Evaluation of COMFORT in Strengthening Family Communication Skills

By

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Practicing clinicians in all areas of health care are required to exhibit competency in end of life care. Despite the growth and acknowledgement of the need for effective end of life practices, health care providers continue to be ill equipped to effectively address issues related to end of life outcomes.[1-3]As our health care communities prepare for an aging population that is living longer, and living with frailty, multimorbidity and disability, the need for developing comprehensive, end of life competency is critical. Furthermore, as patients with serious illnesses rely on caregiver and family for support, care, and decision-making, developing skillful family communication is necessary to transform the patient and family end of life experience.

Although many improvements in the delivery of end of life care have been made through the development of hospice and palliative care specialties, significant gaps remain. In a recent report from the Institute of Medicine (IOM), the need to address the gaps in care of the dying has been acknowledged as critical for creating a sustainable health care system. [3] The IOM report identified six themes for improving the state of end of life care; the need for patient/family centered approaches, professional education and development needs, clinician- patient communication and advance care planning, revisiting of policy and payment systems, and public education and engagement.[3] Communication skills have emerged as one of the "central objectives" for improving end of life care.[4]

The IOM report on Dying in America highlights the "neglect of communication skills" as one of the key challenges in supporting high quality end of life care.[3] Some of the key factors

identified among health care providers contributing to communication barriers are lack of training, insufficient time, and personal discomfort.[3] Inexperience in dealing with death and dying, lack of cultural awareness, difficulty in predicting death, and stress levels of patient and families are other contributing factors.[5] To address this critical need, medical education has mandated eight contact hours focused on communication approaches, whereas nursing has yet to recommend comparable communication training requirements.[6]

The future of nursing education calls upon all levels of nursing to transform practice and build upon the necessary skills to address the growing complex needs of current and future populations. Advance practice nurses (APRNs) have been identified as holding a pivotal role in transforming end-of-life experience for patients and families.[7-9] Quality outcomes specific to end of life care are supported by the development of communication competency. This critical competency is aligned with APRN essential role expectations for developing therapeutic relationships to effectively negotiate and manage patient/family needs, and provide culturally appropriate, evidence-based modalities of care.[10] As communication training is foundational to achieve the goals outlined in the IOM report on Dying in America, there is a critical need for the development and testing of protocols that assist the APRN to effectively meet role expectations. This project aims to evaluate the impact of an innovative approach based on a nurse driven communication strategy using the COMFORT[20] protocol combined with a simulation experience to build confidence and competence of APRNs in initiating, facilitating, and managing difficult discussions common to end of life.

Literature Review

There is a critical need for developing end of life competencies, in particular, competencies related to therapeutic communication as a means to cultivate relationship based care. Nurses consistently report inadequate preparation to provide effective and meaningful end of life care. Gaps in end of life preparation include the lack of evidence regarding end of life training strategies, as well as systematic approaches to measuring competency in end of life practices.[1] Communication skills have emerged as a central theme for improving end of life care outcomes.[4] Despite the recognition of the importance of palliative communication skills, gaps remain in current nursing curriculum to strengthen and build upon theses needed skills.

The End-of-Life Nursing Education Consortium (ELNEC) is commonly cited and known within nursing education as the primary source for end-of-life curriculum. Implemented in 2000, ELNEC has undergone routine curriculum review and has further developed modules for special populations such as pediatrics, veterans, and specialty roles such as the advance practice registered nurse.[11] The implementation of ELNEC was in response to an identified need to strengthen end of life competency among nurses, elevating the critical need for the development of these skills among nurses and advanced practitioners. A component of the ELNEC training program is a focus on communication skills. The ELNEC communication training is based on a 6-step protocol derived from the physician perspective focused on bad news discussions.[6]

Despite the implementation of ELNEC, the literature supports continuing gaps in assessing end of life competence and evaluating end of life training. Even as training for caring for the dying is integrated in nursing curriculum, nurses continue to report the lack of comfort and competence in caring for the dying at both the undergraduate and graduate level. Barrere & Durkin evaluated the effect of ELNEC training for recent graduates of a bacceaularate program in nursing determining that although nurses perceived the training as helpful, it did not provide

adequate preparation to build confidence in the care of the dying.[12] White & Coyne explored the perceived needs for end of life education among oncology nurses and found that although 99% reported that end of life care was important, 25% reported feeling ill-prepared to care for dying patients and families.[1] Finding "the right words to say" remains a common theme among nurses.[1,12-14] Verrissimo & Sousa systematic review of communication strategies among nurses described primarily qualitative perspectives of verbal and nonverbal approaches, concluding an "urgent need to acquire specific skills in the field of communication in order to promote a dignified end of life".[4(p2845)]

