educational background, would assist in identifying more precisely just what change in anxiety level occurred as a result of participating in the death education instruction. It might be necessary, depending on the circumstances, to limit the number of variables to be included.

3. The use of more sensitive instruments than the Templer Death Anxiety Scale, or at the very least, using the DAS in conjunction with the Collett-Lester Scale or with the Fear of Death Scale (FODS), either of which are more sensitive instruments in measuring the change in anxiety level from pre-to-post test.

4. The use of more sensitive research instruments would also allow for a measurement of the change in terms of it being a positive or a negative one resulting from the intervention of the death education instruction. This information could then be used by administrators in long term care facilities about what kind of support and education would be offered to assist staff to make the transition from their acute care training and focus on the psychosocial model recommended by Abramovice (1988), Buckingham (1983), and Mount (1985).

Buckingham (1983) reported that staff in long term care facilities who received assistance in dealing with the daily impact of death and dying were better able to communicate with residents and families about feelings, ideas and needs. Parry (1989) states that it is evident that staff working with the dying frequently experience emotional stress brought on by: 1) multiple deaths in a brief time period and continuing exposure to the lingering process of institutional death, 2) the possibility of stress from other people's behavior -

patients, their families, physicians, co-workers, or social workers, 3) the demands of the care to be given.

5. Future courses being offered in long term care would be more effective if the instructor and the developer collaborate on the following:

a) the principles and background of adult education. Many participants surveyed suggested that more courses should be set up in the same way.

Parry quotes Toft and Anderson in suggesting that staff require support in order to alleviate the stress that results in burnout and turnover among health care professionals who continuously care for dying/institutionalized patients. This would seem to support the type of training and resources which were a part of the Patient Relations and Communications Course presented in this study.

b) the inclusion of the principles of adult education. The content of this specific death education course should be offered in acute care settings.

Examples of adult education principles which were included are: input by staff into the course goals; having a rotation of the leadership role from the instructor to the staff attending, and outlining the evaluation methods to be used at the outset of the course so that all staff were clear about the expectations.

6. The patients/residents/families should be consulted concerning their experiences and observations about any changes in staff behaviors and attitudes. Perhaps this information could be collected in the form of a pre/post test.
7. The results of this study could be used by administrators in determining whether death education would be offered within their institution (i.e. acute care or long term care).

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APPENDIX A

GLOSSARY OF TERMS

For the purposes of this study these definitions were used.

Acute care setting - A hospital where the focus is on the disease oriented concerns of the health care team in investigation and diagnosis, concern with the prolongation of life, and cure by means of surgery, active medicine and rehabilitation (Mount, 1985).

Adult education - refers to the following definition used by Darkenwald and Merriam (1982). " Adult education is the process whereby persons whose major social roles are characteristics of adult status undertake systematic and sustained learning activities for the purposes of bringing about change in knowledge, attitudes, skills or values".

Aging research - The study of the interrelating factors that affect aging - clinical medicine, social/psychological and environmental conditions. Aging research attempts to distinguish the changes occurring normally during aging from changes caused by illness, heredity, or the environment (National Institute on Aging, 1986).

Conducive learning environment - Knowles' (1980) characteristics of a conducive learning environment were used in this study. They include: the environment is physically comfortable; the learners accepted as people of worth whose ideas and feelings are to be

respected; relationships are built on trust and helpfulness; and there is cooperation in the process of learning.

Death anxiety - the anxiety experienced by people when they think about or are faced with the act of dying, the finality of death, and corpses and their burial (Templer, 1971).

Death education - Education/training which focuses on the ways and means of offering humane, dignified, terminal care to the dying (Kane, 1982, Buckingham, 1983).

Demography - The study of a population and those variables bringing about change in that population. Variables studied in this study are: age, sex, educational background, classification of position (e.g. full-time, part-time, volunteer), shift worked, and departmental affiliation (National Institute on Aging, 1986).

Dying process - refers to the time in a person's life when the disease is no longer responsive to the traditional treatment which is aimed at cure or the prolongation of life (Van Bommel,1986).

Geriatric medicine - Refers to a specialized branch of general medicine,founded by Ingnaz L. Nascher, an American physician,in 1909, when he recognized a similarity between the fields of aging and pediatrics within the United States.

Gerontology - The study of aging from the broadest perspective, i.e. the clinical and biological aspects of aging, the psychosocial, economic, and historical conditions (National Institute on Aging, 1986).

Hospice care - A concept that refers to enhancing the dying person's quality of life by providing physical comfort and symptom control, thereby easing the expectation of death and the dying process (Buckingham, 1983). This is the term used in the United Kingdom/United States, although it is now more common in Canada.

Hospice philosophy - The philosophy which permeates the way in which a multidisciplinary staff provide care for the patients/residents in a long term care facility.

Instructor perceptions - The intuitive, mental awareness of the learning environment based on the instructor's involvement and observations of the learning environment (Fox, 1987).

Instructor's style - The actions or behaviors demonstrated in the teaching environment to facilitate learning (Fox, 1987).

Long term care - The medical and social care given to individuals who have severe, chronic impairments (national Institute on Aging, 1986). Long term care in this study refers to care given in an institutional setting.

Long term care setting - An institution where the focus is on the diffuse and global whole-person needs of patients/residents and their families (including the terminally ill) where the psychosocial, financial, spiritual and physical concerns are embraced (Mount, 1985).

Palliative care - This term is used in Canada to describe the type of care the United Kingdom and the United States describe as hospice care. The term hospice care is becoming more commonly used in Canada in recent years (Buckingham, 1983).

Psychosocial model - The implementation of a model of care which incorporates the individual characteristics of the patients/residents and the social environments experienced within the long term care facility (Abramovice, 1988).

Psychosocial research on aging - The scientific investigation of individual characteristics (intellectual ability, personality, attitudes, and behaviors) and social environments (family relationships and work situations) as they influence the way people age (National Institute on Aging, 1986).

Self-directed learning - The attempts of adults to acquire skills,knowledge,and self insight through educational experiences (Brookfield, 1986).

Sharing the learning process - This involves sharing the thinking of options for learning, evaluation, learning materials and teaching strategies to be used with the learners (Knowles, 1980).

Templer's Death Anxiety Scale - The scale developed by Templer (1971) as a means of assessing the anxiety level on experiences with a wide range of items, covering the act of dying, the finality of death, and corpses and their burial. The score on the scale was set up to be measured statistically to determine the degree of anxiety.

