IMPLEMENTING THERAPEUTIC COMMUNICATION STRATEGIES IN HOSPICE CARE AS A PALLIATIVE MEASURE

by

David Emanuel Lup

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As members of the DNP Project Committee, we certify that we have read the DNP project prepared by David Emanuel Lup, titled Implementing Therapeutic Communication Strategies in Hospice Care as a Palliative Measure and recommend that it be accepted as fulfilling the DNP project requirement for the Degree of Doctor of Nursing Practice.

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ABSTRACT

Purpose: The purpose of this quality improvement project is to equip hospice nurses with evidence-based therapeutic communication strategies that will inform their interactions and enable them to have effective communication encounters with patients and their caregivers.

Background: Effective therapeutic communication is essential for promoting better decision-making in end-of-life care and relieving patient and caregiver burden. Sage Hospice is a program based in Scottsdale, Arizona, which provides hospice care to Maricopa County patients. Sage's score for effective *Communication with Family* as measured by CAHPS, was 81 out of 100 from January 1, 2018, through December 31, 2019. Considering advanced nursing practice's hallmark focus on patient education, devising a strategy to improve nurse-patient communication, and subsequently this score, is imperative.

Methods: An educational in-service presentation was provided to Sage Hospice nurses that focused on utilizing effective therapeutic communication strategies to inform nurse-patient encounters. Hospice nurses' responses to the therapeutic communication education, including increased knowledge, confidence, and intent to use the presented knowledge in real-life patient encounters, were evaluated. A descriptive, quantitative approach was utilized to ascertain the educational in-service session's effectiveness.

Results: A total of 21 hospice nurses participated in the in-service and completed the post-survey. A high response rate (52.5%) was achieved as 21 out of the 40 invited nurses participated. After participating in the in-service, most participants either "agree" or "strongly agree" with the statement that they achieved increased knowledge, confidence, and intent to use the presented information in their future patient encounters.

Conclusions: The in-service educational presentation regarding the use of therapeutic communication strategies in hospice care was an effective way to increase hospice nurses' knowledge, confidence, and intent to use the learned information in their day-to-day patient encounters. Future key recommendations include updating the educational content with the latest evidence-based knowledge, developing a plan for face-to-face delivery of the in-service as soon as regulatory guidelines permit, and providing printed pamphlets with therapeutic communication tips to future in-service participants.

INTRODUCTION

Dying is a unique process that poses challenges for patients and their caregivers. Effective therapeutic communication is essential for promoting better decision-making in end-of-life care and relieving caregiver burden (Walczak et al., 2017). Providing care for a loved one at the end-of-life is often a frightening and challenging experience. Some difficulties caregivers experience include anxiety, fear, inadequate medical training, and a feeling of "you only have one chance to get it right" (Totman et al., 2015). These challenges stem from caregiver burdens such as the need to provide direct patient care, coordinate care with healthcare professionals, make decisions on behalf of terminally ill patients, and manage patients' logistical demands of daily living activities (Lavalley, 2018). These challenges are often new for both patients and their loved ones, which further complicates the situation as it makes caregivers and patients unsure of what to expect and how to prepare for and handle the inevitable. Patients and their families place their trust in hospice nurses' hands to help them navigate this difficult journey. Therefore, hospice nurses must develop a deeper understanding of the challenges surrounding dying and proficiency in implementing effective therapeutic communication strategies (Nyatanga, 2015). This project describes a promising intervention to equip hospice nurses with valuable therapeutic communication skills, which can be used as effective palliative measures to alleviate patient and caregiver burdens.

Background Knowledge and Significance

According to The Gale Encyclopedia of Medicine, *Hospice* is end-of-life care that seeks to relieve discomfort rather than cure the patient's disease (Mertz & Wexler, 2020). Hospice care encompasses pain management, emotional and spiritual support, social services, and numerous

other aspects to promote humane and compassionate care for dying patients and their loved ones (Mertz & Wexler, 2020). In 2018, there were 1.55 million Medicare beneficiaries enrolled in hospice care for one day or more. According to the Consumer Assessment of Healthcare Nurses and Systems (CAHPS) Hospice Survey, which assesses the experiences of patients who died while receiving hospice care and their primary informal caregivers, the national average score for *Communication with Family* was only 81 out of 100 (Centers for Medicare and Medicaid Services [CMS], 2020). The scores for this measure are calculated based on answers provided by the caregivers to the following questions:

1. "How often did the hospice team members listen carefully to you when you talked with them about problems with your family member's hospice care?"
2. "While your family member was in hospice care, how often did the hospice team listen carefully to you?"
3. "While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?"
4. "While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?"
5. "While your family member was in hospice care, how often did the hospice team members keep you informed about when they would arrive to care for your family member?"

(Price et al., 2014)

According to *The National Consensus Project Clinical Practice Guidelines for Quality Palliative Care Guidelines* (4th Edition), implementing therapeutic communication via the

provision of empathetic listening and delivery of education in a transparent yet hope-fostering way relieves caregiver's burdens. Also, it promotes better decision-making in terminal care (Ahluwalia et al., 2018). The national hospice average score for the measure *Communication with Family* was only 81% from January 1, 2018, through December 31, 2019 (CMS, 2020). This highlights a significant healthcare delivery failure occurring when patients need it most. Considering advanced nursing practice's hallmark focus on patient education, devising a strategy to improve this score is imperative.

Local Problem

Sage Hospice and Palliative Care is a hospice program based in Scottsdale, Arizona, which provides hospice care to Maricopa County patients. Sage's CAHPS score for effective *Communication with Family* was the same as the national average, 81 out of 100 (CMS, 2020). This evidence suggests there is significant room for improvement for Sage Hospice in the utilization of effective therapeutic communication. Key stakeholders in this organization include the leadership team, comprising the company president and board of directors, whose role is to make crucial decisions and lead the organization. Next is the care delivery team comprising the nurses on the field whose role is to provide bedside hospice care. Lastly, the recipients of care are hospice patients and their caregivers.

The widespread communication problem in hospice care was initially identified by the author of this work from his professional experience as a hospice nurse in various roles over six years. The author subsequently explored the issue further via a comprehensive needs-assessment and detailed literature searches. These inquisitions led the author to believe that empowering hospice bedside nurses to utilize effective therapeutic communication strategies would help Sage

Hospice score higher in national surveys and, more importantly, provide patients and caregivers with much-needed support and relief at the time they need it most.

Intended Improvement

Project Purpose

The purpose of this quality improvement (QI) project was to equip hospice nurses with evidence-based therapeutic communication strategies that will inform their interactions and enable them to have effective communication encounters with patients and their caregivers. Provider led conversations between hospice care recipients and nurses regarding patient values and goals will enhance patient understanding and control of their own medical decisions, ease the burdens of decision-making on family members, and help patients toward achieving peace as they approach the end-of-life (Bernacki & Block, 2014).

Project Question

Will a hospice in-service educational presentation on effective therapeutic communication utilization as a palliative measure increase nurses' knowledge, confidence, and intent to use the presented information as a palliative intervention informing their future patient encounters?

Project Objectives

The specific objectives of this quality improvement (QI) project were:

Objective 1) Host an in-service meeting to educate hospice nurses on utilizing therapeutic communication as a palliative intervention and showcase the most common therapeutic communication shortcomings in hospice care.

Objective 2) Conduct a post-survey questionnaire to assess nurses' knowledge, confidence, and intent to use the presented information in their daily patient encounters.

Objective 3) Offer an executive summary to the leadership team regarding the hospice nurses' response to the therapeutic communication in-service.

Theoretical Framework

An appropriate theoretical framework must guide the process of equipping hospice nurses with evidence-based therapeutic communication strategies that inform their interactions and enable them to have effective communication encounters with patients and their caregivers.

Lewin's Change Theory

The theoretical framework guiding the implementation of this QI project is *Lewin's Change Theory* (LCT). Among other advantages, this framework permits successful accounting for uncertainty and resistance to change (Lucidchart Content Team, 2021). This characteristic makes it an ideal framework for implementing a company-wide change involving all staff levels. Lewin's change theory (LCT) has been successfully used in numerous healthcare organizations, including hospitals, nursing homes, and long-term care facilities, for purposes such as implementing the *bar-coded medication administration system* (Sutherland, 2013). Due to its broad applicability, it has also been used in large non-healthcare organizations such as Amazon to guide change (Lucidchart Content Team, 2021).

As a fundamental premise, this theory presents the idea that organizations must continuously adapt to their environment to survive (Lewin, 1951). According to this theory, complex adaptive systems such as healthcare entities are influenced by two major forces: driving

forces and restraining forces (Wojciechowski et al., 2016). Driving forces are those that push in the direction that enables change to occur. Restraining forces are those that push towards keeping the status quo. Equilibrium occurs when both driving and restraining forces are equal. For change to occur, driving forces must become greater than opposing forces (Wojciechowski et al., 2016).

