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Reducing Nurses' Communication Anxiety During End of Life Care

by

Susan Wolfrom

A thesis submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the
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CHAPTER I

Introduction

Advances in medicine and technology have made it possible for people to live longer lives. The ever-growing aging population living with numerous comorbidities requires an increase in health care needs. Additional needs are required when an individual transitions into palliative and hospice care. Along with the transition into palliative and hospice care comes difficult conversations regarding the patient's goals at the end of life. End of life (EOL) communication is described as sensitive conversations pertaining to the transition from curative treatments and therapies to palliative care options and EOL care. Addressing options for treating EOL symptoms, explaining the course of the dying process (feelings of death and dying) and the plan of care are all included in EOL communication (Montgomery et al., 2017). Discussions focused on EOL care are associated earlier referrals to palliative care, a decrease in pursuing aggressive care, and better quality of life and symptom management (Prod'homme et al., 2018). End of Life discussions require meaningful conversations concerning disease trajectory, symptom management, and the patient’s goals at EOL. Conversely, these meaningful conversations are based upon the readiness and willingness of the patient. They cannot merely be dissected during an hour-long interview at a pre-established time, but rather spontaneously and in the moment. These conversations frequently occur over time with the nurses. Nurses must be knowledgeable, well versed, and comfortable with having EOL conversations with their patients.

Problem Statement

The ability to elicit patient and family concerns during EOL discussions and to interact effectively is frequently attributed to the nurse's experience and on-the-job training, rather than formal education (Clayton et al., 2014). However, research suggests nurses who are provided with training and adequate support can initiate and aid in EOL conversations with patients, resulting in positive patient outcomes (Miller et al., 2019). Furthermore, oncology clinicians who were provided with formal EOL training were more empowered to participate in frank discussions about their patients' prognosis and preferences during EOL care (Pigott el al., 2019). It is evident excellent communication is crucial to provide patients and their loved ones with high-quality EOL care and with training, education, and continued support all nurses can effectively participate in these meaningful conversations. Will providing an educational training class on effective End of Life (EOL) communication reduce nurses' communication anxiety and improve ratings on the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey?

Significance

Commonalities among all individuals include death and dying, regardless of one's ethnic, cultural, or socioeconomic background. Advances in medicine have significantly transformed death and dying. In modern medicine, the focus of the dying process has transitioned into symptom and pain management. The nurse's role at EOL is complex, consisting of not only physical care for the patient, but also providing emotional, spiritual, and psychosocial support for both the patient and the family. To ensure quality patient-centered communication during EOL care has been achieved, critical domains of quality EOL must be addressed. These domains include the patient's goals of care,

psychosocial, cultural, and spiritual aspects of care, ethical and legal concerns, and the physical process of dying and death. In addition to providing care to the dying patient, nurses must provide support to the family. This support can include ensuring the patient does not suffer, offering comfort to the family, helping the family become more accepting of the dying process through education and encouragement, and consoling the family (Arbour & Wiegand, 2014).

Many healthcare professionals across disciplines feel unprepared in language styles, verbiage, education, and experience when communicating to patients and their loved ones about EOL care. Discussions regarding EOL care have been associated with decreased healthcare costs, less aggressive treatments at EOL, and a good death (Pigott et al., 2019; Cardona et al., 2019). In particular, cancer patients who were able to make their EOL wishes known with their healthcare team were more likely to enter into hospice care earlier, have fewer hospital admissions, were more likely to die at home, and experienced a significantly improved quality of life (Pigott et al., 2019). Additionally, EOL conversations reduce stress, anxiety, and depression for the patients' families (Cardona et al., 2019). However, EOL discussions are frequently postponed until the last stages of the patient's life or do not occur at all (Cardona et al., 2019). The omission of EOL discussions can be attributed to a variety of obstacles clinicians may experience. Barriers to communication exist and can be specific to individual providers and range from concern for instilling a loss of hope in patients, to the patient's family acting as a barrier. Additional obstacles include the lack of experience and confidence, unclear roles during EOL discussions, and emotional challenges while providing care to dying patients.