APPENDIX B

A BRIEF HISTORY OF DEER LODGE CENTRE

Deer Lodge Centre stands on a site which once was heavily wooded and was known as a haven for deer, giving them necessary shelter as they gradually withdrew from the expanding Red River Settlement. In 1856, a retired Hudson Bay Officer, John Rowand, built his home in this wooded area. Later (1860), his son-in-law, the Honorable James Mackay (a minister in the first Manitoba Legislature), acquired the home and in 1871, leased it as a summer home to Lieutenant-Governor Adams G. Archibald. Donald A. Smith (who later became Lord Strathcona) acquired the residence in 1873 and made it a great social centre for the Red River Settlement. A fire destroyed most of the buildings in November 1892 but several of the adjacent buildings remained. The largest was leased and later sold to Mr. H.A. Chadwick who operated it as a hotel called "Deer Lodge", although it was popularly known as "CHAD'S PLACE". In 1907, the hotel was renovated and rebuilt after another fire had partially destroyed it. A joint venture between Chadwick and Mr. Roderick Mackenzie (son of Sir William Mackenzie) resulted in the hotel becoming famous for its comfortable lodging, fine food and conviviality.

During World War I, Canadians voted for prohibition, and at the seventh hour of the evening, on May 31, 1916, every bar room in Manitoba closed its doors . Because of the "dry" order, a number of hotels were forced out of business and the premises sold for other purposes. The Deer Lodge Hotel was one of these and on June 29, 1916, H.R.H.,the Duke of Connaught (on his farewell visit to Western Canada), officially opened the building, acquired by the Military Hospitals Commission, as a Convalescent Home for returned soldiers.

The transition of Deer Lodge from an Inn to a Hospital follows the pattern of the development of earlier hospitals through the ages. The words "hospital" and "hospitality" both stem from the Latin "hospes", meaning a host or guest.

In 1919, the Department of Soldiers' Civil Re-Establishment took over the Convalescent Home because of the continued and urgent need for the hospitalization of disabled veterans returning from the end of World War I. The former hotel now was converted to a veterans' hospital with a capacity of 75 beds and with the three storey structure being divided as follows:

1) Ground floor for the Administration offices, Dining rooms, Billiard room and a large rotunda with an open fire place, 2) the second floor contained the patients' wards and nurses` quarters, and 3) the third floor was for patients' wards.

Under the newly established Department of Pensions and National Health, (which was divided into: the Department of National Health and Welfare and the Department of Veterans Affairs) the first wing of the new hospital was completed in May, 1928, raising the bed capacity to 150. The first patients moved from the old building to the new in 1929 and were able to avail themselves of full medical care with X-ray and Laboratory Services and minor surgery. Major surgery was carried out at the Winnipeg General and the St. Boniface General Hospitals with patients being transferred to Deer Lodge Hospital when they were well enough to be moved. At about this same time, the nursing staff ceased living in residence and since that time all nurses have resided in their own personal residences.

Another wing was added in 1930, thereby increasing the number of available beds to 250, and an administration wing was added in 1935. Temporary two storey wooden annexes were quickly constructed in 1940-42 at the rear of the hospital, resulting in another 300 beds being available for the World War II veterans. A fire-resistant wing completed in 1943, provided space for laboratories, operating rooms for major surgery, a dental service and a fever therapy department. The Department of Veterans Affairs in 1944 built two identical three-storey units (now called the North and South Pavilions) which contained 300 active treatment beds.

One of the brick pavilions overlapped the old hotel building (which was now used as maids quarters), necessitating the movement of the old structure to the rear of the property. New wards and new departments were established as the World War II casualties continued to come in from overseas: Psychiatric, Dermatology, Urology, Orthopedics, Eye, Ear Nose and Throat, Physiotherapy, Occupational Therapy and OutPatients. The peak of bed strength was reached in February, 1945 when the bed count was 1025 and the patients in the hospital numbered 1100. A new main kitchen and a powerhouse were built and completed in 1945.

The acquisition of the Children's Home, on the Assiniboine River in River Heights (two miles away) meant that the veterans from previous wars who required institutional care were now accommodated in this 200 bed annex of Deer Lodge Hospital. The

hospital served the entire province of Manitoba and most of northwestern Ontario.

There was a gradual decrease in patient load during the summer of 1948, which continued through 1949 and until the spring of 1950 when a disastrous flood struck Winnipeg and the Red River Valley. Men, women and children from threatened hospitals and nursing homes sought shelter in a safe environment. The Annex on Academy Road was emptied of veterans to make way for 80 tubercular patients from the King George Hospital, as well as many of the aged and infirm from the nursing homes in the district. The main service provided was that of a clearing house, for a few days, until an evacuation to another city could be arranged. After the Flood, conditions returned to normal and over the next three years, the wards on the second floor of Deer Lodge Hospital were gradually closed.

Renovations were costly and in 1955, all wooden ward buildings were razed and construction of an 8 floor replacement structure commenced with completion in 1958. The prime objective of the new structure apart from the replacement aspect, was the enlargement and improvement of the active treatment facilities of Deer Lodge Hospital, since the previous facilities had been cramped and outmoded. The first floor housed the Departments of Pathology and Radiology, with Lab facilities including Biochemistry, Bacteriology, Haematology, Parasitology, Histology and the morgue. The next five floors (2-6 consecutively) contained 300 active treatment beds divided into 10 nursing units. The Service of Surgery required 166 beds and the remaining 164 beds were assigned to the Service of Medicine. The seven operating rooms on the 7th floor, were air conditioned and had humidity controls, and had an attached post-operative recovery room for six cases. The balance of the floor contained interns' single and double rooms with bath facilities and a lounge. The 8th floor featured two chapels (Protestant and Catholic), a Clinical Theatre with a projection booth, the medical library, the patients' library, a nursing demonstration room and an ultramodern Biological Laboratory where diagnostic and research studies were conducted. This new Lodge Building was complete with an auxiliary generator which started automatically within 7 seconds after a power failure, sufficient to maintain all essential services. In addition to the services already described, an active recreation department was established so that the non-medical needs of the patients would be met as well. The total bed capacity was 700. The new building was opened almost

a century after John Rowand built his original Deer Lodge.

As the number of veterans requiring institutional care declined during the 1970's and 1980's, the Department of Veterans Affairs began to consider the investment they had in veterans hospitals across Canada. Several of the hospitals were closed and agreements with the different provinces paved the way for other veterans hospitals to transfer to provincial jurisdiction. Manitoba's Deer Lodge Hospital was one such transfer on April 1, 1983. The transition from 700 acute care military hospital beds to a 277 bed geriatric facility was a traumatic one for the remaining resident veterans and the staff who had been employed as acute care staff. Downsizing of the staff and facilities took a considerable amount of decision making and emotional turmoil for all involved. The final number of staff required to operate the 277 bed facility (which offered both personal care and long term care) was approximately 450 versus the previous number of 700.