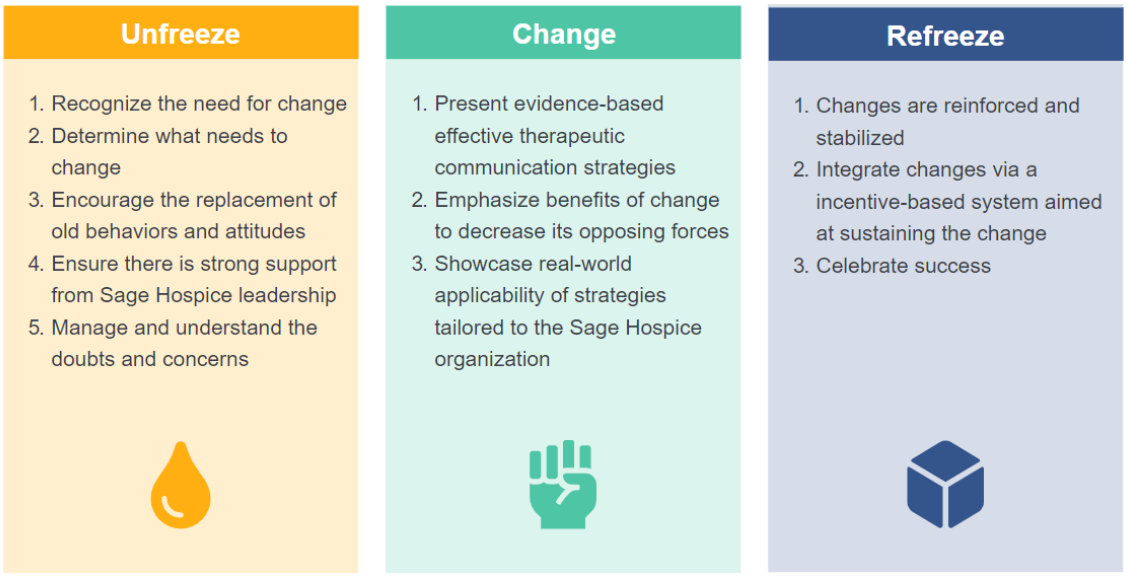
Within the Sage Hospice organization, driving forces, which are positive forces for change that push in the direction that causes change to happen, are the company's desire to deliver more effective patient care, the desire to gain a strategic advantage in the competitive hospice marketplace through continued innovation, and the desire to improve CAHPS national scores. Restraining forces, or obstacles that counter driving forces aimed at keeping the status quo, are employee complacency with the status quo, intimidation of the additional effort required to drive improvement, and a lack of financial and personnel resources needed to implement a company-wide change.

Lewin's Change Model

Lewin's Change Model (LCM) for planned change comprises three phases: *unfreezing, changing,* and *refreezing* (Lewin, 1951, 1997). This process can be understood via a simple imagery depiction. To change the shape of a sphere of ice into a cube, one must first unfreeze the sphere – *unfreezing*, pour the liquid into a cube mold – *changing*, and refreeze it – *refreezing*. During the unfreezing phase, problem awareness is created in the organization. Next, during the changing phase, brainstorming, role-modeling, and training take place. Lastly, celebrating success and promoting sustainability compose the third and final step – *refreezing* (Wojciechowski et al., 2016) (Figure 1).

Figure 1

Lewin's Change Model



(Note. This figure demonstrates Lewin's Change Theory. Adapted from *Understanding Lewin's Change Management Model*. Copyright 2021 by Visual-Paradigm.com)

The Unfreezing Phase – Creating Problem Awareness

During phase one, the unfreezing phase, the principal investigator (PI) demonstrated the shortcomings and missed opportunities created by following the status quo. The status quo represents a lack of intentional application of therapeutic communication strategies. During this phase, key stakeholders in this organization became aware that implementing effective therapeutic communication strategies in the field correlates directly with the quality of care the hospice organization delivers. Conversely, the key stakeholders were made aware that failing to implement therapeutic communication creates tangible care-delivery failures, which lead to increased patient and caregiver burden (Ghesquiere et al., 2019; Lavalley, 2018; Nielsen et al., 2017; Roen et al., 2019; Sulmasy et al., 2017).

The Changing Phase – Brainstorming, Role-modeling, and Training

During the second phase, the principal investigator (PI) presented evidence-based effective therapeutic communication strategies. These strategies were tailored to the Sage Hospice organization's characteristics, emphasizing applicability in real-world patient-care scenarios. During this phase, the PI sought to emphasize the benefits of the change and decrease its opposing forces.

The Refreezing Phase – Celebrating Success and Promoting Sustainability

During the third and final phase (which will occur after and separately from this QI project), Sage Hospice will implement an incentive-based system to refreeze the organizational change and stabilize a new equilibrium. To effectively refreeze the change, the organization must celebrate the intervention's success as it delivers more effective patient care, gains a strategic advantage in the competitive hospice marketplace, and improves CAHPS national scores.

Literature Synthesis

Evidence Search

The principal investigator (PI) performed a literature search for all English-language studies on therapeutic communication in hospice care. The PI searched Medline, CINAHL, PubMed, and Google Scholar for eligible studies using the keywords "therapeutic communication," "hospice care," "physician-patient relations," "truth disclosure," "hospice and palliative care nursing," "education, professional," and other related variations of those terms. This search yielded 110 studies. After applying the inclusion criteria outlined below, 31 studies remained.

Inclusion criteria were original research studies, systematic reviews, or meta-analyses in peer-reviewed journals that examined therapeutic communication in hospice care. Studies relating to pediatric hospice care were excluded because care and communication vary considerably compared to that of adult hospice care recipients. Exclusion criteria were studies that had a narrow focus, such as hospice care delivered to patients with one specific diagnosis (breast cancer) in one specific region (Northern Europe), studies that had specific populations, where the findings were not generalizable to a broader population, and studies which were published before the year 2016 (Figure 2).

Comprehensive Appraisal of Evidence

Culturally Sensitive Therapeutic Communication is Essential

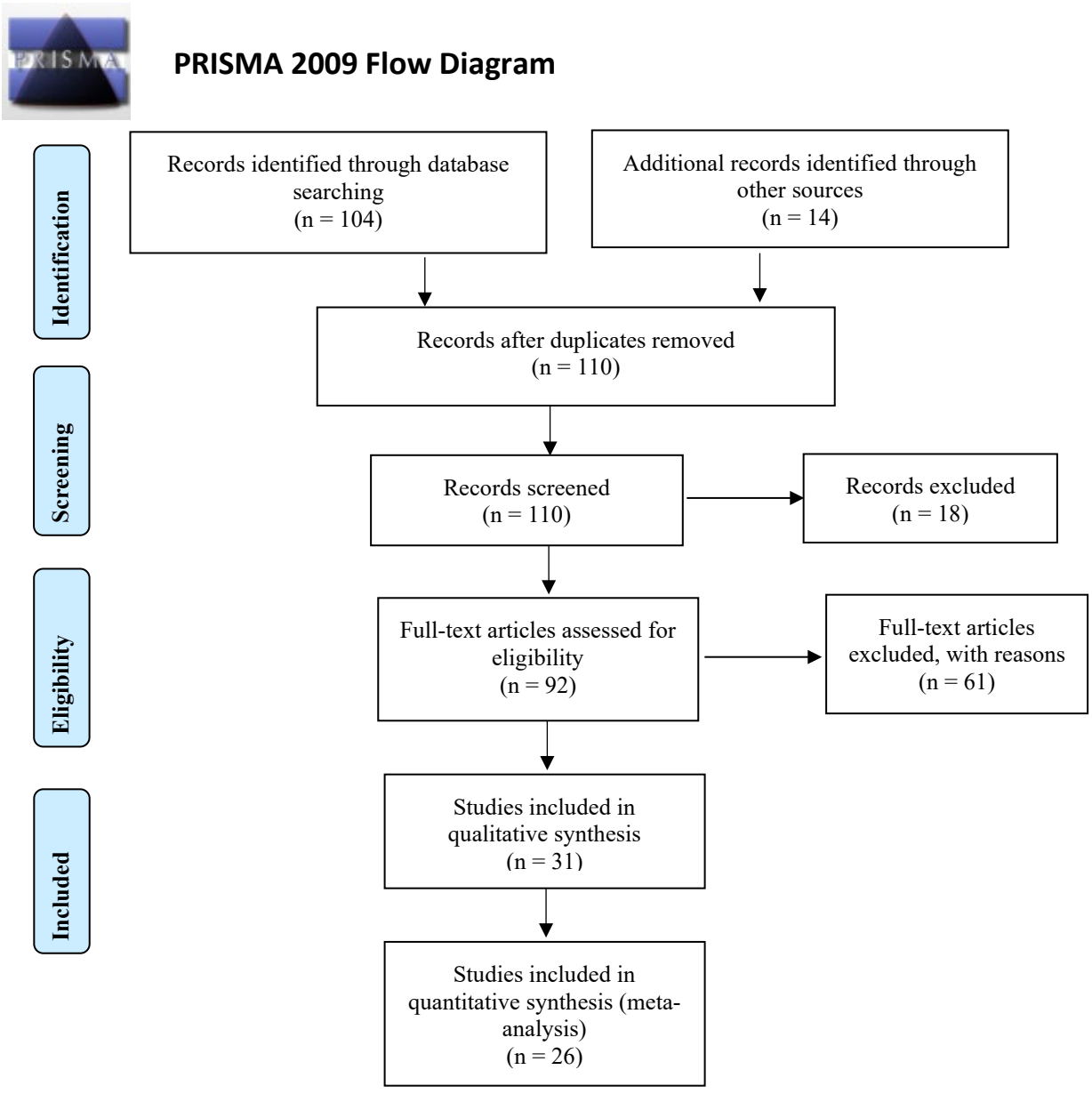
Hospice care cannot be delivered using a one-size-fits-all approach. Research suggests that hospice patients who belong to an ethnocultural minority, and those in underserved areas, are more likely to receive lower-quality hospice care due to the hospice nurses' lack of knowledge regarding therapeutic communication strategies that are culturally tailored to provide individualized care (Fang et al., 2016; Fischer et al., 2018; Isaacson et al., 2019; Ko et al., 2017). When hospice patients and their caregivers do not have an adequate understanding of the resources available to them during end-of-life, their suffering can be exacerbated (Nielsen et al., 2017; Walczak et al., 2017).

