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Improving Rural Emergency Nurses Comfort during Palliative and End-of-Life Communication

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Abstract

Background: Emergency nurses (ENs) often care for patients nearing the end of their lives or with life-limiting illnesses. However, ENs are hesitant to initiate palliative or end-of-life (PEOL) discussions because of a lack of comfort with these topics. Many ENs have no formal PEOL communication training which contributes to the lack of comfort with PEOL discussions in the emergency department (ED). Thus, the purpose of this quality improvement project was to determine how PEOL communication training affected rural ENs perceived comfort level during PEOL conversations.

Sample/Setting: A convenience sample of 14 registered nurses working in a rural Northern Plains ED.

Methods: A quality improvement project was implemented where nurses received online education using the End-of-Life Nursing Education Consortium Critical Care Communication module. This was followed by communication scenario review and group discussion. Changes in nurse comfort with PEOL communication were evaluated using a pre and post survey and reflective practice in the group discussion.

Findings: This quality improvement project demonstrated a statistically significant increased level of comfort (N = 14, $p = 0.006$) when communicating with PEOL patients and their families in the ED. Qualitatively, the ED nurses expressed fears and challenges specific to PEOL communication while also identifying new evidence-based strategies they can use during PEOL conversations.

Conclusion: Communication is vital when caring for PEOL patients in the ED. Formal PEOL communication training is effective for improving PEOL communication skills among ENs. Increasing nurse comfort when communicating with PEOL patients has the potential to improve quality of care at end-of-life.

Keywords: emergency nurses, communication, palliative, end-of-life

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In rural emergency departments (ED), nurses care for patients throughout the lifespan (Emergency Nurses Association, 2013). Emergency nurses (ENs) may care for patients with life-limiting illnesses or at end-of-life. As frontline caregivers, ENs must be comfortable communicating with palliative and end-of-life (PEOL) patients and their families (Bodine & Miller, 2017; Isaacson, Minton, DaRosa et al., 2019). Yet ENs, especially those working in rural areas, may struggle with PEOL communication. This is because in addition to caring for strangers, these nurses are often faced with the challenges associated with caring for someone they know personally. These unique circumstances occur more often in rural settings as ENs tend to have deep roots within their communities and multiple levels of personal contact with patients and families. The nature of these relationships may contribute to the discomfort and distress rural ENs

often experience when caring for and communicating with PEOL patients and their families (Beckstrand et al., 2017; Schlairet, 2017).

Many ENs feel unprepared to facilitate PEOL discussions; most have no formal PEOL communication training for these crucial conversations in the ED (Anderson et al., 2016; Bodine & Miller, 2017; Coyle et al., 2015; Isaacson & Minton, 2018; Isaacson, Minton, Da Rosa et al., 2019; Price et al., 2017; Roth et al., 2017). Formal PEOL communication training reduces communication barriers and increases nurse comfort with PEOL communication (Bodine & Miller, 2017; Coyle et al., 2015; Isaacson, Minton, Da Rosa et al., 2019). Training such as education provided by the End-of-Life Nursing Education Consortium (ELNEC) Critical Care Communication module has been shown to increase nurse comfort when communicating with PEOL patients and their families in the ED (Bodine & Miller, 2017). Thus, the purpose of this quality improvement (QI) project conducted with ENs in a rural Northern Plains ED was to determine how PEOL communication training affected their perceived comfort level during PEOL conversations.

Background

Patients with acute and chronic illnesses often present to the ED. On average, 51% of patients over the age of 65 will seek care in the ED during the last six months of their lives. These visits are often prompted by acute illnesses or exacerbation of chronic illnesses such as heart failure, chronic obstructive pulmonary disease, or cancer. The physical and emotional distress caused by acute illness or exacerbation of chronic illness contributes to the number of patients and families seeking care in the ED (Smith et al., 2012; Mierendorf & Gidvani, 2014).

The uncertain outcome of an ED visit stimulates the rapid development of a trusting relationship between patients and nurses. This relationship provides a level of comfort for patients

to ask nurses difficult questions such as "how long do you think I have to live?" The uncertainty of what to say or how to respond to PEOL questions often leaves nurses feeling uncomfortable (Isaacson, Minton, Da Rosa et al., 2019; McLennon et al., 2013).

