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ORIGINAL RESEARCH

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A QI initiative to enhance nurses comfort level in providing EOL care on a general internal medicine ward

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ABSTRACT

Background and objective: Ideally, nurses should have acquired the knowledge and skills to provide not only pain and symptom management, but emotional support to dying patients and their families. In actual fact, nurses often feel under-educated, under-skilled, inexperienced and uncomfortable in providing comprehensive end of life care. A standardized protocol for assessing imminently dying patients' symptoms and psychosocial needs was implemented at a tertiary academic hospital. The aim of this quality improvement initiative was to enhance the education and training of nurses on one acute care ward, around the implementation of Comfort Measures Order Set for end of life care, specifically focusing on the provision of emotional support for dying patients and their families.

Methods: Education sessions were offered to the nurses on one acute care ward as the study intervention, and the initial phase of one PDSA cycle. Descriptive statistics were used to analyze questionnaire responses; content analysis was used in reviewing the qualitative data.

Results: Pre-intervention, over 70% of nurses did not feel comfortable providing emotional support to dying patients for whom the Comfort Mesaures Order Set was initiated. Post-intervention, nurses reported being more comfortable and knowledgeble.

Conclusions: The goal of comfort care at end of life requires the skilled use of the Comfort Measures Order Set. The Advance Practice Nurse role, as part of the Palliative Care Consult Team, is specialized in providing emotional support to patients on comfort measures through research, theory development, education, practice, collaboration, and leadership across the institution.

Key Words: End of life care, Order sets, Imminently dying, Emotional support, Acute care settings, Nurses

1. INTRODUCTION

Palliative Care Consult Teams (PCCT) embedded in acute care hospitals "provide pain and symptom management, address psychosocial needs of patients and their families, and facilitate decision making and disposition planning for patients at the end of their lives. Imminently dying patients can often have complex care needs and a fairly short timeframe for timely interventions".[1] "Despite Canadian hospitals identifying gaps in the provision of end of life (EOL) care, healthcare professionals still have minimal formal training in diagnosing dying and in managing pain and common symptoms in dying patients.[2] Palliative care teams, themselves, need to find opportunities for education across their institution.[3] As such, inpatient palliative care teams must

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commit to taking on leadership roles in educating learners and colleagues in EOL care and contributing to initiatives that promote best practices around quality dying across the organization.[4]

A lack of community resources for chronic disease management and palliative care resources means that more people with chronic terminal illnesses will be admitted to acute care settings, will likely receive life prolonging treatment(s), and will eventually die in acute care settings.[5] Nevertheless, 50% of Canadians would prefer a less aggressive treatment plan, focusing on palliative care and comfort measures rather than technologically supported death.[6, 7]

Sunnybrook Health Science Centre (SHSC) a tertiary care academic teaching hospital introduced a standardized protocol for the delivery of care at EOL, called the Comfort Measures Order set (CMOS), for patients expected to die within 72 hours. This order set was developed as a comprehensive framework for physicians and nurses outlining a standard approach to EOL care.[4] The CMOS comprises evidence-based management of common symptoms at EOL, regular nursing comfort assessments of the dying patient, and patient and family education around the dying process. The CMOS provides a framework for health care providers to enhance their knowledge around the various aspects of care of imminently dying patients. Specifically, the CMOS outlines evidence base practices for: 1) pharmacological management of common symptoms at EOL, 2) elements of the nurses' comfort assessment, 3) patient and family education, and 4) other disciplines (such as social work and spiritual care) providing psychological, emotional, and spirituals needs. Implementation of the CMOS is reinforced through consistent mentorship and follow-up by the PCCT, who often provide guidance in the initiation of the CMOS to the admitting service, or activate the order set themselves.[8]

While nurses strive to provide good palliative care, the acute care ward in often busy, challenging nurses to provide the needed time and attention to dying patients and their families.[9] Acute care nurses are the crux in providing end of life care; yet, Steinhauser[10] found most health care providers receive EOL education informally. While nurses are expected to have the knowledge and skills to provide comfort measures to dying patients,[11] nurses feel under-skilled and uncomfortable in providing comprehensive care to patients and their families on comfort measures, particularly failing to effectively address the emotional components.[12, 13] Concurrently, patients and families confronting death and dying view psychosocial and spiritual issues as important as physiologic concerns and want relationships with their health care providers that affirm a more encompassing view of EOL.[10]

In addition, these findings further echoed in the works of Miyashita et al.[14] and White et al.[15] Studies show that nurses in acute care settings need more knowledge and skills in order to provide EOL care.[16–18] Moreover, the Canadian Hospice Palliative Care Association,[19] endorses the need for nurses to have specialized knowledge and skills to attend EOL care. Lack of this specialized training has negative impact on the effectiveness of EOL care and may lead to patient discomfort.[20] Of all the members of healthcare team, nurses spend the most time in direct patient care with dying patient and their families.[21]