The literature is limited in scope for exploring the experiences of advance practice registered nurses in the delivery of end-of-life care. Shea, Grossman, Wallace, & Lange found pre-baseline knowledge regarding palliative care of the APRN using questions from the ELNEC exam ranged from 49% to 90% with a mean of 68.72 (*SD* =9.82).[15] Themes of pain control, providing emotional and spiritual comfort, providing choices, and addressing the needs of families were identified as challenges among the APRNs.[15] Hales & Hawryluck described an interactive workshop that focused on cultivating interprofessional interactions to improve comfort and confidence levels with end of life topics among APRNs.[16] Significant improvements was found in measures of comfort with ethical and legal skills, with 82.4% rating the use of standardized families and colleagues as "excellent" for improving communicaiton skills.[16] Rosenzweig, Hravnek, Magdic, Beach, Clifton, & Arnold evaluated the impact of a patient communication simulation laboratory for the acute care nurse practitioner.[17] The study consisted of a didactic session and communication simulation measuring confidence and perceived skill using a 5 point Likert scale before, immediately after, and four months post completion concluding that content and methods used improved student confidence and perceived skill in

communication in potentially difficult acute care situations.[17] Hsu, Chang, & Hseih compared the effect of a traditional course in communication versus scenario based simulation using a randomized control study design.[18] Although the study found no significant difference in communication performance between two groups of nurses, nurses and independent raters found scenario-based simulation to be more effective than traditional classroom lecture.[18]

Nursing communication skills and strategies are largely described in terms of verbal and nonverbal attributes for guiding effective communication.[4] The literature is sparse with nurse specific tools and protocols for guiding difficult discussions. Furthermore, there is limitations in the literature that describe tools and protocols that are specific to the role of the APRN. APRNs are left with seeking existing training protocols that are derived primarily from physician-based approaches. According to Wittenberg-Lyles, Goldsmith, & Ragan, physician-based protocols neglect to address the communication skills that are specific to palliative nursing.[6] With the lack of nurse specific communication protocols, opportunities exist to develop and examine strategies that foster and support the role of the APRN in the care of both patients and families facing end-of-life decisions and situations.

In response to the need for protocols to support palliative nursing communication, an interactive set of guidelines termed "COMFORT Model" for communication has emerged as an approach to guide difficult discussion.[19] The COMFORT approach offers a set of guidelines to assist in enhancing complex communication skills (Figure 1: The COMFORT Model). The COMFORT Model was originally designed based on experiences with delivering bad news among medical students, but has been adapted to address the unique role that nursing plays in palliative communication.[6] The model is founded on principles of narrative practice which is viewed as being aligned with nursing practice.[20] Although the COMFORT initiative is growing

among nurse experts in the field of palliative and end-of-life, little is known about the impact of the COMFORT Model protocol in enhancing communication skills among nurses or APRNs.

Conceptual Framework

The conceptual framework for this project was guided by the theory of Transformational Learning. Transformational learning is a process described as beginning with a disorienting dilemma, progresses through self-examination, resulting in new knowledge, perspectives and course of actions.[21] Transformational learning focuses on the individual as a reflective learner where knowledge and meaning are gained as a result of the experience. [21(p489)] The transformative learning experience involves the development of an enhanced level of awareness of one's beliefs and experiences, a critique of the assumptions underlying them, a realization of one's choice to negate an old perspective, and the acquisition of the desire and ability to act on a new perspective.[22] For transformational learning to occur, the learning experience goes beyond attainment of concepts, transforming the learner to "explore options for new ways of acting and building competence and self-confidence".[22(p21)]

The premise of the application of transformational learning is that "learners develop their understanding of the world through experiences".[23(p327)] Mezirow believed "true learning occurs when individuals are faced with a crisis or major transitional experience" and "transformation occurs through gradual accumulation of related experiences that progressively alter individual meaning schemes".[23(p328)] Transformational learning combines previous experiences, cultural frames of reference, and critical reflection.[23] The interventional strategy for this study is built upon the principles of transformational learning. The intervention consists of participants completing a didactic lesson introducing the COMFORT protocol. The participants are then

introduced to a disorienting dilemma. The disorienting dilemma consists of two family members at odds regarding goals of care through a simulation experience using a standardized patient family. Following the simulation experience, participants are guided through a reflection activity as part of a debriefing session. New knowledge and practice is evaluated through measuring self-perceived confidence and competence through sequential levels of expertise.