On the other hand, family and patient preparedness regarding end-of-life anticipation and preparation reduce the burden of care and grief intensity (Nielsen et al., 2017; Roen et al., 2018). Therefore, it is essential to ensure hospice provider education regarding culturally sensitive therapeutic communication strategies to reduce caregivers' burden in minority groups (Lavalley,

2018; Sallnow et al., 2016; Sulmasy et al., 2017). In doing so, minority groups will receive access to more equitable hospice care that considers their ethnocultural backgrounds and needs.

Figure 2

Flow Diagram of Literature Search



Effective Therapeutic Communication in Hospice Care Reduces Suffering

Due to the extensive repertoire of pharmaceutical pain and anxiety management options, hospice nurses have historically been effective at end-of-life symptom management (Ahluwalia et al., 2018; Fine, 2018). Nevertheless, there is a more abstract realm in hospice care, which necessitates as much attention and management as physical symptoms. Psychological suffering and distress in hospice patients and their caregivers are often of extreme intensity (Ghesquiere et al., 2019; Nielsen et al., 2017; Sulmasy et al., 2017; Walczak et al., 2017). Research shows that even physical complications such as wounds can lead patients and their caregivers into social isolation and depression (Cornish, 2019; Lavalley, 2018). When hospice nurses fail to acknowledge and address non-physical areas of suffering, caregiver and patient grief is intensified, and end-of-life care quality becomes less than optimal (Nielsen et al., 2017; Walczak et al., 2017).

Intense caregiver burden and patient feelings of guilt cannot be medicated away. These fundamental challenges can only be addressed by utilizing effective therapeutic communication (Ghesquiere et al., 2019; Lavalley, 2018; Nielsen et al., 2017; Roen et al., 2019; Sulmasy et al., 2017). The COMFORT strategy for therapeutic communication implementation consists of 7 basic communication principles: C-Connect, O-Options, M-Making Meaning, F-Family Caregivers, O-Openings, R-Relating, and T-Team (Fuoto & Turner, 2019; Goldsmith et al., 2020).

This model emphasizes the collaborative, reciprocal nature of nurse-patient/family interactions in health literacy achievement, as participants relationally create and adapt to shared meaning (Fuoto & Turner, 2019; Goldsmith et al., 2020). Studies suggest that building rapport

and trust with patients and their caregivers through the implementation of therapeutic communication strategies such as the COMFORT model leads to reduced caregiver burden, depression, anxiety, and guilt for caregivers and patients (Ahluwalia et al., 2018; Fuoto & Turner, 2019; Goldsmith et al., 2020; Sulmasy et al., 2017). It also improves end-of-life shared decision-making (Patel et al., 2016; Roen et al., 2018). The COMFORT model was implemented in a palliative care unit in a large tertiary care center in the southeastern United States (US), and it successfully increased the confidence and satisfaction of palliative care nurses engaged in end-of-life communication (Fuoto & Turner, 2019).

Framing Hospice Care Effectively Promotes Increased Utilization

Hospice care has a negative connotation in certain subsets of the general population (Fridman et al., 2018; Ko et al., 2017; Wilson et al., 2019). Individuals' hesitancy to consider hospice care for themselves or their loved ones has adverse effects in relieving end-of-life symptoms. Delivering end-of-life hospice education with confidence and empathy helps frame hospice care in a positive light and increases patients' willingness to utilize it (Fridman et al., 2018). A practical method for hospice nurses to achieve this is by practicing mindfulness of the challenges patients and their caregivers encounter when facing this difficult decision, meeting them where they are and willing to answer questions honestly and compassionately (Rocio et al., 2017). Studies show that patients who are informed of their prognosis and engaged in shared decision-making regarding their treatment choices are more likely to request quality-of-life care focused on symptom management and hospice services (Patel et al., 2016; Roen et al., 2018).

Considering this critical need, it is essential to educate hospice nurses on developing the expert communication skills necessary to frame hospice care in a positive light, as this will

increase its utilization in the general population (Fridman et al., 2018). Teaching hospice nurses' therapeutic communication strategies increases nurse confidence and satisfaction when engaging in end-of-life communication (Fuoto & Turner, 2019; Goldsmith et al., 2020; Hagerty et al., 2017; Sallnow et al., 2016).

Strengths of Evidence

There is a significant quantity of high-level evidence in the body of literature about therapeutic communication in hospice care. Eight of the studies included in the synthesis of evidence were systematic reviews or randomized controlled trials (Ahluwalia et al., 2018; Fischer et al., 2018; Kruse et al., 2017; Oczkowski et al., 2016; Sallnow et al., 2016; Walczak et al., 2017; Wilson et al., 2019; Wyatt et al., 2017). All these studies showed a positive result in the implementation of therapeutic communication strategies. Another strength is that the studies selected covered a broad range of hospice patients, including minorities and those in medically underserved areas (Fang et al., 2016; Fischer et al., 2018; Isaacson et al., 2019; Ko et al., 2017).

Weaknesses of Evidence

One of the most significant limitations noted in the literature review is that there is minimal information regarding the use of therapeutic communication remotely via telehealth. This significant shortcoming is accentuated by the current challenges posed by the Covid-19 pandemic. Based on these limitations, there seems not to be enough data to quantify if any benefit can be achieved by providing therapeutic communication via telehealth; or the actual cost of not providing therapeutic communication via telehealth as a second-best alternative. Another limitation of the literature review is that numerous vital studies were not included due to

publication date restrictions. Many of the studies performed before 2016 contribute significantly to the body of evidence and should be updated.

Gaps in Evidence

The most significant gap in the literature search is the lack of a standardized therapeutic communication tool utilized in hospice care. Although there are numerous therapeutic communication strategies and principles outlined in the body of evidence, there is no single vetted tool that incorporates these into a practical and easily implementable instrument. Hospice care is delivered by many interdisciplinary team members, including certified nursing assistants, registered nurses, social workers, physicians, and chaplains. Another significant gap in the literature is the lack of therapeutic communication strategies specific to each discipline involved in hospice care.

METHODS

Project Design

Education regarding the practical usage of therapeutic communication in hospice care increases the confidence and satisfaction of hospice nurses engaged in end-of-life communication (Fuoto & Turner, 2019). This quality improvement (QI) project aimed to equip hospice nurses with evidence-based therapeutic communication strategies to inform their interactions and enable them to have effective communication encounters with patients and their caregivers. An educational in-service was provided that focused on utilizing effective therapeutic communication strategies to inform nurses' patient encounters. Hospice nurses' responses to the therapeutic communication education, including increased knowledge, confidence, and intent to use the presented knowledge in real-life patient encounters, was evaluated. A descriptive,

quantitative approach was utilized to ascertain the educational in-service session's effectiveness in reaching the goals. This project gathered self-reported data utilizing a post-survey questionnaire.

The following five outcomes were measured to evaluate the achievement of this QI project's purpose. Upon participating in the educational in-service, hospice nurses will:

1) Be able to identify three potential patient care benefits brought about via effective therapeutic communication.
2) Be able to identify three potential patient care failures brought about via the failure to implement effective therapeutic communication.
3) Be able to identify one verbal statement aimed at articulating empathy.
4) Be able to identify one fundamental skill aimed at enhancing therapeutic communication during patient encounters.
5) Be able to report increased knowledge, confidence, and intent to use learned therapeutic communication strategies during future patient encounters.

