Table 2. Summary and Rating of the Evidence in the 19 Articles Reviewed

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<tr>
<th>Author(s), Year</th>
<th>Purpose(s)</th>
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<th>Design</th>
<th>Relevant Findings</th>
<th>Strengths, Limitations, Evidence Grade</th>
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| Zimmerman N, et al., 2002¹¹ | To explain impressions, clarify fallacies, explore options, and suggest strategies for linking prison and broader community  
To determine correctional staff and inmates’ understanding of EOL care and need for prison hospice  
To determine prisoner characteristics and knowledge of hospice | Interviewed 212 inmates (115 women, 97 men), caregivers, corrections officers, administrators, and policymakers from six Connecticut prisons, and relevant outsiders | Mixed methods, cross-sectional, feasibility study | Inmate hospice awareness and EOL preferences:  
• 74% preferred transfer for EOL care (to a hospital, for example)  
• 47% aware of hospice  
• 81% would use prison hospice  
• 91% preferred nonprison staff give care  
• 87% willing to be hospice volunteer  
• 77% would want an inmate caregiver  
Hospice awareness associated with  
• older age  
• higher level of education  
• knowing someone who received hospice or had HIV/AIDS | Strengths: Big sample for feasibility study; six sites; random survey selection  
Limitations: Scant literature; incomplete data analysis; no sample size or demographics for staff interviewees; tools not shared; no reliability/validity of survey; random selection not described  
EG: IIIC |
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<tr>
<td>Yampolskaya S, Winston N, 2003&lt;sup&gt;12&lt;/sup&gt;</td>
<td>To identify the main components of prison hospice and to determine the outcomes of hospice care in prison</td>
<td>Hospice providers in U.S. federal and state prisons: 10 of 15 prison hospice programs identified were able to participate; 66% response rate</td>
<td>Qualitative</td>
<td>Components of prison hospice:  • introduction of hospice care into prisons  • multidisciplinary care teams  • inmate volunteers (selection, screening, training, regular or additional job); involvement in hospice staff meetings  • comfort care (inmate counseling, special privileges, contacting family, relaxed visitation rules, family counseling, funeral or memorial service)  • EOL care: DNR requirements, eligibility criteria</td>
<td>Strengths: Data from 10 U.S. prison hospices; comprehensive exploration  Limitations: Non-peer-reviewed literature and media included; did not specify interviewees at each hospice; used a new tool without addressing reliability or validity; did not share surveys  EG: IIIC</td>
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| O’Connor MF, 2004<sup>13</sup> | To examine the therapy of a prisoner at the EOL; review meaningful life events, current goals, value of the final stage of life, and ethical issues, including pain management and compassionate release | One prisoner with end-stage cancer in U.S. prison | Qualitative, case study | Ethical issues discussed:  
• Inmate’s goal of being released from prison caused him to refuse aggressive pain management and focus on remaining mentally clear and fighting to survive.  
• Health care staff tried to get psychologist to convince inmate to go off-site for increased pain management despite inmate’s wishes.  
• Prison administrators did not want inmate informed that compassionate release was denied, believing it would upset him.  
• After inmate learned release was denied, he accepted prognosis, stopped fighting for his life, and died in prison. | Strengths: Detailed account of prisoner’s EOL experience  
Limitations: Only one participant; no description of case study approach; no mention of themes; did not provide interview guide or selection criteria for case study participant  
EG: VC<sup>b</sup> |
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| Reviere R, Young VD, 2004¹⁴ | To examine the health care issues of incarcerated women, specifically those ages 50 and older | Infirmary directors in U.S. women's prisons: 65 (58 state, seven federal) responded out of 123 invited; 53% response rate. National sample in United States. | Pilot study, cross-sectional, correlational | Just over half the sample had EOL-related findings:  
• Hospice services were offered in prison by 28% of respondents and outside prison by 23% of respondents.  
• Prisons with a higher percentage (≥10%) of older women were more likely to have hospice care (67%) than those with fewer older women (43%).  
• Prisons with a lower percentage of older inmates were more likely to offer bereavement counseling (93%) than those with a higher percentage of older inmates (75%).  
• Prisons that anticipated population aging were only slightly more likely to have hospice services (42%) than those that did not expect an aging population (39%). | Strengths: National sample of U.S. federal and state prisons.  
Limitations: No indication of respondents' disciplines beyond title "director"; did not report extent of hospice services; no reliability/validity of survey; survey tool not shared.  
EG: IIIC |
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<tr>
<td>Aday RH, 2005–200615</td>
<td>To investigate factors associated with death anxiety in older male inmates</td>
<td>Men ages 50 and older (mean age, 59) in a maximum security Mississippi prison (N = 102)</td>
<td>Mixed methods; cross-sectional, correlational, qualitative</td>
<td>Significantly greater death anxiety was reported by inmates whose • health was poor • self-reported mental health was poor • social support was limited The majority (two-thirds) of participants frequently thought about dying in prison. Four themes emerged: • stigma of dying in prison (shame for family) • fear of death (dying alone) • religious activities (prayer) • death as an escape</td>
<td>Strengths: Reliability of scales provided; alpha reliability strong for life satisfaction, social support, TDAS Limitations: No power analysis; unclear how themes derived; items for social support and life satisfaction not provided; no established tool cited for measuring social support or life satisfaction EG: IIIC</td>
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| Enders SR, et al., 2005<sup>16</sup> | To identify informational barriers to decision making about EOL care and advanced care planning in the prison setting | Inmates at a women’s prison in California (N = 113; n = 91 younger than 50; n = 22 ages 50 and older) | Qualitative, focus groups | Content areas:  
• knowledge and information  
• barriers and obstacles  
• experience  
• expectations  