The target setting of an inpatient hospice unit received low engagement and psychosocial support ratings in comparison to the national average according to the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. These rating reflected an area of opportunity to improve patient care. By improving the nurses' communication skills, and decreasing communication anxiety when providing EOL care, the target setting can increase the engagement and psychosocial support ratings in the Hospice CAHPS survey.

Purpose

The purpose of this project was to explore the efficiency of implementing an educational class developed as an intervention to help decrease communication anxiety among nurses when dealing with end of life conversations. Nurses' EOL communication skills are influenced by a variety of factors, including official training in EOL care and obstacles in communication between disciplines and across the continuum of care. Furthermore, additional barriers nurses face to EOL discussions include lack of experience, lack of confidence, and ambiguous roles that are poorly defined (Montgomery et al., 2017). Examining challenges nurses face when initiating EOL conversations and providing educational material to enhance nurses' comfort level with initiating and participating in EOL conversations is vital.

Theoretical Framework

Imogene King's middle-range theory of goal attainment (TGA) provided the theoretical framework for this project. In this theory, the patient grows and develops to attain specific life goals through three interacting systems: personal, interpersonal, and social. Additional factors affecting the achievement of patient goals include roles, stress,

space, and time. Within this theory the nurse and patient relationship is emphasized. Overtime, nurse-patient interactions result in the perception and understanding of one another, and through communication, the nurse and patient together formulate goals, explore methods, and agree on specific methods to achieve the established goals (King, 1999). Goals are based upon the nurse's initial assessment of the patient's apprehensions, problems, stressors, and patient's perceptions of these problems. If the patient can achieve the established goals, this attainment is considered a measure of quality care (King, 1999).

One of the frequent practices of nursing is to engage patients and family members in conversations about what they understand regarding their illness and goals for their illness. Utilizing this theory, the nurse can direct the conversation to what the goals are for the patient's EOL care. These meaningful conversations occur throughout small encounters, over days or weeks, and often take place in the moment rather than in an interview, facilitating better patient outcomes. By creating goals together with the nurse and working towards accomplishing these goals, the patient remains actively engaged in their plan of care. However, a vital component is effective communication. Nurses must develop confidence and competence in EOL communication allowing them to take advantage of the available opportunities to partake in delicate and meaningful conversations with their patients. These significant conversations can occur suddenly, and both the nurse and the patient must exhibit readiness and willingness to contribute so that the patient's goals can be attained and, therefore, quality care achieved.

Definition of Terms

- Terminal illness is a disease or condition that cannot be cured and will likely lead to a person's death. A person who is terminally ill may have a single disease or several conditions (NIH, 2017).
- End-of-life care is the term used to describe the support and medical care given during the time surrounding death. This care can be provided in the final moments of life, but also in the days, weeks, and months leading up to a person's death (NIH, 2017).
- Hospice is a comprehensive approach in which attempts to cure the person's illness are stopped and the patient's plan of care is directed towards physical and psychosocial support and comfort (NIH, 2017). Hospice is provided for a person with a terminal illness whose prognosis is six months or less to live if the illness runs its natural course (NIH, 2017).
- According to the World Health Organization (2018), "palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness." It is an interdisciplinary approach in which suffering, whether physical, psychosocial or spiritual is prevented and relieved through the early identification, correct assessment and treatment of pain and other problems (WHO, 2018).
- The Hospice CAHPS Survey is a widely used survey specific to hospice. It measures and compares patient feedback and involves administering an experience of care survey to caregivers following the death of the hospice patient (CAHPS Hospice Survey Project, 2018). These surveys are administered via mail or email, and the results are returned to the participating institutions with

comparison to similar institutions. The CAHPS survey asks questions specifically addressing a patient's satisfaction with the care provided during there inpatient stay, whether or not the patient received timely care from the nursing staff, and whether or not his or her pain was effectively managed.