The Department of Veterans Affairs promised to assist with the renovation and capital construction of new facilities with 32 million dollars over a five year time period. Provision was made for 155 beds to accommodate veterans requiring institutional care in Manitoba. Other hospitals in Manitoba were given the responsibility of providing acute care for veterans who resided in their home area, rather than adhering to the previous practice of travelling to and staying in the Deer Lodge Hospital in Winnipeg.

The construction and renovation of the facilities for the geriatric facility began with a ground breaking ceremony in June 1985, and ended with the opening of the new seven storey personal care tower in June, 1989. The capacity is 413 beds with services being offered consisting of: personal care beds, long term care beds, assessment and rehabilitation beds, inpatient psychogeriatric assessment beds, a Day Hospital, and an adult day care centre. The Department of Diagnostic Services includes: Radiology, Respiratory Services, and EKG. The Rehabilitation Services Department includes: Communication Disorders, Physiotherapy and Occupational Therapy. Other services include :Recreation Services (including a patient library), Health Information Services, Social Services, the Eye, Ear, Nose and Throat Clinic, Pharmacy, the Prosthetics Dept. and Volunteer Services for the patients/residents and their families. Also housed within the complex is the Dental Services Department and the Provincial Audiology Clinic, thereby providing a complete range of available services. Any surgery requirements are met by

a transfer of the patients/residents to the Grace Hospital or the Health Sciences Centre where they remain until they are well enough to return to Deer Lodge Centre. A non-denominational chapel is open to the residents and their families for worship and the Pastoral Care Department is on call. A well equipped library is available as a resource on aging and geriatrics to staff within the facility as well as a resource centre to the rest of Manitoba.

Deer Lodge Centre is the centre for geriatric care within the Province of Manitoba. Currently it is used for student placements and work experience by 38 agencies/institutions.

A special feature of the new tower is the Main Street walk through which allows people in the neighborhood to walk through from Portage Avenue to Lodge Street (to the north of the tower), making it more of a publicly accessible and homelike atmosphere for the patients/residents who live within the Centre.

APPENDIX C

DESCRIPTION OF THE DEATH EDUCATION COURSE

It is important to understand that the death education course described in this appendix is somewhat different from sales or customer service type training which people in other types of training may experience. The content of this course is geared to increasing the staff's understanding of the patients/residents and their families' problems, therefore the emphasis is on empathic behavior. The aim for the staff is to learn to understand their own and others' behavior, and have practice dealing with that behavior in a safe environment (i.e. the classroom). In general, the staff members are not expected to counsel the patients/residents and their families, but they are expected to respond with sensitivity and helpfulness to whatever the patients/residents want to talk about, e.g. "No one ever listens to me when I talk" or "I want to know if a lawyer or a priest are ever here on a weekend " or What if I want to have my own Doctor take care of me here, how can I do that? " or " No one comes to visit me now that I'm dying" or " Can't you just come and sit with me and read Psalm 23 to me?"

The process of being institutionalized can be stressful for the patients/residents in itself, however institutionalization can often generate other problems as well, e.g. long waits, incomplete information, an impersonal routine and schedule, endless tests. The illness/disability of the patients/residents is always difficult but the staff can create an atmosphere of concern, personal attention, and respect that supports the

patients/residents through painful or trying times. The staff are in a key position to prevent or at least reduce many of the stresses associated with being institutionalized. In spite of the fact that staff members are often expected to handle a wide variety of situations with patients/residents and their families/visitors, the background to understand the dynamics of these situations has not always been provided to the staff, have the staff been made aware of just how significant their role is in their relations with the patients.

In a long term care setting it is important that the staff (nursing and non-nursing), look at their contacts with patients/visitors with a new vision. Developing a climate of trust in the Patient Relations and Communications classes makes it possible for employees to ask for help, admit they have difficulties in communicating, receive suggestions, try them out, and take supportive criticism. The process of personal change takes time and therefore the length of the course allows for that process to begin, gel, and become comfortable. Because the institutionalization of geriatric patients/residents often results in death within the facility (versus an acute care hospital), it is very crucial that the staff develop the skills and abilities to provide sensitive and appropriate care for the patients/residents and their families/visitors on an ongoing basis. The emphasis in this series of ten consecutive sessions then, is to assist the staff to identify their concerns about dealing with the elderly, the terminally ill and death and mourning. Until the staff are

able to identity and deal with their own feelings and reactions to situations they encounter, they will be unable to respond to those situations with empathy. As well the patients/residents will not have the opportunity to receive and benefit from the complete psychosocial model where holistic care is afforded to them (i.e. physical, emotional, psychological,financial, spiritual needs are met). In approach, the concept promoted within the framework of this ten session course is that of a palliative or hospice philosophy as much as it is that of a program or an institution. This does not mean that specific beds must be identified as "hospice or palliative" beds. The paramount issue is the concern for the whole person, with the focus being the patients/residents symptoms (i.e. physical, emotional, spiritual, psychological, financial). This is the time for active, compassionate care of the elderly, particularly the terminally ill/dying. The aim is to improve the quality of the remaining time, because their disease or illness is no longer responsive to traditional treatment which has been intended to cure or prolong life. This philosophical base for the care required is multidisciplinary in nature and includes the patient/resident, family and community within its scope (Van Bommel, 1986). The involvement of the family in the actual care of the patient/resident can help to alleviate the guilt and sense of helplessness felt by the family and can give assistance and comfort to the patient/resident. Therefore, it is important that the staff treat the patient/resident and their family as one unit of care, as an informed family is usually a less anxious one, and

consequently the interactions with the staff are less stressful (Buckingham, 1983). Death education training for all staff within this long term care facility is especially important in that a number of the patients/residents are veterans and they do not have families/visitors. Who then can provide or participate in the care of the patients/residents? This role must be filled only by staff (nursing and non-nursing). If the staff are aware of the needs of the patients/residents and are prepared to offer the empathic and supportive care which enable the patients/residents to enjoy their remaining life, the helpful environment of the facility can be felt by staff, patients/residents and their families.

The basic rationale for this course has been drawn from Buckingham's (1983) quote of Dame Cicely Saunders when she explained her belief in the kind of philosophy used in hospice type care: " You matter because you are you. You matter to the last moment of your life and we will do all we can not only to help you die peacefully, but also to live until you die".