Model for Implementation

The Model for Improvement (MFI)

According to the Institute for Healthcare Improvement (IHI), QI projects enhance patient care delivery and processes (2020). The Model for Improvement (MFI) was developed by Associates in Process Improvement as a tool to accelerate improvement (IHI, 2020). Figure 2 provides a visual depiction of the MFI. The initial step in the MFI is to set clear aims. Aims should be time-specific and measurable, and they should also define the specific population of patients that will be affected (IHI, 2020). Three key questions integral to setting the aims are:

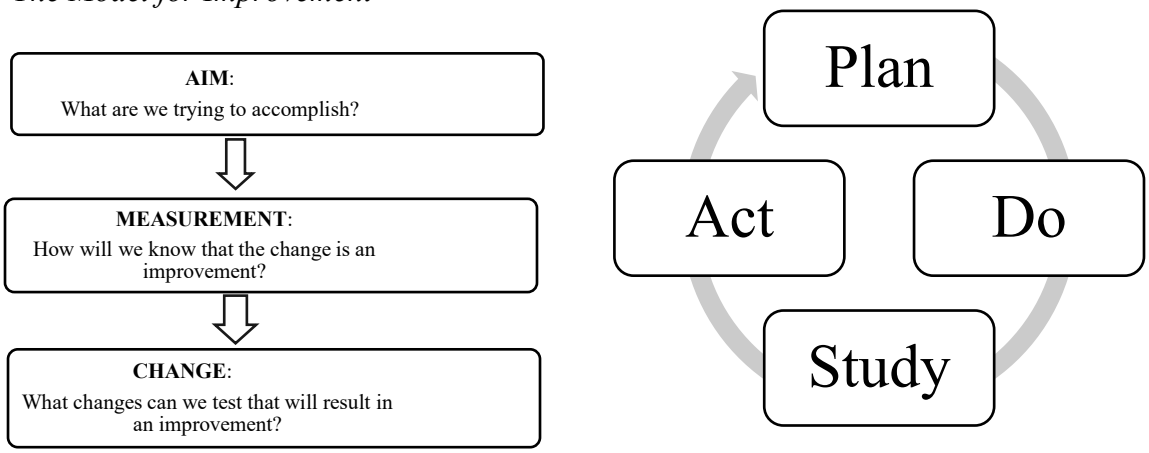
What are we trying to accomplish? How will we know that the change is an improvement? What changes can we test that will result in an improvement? (IHI, 2020). The principal investigator (PI) aimed to equip hospice nurses with evidence-based therapeutic communication strategies to inform their interactions via a hospice in-service meeting. The project also aimed to showcase potential patient care benefits brought about through effective therapeutic communication and potential harms resulting from the failure to do so. Via the hospice in-service meeting, the PI strived to increase hospice direct patient care provider knowledge, confidence, and intent to use therapeutic communication strategies during future patient encounters. The degree to which these outcomes were met was analyzed through the hospice nurses' post-survey data obtained at the end of the in-service meeting. The change was the in-service presentation delivered to Sage Hospice's nurses.

Plan-Do-Study-Act (PDSA) Cycle

The next step in the MFI is the PDSA cycle. This cycle enables testing a change in the actual work setting by planning it, trying it, observing the results, and acting on what is learned (IHI, 2019). The PDSA cycle helps determine if the proposed practice influences actual improvement changes and adoption by stakeholders (IHI, 2019). Obstacles may be identified quickly, and the appropriate solutions can be made to the QI project to increase the probability of attaining the project goals by obtaining and evaluating real-time feedback using the PDSA cycle (IHI, 2019). The MFI's PDSA cycle guided this QI project by curating the educational material presented at the hospice in-service meeting. Utilizing the PDSA cycle permitted the therapeutic communication educational materials and delivery process to be continuously evaluated, updated, and reconfigured, to assure that the project objectives were met (Figure 3)

Figure 3

The Model for Improvement



(Adapted from *Model for Improvement,* by the Institute for Healthcare Improvement, http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx, Copyright 2019).

Plan

The first phase of the PDSA cycle is planning (IHI, 2020). This portion of the PDSA cycle consists of initial preparation and project development, including identifying what data needs to be collected (IHI, 2020). During this phase, the PI consulted with the leadership team of Sage Hospice and Palliative Care to establish the QI project's need and obtain approval for the in-service educational meeting. Once the designated Sage Hospice leadership team member authorized the project's implementation within the organization, the PI collaborated with her to discuss the educational material and resources to be presented during the in-service meeting. Evidence-based online resources and educational material were incorporated to formulate the in-service presentation slideshow. The slideshow was created by the PI and sent to the project chair for feedback and approval. The slideshow was also reviewed and approved by the leadership team at Sage Hospice and Palliative Care. The PI collaborated with the Sage Hospice Leadership Team to determine how and when the in-service meeting would occur.

Do

During the second step of the PDSA cycle '*Do*,' the in-service meeting was carried out. The date the PI conducted the in-service meeting and collected the data was July 8, 2021. The disclosure statement, presentation slides, and post-survey were accessible by a uniform resource locator (URL) link provided by the PI. This allowed the participants to view the presentation slides and complete the post-survey conveniently within one online platform. The PI noted any technical difficulties, challenges, or unexpected events during the implementation phase. The PI promptly fixed technical issues to ensure optimal usability.

Study

During the third step of the PDSA cycle, the obtained post-survey data was critically examined (IHI, 2020). The PI analyzed the data and determined the extent to which the intended project objectives and outcomes were met. The collected data was examined to determine if it aligned with the project's predictions of increasing hospice nurses' knowledge, confidence, and intent to use therapeutic communication strategies during future patient encounters. The PI constructed an executive summary to explain the implementation findings and describe what was learned throughout the process. By critically appraising the data, the PI was able to determine if the change process was effective and identify possible intrinsic and extrinsic factors that could have led to the results (IHI, 2020). Once the results were compiled, they were presented to the project committee members and Sage Hospice Leadership Team to reflect and discuss the in-service meeting efficacy.

Act

The fourth and final step of the PDSA cycle enables the PI to propose sustainability derived from what was learned via the first iteration of the PDSA cycle (IHI, 2020). The post-survey results and data summary were utilized to determine whether the in-service meeting was beneficial for the hospice nurses. As the project successfully achieved the intended goals, the PI will discuss future utilization within and outside of the organization.

Setting and Stakeholders

Setting

The in-service presentation was delivered to Sage Hospice's nurses in Scottsdale, Arizona. This company provides hospice care to terminally ill patients in Maricopa County. The nurses comprise a team of registered nurses who are case managers (RNCMs) responsible for 10-15 hospice patients. These hospice nurses provide comprehensive patient care, including teaching, assessment, and intervention skills to enhance comfort and maximize the quality-of-life for the patients and their families. Hospice patients are visited in their residential setting by the hospice nurses one to two times per week on average.

Due to the COVID-19 pandemic, Sage Hospice has transitioned their monthly in-service staff meetings to an online platform, conducting these meetings via Microsoft® Teams. The PI coordinated with the leadership team at Sage Hospice to implement the QI according to their online specifications. The monthly in-service meetings are used by Sage Hospice leadership to train and support nurses in utilizing the most up-to-date evidence-based hospice care delivery strategies. Also, these meetings provide nurses with the opportunity to share ideas, ask questions,

and connect with the hospice leadership team. On average, there are 20-40 nurses in each of these meetings.

Stakeholders

Authorization for implementation at the Sage Hospice site in Scottsdale, Arizona, was provided by a critical leadership team member (Appendix A). Critical stakeholders for this project were the hospice nurses (RN-Case Managers), the leadership team (Director of Clinical Quality and Compliance, Clinical Education Coordinator, Area Vice President of Operations), and office staff. The hospice nurses are the primary stakeholders as they received the educational content and provide their perceptions and experiences. Support, buy-in, and approval by the leadership team were integral to implementing the QI project. Their input for the presentation slides was needed to ensure appropriateness and relevancy to their employees. Their agreement to allow the PI to deliver the in-service education and post-survey to their nurses was essential to the project implementation and data collection's success. The office staff were also vital members of the project team as they were able to assist the nurses with questions or concerns about the project.

Planning the Intervention

The QI implementation phase occurred on July 8, 2021. The presentation materials and post-survey URL were made available to the nurses at the beginning of the in-service meeting via email. The PI sent the invitation email to the Clinical Education Coordinator, who forwarded it to all hospice nurses. The PI presented the educational material during the duration of the in-service meeting and was available for a question and answer (Q&A) session at the end of the presentation. After the in-service meeting, the participants scanned an on-screen QR code which

gave them access the post-survey within Qualtrics. The disclosure form was provided within the email invitation; participation in the activity signified consent (Appendix B). After the in-service presentation, the participants had the opportunity to complete the post-survey. Potential barriers of the QI project implementation included technological difficulties and a lack of participant willingness to participate. However, no technical barriers were communicated to the PI.

The slideshow presentation (Appendix E) contained information curated and delivered by the PI. The presentation included pertinent, evidence-based facts and descriptions about the utilization of therapeutic communication in the hospice setting, its benefits; and risks if not implemented, and practical communication tips designed to promote therapeutic communication effectiveness during real-life patient encounters. The presentation content was developed from evidence-based material of peer-reviewed research articles and nationally recognized organizations. One such organization is Vital Talk, which utilizes evidence-based strategies to help healthcare professionals communicate effectively with patients with serious illnesses. The slides for the 15-to-20-minute presentation content was reviewed by expert clinicians and the leadership team at Sage Hospice.