Content linked to four themes:  
• physician visits  
• understanding  
• trust  
• self-advocacy  

Knowledge and information:  
• unsure how to report problems  
• unsure what questions to ask  

Barriers and obstacles:  
• illiteracy (not understanding procedural or treatment risks)  
• lack of physician attention  
• inconsistent information provided  

Experience:  
• singular focus on one problem per visit  
• not heard by providers  

Expectations:  
• better care and communication | Strengths: Detailed data collection methods and determination of themes  
Limitations: Results section failed to specify EOL care; no mention of data saturation; discussion guide not provided; some overlap across themes; no mention of trustworthiness  
EG: IIIC |
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<td>Bronstein LR, Wright K, 2006</td>
<td>To examine interdisciplinary collaboration in prison hospice programs</td>
<td>Prison hospice program directors from 11 U.S. states (nurses, psychologists, social workers, corrections officers, business administrators, chaplains), N = 14</td>
<td>Qualitative, grounded theory; analytic techniques</td>
<td>Six themes: • quality of IDT alliance (most had positive experience) • collaboration between corrections and medical staff (support of wardens; less support from security) • collaboration with people beyond the prison hospice (such as community hospice) • IDT (including inmate volunteers) had positive effect on dying inmates • IDT had positive (transformative) effect on inmate volunteers • IDT positively affected overall prison culture (reduced stress and calmed environment)</td>
<td>Strengths: National sample; subjects of varied disciplines; data saturation; multiple coders; noted trustworthiness; included interview guide Limitations: Information only from hospice directors, which may bias findings EG: IIIB</td>
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<td>Wright KN, Bronstein LR, 2007&lt;sup&gt;c&lt;/sup&gt;</td>
<td>To explore structure and operations of hospice services in U.S. prisons, how they have been integrated into the overall structure of the institution, and their effect on the prison environment</td>
<td>Prison hospice program directors (N = 14; five social workers, three chaplains, two health administrators, two nurses, one psychologist, and one correctional staff member) National sample in the United States</td>
<td>Qualitative, grounded theory; analytic techniques</td>
<td>Hospice directors had a mean 7.3 years of experience. Hospice team members: social workers, nurses, chaplains, dieticians, physician (sometimes a psychiatrist) Actions promoting collaboration and quality included inmate care plans, team meetings, training Reception of hospice: mostly well received; mixed reaction from security and some nurses Role of volunteers and transformative impact on volunteers Hospice impact on prison culture: increased care and compassion Community hospice: a third of programs have relationships with community hospice and were well received</td>
<td>Strengths: Most U.S. hospice directors interviewed Limitations: No mention of data saturation; only interviewed prison hospice directors, which may bias findings; did not provide full discussion guide of interview questions EG: IIIB</td>
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| Wright K, Bronstein LR, 2007<sup>19,c</sup> | To explore integration of hospice programs into prison organizations and the role of social workers and correctional staff in hospice services | Prison hospice program directors from 11 U.S. states (social workers, chaplains, health care administrators, nurses, psychologists, corrections staff), N = 14 | Qualitative, grounded theory; analytic techniques | Two main themes:  
- transformative effect of EOL care on the individual  
- transformative effect of EOL care on the environment  
Individual transformation:  
- Inmate volunteers perceived increased compassion, self-worth, and empowerment.  
Environmental transformation:  
- EOL care increased inmates’ positive feelings toward staff.  
- EOL care enabled staff to see dying inmates as deserving of humane care.  
- EOL care collaboration improved relationships between infirmary and corrections staff. | Strengths: Data saturated; most U.S. hospice directors interviewed; provided interview questions  
Limitations: Did not clarify relationship with previously reported studies; all participants were prison hospice directors, which may bias findings  
EG: IIIB |