The more that staff become aware that more harm is done to patients/residents out of ignorance than any other way, they will then realize the importance of ending relationships with patients/residents as well as beginning relationships. This cycle, therefore, allows the staff, patients/residents and their families to achieve a sense of completeness. The staff's feelings of hurt, anger, despair, loneliness, sadness, and emptiness can raise a question of whether it is worth it to become involved with people who will die, yet the understanding of the role that death plays

as well as the role that birth plays in the cycle of life, can assist the caregivers (nursing and non-nursing) to recognize the importance of the care they provide. Once the staff have an opportunity (by participating in a course such as the Patient Relations and Communications Course) to experience and practice ways of dealing with their own feelings and needs, when giving care to long term care patients/residents, staff will be in a better position to understand the feelings, ideas and needs of the patients/residents and their families (Buckingham, 1983, Mount, 1985, Broadfield, 1988, Parry, 1989).

The Patient Relations and Communications Course consists of a series of ten weekly sessions . Each session was composed of two hours of class time, 1/2 hour of assigned readings, an application assignment, and a journal type of assignment for the recording of experiences during that week.

Course goals:

1. To explore personal feelings about institutionalized settings and the effects of those feelings on communication with the long term care patients/residents.
2. To consider the impact of institutionalization, aging, illness and death on patients/residents and their families/significant others.
3. To increase personal and professional skills in communicating with patients/residents, families, colleagues and friends during the daily care given, as

well as the specific needs during the dying process.

4. To apply the understandings about institutionalization and communication with the terminally ill, both personally and professionally.

Basic assumptions of this education/training

1. Employees want to understand the human side of their jobs in more depth and so will welcome the opportunity to develop that aspect of their job because it will give significance to what they do.
2. Staff can learn and develop communication skills and change their negative attitudes.
3. Staff at every level have insights to offer to each other
4. Personal change can occur, but over a period of time, when rethinking of old attitudes is allowed and new behaviors can be tried out in a safe atmosphere.
5. Changes in attitudes and behaviors occur through contact with other people, and a positive class atmosphere provides opportunities to share a problem, get help with it, be listened to, and receive helpful criticism.

Assumptions about how people learn:

When deciding on the teaching techniques and methodologies to be used in this course some basic assumptions about how people learn were used as the foundation of those decisions. They are,

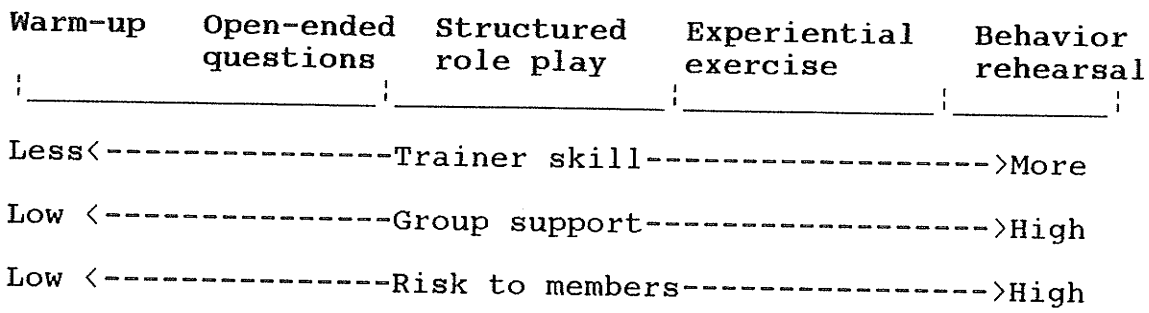
that people learn:

1. when they decide that they need to learn something.
2. from their own experience.
3. from practice.
4. by watching others and imitating them.
5. when they feel understood by others, and not judged.

Methodology

The training methods used in this course can be placed on a continuum from the least to the most complex as in the model below. While not every method used fits exactly, in general the methods selected tend to require less trainer skill, lower group support and a lower sense of risk for the group member on the left side of the continuum, and the reverse is true as there is movement toward the right side of the continuum. The early sessions began with activities from the left side and as the course progressed, movement toward the right side was increased.

Continuum of training methods used in the course (Alaire and McNeil, 1983)



The participants were involved in selecting the content even before the first class. A sheet for the recording of individual objectives was sent to each participant who signed up to attend the classes. During the first class, the overview of the course was presented and there were alterations made in content and methodology to meet the needs expressed by the participants. This process was reviewed again after the fourth class, the sixth class and the eighth class. The classes consisted of lectures, mini-lectures, role plays, self assessment activities, the use of audio and video tapes , 16 mm films, readings, guest speakers, small and large group discussions/activities. The instructor used a variety of warm-up activities, open ended questioning techniques, experiential exercises, and behavior rehearsals. When the weekly assignments were handed in, the instructor made a personal comment about how each participant was progressing and returned the assignment the following week. The content of the assignments was confidential and offered each participant an opportunity for personal feedback from the instructor. The level of trust and

respect for each other and themselves developed and increased over the period of ten weeks. The participants were encouraged to try new behaviors in their own work settings and to report back during the next class about their experiences. The degree of success in practising new behaviors increased over the length of the course. The reports of the successes in dealing with dying patients/residents and their families became less stressful and less avoidance behavior was reported. The responses of the patients/residents and their families also grew to be more positive as the staff were less anxious in their dealings with them.

Content

Session 1. Introduction to the course

Participants met each other, reviewed the content of the course, discussed their own expectations of the course and the instructor. Some preliminary activities began the examination of personal feelings and attitudes and how these feelings/attitudes affect relations with patients/residents and others in a long term care setting.

Session 2. Looking at Ourselves

Discussions about personal feelings and reactions to various institutional type situations were a major focus in this session. The impact of these attitudes on communications with others was demonstrated in role play skits and the resulting behavior was analyzed/discussed. Class members were asked to identify their own

feelings when dealing with people in their own departmental situations, and to discuss how they handled those situations.

Session 3. Impact of Institutionalization and Illness on Patients/Residents and their Families

The institution with schedules, routines, atmosphere and rules can be as strange to the patients,residents and their families as it is familiar to the staff. The impact which the familiar and sometimes frightening world of an institution has on the patient/ resident and family is discussed and assessed from a personal perspective. This understanding forms the basis for the balance of the course, and how they as individual staff members are responsible for their own feelings, how their behavior reflects those feelings, particularly in the long term care facility, when their original training prepared them to function in an acute care setting.