ENs have a unique role in the care of patients and their families because of their ability to recognize the seriousness of the illness, associated needs, and distress. This role places ENs in a prime position for PEOL conversations (American Nurses Association [ANA], 2017). However, initiating PEOL discussions with patients and families can be an intimidating experience for nurses because of a lack of training in this area (Isaacson, Minton, DaRosa et al., 2019). PEOL communication skills are often learned on the job. Yet, nurses feel that these skills are not enough and are requesting formal PEOL communication training (Anderson et al., 2016; Coyle et al., 2015).

Effective PEOL communication is key because it reduces distress, empowers patients and families, and encourages patients and families to prepare for the PEOL experience (Price et al., 2017; Moir et al., 2015). ENs must be confident in their ability to communicate with PEOL patients and their families (Bodine & Miller, 2017; Isaacson, Minton, Da Rosa et al., 2019). Therefore, ENs would benefit from formal PEOL communication training.

The PICOT question for this QI project was: Among ENs in a rural Northern Plains hospital (P), how does PEOL communication training (I) compared to current practice of no formal PEOL training (C) affect ENs perceived comfort level when communicating with patients and families about PEOL care (O) over a two-month time frame (T)?

Evidence Based Practice Model

To guide this QI project, the first author used the Johns Hopkins Nursing Evidence-Based Practice Model (Dang & Dearholt, 2018). This model includes three phases and uses the acronym

PET: a practice question (P), evidence (E), and translation (T). Phase one consisted of identifying the stakeholder, forming the team, and developing the evidence-based practice question (PICOT).

During phase two, the first author conducted a review of the literature guided by the PICOT question. The literature was then critically appraised for the level and quality of the evidence using the Johns Hopkins Evidence-Based Practice Evidence Level and Quality Guides. The first author then synthesized the evidence, identified recommendations for change, and developed the intervention. The final translational phase consisted of creating a plan in collaboration with the stakeholder and team for implementing and evaluating the intervention. (Dang & Dearholt, 2018).

Methodology

Setting

The setting for this project was a 12-bed ED which is part of an 81-bed rural Northern Plains hospital. This location was identified as rural because the population is less than 50,000 and is a nonmetro county (United States Department of Agriculture, n.d.). The ED is designated as a community trauma hospital and serves patients of all ages (South Dakota [SD] Department of Health, n.d.). On average, nurses working in this department provide care for 30 patients per day and approximately 11,000 patients per year. Annually, nurses in this ED participate in approximately 48 trauma codes and 48-50 resuscitation codes. The actual number of patients receiving care with life-limiting illnesses is not recorded (M. Everson, personal communication, June 19, 2019).

Current practice is to ensure that nurses receive training in life saving measures. The required education courses include Trauma Nurse Core Course, Basic Life Support, Advanced Cardiac Life Support, and Pediatric Advanced Life Support. Prior to this QI project, there was no formal PEOL

communication training offered to the ED nurses in this facility (M. Eversion, personal communication, July 11, 2019).

Sample

Twenty-three registered nurses comprised the ED nursing team. Inclusion criteria for this QI project included registered nurses that worked a full or part time position in the ED. Based on feedback from the ED director (project stakeholder), those with less than part time status were not invited to participate due to minimal hours they may work in the ED. Thus, a convenience sample of 18 registered nurses were invited to participate in this project.

Evidence Based Practice Intervention and Instrument

The training for this project included a two phased approach. Phase one comprised the use of the online ELNEC Critical Care Module 6: Communication through Relias Academy (2020). This module was designed to improve PEOL communication for nurses working in critical care and was recommended by one of the designers of ELNEC (P. Malloy, personal communication, December 21, 2018). Education from ELNEC on the topic of PEOL communication has been provided to over 732,000 nurses (American Association of Colleges of Nursing, 2019). Material covered in this module includes an overview of communication such as types of communication, barriers, expectations, attentive listening, mindful presence, and key statements to use. This module also presents communication key phrases such as using "I wish vs. I am sorry." In addition, there is education on communicating with providers, the interdisciplinary team, and with patients and family members (Relias Academy, 2020).