Participants and Recruitment

Nurses whom Sage Hospice currently employs were invited to participate in the in-service meeting. Exclusion criteria included non-nursing staff and nurses who do not provide direct patient care services. A convenience sampling or availability sampling method was used for recruitment as this is most useful for pilot testing (Etikan et al., 2016). This type of sampling is a nonrandom technique in which the target audience (hospice nurses) of this project was readily available at a specific time and was invited to participate (Etikan et al., 2016). The nurses

were invited to participate via an email sent by the Clinical Education Coordinator. Participation in the project was entirely voluntary. The sample size goal was to have at least 70-80% of the nurses participate in the project, with a target of approximately 32 participants. The actual number of nurses who participated in the presentation and completed the post-survey was 21.

Consent and Ethical Considerations

It is crucial to consider ethical principles when formulating and implementing projects using human subjects to reduce the risk of potential harm and protect participants' rights (Polit & Beck, 2017). According to the Office for Human Research Protections, the principle of *Beneficence* means "to do no harm" (OHRP, 2018). Following this principle, investigators must continually develop interventions that aim to maximize benefits while minimizing harm which includes but is not limited to emotional distress, discomfort, social inconveniences, financial implications, and injuries (Polit & Beck, 2018). Throughout the completion of the QI project, the PI had a personal commitment to abide by the *beneficence* principle. The project was submitted to and reviewed by the Institutional Review Board (IRB) at the University of Arizona to ensure it aligns with ethical guidelines (Appendix A). Privacy was maintained by not collecting any individual personal identifiers and through proper data storage. Participants were informed that their post-survey responses were going to be utilized strictly for analysis, and only aggregate data would be shared. A disclosure form was provided for participant review prior to completing the post-survey and viewing the educational materials (Appendix B). The educational intervention material was as concise as possible to minimize time-related inconveniences, and the content was based on recent and current evidence and delivered appropriately. The in-service

meeting was entirely voluntary, and the names of participants were not collected. Lastly, participants were able to withdraw at any time.

A potential risk of this project was that the educational material may stir up negative feelings in a participant who may have had a recent challenging patient encounter. The PI was available to discuss these potential feelings safely one on one with the affected participant(s) to address and minimize this risk. Participants were encouraged to contact the PI and leadership team if they had any concerns or questions after participating in the in-service meeting. As the in-service presentation was informative and educational, there were no anticipated physical consequences or risks for the participants. The benefits of understanding the rationale and strategies to use therapeutic communication during patient encounters outweighed the potential risks.

Timeline

A timeline (Appendix F) was created to ensure the adequate progression of the QI project. The timeline projected dates were adjusted based on the University of Arizona College of Nursing and IRB's review, the educational material development, and implementation time request from Sage Hospice.

Data Collection

Post-survey responses were collected from the in-service meeting participants. The secure network of Qualtrics and clinical database provided by the University of Arizona were utilized to construct the project post-survey and as the platform for participants to complete the post-survey. The post-survey was made accessible to participants for one week after the in-service presentation and they received an email reminder (Appendix C) to take the post-survey at

three-day post-intervention. The post-survey information was only accessible to the PI. The PI only knows the passwords to the online survey program. After the project's conclusion, the materials (survey tools/links) and the data set will be filed within the College of Nursing's secure online cloud service for six years, the required minimum set forth by the institution's data policy (OHRP, 2018).

The PI created the post-survey (Appendix D). Three doctoral-prepared nurse practitioner experts reviewed the post-survey (Appendix D) for accuracy and comprehensibility. The participant's personally identifiable data was not collected in the post-survey. The post-survey (Appendix D) collected data about perceived knowledge, confidence levels, and intent to use therapeutic communication during patient encounters. Additionally, the post-survey (Appendix D) contained three brief questions assessing the in-service presentation format's effectiveness. Question formats contained multiple choice, yes/no, and 5-point Likert scale responses. Likert scales helped the participants rate their perceptions and attitudes with heightened precision (Harpe, 2015). The Likert scales were formatted using a five-point scale of agreement. The agreement statements included "strongly disagree," "disagree," "undecided," "agree," and "strongly agree." A free text box was provided to permit any additional comments.

Data Analysis

The data was analyzed using descriptive statistics to score and analyze the post-survey responses to evaluate knowledge, confidence, and intent to incorporate this knowledge in their practice. The categorical results (yes/no responses) were presented as frequencies (percentages). For the true/false knowledge questions, the data was analyzed as categorical with percentages to depict the responses' frequency. The post-survey's Likert scale results were analyzed as ordinal

data and scored according to the response. A “strongly disagree” was assigned a score of “1,” “disagree” was assigned a score of “2,” “undecided” was assigned a score of “3,” “agree” was assigned a score of “4,” and “strongly agree” was assigned a score of “5.” The mean and standard deviation was measured from the collected post-survey data. The data was formulated and displayed as bar charts. Free text responses were summarized.

The scientific rigor of reliability, validity, and generalizability were maintained throughout the QI project’s development and implementation. The educational material was created based on evidence and reviewed for accuracy by content experts. The in-service presentation conveyed generalizable information to other nurses in various locations and at different hospice points of care.

RESULTS

The post-survey opened on Qualtrics on July 8, 2021, and closed on July 15, 2021, at midnight. The clinical education coordinator at Sage Hospice invited the hospice nurses to participate in the in-service and to complete the subsequent survey via email provided by the PI. The invitation email included the Qualtrics survey link. The first email was sent one week before the in-service on July 1, 2021, and the second email (reminder email) was sent on the third day after the open of the survey, on July 10, 2021.

Sample Size and Demographics

A total of 21 hospice nurses participated in the in-service and completed the post-survey. A high response rate (52.5%) was achieved as 21 out of the 40 invited nurses participated. Of the final sample size of 21 nurses, 38.1% (n=8) had 0-2 years of hospice experience, 23.8% (n=5)

had 3-5 years of hospice experience, and 38.1% (n=8) had more than five years of hospice experience (Table 1).

Table 1

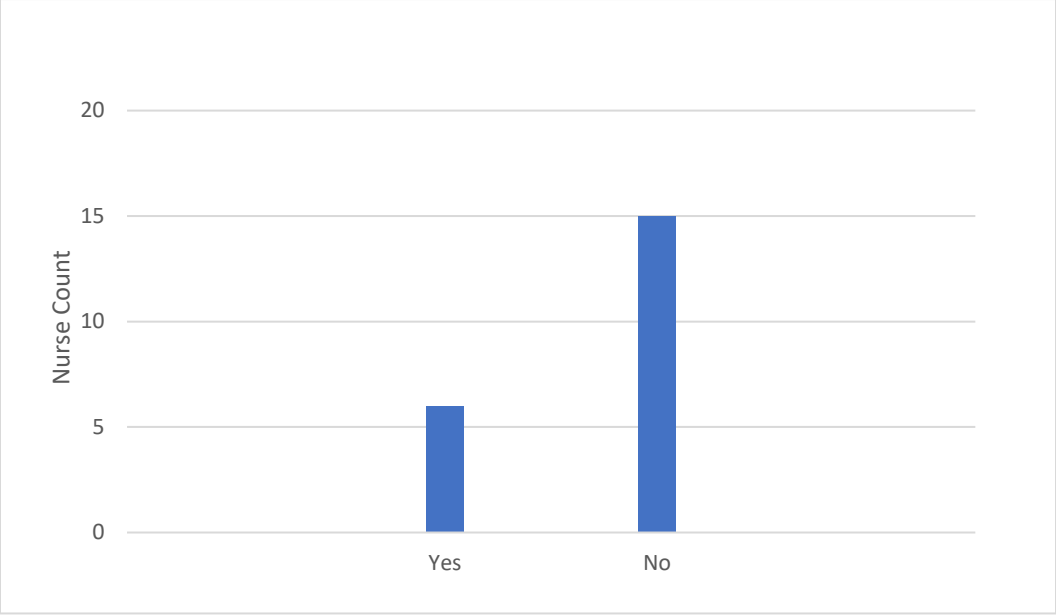
Years of Hospice Experience

#	Years	N	%
1	0-2 years	8	38.10%
2	3-5 years	5	23.81%
3	More than 5 years	8	38.10%
	Total	21	100%

Of the 24 participants, 28.57% (n=6) reported having had previous formal education or training about utilizing therapeutic communication in hospice care, and 71.4% (n=15) reported they did not (Figure 4).

Figure 4

Prior Education Question Two



Outcomes

The following five outcomes were measured to evaluate the achievement of this QI project's purpose. Upon participating in the educational in-service, hospice nurses will:

1. Be able to identify three potential patient care benefits brought about via effective therapeutic communication.
2. Be able to identify three potential patient care failures brought about via the failure to implement effective therapeutic communication.
3. Be able to identify one verbal statement aimed at articulating empathy.
4. Be able to identify one fundamental skill aimed at enhancing therapeutic communication during patient encounters.
5. Be able to report increased knowledge, confidence, and intent to use learned therapeutic communication strategies during future patient encounters.