CHAPTER II

Literature Review

Communication is a vital element of palliative and EOL care. Patients who are suffering from terminal illnesses require nurses skilled in communicating treatment options, able to express what to expect during the dying process and who can elicit the patient's goals of care. However, many nurses experience difficulties when providing EOL communication. These obstacles can include lack of experience, ambiguous roles during EOL discussions, and emotional challenges while participating in EOL discussions with patients. Additional barriers impeding communication are concern for instilling hopelessness and disappointment in the patient, lack of time, and perceiving the patient's family as a barrier.

Barriers to End-of-Life Care Conversations

Communication between patients and providers has been regarded as a fundamental quality of good health care. Furthermore, the need for maintaining open and honest conversations between patient and clinician is continually emphasized in research and patient reports (Brighton & Bristowe, 2016). While it has been established that early EOL discussions can lead to improved quality of care without increasing the risk of depression among patients, barriers to EOL conversations continue to exist (Prod'homme et al., 2018). End of life conversations are difficult for clinicians to initiate and are often overlooked in patient care. Frequent barriers that clinicians face concerning EOL discussions include: lack of time, uncertainty about the patient's prognosis, the patient's lack of mental capacity, instilling a loss of hope in patients, patient readiness, the provider's lack of confidence in their communication delivery, role confusion regarding

which provider should initiate the conversation, and the fear of engaging in an EOL discussion will weaken the patient-clinician relationship (Brighton & Bristowe, 2016; Oh et al., 2019; Prod'homme et al., 2018).

Barriers to EOL communication exist throughout all specialties and roles within health care. Oh et al. (2019) explored the potential barriers radiation oncologists experience in initiating EOL conversations with patients and the content of these conversations. Barriers identified included lack of time, uncertainty about prognosis, concern for triggering hopelessness and disappointment in the patient, and vagueness about which provider should initiate the EOL discussion. Lack of time was the most frequently identified barrier. Additionally, participants who were less confident in the ability to discuss prognosis were less likely to engage in EOL discussions (Oh et al., 2019).

Many perceived barriers exist among clinicians impeding the goals of care (GOC) and EOL of discussions. One of the many perceived barriers is the role of the patient and family members. Piggott et al., (2019) explored the barriers to GOC discussions as perceived by oncology clinicians with hospitalized patients who have advanced cancer. The most common barriers identified were the patient and family member and their ability to accept the poor prognosis, failure of the family to agree on goals of care, difficulty understanding the limitations of life-sustaining treatments, language barriers, and the lack of the patient's mental capacity to make decisions (Pigott et al., 2019). Additionally, oncology clinicians identified a lack of time as a significant barrier in participating in GOC discussions. Furthermore, study participants acknowledged GOC discussions were easier to engage in and more productive when an interdisciplinary

approach was utilized with the patient, including the oncologist, resident, nurses, and social worker (Pigott et al., 2019).

Challenges exist in the delivery of quality palliative/end of life care in the hospital setting especially in communication between patients/families and providers. Oncology nurses have especially intense and enduring interactions with patients and families in which they are often involved in discussions of prognosis, GOC, and palliative and hospice care. Beckstrand et al., (2012) explored the perceptions of hospital-based oncology nurses regarding the influence of obstacles and supportive behaviors in end of life care. In a questionnaire, oncology nurses were asked what do nurses believe to be the largest and most frequently occurring supportive behaviors while providing EOL care. The most frequently cited supportive behaviors nurses can provide are listed in order from highest ranking: allowing ample time for the family to be alone with the patient after death, providing a peaceful environment for the family after the patient's death, allowing the family unlimited access to the dying patient, and teaching family members about signs/symptoms of the death and dying process (Beckstrand et al., 2012). Additionally, findings concluded the most frequently cited obstacle listed in order from highest ranking were as follows: dealing with anxious family members, the families' inability to accept patients' poor prognosis, lack of nurse availability and inability to provide support, and families being overly optimistic despite the patient's poor prognosis (Beckstrand et al., 2012). The study signified the vital role family members play in patient care and the importance of family issues and attitude in improving end of life care.