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<td>Deaton D, et al., 2009–2010&lt;sup&gt;20&lt;/sup&gt;</td>
<td>To investigate relationship between health variables and TDAS scores among female inmates</td>
<td>Female inmates (N = 327; 75% response rate) ages 50 to 78 (mean age, 56.6) Women's state prisons in Arkansas, Georgia, Kentucky, Mississippi, and Tennessee</td>
<td>Mixed methods, cross-sectional, correlational, qualitative</td>
<td>Mean TDAS score was 6.4 (out of 15) 77% worried about getting ill in prison also had greater death anxiety Perceived mental and physical health inversely related to death anxiety Thoughts of death and death anxiety directly related Number of chronic conditions and daily medications directly related to fear of getting sick Qualitative findings integrated with above findings: • health status and fear of death • thoughts of dying in prison • avoidance and denial • acceptance of death</td>
<td>Strengths: Large sample size; multiple prison sites; valid and reliable data collection tools; included questions asked of participants for qualitative portion; strong response rate Limitations: No formal themes identified; qualitative analysis not described EG: IIIB</td>
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| Phillips LL, et al., 2009  
21 | To determine the effects of age at the end of prison sentence, race, and psychosocial factors on EOL treatment preferences of prison inmates | Male inmates ages 50 and older (N = 73; n = 45 with life sentences or not due for release until after 75th birthday; n = 28 due for release prior to 75th birthday; 90% response rate)  
Alabama state prison for older and sick inmates | Cross-sectional, correlational                                                     | Treatment preferences based on full model (end of sentence, age, race, death anxiety, and spiritual beliefs) and individual factors  
CPR: full model significantly predicted preference; no individual factor was significantly predictive  
Feeding tube: full model significantly predicted preference; individually, end of sentence before age 75, racial minority, and greater death anxiety were significantly predictive  
Palliative care: full model significantly predicted preference; individually, end of sentence after age 75 and white race were significantly predictive | Strengths: Examined multiple variables using many valid and reliable tools; strong response rate  
Limitations: No power analysis performed; minority sample was mostly African American  
EG: IIIB |
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<td>Hoffman HC, Dickinson GE, 2011(^2)</td>
<td>To compare prison and community hospice programs’ adherence to practice standards of the NPHA and the GRACE project</td>
<td>U.S. prison hospice programs (N = 43, 62% response rate) Respondents included nurses, chaplains, medical directors, social workers, coordinators of hospice, wardens, and deputy wardens</td>
<td>Cross-sectional, descriptive</td>
<td>Interdisciplinary hospice teams (42 of 43) included nurses, physicians, social workers, chaplains, corrections officers, dieticians, community volunteers, inmate caregivers, and pharmacists. 24% allowed inmate’s family to participate in plan of care Most (59%) had inmate volunteers; 78% organized round-the-clock vigils within 72 hours of death, 38% allowed family vigils Family care after inmate death: cards or letters (33%), telephone calls (43%), referral to community grief counseling services (21%)</td>
<td>Strengths: Good response rate from majority of U.S. hospices Limitations: Did not share survey questions; potential for response bias owing to respondents’ desire to paint hospice in positive light; variety of respondent disciplines (may have varying knowledge levels); no reliability or validity data for the survey EG: IIIB</td>
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<td>Phillips LL, et al., 2011[23]</td>
<td>To determine applicability of the “Prospect Theory” in examining how functional ability and prison context affects inmates’ EOL decision making</td>
<td>Male inmates over age 45 (mean age, 57.7), N = 94; response rate, 63% Alabama state prison for older and sick inmates</td>
<td>Cross-sectional, correlational</td>
<td>The effect of parole expectation on desire for life-sustaining treatment varied by race or ethnicity and treatment. Active treatment: Racial minority inmates with an expectation of parole had a greater desire for active treatment regardless of illness; those with no expectation of parole were less likely to want active treatment for cancer with pain. Parole expectation did not affect white inmates’ desire for active treatment for emphysema or cancer with pain, but those with an expectation of parole had a greater desire for active treatment for Alzheimer’s disease. Palliative care: no significant effects Days of desired life: wanted shorter life if immobile, in pain, or confused</td>
<td>Strengths: Sample size; numerous variables measured using valid and reliable data collection tools; performed cognitive screening on inmates; strong response rate Limitations: Generalizability owing to prisoners in a setting already aimed at the sick or aging; no power analysis EG: IIIB</td>
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<td>Turner M, et al., 2011²⁴</td>