Of the 21 participants, 100% (n=21) were able to identify "Decreased patient suffering," "Decreased family suffering," and "Improved overall hospice quality of care," as potential patient care benefits which are brought about via the implementation of effective therapeutic communication. 28.6% (n=6) also selected the incorrect choice "Decreased hospice nurse workload" (Table 2).

Table 2

Patient Care Benefits

#	Answer	N	%
1	Decreased patient suffering	21	100%
2	Decrease family suffering	21	100%
3	Improved overall hospice quality of care	21	100%
4	Decreased hospice nurse workload	6	28.6%

Of the total participants (n=21), 95.2% (n=20) selected the correct potential patient care shortcomings which are brought about via the failure to utilize effective therapeutic communication, and 4.8% (n=1) selected the wrong choice (Table 3).

Table 3

Patient Care Failures

#	Answer	N	%
1	Increased feeling of guilt, loneliness, and hopelessness for patients and their families	20	95.2%
2	Increased hospice legal liability in the event of service failure	20	95.2%
3	Decrease incidence of hospice benefit revocation and hospitalization	1	4.8%
4	Decreased hospice CAHPS scores for the measure “communication with family”	20	95.2%

Next, on the multiple-choice question in which participants were asked to identify one verbal statement aimed at articulating empathy, 100% of participants (n=21) selected the correct statement (Table 4).

Table 4

Verbal Statement for Empathy

#	Answer	N	%
1	“I will do my best to make sure you have what you need”	21	100.00%
2	“Being on hospice means you have six months or less to live”	0	0.00%
3	"Dying is a natural part of life, you should not be sad about it”	0	0.00%
4	“I am running late today so I can only stay with you for a few minutes”	0	0.00%

Almost all (95.2%) of participants correctly identified one fundamental skill aimed at enhancing therapeutic communication during patient encounters (n=20) (Table 5).

Table 5

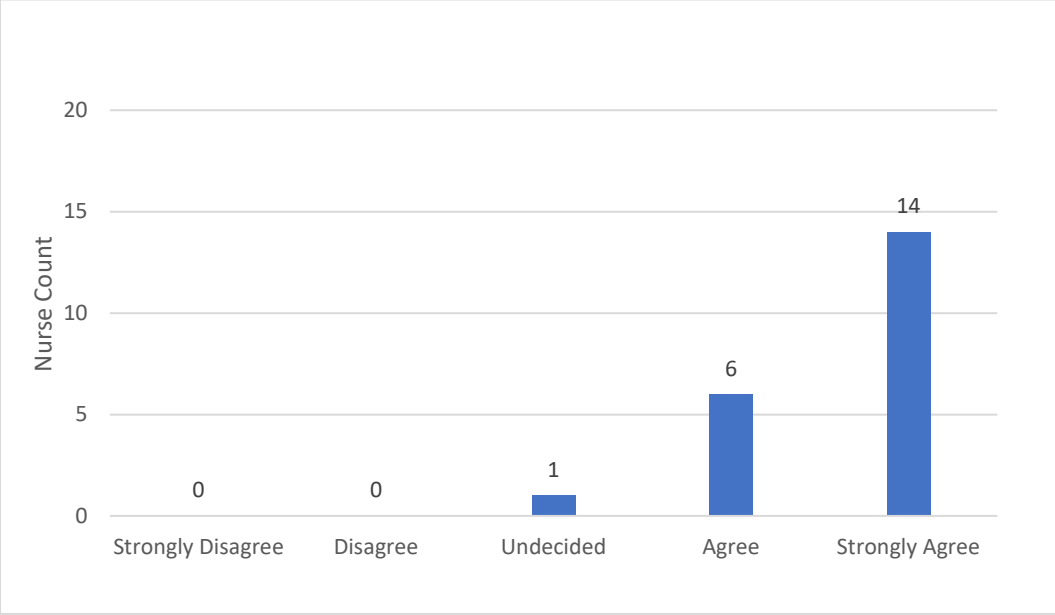
One Fundamental Skill

#	Answer	N	%
1	Aligning yourself with the patient while acknowledging the reality of the situation.	20	95.24%
2	Trying to complete a hospice visit quickly to minimize the time you are intruding in the patient's home	0	0.00%
3	Telling patients and families a "white lie" when needed to comfort them.	1	4.76%
4	Avoiding difficult conversations entirely to minimize suffering.	0	0.00%

As a result of participating in the in-service, 66.7% of participants (n=14) "strongly agree" with the statement "I am more knowledgeable regarding the use of therapeutic communication in hospice care," 28.6% (n=6) "agree" with the statement, and 4.8% (n=1) were "undecided" (Figure 5).

Figure 5

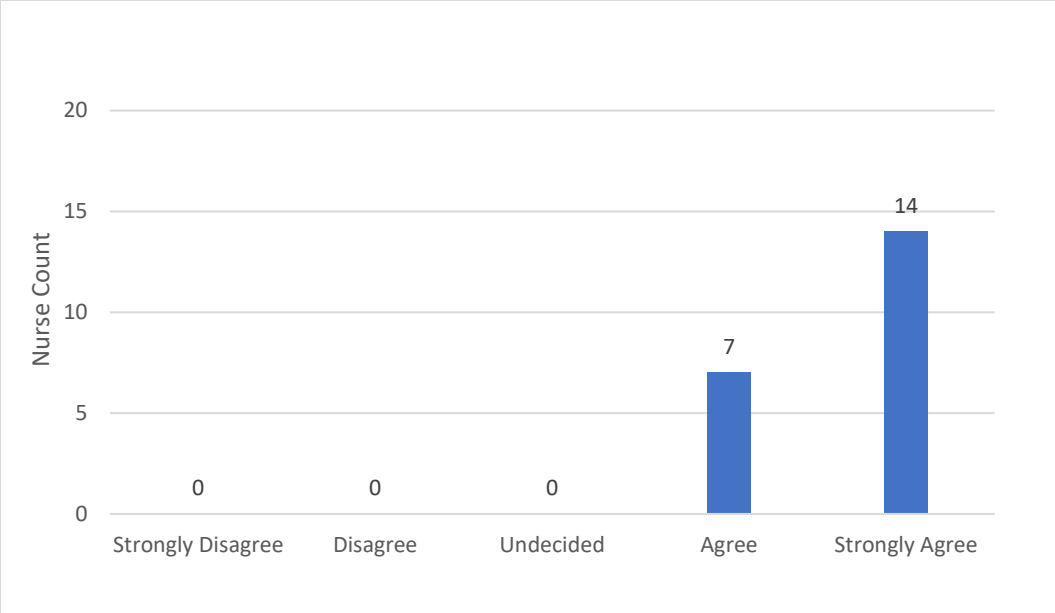
Improved Knowledge for Therapeutic Communication



66.7% of participants (n=14) “strongly agree” and 33.3% (n=7) “agree” with the statement “As a result of this presentation, I feel more confident to use therapeutic communication strategies in my future patient encounters” (Figure 6).

Figure 6

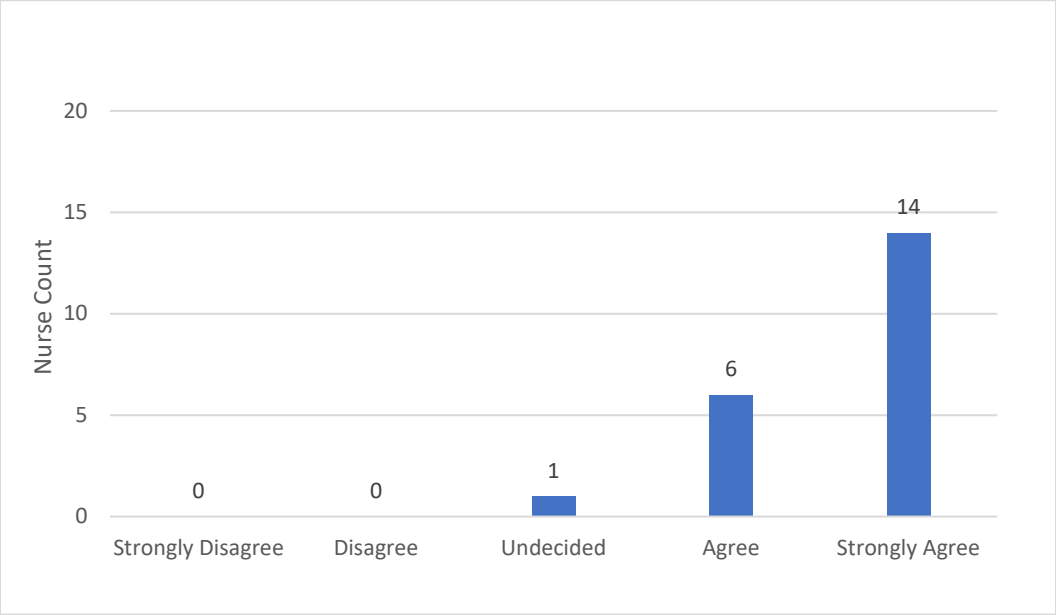
Increased Confidence in Utilizing Therapeutic Communication



As a result of participating in the in-service, 66.7% (n=14) “strongly agree” with the statement “I intend to use the information I learned at the in-service presentation during my future patient encounters.” And 28.6% of participants (n=6) “agree” with that statement, and 4.8% (n=1) remained “undecided” (Figure 7).