Nurses' Roles during EOL Communication

Nurses must perform many roles during their day-to-day jobs. However, these roles can become more complex and conveyed in multiple forms when providing care for a patient and their family at EOL. Patients and families frequently rely on the nurse to provide honest education regarding the dying process and symptoms the patient may experience (Arbour & Wiegand, 2014). In addition to providing EOL education, nurses must also provide symptom management. Arbour and Wiegand (2014), revealed six major roles nurses perform when providing EOL care: educating the family, advocating for the patient, encouraging and supporting family presence, managing patient symptoms, protecting families while creating positive memories, and family support. Nedjat-Haiem et al. (2017) noted nurses described their role in EOL discussions as providing support and comfort to the patient and family, as well as clarifying the plan of care, and any confusing information provided by the physicians.

Nurses' Work Experience and EOL Discussions

Nurses interact with patients and their families more than any other member of the health care team. Due to this fact, and the trust this interaction builds, nurses are well suited to engage with discussions about EOL care. Previous research has revealed nurses frequently exhibit discomfort about death and dying and often lack acceptable knowledge on how to care for EOL patients (Jeffers, 2014). Additionally, the level of experience a nurse possesses can contribute to the level of comfort nurses have when partaking in EOL discussions.

Providing EOL care can be a difficult process for the novice nurse (less than 1 year of work experience). In a study conducted with novice pediatric oncology nurses, many of the nurses felt they lacked the skills necessary to act independently during the

complex and shifting needs of the dying patient (Hendricks-Ferguson et al., 2015). Additionally, participants recognized their lack of knowledge regarding the dying process in general. Furthermore, the nurses discussed their discomfort with the uncertainty of their role in talking about EOL concerns with the patient and their families (Hendricks-Ferguson et al., 2015).

Insight can be gained from experienced nurses and their involvement with communication during EOL care. Research provides evidence the more experience a nurse possesses, the more comfortable he or she may be when providing EOL care to a patient at (Dunn et al., 2005; Isaacson et al., 2019; Moir et al., 2015). One study revealed work experience is a contributing factor to EOL communication styles and care (Dunn et al., 2005). Nurses who had more experience caring for patients at EOL experienced more positive perceptions regarding death and exhibited more confidence to care for patients at EOL. Additionally, exposure to EOL care allows for nurses to reflect and learn from previous EOL experiences (Dunn et al., 2005). Furthermore, nurses with more experience were significantly associated with increased comfort in communicating about EOL care (Isaacson et al., 2019; Moir et al., 2015). Certain factors were found at statistically significant levels to contribute to higher levels of confidence in participating in EOL discussions. These factors include: clinicians being older in age, frequently caring for patients at EOL, and finding EOL conversations rewarding (Cardona et al., 2019). Research concluded experience provided these nurses with the ability of knowing how to engage patients and their families in difficult conversations, how to assess his or her level of understanding the information provided, and when to provide appropriate psychosocial support (Montgomery et al., 2017).

Emotional Challenges while Providing EOL Care

Hospice nurses face daily challenges when providing EOL care to their patients. By exploring how these nurses cope with the emotional challenges, we can gain an increased awareness of the personal and professional difficulties of this nursing role. Ingebretsen and Sagbakken (2016) investigate the emotional challenges experienced by hospice nurses while caring for EOL patients. Four central themes were revealed. The first theme revealed nurses feel emotionally touched when caring for a dying patient. Furthermore, the nurses expressed feeling emotionally drained and enriched while caring care for patients at the end of life (Ingebretsen & Sagbakken, 2016). Tunnah et al. (2012) revealed the more hospice nurses were able to contribute to helping their patients achieve a good death, the higher their job satisfaction was perceived and the lower their perceived stress level. The second theme uncovered by Ingebresten and Sagbakken (2016) was the need for the nurses to create an emotional distance between their patients so the nurses did not project themself into their patients' situations. Participants admitted that each one had developed a strategy to foster emotional distancing while providing care. Similarly, Tunnah et al. (2012) identified the need for hospice nurses to incorporate coping strategies after completing their shift or after experiencing an overly difficult day due to being at increased risk of suffering from compassion fatigue due to the nature of their job. The third theme illustrates the emotional challenges nurses experience in balancing their personal and professional dimensions (Ingebretsen & Sagbakken, 2016). Many participants expressed the need to achieve separation from their personal and professional roles to harbor emotional harmony. The final theme explored was the nurses' mortality, and that caring for a dying patient further strengthens the concept that everyone will

eventually experience death (Ingebretsen & Sagbakken, 2016). Nurses expressed how working so closely to death confirmed how natural death was.