Session 4. Nonverbal Communication: Listening

This session is the beginning of 5 sessions on communication skills, with each one building on the previous one. This session examines the use of basic nonverbal ways of sending messages to others: appearance, tone of voice, eye contact, posture, facial expression, gestures, distance and touch. The section on listening skills presents ways to focus on the other person's message. Opportunities to practice each skill provide the basis for discussions and for completion of the assignment. The difference

between empathy and sympathy is explored in this class and class members tend to have difficulty understanding the difference and how an empathic response can favorably influence their interactions. The bulk of class time in this session is on the practice of good listening and the giving of empathic responses.

Session 5. Listening (Getting and Giving Information)

The discussion of listening and the role played by empathy and paraphrasing lead to a considerable number of practice exercises. The skills involved in the getting and giving of information focused on how the patient/resident experiences frustration and inaction by staff, when only partial information is available. Practice opportunities were provided in reassuring patients/residents and in ways of offering them choices whenever possible. Discussions centered on ways of involving the families/significant others in the care of the patients/residents, as a means of providing comfort to both the patients/residents and the families/significant others.

Session 6. Calming Hostile People

Dealing with explosive situations, when patients/residents, families, visitors or staff are taking out their anger on others can be extremely difficult. This session provides some theory as well as practice exercises for dealing with such situations. Staff members seemed to find this session somewhat theoretical and at

times, threatening, since they are asked to identify situations when they have been hostile and/or angry with others. This requires self-disclosure and usually it takes more than one session to explore the staff's experiences and for them to be ready to discuss these situations in class. Dyads and small group discussions (groups of 2-3) seem to be a safe way for staff to divulge their experiences and to practice different ways of handling those situations. The behavior rehearsal technique seemed to be an important vehicle in improving skills in dealing with hostile and angry people.

Session 7. Assertiveness

Situations arise when staff must enforce regulations or insist upon a particular procedure even when they meet with resistance from patients/residents, families, visitors. Different ways of dealing with the conflicts (passively, aggressively or assertively) and practice with being assertive in situations from participants' experiences is the major part of this session. A number of situations raised for discussion in this class center on the staff members' home situations with spouse and family members. Once these have been safely practiced more work related situation tend to surface for discussion and practice. This session serves to integrate all of the skills from the previous sessions and generally tends to be rated as highly effective and valuable by those attending.

Session 8. Terminal Illness

Personal Perspective

The personal perspective on terminal illness and the staff's experiences in their own lives with dying people, is the emphasis in this class. The discussions revolve around how the staff would like to deal with situations differently should they occur again. The role of good communication skills and the need for understanding the role that staff play in dealing with death was the focus in this session. The discussions centered on the importance of ending relationships helpfully and empathically. Feelings and emotions generally ran high in this session and class members were very fatigued at the end of this session. They have even reported the following week that they may not have slept well that night and that discussions with family members had revealed the need to discuss issues related to the death of parents, family members, children's guardianship, the need to make a will, insurance coverage, the location of important papers, and funeral arrangements. However, once these issues have been resolved for themselves, they have even gone so far as to broach this formerly unmentionable topic with their own parents. The responses of parents in some cases surprised them with a range from "Thank goodness you raised this, we didn't know how to approach YOU" to "We will discuss this ourselves when we are ready". In any event, the staff members felt better for having raised the topic. At times the staff have reported (after the completion of the course) that

these issues have been resolved with their parents and that there is less fear about what will happen when death occurs. That is not to say that the feelings of loss and sadness will be less, but that the knowledge of what the wishes are for the final arrangements are, will help.

Session 9. Terminal Illness

Professional Perspective

The particular needs of the dying patient/resident and their families is emphasized here. The application of personal feelings and experiences is used as a basis for improving the staff understanding of the patient and resident needs. The specific areas which may be requested of the staff in caring for the dying are discussed in detail. Opportunities to review professional experiences in the long term care setting are provided in this session. The discussions of the previous eight classes are a valuable source of support in this session as people discuss quite openly their fears, anxieties and desires to make things better for the dying patients/residents. It is not unusual for frustration and anger to be expressed, at not being able to make some of the changes they believe would be of benefit to the patients/residents when they are dying. Part of the summary of these sessions therefore, is to prepare a list of the desired changes within the long term care setting. This list becomes part of the Course evaluation summary which is then forwarded to the administration of the facility following completion of the course.

Session 10. Summary and Course Evaluation

The themes of the course are tied together in this session by using the film " Cause the Effect: Affect the Cause" . Discussions of how the key roles in the film display the various parts of the course are discussed in small and large groups. Evaluations of the course are conducted verbally and in writing. Personal gains from the course are discussed and occupy the bulk of the time in this class. The use of a post training feedback form is discussed and explained in this session. The staff are asked to identify their own learning and their ability to apply the content from the course on the job. One month after the course has been completed, they receive a copy of the post training feedback form. They are to complete part of it themselves, and then discuss the changes they believe they have demonstrated with their supervisor. The supervisor is asked to comment on what they have observed, make comments and return the completed form to the instructor. It is on the basis of some of the observed changes, that policies within the facility have been made, thereby increasing the staff's sense of control and perceived importance of their role in providing care to the patients/residents in a long term care facility. A sample of the post-training feedback form is included at the end of this appendix.

A date for the Executive Director of the facility to award Certificates for participation and completion of the course is announced. Family/friends are invited to attend this certificate

ceremony since they have often observed/experienced changes in the behavior of the person attending the course. Positive comments are made by family members about the changes they have observed, and at times some have asked if they could attend the course themselves. A sample certificate is included at the end of this Appendix D.iii.

Post Training Feedback Form

Note: to be sent out and completed one month after the date of the last session of the Patient Relations and Communications Course.

Name of supervisor_____

Name of staff attending the course e.g. Jane Doe

Dates classes were attended e.g. September 3-November 19, 1989

Department e.g. Health Information Services

Now that you have had a chance to apply what you learned in the Patient Relations and Communications Course, how is it going? Your opinion is valued. After you have completed the form, please discuss it with your immediate supervisor, and then forward it with the supervisor's comments to: Lila Larson, Education Services Department. Thanks for helping to indicate what happens when you use the education/training on the job.

1. I've done these things that I feel good about:

2. And this is what happened to make me feel glad that I used the new skill:

3. I've done these things that I wish I hadn't:

4. This is what happened to make me feel the new behaviors didn't work out very well:

5. If I were to get the training now, I would also like to learn how to:

Supervisor's comments:

APPENDIX D.i

TEMPLER'S DEATH ANXIETY SCALE

(NOTE: This was given as a pre-test and as a post-test)

Please circle T (for true) or F (for false) for each statement as it applies to you now.