The Comfort with Communication in Palliative and End-of-Life Care (C-COPE) instrument was used as a pre and post survey to measure the nurses' comfort level with PEOL communication (Minton et al., 2020). The 26 item C-COPE instrument consists of two ranked items and 24 items

rated on a 5-point Likert-type scale (1 = not difficult, 2 = slightly difficult, 3 = uncertain, 4 = difficult, 5 = very difficult) to assess nurse comfort with PEOL communication. Composite scores for the 24 Likert-type items range from 24-120 with higher scores indicating less comfort with PEOL communication. The rated items are categorized according to patient, family, and team communication.

The two ranked items encompass six topics of communication that provide a descriptive assessment of the topics and are ranked as more or less comfortable for nurses to discuss with patients and families (Isaacson, Minton, Da Rosa et al., 2019). The C-COPE has demonstrated satisfactory content validity, and internal consistency (Cronbach's alpha = 0.90) in measuring nurse comfort level with PEOL communication (Isaacson, Da Rosa, Minton et al., 2017). The Cronbach's alpha for the C-COPE in this project was good at 0.86.

Phase two of this project included PEOL communication scenario reviews and group discussion. The communication scenarios were developed by the first author and approved by the project advisor (the second author). The communication scenarios were tested for face validity and approved by the stakeholder (ED director) and the education director of the hospital.

Project Procedure

The first author applied for Institutional Review Board (IRB) approval from the university IRB. As a QI project, IRB oversight was not required. Nurses were assured that privacy would be maintained using a pseudo-name on each survey and only the first author had access to the information provided on the surveys. Per recommendations from the project stakeholder, an email was sent out to the ED nurses one week before launching the project. The email described the purpose of the project and ascertained the nurses' willingness to participate.

The project was launched during a monthly staff meeting, where nurses interested in participating registered on the project roster with their name and email address prior to the beginning of the meeting. During the staff meeting project details were introduced and described to the participants by the first author. ENs that agreed to participate completed a paper copy of the C-COPE as a pre-survey and were informed that they would repeat the C-COPE as a post-survey in approximately two months.

After determining the number of participants, the first author purchased the ELNEC Critical Care Communication module for each participant from Relias Academy (Relias Academy, 2020). An account created on the Relias Academy website enabled the first author to assign and deliver the module via email to each participant. The ED nurses accessed the module by using the link provided in the email and were given approximately one month to complete the online module.

Phase two of this project began approximately one month after the initial staff meeting. During this phase, the first author presented PEOL communication scenarios for review which were scheduled on two different dates and times to accommodate nurses' schedules. This review gave the nurses the opportunity to practice the communication skills they had learned from the online module in a safe environment. The ED nurses only attended one session. Research demonstrates that the use of scenarios helps solidify understanding (Bodine & Miller, 2017).

Following the communication scenarios, the first author lead a group discussion where the nurses freely expressed their concerns and raised questions regarding the topics included in the formal PEOL communication training. The first author was a coworker of these nurses and because of this relationship wanted the nurses to feel comfortable expressing their personal experiences and knew they would not be comfortable doing so if they were recorded.

To help spur conversation, the first author asked the following questions:

1. During this training, what was the most interesting thing you learned and why?
2. How do you feel this training will help you in your role as an emergency nurse?
3. Have you taken care of any PEOL patients that you knew personally?

Approximately two weeks after the implementation of phase two, the post C-COPE survey was made available. The first author was present in the ED at various times for a period of two weeks to personally provide a paper copy of the C-COPE survey for the participating ENs to complete. Each participant received a copy of the C-COPE that was labeled with the number associated with the participant's name on the project roster. After completing the C-COPE, the participants handed the completed survey directly to the first author. To maintain confidentiality, the C-COPE surveys were placed in a binder that was only accessed by the first author.