Purpose Statement

The purpose of this project was to evaluate the effectiveness of a COMFORT communication strategy that combines a didactic and simulated experience to strengthen perceived confidence and competence of advance practice registered nurses communicating with families facing difficult decisions and situations. The following research questions guided the project aims:

Research Question: Does participation in a COMFORT simulation using a standardized patient family increase perceived confidence and competence in developing complex communication skills among adult gerontology acute care nurse practitioner students?

Research Question: Do adult gerontology acute care nurse practitioner students perceive the COMFORT protocol as an effective strategy for guiding difficult discussions at end of life?

Development of the Communication Competence and Confidence Level Survey

As no tool exists to measure the specific attributes for measuring communication competency specific to families in crisis, items to measure self-perceived confidence and competence were developed following a review of the literature focused on family and handling of emotional encounters, thus establishing content validity.[13,15-17,24] Four areas of competency

were developed to measure competence and confidence in communicating with families in crisis at end of life. Two questions explored the participants ability to initiate difficult communication topics and ability to communicate in difficult situations. Two additional questions explored participant's ability to manage family emotional needs and family conflict. Using a pre and post design, self-perceived measures of competency and confidence were collected using a sequential continuum of expertise measured at four levels, novice, intermediate, advanced, and expert.[25]

Table 1: Pre and Post Survey Questions – Communication Confidence and Competence Levels.

Methods

The setting for this descriptive study was completed at a Midwest private university within the college of nursing and health using a convenience sample. Students enrolled in the acute care nurse practitioner program were invited to participate. The rationale for focusing on graduate student nurses in an acute nurse practitioner program was to address essential role expectations in the attainment of competency in developing therapeutic relationships to effectively negotiate patient/family centered, culturally appropriate, evidence-based goals and modalities for care.[26]

Inclusion criteria for this project were students enrolled in the adult gerontology acute care nurse practitioner clinical course and willing to participate in the study. There was no specific exclusion criterion. Faculty provided verbal permission for access to the students enrolled in the course. The faculty teaching the course made provisions within the overall course schedule for students to participate in this study without having to endure additional out of class time commitment. Students were compensated for clinical time that was spent during the simulation experience. Upon institutional review board approval, the students enrolled in the

adult gerontology acute care nurse practitioner clinical course were invited to participate in the study. As part of the informed consent process, students were notified that faculty would not participate in the simulation or debriefing exercise. Participants were informed that note taking during the debriefing process may occur to capture themes.

During a designated one-hour post conference within the adult gerontology acute care course, students agreeable to participate in the study were asked to complete a communication confidence and competence pre-survey and demographic data collection tool. To maintain confidentiality, participants received a paired packet/envelope randomly assigned with a number between 001 and 025. Pre-survey information was completed by each participant and returned to the researchers in a self-sealed envelope. The second paired packet envelope was retained by the participants to be completed and returned to the researchers in a sealed envelope at the end of the assigned simulation and debriefing session. Following the completion and collection of the pre-survey and demographic tool, the researcher provided a 50-minute didactic lesson introducing the COMFORT communication protocol. Following the didactic lesson and discussion, students were assigned a simulation session and provided with the simulation scenario. Students were allowed to self-assign in groups of four to five for the simulation experience. The simulations were completed over a three-week period during the course semester.

As part of the simulation session, two volunteers were trained for roles as the standardized patient family. The researcher selected volunteers with previous end of life experience as a student, family member and/or health professional. The researcher trained volunteers in simulation role playing prior to the sessions. Sessions were held in the community simulation center as part of the university's nursing simulation lab. The simulation session consisted of two family members conflicted to the goals of care for a seriously ill loved one.

Students utilized the COMFORT communication techniques to identify the current issues and needs of the standardized patient family. Immediately following the simulation session, participants proceeded to a facilitated debriefing exercise informed by Gibbs Reflective Cycle.[19] The Gibbs Reflective Cycle, commonly used in simulation and debriefing activities, was selected to support the process of reflection, a key aspect of transformational learning. Upon completion of the debriefing session, participants completed the paired post-survey packet. Data was entered into SPSS version 21 for analysis.

Results

The study was completed in the Fall term of 2015. Of the 24 eligible students asked to participate, 20 completed the study. The majority of study participants were female (85%) with a range of ages between 27 and 53 years (M = 37.5, SD = 7.4). Participant length of time employed ranged from 4 to 23 years (M = 11 years, SD = 6). Nearly all of the participants reported their primary work setting as inpatient critical care for (95%). The majority of the participants (75%) reported previous communication training. Similarly, 80% of the participants reported previous exposure to end of life care training. The greatest area of perceived competence was identified as "managing emotional needs of patients and families at end of life" (M = 2.8, SD = .62). Perceived confidence and competence pre and post intervention are summarized in Table 1: Perceived Confidence and Competence Pre and Post Measures.