1.	I am very much afraid to die.	T	F
2.	The thought of death seldom enters my mind.	T	F
3.	It doesn't make me nervous when people talk about death.	T	F
4.	I dread to think about having to have an operation.	T	F
5.	I am not at all afraid to die.	T	F
6.	I am not particularly afraid of getting cancer.	T	F
7.	The thought of death never bothers me.	T	F
8.	I am often distressed by the way time flies so very rapidly.	T	F
9.	I fear dying a painful death.	T	F
10.	The subject of life after death troubles me greatly.	T	F
11.	I am really scared of having a heart attack.	T	F
12.	I often think about how short life really is.	T	F
13.	I shudder when I hear people talking about a World War III.	T	F
14.	The sight of a dead body is horrifying to me.	T	F
15.	I feel that the future holds nothing for me to fear.	T	F

APPENDIX D.ii

DEMOGRAPHIC SHEET

1. Age _____

2. Sex _____ Female _____Male

3. Education (please check the applicable ones)

   _____ high school or G.E.D.

   _____ trade school or diploma

   _____ nursing training

   (Please specify R.N., L.P.N., Aide, orderly)

   _____ community college certificate program

   _____ University degree

   _____ Graduate degree

4. Shift most often worked

   _____ days _____ evenings _____ nights

5. Category of work:___ full time ___ part-time ___ volunteer

6. Department (please specify)_____

7. What was the most significant learning for you?

8. What has been your contact with dying patients since you completed the course?

   a) frequency? b) relationship?

   c) contacts with others who were dying?

APPENDIX D.iii

COURSE EVALUATION

Please complete these evaluations as honestly as you can. If there is a question which you do not want to complete, leave it blank. The responses will remain confidential. A summary of the responses from each series of ten sessions will be compiled and you will receive a copy of the responses from your own group.

1. During this course, the following topics were presented. How helpful was each topic to you? Please answer by circling the appropriate number. If you were not present for that session, cross out that topic.

   a) Introductory Session

   1 2 3 4 5

   Not helpful Somewhat helpful Very helpful

   b) Looking at Ourselves (Attitude cycle, feelings)

   1 2 3 4 5

   c) Understanding the Impact of Institutionalization

   1 2 3 4 5

   d) Nonverbal Communication

   1 2 3 4 5

e) Listening, Getting and Giving Information

1 2 3 4 5

____\\

f) Calming Hostile People

1 2 3 4 5

____\\

g) Assertiveness

1 2 3 4 5

____\\

h) Terminal Illness - Personal Perspective

1 2 3 4 5

____\\

i) Terminal Illness - Professional Perspective

1 2 3 4 5

____\\

j) Summary and Course Evaluation

1 2 3 4 5

____\\

2. How effective were the following teaching methods? Please rate them on a scale of 1 (least effective) to 5 (the most effective).

If you were not present for a method, cross it out.

	Least				Most
Use of Films	1	2	3	4	5
Role plays	1	2	3	4	5
Behavior rehearsals	1	2	3	4	5
Mini-lectures	1	2	3	4	5
Group discussions (small and large)	1	2	3	4	5
Feeling Reaction Sheet	1	2	3	4	5
Self assessment activities	1	2	3	4	5
This is my Week sheets	1	2	3	4	5

3. What did you hope to get out of this course?

4 a. How well did this course meet your expectations?

4 b. Why?

5 a. How much of the material covered in the course have you been able to apply on the job?

1	2	3	4	5
Very little		Some		Considerable

b. Please name some specific ways in which you have been able to apply this course to your job.

6 a. Would you recommend this course to others?

Yes_____ No_____

Why?

b. Who would benefit most from this course? (please check as many as you need)

Day Hospital _____ Dietary____ HIS_____

Housekeeping_____ Lab_____ Nursing_____

Occ. Therapy _____ Physiotherapy _____

Radiology_____Recreation____ Respiratory_____

Social Services _____ Volunteers_____

Others (please specify) _____

7. Please comment on each of the following:

a. Handouts:

b. Instructor:

c. Classroom:

d. Length and schedule of course:

e. Group feeling:

8. What other topics would you like to see included in this course?

9. What changes would you make in the course?

10. Other comments regarding the course:

NOTE: Determining the impact of such a course on the staff is a difficult question to answer, yet one which is important if the facility is to be convinced that death education instruction is worth offering and that it produces result. The strongest

evaluation of such a course, of course, is to ask those attending, how and when did they apply the principles on the job. The best way to evaluate their application is to ask them, verbally and in writing during the last session. The premise is that their perceptions of themselves can be trusted.

One measure of determining the changes in behavior, is to make use of the post training feedback form discussed earlier in Appendix C. In this way, the staff members and their supervisors are clear as to what skills are being applied and what the results are observed to be.

Certificate

Deer Lodge Centre

PRESENTED TO

_____

FOR

_____

_____

APPENDIX E

PERMISSION TO CONDUCT THE STUDY AT DEER LODGE CENTRE

1425 Wellington Crescent
Winnipeg, Manitoba
R3N 0B2
October 17, 1988

Mr. Roy Brown
Executive Director
Deer Lodge Centre
2109 Portage Avenue
Winnipeg, Manitoba
R3J 0L3

Dear Mr. Brown,

Re: Permission to Conduct a Study at Deer Lodge Centre

As a Masters' student for a degree in Adult Education at the University of Manitoba, I am conducting research in the area of long term care and death education which has been developed according to adult education principles. Specifically, I hope to assess the effect of the Patient Relations Course on a multidisciplinary mix of staff and any changes in their death anxiety levels as measured on a pre/post test. Attached please find a brief proposal which includes a further explanation of the study. The purpose of this letter is to request access to the facility for the selection of subjects.

The study is being supervised by Dr. Deo Poonwassie, Dept. of Educational Administration and Foundations (chairperson), Dr. Hal May, Dept. of Educational Administration and Foundations, and Dr. Janet Beaton, School of Nursing, Faculty of Education, University of Manitoba and Dr. David Murray, Clinical Director, Deer Lodge Centre. Ethical approval for

this study will be sought from the Ethics Review Committee, Graduate Studies, and evidence of approval by the committee will be supplied to Deer Lodge Centre. If there is an internal ethics review procedure for the Centre, I will be happy to meet the requirements.

The time requirements for this study are outlined in the attached proposal but should not exceed twenty minutes per participant. The data collection phase should be completed within one month. A final report of the results will be submitted to Deer Lodge Centre. A copy of the investigator's thesis will be provided to the institution if desired.

I am requesting that you review the proposal and circulate it to the appropriate personnel. If you have any questions about the proposal, I would be pleased to meet with you or with any internal review committee at your convenience but as soon as possible. I anticipate hearing from you.