Findings

Results

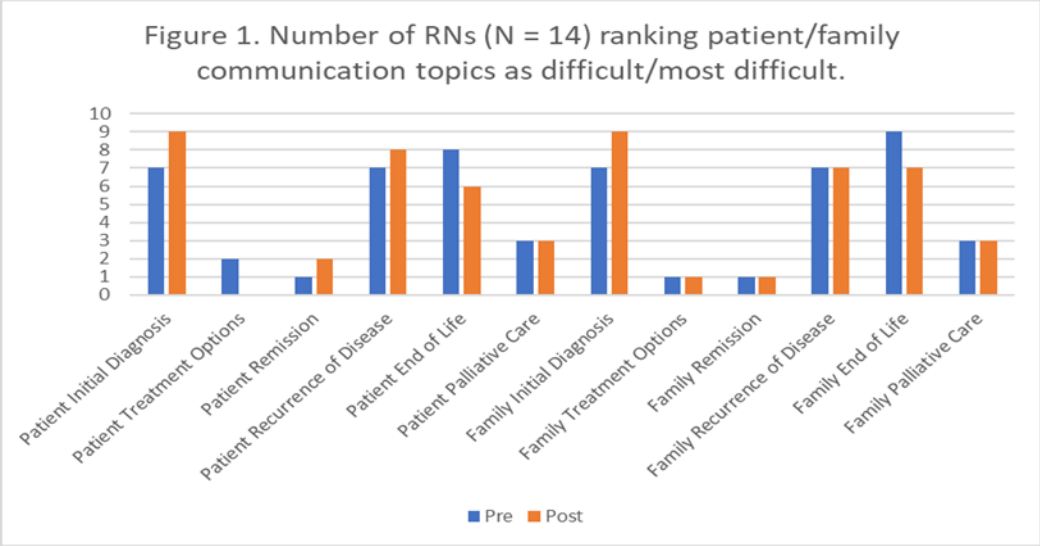
The primary aim of this QI project was to investigate differences in ENs perceived comfort before and after the PEOL communication training using the C-COPE survey. A total of 14 ENs elected to complete the project. This sample included 4 male and 10 female participants whose ages ranged from 21 to 55 years of age. Their educational preparation comprised three with an Associate's degree and 11 with a Bachelor of Science in nursing. Nursing experience varied from new graduates to 30 years.

A Wilcoxon signed-rank test was conducted to compare median scores on the pre and post C-COPE. Results of the Wilcoxon signed-rank test indicated that the C-COPE scores were significantly lower at post-test (Mdn = 36.5) than at pre-test (Mdn = 51.5), $z = -2.731$, $p = .006$. Thus, after completing the PEOL communication training participants reported more comfort with

PEOL communication. To evaluate the impact of the intervention an effect size was calculated, *r* = 0.51 indicating a large effect (McLeod, 2019).

Figure 1

Number of RNs Ranking Patient / Family Communication as Difficult / Most Difficult



Results from the two ranked items are reported by the number of nurses with rankings of 5 and 6, indicating difficult or most difficult topics. Overall, nurses continued to identify the following topics as difficult before and after the intervention: patient/family initial diagnosis, patient/family recurrence of disease, and patient/family end-of-life.

Summary of Reponses to Questions from Group Discussions

The questions asked by the first author during Phase two provided an opening for rich discussion by the nurse participants. The first author took notes of participants' comments during these discussions; therefore, a more in-depth content analysis was not possible. Below is a summary of these informal discussions.

In response to question 1, the participants identified that education regarding the use of key words was the most interesting part of this PEOL communication training. They reported they had

not previously considered using phrases like “I wish things were different” versus “I’m sorry.” Several of the nurses described being unaware of how phrases such as “I’m sorry” may be taken negatively by family members who had lost a loved one. One nurse mentioned she liked phrases that showed empathy such as “I can’t imagine how overwhelming this is.”

For question 2, many indicated the education would help them feel more comfortable communicating in end-of-life situations and they now are equipped with better ways to speak with patients and families in PEOL circumstances. Another nurse identified that after the training she was more aware of how much communication occurs through body language such as leaning in during a conversation. She expressed being more cognizant of how her own body language would help her communicate more sincerely during these difficult conversations. Other participants vocalized agreement with her statements. Another nurse shared how challenging it is to maintain a poker face with families with whom you are familiar, especially in the event of an unsuccessful resuscitation. She feels that these family members realize the outcome was not ideal as soon as they see your face and body language. Overall, the nurses expressed the PEOL communication training equipped them with the communication skills needed to feel less uncertain of what to say during PEOL conversations.

In response to question 3, many nurses reported caring for someone they knew was more difficult than caring for a stranger. Yet, while this is difficult, these nurses also expressed because they already have trust and rapport with the patient and family, that to be the primary nurse is preferable for families. However, several nurses verbalized concern about seeing the family in public at a later time, feeling that this contact may trigger memories of the death of their loved one. One nurse reported avoiding a family member for three years because of that fear, later learning the family member was just so thankful she was there because she trusted her.