Figure 7

Intent to Utilize Therapeutic Communication



Presentation Format

The participants were asked questions regarding the presentation's format. All of the participants (n=21) either "agree" or "strongly agree" with the statement, "The presentation contained the right amount of information (i.e., not too much, and not too little)" (Table 6).

Table 6

First Presentation Format

#	Answer	N	%
1	Strongly Disagree	0	0.00%
2	Disagree	0	0.00%
3	Undecided	0	0.00%
4	Agree	5	23.81%
5	Strongly Agree	16	76.19%
	Total	21	100%

In addition, all participants (n=21) either “strongly agree” or “agree” with the statement “The presentation length of time was appropriate” (Table 7).

Table 7

Second Presentation Format

#	Answer	N	%
1	Strongly Disagree	0	0.00%
2	Disagree	0	0.00%
3	Undecided	0	0.00%
4	Agree	4	20.00%
5	Strongly Agree	16	80.00%
	Total	20	100%

Lastly, 95.2% of participants (n=20) “agree” with the statement “I enjoyed the presentation format.” And 4.8% (n=1) were “undecided” (Table 8).

Table 8

Third Presentation Format

#	Answer	Count	%
1	Strongly Disagree	0	0.00%
2	Disagree	0	0.00%
3	Undecided	1	4.76%
4	Agree	4	19.05%
5	Strongly Agree	16	76.19%
	Total	21	100%

Only 9.5% of participants (n=2) utilized the free text box provided, and both participants wrote “Great Job” in the free text box.

DISCUSSION

Summary

Caring for a loved one at end-of-life is often an exhausting task for both patients and their caregivers. Challenges patients experience at end-of-life include but are not limited to feelings of guilt, hopelessness, being a burden, and fear (Totman et al., 2015). Caregivers, on the other hand, can face difficulties such as lack of medical knowledge, depression, anxiety, and an overwhelming feeling of "you only have one chance to get it right" (Lavalley, 2018). As exemplified in the body of evidence, both patient and caregiver burdens can be alleviated by the effective utilization of therapeutic communication strategies. Considering this intervention's implications, hospice nurses must become proficient therapeutic communicators (Nyatanga, 2015). The purpose of this QI project was to equip Sage Hospice nurses with evidence-based therapeutic communication strategies that will inform their interactions and enable them to have effective communication encounters with patients and their caregivers. In addition, it was intended that the in-service presentation would increase nurse's knowledge, confidence, and intent to use learned therapeutic communication strategies during future patient encounters. The findings of this QI project closely correlate with the synthesis of evidence as it was found in both that providing teaching regarding therapeutic communication strategies to hospice nurses increases their confidence and satisfaction when engaging in end-of-life communication with patients and their families (Fuoto & Turner, 2019; Goldsmith et al., 2020; Hagerty et al., 2017; Sallnow et al., 2016). In addition, hospice nurses trained in utilizing therapeutic communication strategies can empower their patients and respective caregivers to be engaged in end-of-life

decision making which reduces caregiver burden and patient guilt (Ahluwalia et al., 2018; Fuoto & Turner, 2019; Goldsmith et al., 2020; Sulmasy et al., 2017).

Interpretation

Knowledge and Experience

This QI project confirms that the in-service education was successful in increasing Sage Hospice nurses' knowledge regarding the effective use of therapeutic communication strategies in hospice care. Twenty-one (52.5%) Sage Hospice nurses participated in this project. Questions 1 and 2 were designed to ascertain the amount of hospice experience and previous exposure to hospice-focused therapeutic communication education. Among participants, years of hospice experience were well represented with two equal proportions (n=8) of nurses reporting 0-2 years of experience, and the same proportion reporting more than five years. The remaining participants (n=5) reported having 3-5 years of experience. Among all the groups, most nurses reported they had never received formal education or training about utilizing therapeutic communication in hospice care. As a result of participating in the educational in-service, an overwhelming majority of participants reported an increase in knowledge regarding the use of therapeutic communication in hospice care.

Confidence

An objective of this QI project was to equip hospice nurses with evidence-based knowledge regarding therapeutic communication. During the educational in-service, hospice nurses received education on expected patient care benefits of utilizing this intervention, potential adverse consequences of failing to utilize it, as well as specific strategies they can immediately implement in their future patient encounters. This education was aimed at

increasing hospice nurse's confidence levels with implementing therapeutic communication daily. As part of the post-survey, a direct question was asked to participants regarding their gain in confidence regarding the use of therapeutic communication strategies in hospice care. Among participants, all of them either "agree" or "strongly agree" with the statement "As a result of this presentation, I feel more confident to use therapeutic communication strategies in my future patient encounters." This encouraging result indicates that the QI project was effective in reaching its goal of increasing hospice nurse's confidence.

Intent

The third, and arguably most important component of the QI project's objective, was ensuring participant's intent to utilize the learned therapeutic communication strategies during their future patient encounters. A significant effort was made during the in-service education to not only focus on the theoretical aspects of therapeutic communication, but also on presenting practical tips and principles that hospice nurses could start utilizing immediately during their patient encounters. Nearly half of the in-service time was dedicated to this later purpose in the form of short videos and specific communication scripts. This was effective, as all participants but one reported that they intend to use the information learned during the in-service presentation in their future patient encounters.

The theoretical framework which guided the implementation of this QI project was Lewin's change theory (LCT). This theory emphasizes the importance of approaching organizational change systematically and methodically (Lewin, 1951). Utilizing LCT as a frame, the in-service presentation focused on first *unfreezing* the current beliefs and practices of hospice nurses regarding the use of therapeutic communication, then *changing* those beliefs and practices

to mirror current evidence-based practices. Lastly, the *re-freezing* phase is a continual process in which successful and rewarding future patient encounters will solidify the new practices until they become the de facto status quo.

Strengths

This QI project successfully utilized the Microsoft® Teams platform to host an educational in-service focused on showcasing therapeutic communication in hospice care and increase its utilization. Technological issues were observed in the process of broadcasting the in-service media components which included online videos, a slide show, and the PI's live voice and video presentation. This PI's previous experience in the information technology field, permitted promptly being able to address all the technological issues before the scheduled in-service time. After the in-service, a vast majority of participants reported having enjoyed the presentation format.

Implications

Practice

Providing hospice nurses with effective therapeutic communication education increases their confidence and satisfaction when engaging in end-of-life communication with patients and their families. The presentation material utilized during the in-service presentation including slideshow and videos could be a supplemental resource distributed to other hospice providers. Other hospice providers could use this material to educate and train their hospice nurses. The favorable outcomes of this QI project should prompt hospice providers to further research the implementation of a therapeutic communication curriculum to promote the advancement of hospice nurse's education and practice.

Education

This QI project included both theoretical and practical educational elements regarding the utilization of therapeutic communication strategies in end-of-life care. The QI project demonstrated that in-service therapeutic communication education is valuable, and it increases hospice nurses' knowledge, confidence, and intent to utilize the learned material in their day-to-day patient encounter. This project supports the current National Consensus Project Clinical Practice Guidelines for Quality Palliative Care regarding implementing therapeutic communication via the provision of empathetic listening and delivery of education in a transparent yet hope-fostering way (Ahluwalia et al., 2018).

Research and Policy

Future research may include integrating therapeutic communication in-service training for palliative care providers in addition to hospice care providers to determine if the education is effective at increasing knowledge among palliative care providers who work with chronically ill patients as opposed to only with the end-of-life patient population. If the in-service training is found effective in palliative care, it could then be incorporated into routine training for palliative care nurses in addition to hospice nurses. Future local and national (at the Medicare level) policies should be enacted which emphasize educational interventions such as the therapeutic communication in-service presentation, because of its positive impact on end-of-life quality of care delivery and increase in nurse work satisfaction.

Limitations

The limitations of this study included participant sample size and the effects of the COVID-19 pandemic. The setting for the in-service presentation was originally to take place

inside Sage hospice's conference room in an in-person format. However, due to the current COVID-19 pandemic, this was not possible. As a result of this, the participant sample size was potentially decreased. In addition, essential components of an in-service presentation such as maintaining good eye contact and engaging the audience at every step of the presentation were hindered. The PI presented the material in front of a camera and unfortunately was unable to see the faces of the hospice nurses participating, let alone maintain good eye contact or actively engage with them during the presentation. In addition, because of the extra technological requirements associated with delivering the in-service in a virtual synchronous format, the PI was unable to place all his focus on the content of the in-service but instead had to divide his attention to address technological requirements, without which the presentation content would have not been visible or audible.

DNP Essentials Addressed

According to the American Association of Colleges of Nursing (AACN) Doctor of Nursing Practice (DNP) essentials are foundational building stones by which advanced practice nurses build and maintain knowledge and component practice (AACN, 2006). This QI project incorporates three DNP essentials.