EOL Care Educational Interventions

Nurses skilled and comfortable with EOL discussions improve quality of life and patient satisfaction (Stacy et al., 2019; Moir et al., 2019). Nurses who have received EOL care education have more positive attitudes toward caring for patients and their families (Lee et al., 2018). Therefore, enhancements in the knowledge and skill level of nurses in such areas of symptom management, communication, and the dying process are recommended (Thorne et al., 2016). Nurses must be able to develop confidence and competence in EOL communication so these nurses can readily take advantage of available opportunities for sensitive conversations (Thorne et al., 2016).

Bishop et al. (2019) conducted a study in which acute and ambulatory care nurses were provided an online ELNEC educational intervention in order to provide primary palliative care education. The study concluded nurses who completed the intervention experienced statistically significant improvements in symptom management and communication skills when providing EOL care. Additionally, the education caused a statistically significant impact on the nurses' clinical practice as reported by the nurses in a 3-month follow-up survey (Bishop et al., 2019). Lee et al. (2018) revealed that an in-person, evidence-based educational intervention improved nurses' attitudes when caring for and communicating with the patient and family at end of life. Acute care nurses with varying levels of experience had statistically significant attitude improvements after receiving a face-to-face EOL communication workshop immediately following the intervention and at one month (Lee et al., 2018). Institutions have a commitment to

ensure nurses are adeptly trained and educated in EOL communication to maintain quality patient care.

CHAPTER III

Needs Assessment

Target Population

The target population for this project includes practicing registered nurses providing direct care to patients on an inpatient hospice unit. Theses nurses provide EOL care needs for patients within the unit. The target population possesses a variety of nursing experience, ranging from the novice to the expert nurse.

Target Setting

The target setting is a 20-bed inpatient hospice unit from a large, academic university medical center in eastern Pennsylvania. The selected unit is designed for adult and/or older adult patients who suffer from a terminal illness and require hospitalization for the symptom management of their terminal illness. The unit provides care to patients with a wide range of diagnoses and levels of care.

Stakeholders

In order to coordinate improved patient satisfaction through effective EOL communication and education, many stakeholders are involved. First and foremost, the patients and patient families from the community are the priority stakeholders as it is the patients' needs and preferences healthcare must support. Subsequently, the clinical staff is also a stakeholder. The registered nurses, certified nursing assistants, physicians, and social workers make up the clinical staff, and provide care for the patients, and are responsible for the implementation of the project goals. Indirectly, the nursing management and nursing directors are also stakeholders as they provide oversight with

administration, finances, regulations, and are concerned with the overall success of the project interventions.

SWOT Analysis

Strengths:	Weaknesses:
• Strong clinical skills among nurses • Nurses have a commitment to provide quality patient care • Excellent team work among nursing staff • Nursing staff is open to learn new practices to improve patient care • Strong staff engagement in the target population • Strong name recognition of the organization • Magnet accredited hospital	• Lack of comfort and confidence in initiating EOL discussion with patients and families • Staff aversions to participate in sensitive, EOL discussions with patients • Participation and enrollment into the improvement project is voluntary • No standardized EOL discussion education for staff
Opportunities:	**Threats:**
• Education provided to staff nurses so that nurses feel more comfortable and empowered to initiate and participate in EOL discussions • Quality improvement project supported by department leadership • Email announcements and shift huddles to present the purpose of the project • Meeting the community needs through implementation of an educational program • Increasing patient and family satisfaction • Partnerships with educational institutions	• Insufficient education/training due to lack of resources and time • High turnover rates among hospice staff

Available Resources

In an institutional environment, many resources are readily available to enable the implementation of an educational intervention. The target setting has a dedicated conference room with a projector and screen, which can be utilized for the educational program. Resources to supplement the educational program include: PowerPoint, handouts, scripted role-play, and lecture notes. The use of an internal, content-expert, as well as the clinical educator, can be valuable resources to aide in the planning and facilitate the educational program.