The nurses then began a discussion specific to "showing emotions." Death in the ED is often tragic and unexpected. The nurses shared that at times the emotions they experience are like a rollercoaster; one minute they are fighting for a patient's life and a few minutes later they face the let-down of losing the patient they worked so hard to save. Many of the nurses shared prior to the training, they were uncertain if it was acceptable to feel sad or even shed tears around the patient's family members. Instead, they are now aware that their willingness to be vulnerable around patients and family members promotes empathy and a sense of connection during these difficult times.

Discussion

This QI project identified that PEOL communication training increased nurse comfort with PEOL communication in this rural ED. Communication training can also improve self-assessed competency in palliative care communication as noted in a study conducted by Brown and colleagues (2018). Their study identified that simulation-based skills-building using Codetalk improved self-assessed competency with a large sample of healthcare professional trainees as compared to those receiving usual education.

Palliative and end-of-life communication training demonstrates great promise for improving self-assessed competency and nurse comfort with these difficult conversations. Yet, even with PEOL communication training, the results of the ranking of difficult topics in this QI project demonstrated that initial diagnosis, recurrence of disease, and end-of-life discussions remain difficult. These results are similar to those reported by Bodine and Miller (2017). The nurse researchers found that end-of-life training with simulation in the ED improved the nurses' knowledge of end-of-life care; however, the participants continued to identify that communication

with patients, families, and physicians remained challenging (Bodine & Miller, 2017). More research is needed to determine why these topics remain difficult.

The qualitative findings of this project demonstrate the importance of reflective practice to the ENs. Salins (2018) describes reflective practice as a more mindful approach to clinical practice. Reflective practice allows healthcare professionals to take a step back or pause from the situation in the hopes of gaining greater awareness and ultimately to improve practice (Salins, 2018). Moreover, incorporating reflective practice can enhance healthcare professionals' ability to cope with adverse or difficult situations (Mantzourani et al., 2019). In this project, offering the nurses the opportunity to share their personal experiences in a safe environment encouraged them to pause and reflect on their feelings and responses in PEOL situations. Reflective practice encouraged the nurses to acknowledge their own feelings and consider the feelings of those they are communicating with and caring for in PEOL situations.

Implications for Practice

The results of this QI project are specific to the nurses working in this rural Northern Plains ED. However, ENs in other rural facilities may face similar struggles and could benefit from formal PEOL communication training (Beckstrand et al., 2017). Beckstrand and colleagues study of rural ED nurses identified three themes: (a) providing care to patients they know; (b) families are challenging during end-of-life care; and (c) not knowing the patients end-of-life wishes. The PEOL communication training in this project demonstrated great potential toward helping rural ED nurses become more comfortable engaging patients and families at end-of-life.

This QI project revealed that implementing formal PEOL communication training with discussion and reflection can improve nurse comfort with these difficult conversations. Targeted communication training provides nurses with tools needed to not only impact their own practice

but also the lives of patients and families receiving PEOL care in the ED. PEOL communication training enhances nurses' collaboration skills with other members of the interdisciplinary team and increases their comfort in helping patients and families define their wishes and goals of care (ANA, 2016).

Limitations

The limitations for this project include gender, ethnicity, sample size, and participation. The sample of ENs consisted of all Caucasian participants who were predominately female. This composition is similar to registered nurses in the United States, although national statistics indicate the Caucasian nurse population is approximately 76%. (Minority Nurse, 2020).

The sample size for this project was initially 18 nurses, however only 14 completed the module. This may be due to the email invitation for the communication module from Relias Academy to the ENs being deferred to their junk mail, which initially caused a delay in the start of the module. In addition, this project was launched close to the holidays potentially impacting full participation.

Conclusion

The PEOL communication training offered by this QI project significantly improved rural ENs' perceived comfort when communicating with PEOL patients and their families. Rural ENs will continue to care for PEOL patients and families including those they may personally know; therefore, they must be provided with educational opportunities to enhance their level of comfort with PEOL communication (Bodine & Miller, 2017). Providing targeted education in PEOL communication and opportunities for reflective practice to rural ENs, has the potential to advance and improve PEOL care for patients and families. Rural ENs, who are comfortable and skilled in

PEOL conversations, serve as key advocates and supporters in addressing patients' and families' wishes and goals of care.

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