Sincerely,

Lila M. Larson

2109 Portage Avenue • Winnipeg • Manitoba • R3J 0L3 • Telephone (204) 837-1301

December 15, 1989

Mrs. Lila Larson
1425 Wellington Crescent
Winnipeg, Manitoba
R3N OB2

Dear Mrs. Larson:

I have read your thesis proposal with great interest.

I am pleased to advise that you have approval to proceed to collect the necessary data utilizing Deer Lodge Centre records and to conduct an evaluation test on Centre staff who participated in the death education course.

Yours sincerely,

R.S. Brown
Executive Director

APPENDIX G

LETTER AND CONSENT FORM SENT TO POTENTIAL SUBJECTS

Education Services
Deer Lodge Centre
2109 Portage Avenue
Winnipeg, Manitoba R3J 0L3
December 1, 1989

Dear Staff Member,

As a student in Adult Education at the University of Manitoba I have the pleasure of inviting you to participate in a study for a Master's thesis.

You are invited to take part in a study to identify the effect of a death education course which was developed and offered to a mix of nursing and non-nursing staff at Deer Lodge Centre. You were picked at random from a number of staff who have completed the Patient Relations Course at Deer Lodge. Your participation is solely on a voluntary basis. This study will provide information on the effect that a death education course has on staff and may provide information on the value of providing such courses in the future as a way of improving the care given to geriatric residents. Your supervisor(s) will not be informed as to who participated in the study and who did not. If you do decide to participate in the study, you will be free to discontinue at any time without prejudice. A maximum time of twenty minutes will be all that is required to complete the forms.

Your part in this study would involve giving consent to participate by returning the attached consent form to the researcher. You would then receive the following forms for completion:

1) Post-Test of the Death Anxiety Scale

2) Demographic sheet of information on your background (age, sex, education, effect of the course on you)

Your name will not appear on any of the forms. To further facilitate anonymity, an envelope, pre-addressed to the researcher, will be provided with the forms. Any information obtained will be considered confidential. Data will be kept in a locked drawer during the study and upon completion of the study will be destroyed.

If you have any questions or concerns please contact me at 831-2101 (business) or 489-4923 (residence). The final results of the study will be forwarded to the administration of Deer Lodge Centre. A summary of the completed study will also be made available to you upon request.

Your completion of the attached form indicates that you have read the above information and have decided to participate in this study. By agreeing to participate in this study you are consenting to give the investigator permission to consult and use your comments from the Course Evaluation contained on your training file in the Education Services Department, Deer Lodge Center.I understand how busy your schedule is, however, your cooperation in this research effort may help to provide information for improving staff development programs. I offer my thanks in making time to consider your participation in this study.

Yours sincerely,

Lila M. Larson

CONSENT FORM

1. I consent to participate in this study. Yes___ No___

2. I would like to receive a copy of this letter for my own files. Yes___ No___

3. I would like to receive a copy of the completed study. Yes___ No___

Name of participant_____

Date:_____/89 Signature of participant_____

Date:_____/89 Signature of investigator _____

Lila M. Larson

NOTE: UPON RETURN OF THIS LETTER, THOSE WHO ARE PARTICIPATING IN THE STUDY WILL RECEIVE COPIES OF THE DEATH ANXIETY SCALE POST-TEST AND THE DEMOGRAPHIC SHEET IMMEDIATELY.

PLEASE RETURN TO:
LILA M. LARSON
1425 WELLINGTON CRESCENT
WINNIPEG, MB
R3N 0B2

APPENDIX H
VALUES FOR CALCULATING "z" SCORES
(on the Templar's Death Anxiety Scale)

Item	Npre	Xpre	Ppre	Npost	Xpost	Ppost	"z"score
1.	88	34	34/88= 0.386	83	18	18/83= 0.217	2.40 *
2.	89	30	30/89= 0.337	87	40	40/87= 0.460	1.685 #
3.	88	61	61/88= 0.483	87	68	68/87= 0.781	1.347 ~
4.	89	43	43/89= 0.483	83	35	35/83= 0.422	0.808 ~
5.	89	23	23/89= 0.258	87	23	23/89= 0.264	0.092 ~
6.	89	23	23/89= 0.258	87	32	32/87= 0.368	1.599 ~
7.	88	06	06/88= 0.067	87	10	10/87= 0.115	1.125 ~
8.	89	50	50/89= 0.562	87	47	47/87= 0.540	0.298 ~
9.	89	71	71/89= 0.798	87	65	65/87= 0.747	0.820 ~
10.	89	41	41/89= 0.461	87	22	22/87= 0.253	2.930 *
11.	89	21	21/89= 0.236	87	12	12/87= 0.138	1.691 #
12.	89	63	63/89= 0.708	86	48	48/86= 0.907	2.785 *
13.	88	38	38/88= 0.427	87	37	37/87= 0.425	0.027 ~
14.	88	22	22/88= 0.250	85	12	12/85= 0.141	1.807 #
15.	89	19	19/89= 0.213	86	37	37/86= 0.430	3.067 *

Code: * P<.05, Z=1.96 # P<.1, Z=1.671
~ No statistical significance

APPENDIX I

CALCULATION OF THE "t" SCORE

Assuming that:

1. N = 91 responses

.....

2. $\bar{D} = \frac{\Sigma Di}{N}$

$\bar{D} = 1.066$

.....

3. $s = \sqrt{\frac{(\Sigma Di)2}{N} - (\bar{D})2}$

$= \sqrt{591/91 - (1.066)2}$

$= \sqrt{6.495 - 1.137}$

$= \sqrt{5.358}$

$S = 2.315$

4. T or "z" score

$$t = \frac{\bar{D}}{\frac{s}{\sqrt{N}}}$$

$$= \frac{1.066}{\frac{2.315}{\sqrt{91}}}$$

$$= \frac{1.066}{\frac{2.315}{9.539}}$$

$$= \frac{1.066}{.243}$$

$$t = 4.387$$

Because the "t" score value of 4.387 is larger than $p<.05$, $z = 1.96$, the null hypothesis of Ho: P pre = P post is rejected and the non-directional research hypothesis of Ha: P pre =/= P post is accepted.

APPENDIX J

OTHER COMMENTS

(COURSE EVALUATION, QUESTION 10)

These comments are drawn verbatim from the responses of the staff/volunteers who participated in this study. They are in random order.