In order to determine if participation in a COMFORT simulation using a standardized patient family increased perceived confidence and competence in developing complex communication skills among the APRN students, the Wilcoxon matched-pairs signed rank test was conducted. The results of the Wilcoxon matched-pairs signed rank test revealed no

significant change in the COMFORT protocol's ability to increase perceived confidence or competence levels.

To address the adult gerontology acute care nurse practitioner students' perception of the COMFORT protocol for enhancing communication skills to guide difficult discussions, participants were asked to rate the COMFORT protocol as an effective communication tool using a five point Likert scale. Participants positively evaluated the COMFORT protocol as an effective strategy for guiding difficult discussion (M = 4.35, SD = 0.48) and an effective strategy for APRN communication at end of life (M = 4.4, SD = 0.6). Participants shared during the debriefing sessions that the COMFORT protocol reflected common communication techniques currently used to guide discussions and reflected common essentials of nursing practice.

Discussion

Faced with a disorienting dilemma of a family in crisis at end of life, the COMFORT communication protocol was perceived as an effective strategy for guiding difficult discussions at end of life among adult acute nurse practitioner students. Although the COMFORT protocol did not significantly increase perceived confidence and competence levels among the APRN students, several insights can be gained through the transformational learning experience of the students that participated in this project. As transformational learning is focused on the individual as a reflective practitioner, the work of developing and enhancing communication skills begins and continues with the process of self-examination. This transformative process was reflective of themes and patterns of the COMFORT guideline that was shared and observed during the debriefing process.

As the simulation scenario unfolded, the student participants were faced with a disorienting dilemma of two family members conflicted regarding goals of care. The depiction of a standardized patient family in crisis created a sense of reality among student participants representative of common emotions and conflicts associated with end of life decision-making. A common theme shared in the debriefing process and observed in the simulation scenarios was the phenomenon of "Bearing Witness", a strategy within the COMFORT Model. Participants were observed to approach the scenario using techniques of "Bearing Witness" in two ways - by seeking to understand the relationship of the family member to the patient, and going beyond medical information seeking. Bearing witness was further noted in the debriefing process through participant sharing of similar personal stories and relatedness as they explored the perspectives and emotions of the standardized patient family.

Although a part of the lesson of the COMFORT Model introduced the concept of practicing "Mindful Presence", some of the participants struggled with not having a clear goal as part of the simulation scenario. Several participants shared a desire to set and accomplish a goal such as obtaining a "Do Not Resuscitate" status as a measure of communication success. Several participants who approached the simulation with a set goal, shared that this quickly "fell apart" as the scenario unfolded. Others participants reflected on "being ok" with not having a goal in mind, allowing the discussion to "go where it needed to go". Participant teams that identified themselves as "successful" attributed this success to finding a "common ground" or agreement to next steps between the two family members. Several participant teams were observed to demonstrate the COMFORT strategy of "Relating" by shifting focus and communication strategies on the families' experience, rather than relying on a scripted approach or an intended goal.

Finally, the value of "Team" an element of the COMFORT Model was articulated as a common theme in the majority of debriefing sessions. Through the reflective activity, participants shared that the best approach for managing a complex situation, as faced within this scenario, is best accomplished through interprofessional collaboration or a "team approach". One team approached addressing the unfolding conflict by negotiating a family meeting, sharing that this attributed to a "successful compromise and solution". Several participants explored new knowledge by sharing that the use of a "planned" family meeting with other health care team members would have been a preferable approach. The value and use of "Team" was commonly reported as new practice that would be carried forward in current settings.

As participants reflected on the value of the team approach, the role of the scope of the APRN in "prognosticating" emerged. Several participants verbalized reluctance to address the standardized patient family questions regarding the severity of the patient's condition. Although participants stated, "I knew he was dying", the participants did not feel that it was within their scope of practice to "prognosticate". The conflict in role became a common discussion point in many of the debriefing sessions, with many participants reflecting on his or her own past experiences and self-examination of current practices in end of life situations. Overall, the use of a team approach was viewed as desirable and valuable, with participants reflecting on the power of interprofessional collaboration. This phenomenon warrants further exploration of the potential barriers and opportunities associated with APRN scope of practice and role in initiating or facilitating "bad news" discussions.