Emotional support and compassion are frequently cited as important aspects in the delivery of EOL care. While clinicians are educated and trained in approaching care around physical signs and symptoms, patients and their families view the end of life broadly, encompassing their unique psychosocial needs and cultural and spiritual rituals.[22] The specialized knowledge and skills needed extends beyond the concrete tasks of the provision of information and communication; and, is known as "presence" or "effective use of self", and is considered a key clinical competency in caring for patients and families. The supportive presence of self has been identified as a routine part of one's professional role in EOL care[23] and has also been described as an essential part of providing compassionate care.[24, 25] A qualitative study described 'presence' as "providing one-on-one time that is devoted solely to a patient and their family that allowed for a sharing of thoughts and reflections. It implies a focus, a dedication, and an immersion in the moment".[25] This has also been described "as a use of self and presence during interactions, being authentic and using smiles, eye contact, and touch; and listening".[24]

"Components of emotional support are compassion, responsiveness to emotional needs, maintaining hope and a positive attitude, and providing comfort through touch".[13] In parallel, neglecting self-care while caring for others is not sustainable. In fact, self-compassion in health care professionals does not only benefit clinicians' well-being, but also enhances compassionate patient care.[26]

In our own organization's internal staff survey, 98% of clinical staff agreed or strongly agreed with the statement: "I view the quality of the dying experience to be as important as the quality of any other care element provided in the hospital setting".[27] In this survey, both nurses and physicians raised multiple challenges faced in the delivery of EOL care, and other studies identified similar challenges around uncertainty and communication with families.[28, 29] Specifically, nurses in our organization "identified uncertainty around how to address family [questions about the dying process] like 'her

breathing looks different today', and 'can you tell me when he will die?'[4]

This study revealed the greatest challenge in the acute care ward was lack of nursing knowledge related to the provision of emotional support for patients on CMOS. The purpose of this project was to enhance the knowledge and to deliver training to nurses, focusing on effective provision of emotional support for patients and their families.

This paper will describe the initial phase of one Plan-Do-Study-Act (PDSA) cycle. This conceptual framework is used as a problem-solving model in the context of quality improvement.[30, 31] The nurses in this study were familiar with the PDSA cycle, which significantly enhanced their engagement, participation and feedback. Furthermore, this framework was appropriate for this project, because of its simply-structured approach, which allowed systematic and rapid tracking of change.[32]

2. METHOD

This project took place at SHSC on one acute medical unit between October 2016 to March 2017. Nursing engagement was achieved via e-mail invitation. The project working group, included the Advance Practice Nurse (APN) on one acute care ward, the PCCT APN, a PCCT Physician, a member of the SHSC Quality Dying & Living Committee and the spiritual care provider on the acute care ward.

Institutional ethics review was not required for this project as determined by the SHSC Ethics Review Self-Assessment Tool (ER-SAT). Nurses were informed that their participation was voluntary and all questionnaires were collected anonymously.[33]

As per the ward APN, the majority of the nurses on this unit had less than five years nursing experience, qualifying this cohort as 40% novice. The literature suggests that novice nurses are often not adequately prepared, either educationally and/or emotionally to provide comfort measures to patients and families.[16, 34, 35] Literature and anecdotal evidence from key stakeholders supported the development of an educational session for these nurses.

Initially a needs assessment was conducted. A five point Likert scale questionnaire was used to encourage participation[36] and to observe the responses after the intervention.[37] Open-ended questions were used to encourage additional comments.[38] Descriptive statistics were used to analyze questionnaire responses and content analysis was used in reviewing the qualitative data.[39]

In February 2017, four 45-minute educational sessions were provided by the APN of the PCCT, the PCCT physician and the spiritual care provider. Every Monday, for four consecutive weeks, the in-service was held during the nurses' morning break to minimize the potential intrusion on patient care. A hot beverage and snack were supplied in order to entice staff and provide them with a needed morning break.[40] The in-service began with a 35 minute didactic component highlighting the results of the needs assessment, which informed the development of the educational content to address: a) raising nurses' awareness to the importance of providing emotional support to patients on CMOS; b) teaching nurses techniques of emotional support; c) improving nurses' understanding of existing hospital resources and the roles of interdisciplinary teams, that can help provide emotional support to patients on CMOS. The session was followed by a 10-minute question and answer period and verbal feedback.

3. RESULTS

Twenty-six (93%) of the nurses on the ward responded, and voluntarily filled out the questionnaires. The demographic characteristics of participants included 24 females and two males, with 10 participants within the age group 20-25, 11 participants within the age group 26-35, and five participants over the age of 36. Of the 26 participants, 16 (61%) had worked as a Registered Nurse for five years or less (see Table 1).

Table 1. The number of years working as an RN

	n	% (n = 26)
Less than a year	10	39%
1-2 years	3	11%
3-5 years	3	11%
> 5 years	10	39%

Only, two (8%) participants completed an existing eLearning module developed by our institution, entitled: "Quality Dying Initiative at Sunnybrook: Care of the Imminently Dying Patients and their Families". Twenty (77%) indicated they had participated in Sunnybrook's in-service "Care of the Imminently Dying Patients and Their Families". Twenty-two (85%) respondents stated that they were able to identify a dying patient.