1. I'll miss the classes I enjoyed each week.
2. The library reference material was inconvenient to access, and we couldn't get copies because there was no Xerox available.
3. I would like to attend more courses set up in the same way.
4. It was an enjoyable and informative course.
5. We have a better understanding of ourselves and why we handled some past events badly.
6. Great course, (I haven't been this enthused about anything since sliced bread).
7. I have been talking about this course with co-workers so much that they have thanked me for sharing it with them and are trying to get onto a waiting list to take it themselves.

APPENDIX K

SIGNIFICANT LEARNINGS FROM THE COURSE

(Demographic sheet, question 7)

These comments were drawn verbatim from the responses of the nursing and non-nursing staff who participated in this study. They are in random order.

1. I learned more about other people's feelings.
2. A positive attitude is the key to self-awareness and to help me deal with the various tasks before me everyday.
3. I am better prepared to communicate and express myself
4. My self-confidence has been built up by learning how to communicate and understand myself and others.
5. I learned new communication skills while receiving reassurance that I could use them with my nursing experiences.
6. I learned to know myself and gained a new approach to listening to others.
7. I increased my sensitivity to the residents and what they might be experiencing emotionally e.g. needs, losses, etc.
8. I have improved my awareness of my own strengths and weaknesses. Hopefully the course has increased my ability to respond to rather than react to residents and co-workers.
9. I learned the value of being a willing and good listener, hand holding, silence.
10. I had a chance to think about death as one of the natural things in life.
11. How to deal with the terminally ill.
12. Understanding empathy and how to practice it when dealing with geriatric residents.
13. That I was not the only one who could get anxious about death and dying, lots do.
14. That I am very scared of dying a painful death, I hope that when I leave this world I leave fast and peacefully.
15. I feel more compassionate towards people with illness.

16. A renewal of enthusiasm for residents' concerns which get lost in the day-to-day routine.

17. The course helped me to deal with my own fears of death.

18. That I dread pain more than death itself.

19. Communication skills with others such as the dying patient and family members are important and that death could be something which should be discussed openly.

20. I learned how important it is to allow other people to express their fears and concerns about dying without imposing my own opinion.

21. The importance of listening and allowing others the opportunity to speak out.

22. Coming to terms with my own feelings about death and dying.

23. The importance of a death review to help me grieve with my co-workers.

24. The importance of preparing the patient and myself for impending death and communicating with families during the grieving process.

25. Dealing with co-workers who are also grieving.

26. Facing up to one's own mortality.

27. Understanding my own losses and dealing with them in a more appropriate way.

28. Dealing with and caring for the dying patient and understanding the families needs better.

29. Making sure that my appropriate personal papers are ready e.g. wills, funeral arrangements.

30. I learned how to talk with my own family about my death.

31. There are other losses in life besides death.

32. Knowing myself and coming to terms with my own death and the deaths of my family members has been helpful.

33. I have a greater understanding of the effect of my culture on death.

34. That everyone goes through some form of grieving.

35. I have a better understanding of my own ideas and thoughts about death.

36. I know how to better deal with others facing death both at work and personally.

37. I have a greater understanding of communication methods and skills and how to apply them at work and in my personal life.

38. I have more self-understanding and my insight has grown and developed.

39. I understand death more and relate better to the situation when it happens. I have done things I learned from the course and still have patients' families calling in or dropping in just to say Hi.

40. I valued the time to talk about death without people thinking I was morbid.

41. I examined myself and learned more about what I think and feel.

42. I learned how to live each day to the fullest, to enjoy everyone I come in contact with, either at home or at work, and to come to terms with my past life experiences and feelings in order to continue on with my life, reaching one small goal at a time.

43. I feel that I have learned valuable insight into how mentally or physically disabled people must feel, and how to be a part of a team to help them focus on their "unwounded" parts.

44. I feel that my belief in God has been strengthened tremendously and the fears that I used to have seem to have vanished.

45. I now put myself in the other person's place (patients/friends) and value them for who they are, not who they would be or who they were in the past. I have learned what "unconditional love" really means.

46. I think the course has made me take a second look at how to really live (enjoy the life I have now) and help others desire to live and not fear death.

47. My most significant learning has been that I am prepared to die at any time knowing that I have done my best to help my fellow human beings each day and that by my helping them, they have helped me.

APPENDIX L
EXPERIENCES WITH DEATH SINCE THE COURSE ENDED
(Demographic sheet, question 8)

The comments in this appendix have been drawn from those made by the nursing and non-nursing staff who completed the course and agreed to participate in this study. The comments are in random order as they were recorded from the demographic sheet, question 8.

1. Many patients/residents want to talk about how they feel concerning death. I now feel completely comfortable discussing their fears, concerns and beliefs with them, and many have remarked on how relieved they feel to have someone to talk to about this subject, without feeling morbid or afraid.

2. I was asked to look after a friend and co-worker who went in for a routine ulcer operation and found out he had cancer. I became aware of how easily he tired. I can relate better to this person because of this course.

3. This course reassured me that what I had done for my husband when he had terminal cancer was OK. I did the best I could and I knew I could not have done any more.

4. I would find it easier to say how I feel if someone close to me died right now.

5. When my grandmother was dying I was able to sit and hold her hand and I was able to tell her not to be scared and to think of it as a deep peaceful sleep with no pain.

6. I find it easier to talk about dying than I did in the past.

7. I have taken care of two dying people who were very close to me. I could not have done this before the course.

8. I know when my turn comes I'd like to have a priest and my family at my bedside.

9. I have been around while my two brothers, one sister and both parents died. They were prepared mentally and physically because my father always taught us to prepare ourselves to die as if it would be tomorrow and then to live joyfully as if we would never die. I found this course to be excellent.

10. I have been able to reach out to people in a more meaningful way when they needed comfort.

11. I learned a lot about myself in this course.

12. Just recently I've been involved with a death and settling an estate which makes me aware of how important a will can be.

13. It is too bad that the patient who wants to die is not allowed to when he's found with no pulse and is revived to live as a living corpse. There is no dignity for them.

14. I am more assertive now and more confident in being able to come out and say how I feel about the patients' care.

15. My sister (35) recently died and even though I can help dying patients I still grieve more when it's a member of my own family.

16. My feelings about death and dying are very different than before the course. It is not sad for me to see a patient die when he is ready but the loss of his friendship is hard for me to take.

17. I have found that the classes, discussions with others' opinions have been helpful and very moving and helped me to think about a very sensitive area more easily.

18. Coming to terms with my own death has made me very appreciative of life.

19. Since the course finished I have asked my children how they feel about death. My youngest told me she was afraid to die. My husband and I never talked about death before, but we intend to discuss it more with our children. I also found it helpful to get in touch with my own feelings about death and dying.