Desired and Expected Outcomes

The expected outcome is for participants to increase their knowledge and understanding of EOL communication as evidenced by a pre-posttest comparison evaluation used to examine the effectiveness of the educational intervention. It is expected that there will be an increase in the nurse's comfort level and increased empowerment to initiate and participate in EOL discussion with patients. Additionally, with an increased comfort to participate in EOL discussions with patients, an increase in the engagement and psychosocial support ratings in the Hospice CAHPS Survey will be noted.

Team Members

The primary investigator was a key team member. She developed and presented the project idea. The project chair was a doctoral prepared nurse practitioner/nurse educator who assisted in the guidance of this project. Additional team members included the inpatient hospice nurse manager, inpatient hospice assistant manager, and director of professional development

Cost/Benefit Analysis

The estimated cost of this project is minimal. The cost incurred to implement this intervention included approximately two hours of wages for each employee attending the educational session. The potential benefits of the implementation of this intervention far outweigh the cost incurred to the facility during the implementation process. Reducing nurses' communication anxiety and increasing their comfort with providing EOL care can lead to improved communication and outcomes for patients while ensuring quality patient-centered communication during EOL care has been achieved. Additionally, effective EOL communication and care can lead to a reduction of unwanted aggressive care at EOL which has been associated with increased healthcare costs, worse quality of life, and a worse death (Pigott et al., 2019).

CHAPTER IV

Project Design

Goal

The purpose of the project is to develop and implement an educational program about EOL discussions for hospice nursing staff at an inpatient hospice unit. The goal of the educational program is to enhance the nurses' knowledge and understanding of EOL communication to reduce the nurse's communication anxiety with EOL discussions. Nurses will feel more comfortable and empowered to initiate and participate in EOL discussions with patients and families.

Objectives

The following objectives will be investigated to understand better the challenges nurses face when initiating and participating in EOL conversations:

- Objective 1: To explore the challenges clinicians, specifically nurses, face when participating in EOL discussions.
- Objective 2: To evaluate how nurses report their current comfort level and ability to participate in EOL discussions with their patients and family members using an assessment tool.
- Objective 3: To implement an education intervention for nurses in order to improve their comfort level when participating in EOL discussions.
- Objective 4: To evaluate how nurses report their comfort level and ability to participate in EOL discussions with their patients and family members following the intervention of EOL communication education by utilizing an assessment tool.

Plan and Material Development

Utilizing the information gathered in the literature review, an educational session was developed. The two-hour face-to-face educational class will consist of a didactic component and a simulation component in which scenarios will be performed. Prior to the educational class, participants will complete the Frommelt Attitude Toward Care of the Dying (FATCOD) Scale. The FATCOD is a 30-item questionnaire (five-point Likert-type scale) designed to measure participants' attitudes toward providing care to dying patients and the nurses' attitude toward the patient's family (Lee et al., 2018). Completion of the survey is voluntary. Participants will receive slides, lecture notes, associated video clips, and handouts containing helpful phrases to use with dying patients. After the didactic component is delivered, participants will complete the simulation component. Scripted and non-scripted scenarios will be provided to allow participants to practice methods learned in the educational program. Below is the program outline:

Content Outline	Objectives of the Content
Overview of Symptoms and Management during EOL care	Staff will be able to identify a variety of symptoms patients can experience at EOL and possible symptom management options
Introduction to Effective Communication	Staff will be able to describe basic communication techniques and ways to enhance effective communication
Cues for Conversation	Staff will be able to identify cues to initiate conversations from patients and/or families
Starting the Conversation	Staff will be able to identify and describe opportunities and facilitate discussions to EOL
Seeking Appropriate Help or Resources	Staff will be able to identify appropriate personnel and/or educational resources to assist with conversations
Simulations	Staff will participate in EOL discussion simulations between nurse and patient, and nurse and family in order to apply learned knowledge.

Immediately following the educational class, participants will again complete the FATCOD questionnaire. The project investigator will compare the pre and posttest score.