Transformation of perspectives emerged through the debriefing process as students participated in critical reflection and self-examination related to managing family emotions, family conflict, and the challenges faced with end of life decision-making. Several students

reflected on the challenges of caring for diverse families, reiterating that the simulation scenario presented is commonly experienced in the acute care environment demonstrating a cultural frame of reference. Several participants shared during the debriefing experience feeling less "confident" following the simulation session. Other participants shared that comfort and confidence with difficult family situations "comes with time and experience". Several students demonstrated the ability to act on a new perspective, commenting that the scenario challenged their previously held perceptions of confidence and competence with communicating in difficult situations expressing new knowledge and meaning gained as a result of experience. This finding was evident in a small drop in overall confidence in communicating in difficult situations, and perceived ability to manage conflict among family members post simulation (Table 2: Perceived Confidence and Competence Pre and Post Measures).

There are several limitations to be considered for this study. Along with the limited sample size, fully understanding the perceived role of the APRN in having discussions regarding goals of care discussions at end of life was not considered, and should be further explored in future efforts. The study was limited in design in capturing all observations and shared reflections as part of the simulation and debriefing process. Several student participants expressed a desire to receive feedback directly from the standardized patient family as a method to further reflect on performance. As participants perceived the COMFORT Model as an effective tool, additional studies that include a performance based evaluation of participant use of COMFORT concepts during the simulation process could further enhance understanding the utility and effectiveness of the COMFORT protocol.

As the role of the APRN is viewed as critical to transforming the end of life experiences of patients and families, developing confidence and competence in communication skills is

imperative for the APRN to meet the aims established within the IOM's call for transforming end of life care. Currently, communication strategies for guiding difficult discussions rely primarily on physician based communication protocols. As the role of nursing at end of life is both critical and complex, the need for nurse specific communication protocols that reflect the unique role and practice of nursing is essential. As APRNs continue to explore and address roles and attitudes toward facilitating end of life discussions, the need for further education and testing of nurse driven communication protocol will be essential to meeting end of life competencies and IOM recommendations. The COMFORT Model, is reflective and in alignment with nursing practice, and holds promise for guiding and preparing APRNs to initiate and facilitate difficult discussions building upon critical skills essential for effective patient and family communication at end of life.

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Figure 1: The COMFORT Model

The COMFORT Model	**Communication Skills to Develop**
C - Communicative	Learning to bear witness
	Utilizing person-centered messages
	Narrative clinical practice, verbal clarity, nonverbal immediacy
O - Orientation and Opportunity	Gauging health literacy
	Acknowledge vulnerability
	Understanding cultural humility
	Formulating a pathway of care
M- Mindful Presence	Practicing empathy
	Engage in active listening, staying in the moment, lack of prejudgment
	Employing non-verbal communication
F- Family	Viewing family as an open or closed system
	Recognizing predictable family communication patterns
	Responding to varying needs of family caregivers.
O - Openings	Identifying pivotal events of change in patient/family care
	Communicating despite tension
	Practicing complementary disclosure
R - Relating	Embracing multiple goals of patient/family
	Accepting inherent conflicts in goals.
	Using communication with patient/family to practice care.

T - Team	Contributing to interdisciplinary collaboration Distinguishing successful collaboration form group cohesion

Table 1

Pre and Post Survey Questions – Communication Confidence and Competence Levels

1. Using the following confidence continuum, circle your level of confidence that best describes your overall ability to communicate in difficult situations

Novice	Intermediate	Advanced	Expert
1	2	3	4

Using the following scale, circle what best describes your level of competence with each of the following areas:

2. Initiating potentially difficult communication topics with families in crisis.

Novice	Intermediate	Advanced	Expert
1	2	3	4

3. Managing the emotional needs of patients and families at end of life.

Novice	Intermediate	Advanced	Expert
1	2	3	4

4. Managing conflict among family members.

Novice	Intermediate	Advanced	Expert
1	2	3	4

5. Overall ability to communicate in difficult end of life clinical situations.

Novice	Intermediate	Advanced	Expert
1	2	3	4

Table 2

Perceived Confidence and Competence Pre and Post Measures

Measure	Mean	Std. Deviation
Pre Overall Confidence in Communicating in Difficult Situations	2.45	.510
Post Overall Confidence in Communicating in Difficult Situations	2.43	.591
Pre Initiating Potentially Difficult Communication Topics	2.45	.510
Post Initiating Potentially Difficult Communication Topics	2.60	.503
Pre Managing Emotional Needs of Patients and Families at End of Life	2.70	.571
Post Managing Emotional Needs of Patients and Families at End of Life	2.80	.616
Pre Managing Conflict among Family Members	2.45	.605
Post Managing Conflict among Family Members	2.35	.651
Pre Overall Ability to Communicate in Difficult EOL Situations	2.45	.510
Post Overall Ability to Communicate in Difficult EOL Situations	2.65	.489