<td>To evaluate health professionals’ perception of EOL care in prisons</td>
<td>Health care professionals (N = 27; n = 18 from prison health care; n = 9 from community hospice) Six prisons and four hospices in two counties in northwest England</td>
<td>Mixed methods</td>
<td>No formal themes, but headings highlighted challenges related to prison environment, medication access, and location of death Interviewees felt inmates should have EOL care on par with community Prison staff worried about inmates sharing pain medication Difficult to get some pain medications in a timely manner Inmates may not have caregiver upon release</td>
<td>Strengths: Community hospice perspective; included discussion guides Limitations: Did not report quantitative findings; small sample; no power analysis; no reliability or validity data on new tools used; no formal themes; no discussion of saturation or the trustworthiness and interpretation of qualitative data EG: IIIC</td>
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<td>Cloyes KG, et al, 2014&lt;sup&gt;d&lt;/sup&gt;</td>
<td>To explore motivations of inmate EOL caregivers</td>
<td>Inmate hospice volunteers, N = 75 of 121 attendees at prison hospice conference; 62% response rate (18 female; 57 male)</td>
<td>Qualitative, grounded theory; analytic techniques</td>
<td>Those with ≥ 2 years of experience were significantly more likely to view hospice caregiving as a moral obligation. Nine themes: • transforming personal identity • expressing true self • personal redemption • having a God kind of heart • living the Golden Rule • witnessing and legacy vs. passing without notice • stepping up • paying it forward by giving back • collective identity through common humanity Three transformative themes: • constructing self-identity • constructing self-in-relation • constructing collective identity</td>
<td>Strengths: Size of sample; strong data analysis methods; color-coded surveys for anonymity while noting gender and experience; provided survey questions Limitations: No demographic data for 53% of participants; written surveys given to inmates who generally have low literacy EG: IIIB</td>
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| Loeb SJ, et al., 2013<sup>e</sup> | To determine inmate caregivers' values, beliefs, and perceptions of EOL care in the prison setting | Male inmate volunteers ages 35 to 74 (N = 17) State correctional institutions with different degrees of security in a mid-Atlantic U.S. state | Qualitative, descriptive | Three hierarchal themes:  
• getting involved (five subthemes)  
• living the role of an EOL volunteer (three subthemes)  
• transforming self by caring for others (four subthemes)  
Three levels of contextual features:  
• institutional (support from prison staff)  
• peer (support from other inmate volunteers)  
• personal (internal support, such as prayer) | Strengths: Reached saturation; rigorous data collection and analysis; gave detailed account of data extraction; provided discussion guide  
Limitations: Couldn't use audio recorders for interviews; no member checking  
EG: IIIB |
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| Penrod J, et al., 201427, e | To determine prison administrators’ view of EOL care in prison and explore barriers to changing current practice | Administrators from a U.S. state department of corrections (N = 12) | Qualitative, descriptive | Six themes:  
• statewide policy vs. prison culture (implementation depended on prison’s culture)  
• focus on need to treat vs. need for security (culture determines priority given to competing demands)  
• individual vs. systemwide views (some EOL care is on case-by-case basis)  
• needs of prison vs. public perception (may be little public support)  
• budget neutral vs. increased strain on the system  
• services for inmates vs. services for staff after inmate death (no inmate or staff services in unexpected deaths) | Strengths: Detailed description of data extraction; included table of evaluative insights and implications for practice; rigorous data collection and analysis  
Limitations: No mention of data saturation; unable to use audio recorder for all participants; discussion guide not provided  
EG: IIIB |
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| Loeb SJ, et al., 2014<sup>e</sup> | To determine inmates’ perceptions, attitudes, and beliefs about EOL care in prisons (both current and potential future consumers) and to explore the challenges and facilitators to providing care | Male prisoners (N = 21) ages 40 to 79; n = 14 current consumers; n = 7 potential future consumers | Qualitative, descriptive | Six themes:  
• seeking human interaction (within and outside of prison)  
• accessing material resources (equipment and books)  
• receiving compassionate care (varied by staff and staffing, wait time, and environment)  
• seeking equitable care (may vary based on inmates’ communication skills, resources, or crime[s] committed)  
• ensuring needs are met (physical and medical)  
• facing death (worrying about suffering) | Strengths: Rigorous data collection and analysis process, reached saturation, provided discussion guides; detailed account of data extraction  
Limitations: Unable to audio record interviews owing to prison restrictions; no member checking  
EG: IIIB |