Timeline

Educational sessions were delivered at different times, convenient to all shifts within three weeks. Initial self-evaluations were performed at the time in which the educational session occurred. Post-implementation self-evaluations occurred immediately following the two-hour educational session. After the educational sessions, staff will begin utilization of the communication skills learned.

Budget

The nurses will not receive any additional compensation to participate in this project. Participants will receive their normal hourly wage for attending the education session. Educational time and training is embedded into the unit's nursing budget; therefore, no additional cost incurred for the unit or healthcare institution. Costs for the proposed project are minimal and limited to the form of printed materials.

Evaluation Plan

Prior to the project intervention the FATCOD Scale will be given to participants. After completion of the two-hour educational session, participants will again complete the FATCOD Scale. Scores from the pre and posttest will be compared to assess the program effectiveness. A higher score indicates a more positive attitude for caring for dying patients (Lee et al., 2018). Additionally, the organization will see an increase in the Hospice CAHPS Survey.

CHAPTER V

Dissemination

Dissemination Activity

The findings gathered from the literature review and the development of the educational intervention were shared in a Power point presentation with the inpatient hospice nurse manager, assistant nurse manager, and director of professional development. The project was viewed as necessary and aligned with the goals of improving the patient experience. Nurse managers provided additional feedback regarding extending the project to all inpatient staff members, as well as the sister inpatient hospice unit. The director of professional development suggested adding the content to the annual, mandatory competency training, and the new-hire, unit specific orientation.

Limitations

While this project presented many strengths and opportunities, it was also met with limitations and challenges. One limitation in dissemination was the arise of the COVID-19 and limited availability of staff during this pandemic. An additional limitation of dissemination of this information was the time constraint. The sessions were limited to 2-hours making it impossible to share all information found regarding effective EOL communication.

Implications for Nursing

The nursing discipline must integrate the inclusion of EOL education into professional development and orientation in areas not traditionally educated in palliative and hospice care. This allows nurses to have an education background on effective

communication preventing them from missing key opportunities to participate in EOL conversations. Furthermore, the discipline must equip the nurse with the ability to provide continuity of ongoing engagement with patients and families as conditions change. Providing support for nurses to develop confidence and competence during sensitive conversations is vital to foster the interactional engagement between nurses, patients, and families in order to achieve patient-centered care.

Recommendations

Recommendations for practice include incorporating EOL communication and care into staff nursing education and development, as well as into nursing orientation. Education directed towards EOL communication provides essential communication skills, improves nurses' attitudes, and decreases anxiety when providing care at EOL (Lee et al., 2018). Further evaluation should be focused on educational interventions to decrease nurses' anxiety and communication apprehension surrounding EOL care.

Conclusion

While it has been traditionally accepted to consider palliative and hospice care as specialties, it is important that all nurses can integrate such approaches into their daily nursing care. This would necessitate nurses be oriented and educated in such areas and symptom management and the dying process, as well as the inclusion of EOL understandings and sensitivities into the care planning process of the patients (Thorne et al., 2016). Additionally, support must be provided to nurses so they can develop confidence and competence in their ability to participate in sensitive conversations. To foster meaningful relationships between nurses, patients, and families, models of service delivery need to be reevaluated (Thorne et al., 2016). Research suggests nurses who are

provided with training and adequate support can initiate and aid in EOL conversations with patients, resulting in positive patient outcomes (Miller et al., 2019). It is evident excellent communication is crucial to provide patients and their loved ones with high-quality EOL care, and with training, education, and continued support all nurses can effectively participate in these meaningful conversations.

Conversations with patients regarding EOL care can lead to increased patient hope, higher quality of life, closure, and ability to experience a good death (Brighton & Bristowe, 2016). These meaningful conversations are based upon the readiness and willingness of the patient, and it is the nurse who is at the frontline of care to both participate in the conversations and advocate in order to promote the patient's EOL wishes. Therefore, as a nursing discipline, it is vital to increase nurses' skillset in EOL communication so they are equipped, knowledgeable, well versed, and comfortable with having EOL conversations with their patient in order to improve quality of care outcomes.

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