During the in-service, nurses were asked to identify words they associated with EOL. The most common words were: "comfort", "no pain", and "no suffering". Overwhelmingly, all participants were able to identify elements associated with the CMOS. When asked "what areas of comfort measures are you most comfortable with?" they responded: identifying the physical changes, monitoring and administration of medications for comfort, and addressing the environmental needs of the patient (such as transitioning a patient to a private

room). Furthermore, when asked "what areas of comfort measures are you less comfortable with?" two main themes emerged: dying patients' and families' spiritual and emotional needs, and the nurses' own emotional needs in caring for dying patients. They expressed discomfort listening to families and answering any questions that were ambiguous and not related to physical symptoms. The majority of nurses (57%) did not feel comfortable providing emotional support to dying patients and their families. Twenty nurses (77%) confirmed they were not familiar with any organizational resources to support families when they could not. Six nurses (23%) added that, at times, they avoided entering the dying patient's room, because they felt under skilled and not adequately prepared to provide the emotional care necessary.

In-total, 20 nurses participated in the educational sessions. After the completion of each educational session, participating nurses anecdotally reported that they felt more prepared educationally and emotionally to provide emotional support to patients on comfort measures and their families. Additionally, they commented on how they were surprised by the number of resources Sunnybrook offered to help them to deliver emotional support and partake in self-care strategies; particularly in the availability of the spiritual care team's role.

4. DISCUSSION

The goal of this project was to deliver educational training to nurses around three domains: a) raising nurses' awareness to the importance of providing emotional support to patients on comfort measures and their families; b) teaching nurses techniques of emotional support; and, c) improving nurses' understanding of existing hospital resources and the roles of interdisciplinary teams, to help provide emotional support to patients on CMOS. In order to increase the satisfaction of care at EOL, adequate emotional support is one of the key issues identified by patients and their families as requiring improvement across Canada's health care system.[41] The front line nurse's role is central in assessing and attending to the spiritual needs of dying patients and their families; however, nurses often feel insufficiently educated, trained and experienced in the assessment and delivery of spiritual care at EOL. In our study, nurses frequently felt uncomfortable discussing spirituality or religion with the patients they cared for.[42] Ferrand[43] offers various suggestions for improving end of life care, citing positive factors identified by nurses, including the presence of family and loved ones at the bedside, identification of a surrogate decision maker, and the availability of prior written directives.

Our data showed that most novice nurses, with less than five years of experience, felt that they were often inadequately prepared, educationally and emotionally, to provide emotional support at EOL. These findings are consistent with the literature.[35, 44, 45] More specifically, these shortfalls lead nurses to feel overwhelmed and frustrated, sentiments echoed by Bush and Shahwan-Akl,[16] and White et al.[45] Addressing these gaps effectively will enhance nurses' therapeutic relationship with their patients and their own efficacy in having difficult conversations with their families.[46]

Anecdotal feedback collected after the in-services highlighted that the nurses welcomed the opportunity to share their thoughts and experiences. They also expressed that these sessions were a useful resource to them as they could have their concerns validated and explored. This was reassuring to observe as another study conducted within our organization demonstrated a statistically significant improvement in perceived self-efficacy in the delivery of EOL care following a PCCT-led educational intervention aimed at Medical Residents.[2] Providing EOL education early in their training of all health care providers, including assessing, monitoring and other comprehensive aspects of EOL care can translate to the enhanced delivery of EOL care.[42] Additional broader feedback raised the need for organizational commitment to support spiritual care needs, beyond the capacity of nurses alone.

Specific recommendations from this study were put forward from the working group to the manager on the acute medical ward. Firstly, it was recommended that "Comfort Measures" be offered as an annual one day workshop for all staff on the acute ward. Secondly, it was recommended that the existing eLearning module, entitled "Quality Dying Initiative at Sunnybrook: Care of the Imminently Dying Patient and their Family" be mandatory for all new nursing hires. Thirdly, it was recommended that death rounds be embedded in the regular ward rounds, whereby after the passing of a patient, nurses have the opportunity to process the loss and gain new insights into the death and dying experience.

Limitations

The nurses in attendance comprised those doing 12 hour shifts (day-evening) and excluded nurses that only worked the night shift. This was limited due to the fact that the APN of the PCCT, the PCCT physician and the spiritual care provider workhours were 9am-5pm. This study was also limited by its relatively small sample of nurses on one acute care ward at a single academic teaching hospital in an urban center. More reliable conclusions can be drawn by expanding the research with sufficient power through the inclusion of multiple acute care wards, multiple sessions covering all nursing shifts, and inclusion of broader spiritual care representation. Furthermore, expanding studies to include the

impact of this intervention on family satisfaction at EOL, would provide a valuable perspective on care of the dying.

5. CONCLUSION

Based on this educational intervention, a gap in the delivery of EOL care was identified. Nurses caring for dying patients required additional education in addressing the emotional needs of dying patients; and, nurses required emotional support for themselves. For Canadians, the goal of delivering holistic EOL care requires the skilled use of CMOS in conjunction with the provision of emotional support for the dying, along with access to emotional supports for those caring for the dying.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare that there is no conflict of interest.

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76

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