<sup>a</sup>Evidence Grade:  
- I: Best evidence  
- II: Strong evidence  
- III: Weak evidence  
- IV: No Evidence  
- V: No Evidence
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| Supiano KP, et al., 2014\(^{29,d}\) | To explore the experiences of inmate hospice caregivers with death, both inside and outside of the prison setting, to help determine their bereavement needs | Inmate hospice volunteers (N = 27 of 36 hospice volunteers at Louisiana State Penitentiary; 75% response rate), mean age, 48 | Qualitative, descriptive, grounded theory; analytic techniques | Three patterns emerged:  
• experience with death  
• death of patients in hospice care  
• grief of volunteers  
Experience with death:  
• most described experiences as traumatic  
• many had grief related to not being there for a dying family member  
Death of patients in hospice care:  
• past encounters with death affected inmate's perception of the death  
• hospice death can be positive but takes a toll  
Grief of volunteers: they established firm boundaries or relied on support of others to cope with grief | Strengths: Rigorous process of extracting data and analyzing themes; provided interview discussion guide; strong response rate and sample size  
Limitations: No mention of saturation  
EG: IIIb |

**CPR** = cardiopulmonary resuscitation; **DNR** = do-not-resuscitate; **EG** = evidence grade; **EOL** = end of life; **IDT** = interdisciplinary team; **GRACE** = Guiding Responsive Action in Corrections at End of Life; **NPHA** = National Prison Hospice Association; **TDAS** = Templer Death Anxiety Scale.

\(^a\) For an explanation of the different evidence levels, see Table 1.

\(^b\) According to the Johns Hopkins Nursing Evidence-Based Practice evidence levels, Level V evidence is that from literature reviews, quality improvement, program evaluation, financial evaluation, or case reports, or the opinion of a nationally recognized expert based on experiential evidence.

\(^c\) One of three studies to report on the same 14 prison hospice programs.

\(^d\) One of two studies conducted on inmate hospice volunteers within the same state program and to share three of the same researchers.

\(^e\) One of three studies to cover different aspects of a global study.