DNP Essential III – Clinical Scholarship and Analytical Methods for Evidence-Based Practice

DNP Essential III is addressed in this project as a comprehensive review of evidence-based literature was undertaken to support the project's purpose. This QI project employed the utilization of literature and analytical processes to create the educational in-service presentation and improve current hospice practice and patient outcomes.

DNP Essential IV – Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care

DNP Essential IV was also incorporated as the PI successfully utilized the Microsoft® Teams platform to deliver effective and evidence-based therapeutic communication education which increased hospice nurses' knowledge, confidence, and intent to utilize the learned material. These achievements are small but significant steps in the improvement and transformation of healthcare.

DNP Essential VII – Clinical Prevention and Population Health

Lastly, DNP Essential VII was successfully implemented. Among other objectives, this DNP essential emphasizes the importance of clinical prevention. Aligning with this goal, the QI project focused on creating an educational initiative that will help hospice nurses address the end-of-life patient populations' diverse challenges. The knowledge and confidence gained by the hospice nurses who participated in the in-service will enable them to anticipate and prevent an array of adverse outcomes which could otherwise manifest as a direct result of failing to communicate therapeutically with hospice patients and their families.

Conclusions

In-service educational presentations regarding the use of therapeutic communication strategies in hospice care are an effective way to increase hospice nurse's knowledge, confidence, and intent to use the learned information in their day-to-day patient encounters. Due to the unforeseen ramifications of the COVID-19 pandemic, the in-service presentation was changed from a face-to-face to a virtual synchronous format using the Microsoft® Teams platform. This change likely produced a decrease in participant engagement. Although a smaller

than expected sample size was observed, most participants reported an increase in knowledge, confidence, and intent to use the learned information in their day-to-day patient encounters because of participating in the in-service. It can therefore be concluded that an in-service presentation is an appropriate and effective method to deliver therapeutic communication education to hospice nurses.

Plan for Sustainability

To ensure this project's sustainability, the content must be reviewed frequently and systematically as indicated by the PDSA cycle. In doing so, changes can be made to enhance implementation and participant response. Suggested future improvements include updating the educational content with the latest evidence-based knowledge and developing a plan for the face-to-face delivery of the in-service as soon as regulatory guidelines permit. In addition, printed pamphlets with therapeutic communication tips given to in-service participants may also prove valuable.

Plan for Dissemination

An executive summary letter including the project implementation process, results, and key findings was delivered to the leadership team at Sage hospice. A final defense of the project and key findings with the project's committee members was conducted. Future dissemination of this QI project may include a summary of the findings as well as perpetual access to the presentation's educational content given to all Sage hospice employees and stakeholders upon the company's leadership team approval.

Funding

No funding was received for this project.

APPENDIX A:

SAGE HOSPICE SITE APPROVAL / THE UNIVERSITY OF ARIZONA INSTITUTIONAL REVIEW BOARD AUTHORIZATION LETTER

Sage Hospice & Palliative Care

May 12th, 2021
University of Arizona Institutional Review Board
c/o Office of Human Subjects
1618 E Helen St
Tucson, AZ 85721

Please note that Mr. David Lup, UA Doctor of Nursing Practice student, has permission of Sage Hospice to conduct a Quality Improvement project entitled "IMPLEMENTING THERAPEUTIC COMMUNICATION STRATEGIES IN HOSPICE CARE AS A PALLIATIVE MEASURE."

Mr. David Lup will conduct an educational presentation on the use of therapeutic communication in hospice care for Sage Hospice nurses involved in direct patient care. He will recruit participants via an invitation email sent to Sage Hospice nurses. The educational presentation will be conducted during a monthly in-service meeting and focus on the implementation of therapeutic communication strategies in hospice care. A disclosure document, including description of the project, what participants will be asked to do, and the time involved will be provided for the participants within the invitation email. After participating in the in-service educational presentation, participants will have the opportunity to complete an anonymous survey to assess knowledge, confidence, and intent to use the presented strategies during future patient encounters. Mr. David Lup's activities will be completed by December 1st, 2021.

Mr. David Lup has agreed to provide my office a copy of the University of Arizona IRB review document before he recruits participants. He will also present aggregate results to the Clinical Education Coordinator at Sage Hospice via an online Zoom meeting.

If there are any questions, please contact my office.

Signed,

Vilma Blum RN, BSN
Clinical Educational Coordinator
Sage Hospice and Palliative Care
5111 North Scottsdale Rd #204
Scottsdale, AZ 85250
480-777-5117

THE UNIVERSITY OF ARIZONA
Research, Discovery & Innovation

Human Subjects Protection Program

1618 E. Helen St.
P.O.Box 245137
Tucson, AZ 85724-5137
Tel: (520) 626-6721
http://rgw.arizona.edu/compliance/home

Date:	June 25, 2021
Principal Investigator:	David Emanuel Lup
Protocol Number:	2106950691
Protocol Title:	IMPLEMENTING THERAPEUTIC COMMUNICATION STRATEGIES IN HOSPICE CARE AS A PALLIATIVE MEASURE
Determination:	Human Subjects Review not Required

Documents Reviewed Concurrently:

Data Collection Tools: *Post Survey.docx*
HSPP Forms/Correspondence: *2019 form - Updated IRB application.pdf*
HSPP Forms/Correspondence: *Advisor Confirmation Email.pdf*
Informed Consent/PHI Forms: *Disclosure Form.docx*
Other: *Presentation Outline.docx*
Other Approvals and Authorizations: *Site Authorization Letter.docx*
Recruitment Material: *Recruitment and Reminder Email.docx*

Regulatory Determinations/Comments:

- Not Research as defined by 45 CFR 46.102(l): As presented, the activities described above do not meet the definition of research cited in the regulations issued by U.S. Department of Health and Human Services which state that "Research means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities. For purposes of this part, the following activities are deemed not to be research."

The project listed above does not require oversight by the University of Arizona.

If the nature of the project changes, submit a new determination form to the Human Subjects Protection Program (HSPP) for reassessment. Changes include addition of research with children, specimen collection, participant observation, prospective collection of data when the study was previously retrospective in nature, and broadening the scope or nature of the study activity. Please contact the HSPP to consult on whether the proposed changes need further review.

The University of Arizona maintains a Federalwide Assurance with the Office for Human Research Protections (FWA #00004218).

APPENDIX B:

CONSENT DOCUMENT (DISCLOSURE FORM)

IMPLEMENTING THERAPEUTIC COMMUNICATION STRATEGIES IN HOSPICE CARE AS A PALLIATIVE MEASURE

Principal Investigator: David Lup, BSN, RN, DNP Candidate

The purpose of this Quality Improvement project is to equip Sage hospice nurses with evidence-based therapeutic communication strategies that will inform their interactions and enable them to have effective communication encounters with patients and their caregivers through an in-service educational presentation. The goal is to increase knowledge, confidence, and intent to use the presented information as a palliative intervention informing their future patient encounters in the hospice setting.

If you choose to take part in this project, you will be asked to:

1) Participate in the in-service presentation.
2) Complete a short, anonymous post-survey after the in-service presentation.

It will take no more than 30 minutes to participate in the in-service educational presentation and complete the post survey. There are no foreseeable risks associated with participating. Benefits of participation may include increased knowledge, confidence, and intent to use the presented information as a palliative intervention informing your future patient encounters. There are minimal or no risks to participation.

If you choose to participate in the project, participation is voluntary, and you may withdraw at any time. A list of participants will not be shared with Sage Hospice.

Your survey responses will be anonymous. No identifiable information will be collected. Only aggregate findings will be shared.

The information that you provide in the study will be handled confidentially. However, there may be circumstances where this information must be released or shared as required by law. The University of Arizona Institutional Review Board may review the records for monitoring purposes.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the project team, you may contact the Human Subjects Protection Program at 520-626-6721 or online at http://rgw.arizona.edu/compliance/human-subjects-protection-program.

Participation in the presentation and/or survey signifies consent.

For questions, concerns, or complaints about the project, you may call:

David Lup, BSN, RN
DNP-FNP Candidate
dlup@email.arizona.edu

APPENDIX C:

RECRUITMENT MATERIAL (RECRUITMENT EMAIL/REMINDER EMAIL/ “FORWARD” OF INVITE EMAIL)

THE UNIVERSITY OF ARIZONA

Recruitment Email

My name is David Lup and I am a Doctor of Nursing Practice (DNP) student at the University of Arizona. For my doctoral project, I am conducting a quality improvement project about Implementing Therapeutic Communication strategies in hospice care as a palliative measure. This is an opportunity to learn about communicating more effectively and empathetically with your patients and their families.

If you choose to participate, you will be asked to participate in a short educational presentation during our next monthly in-service meeting and complete a post-survey questionnaire. It will take approximately 30 minutes to participate in the in-service and complete the post-survey. The survey is completely confidential. This project has been approved by Sage Hospice and reviewed by the University of Arizona Institution Review Board

Please see the attached Disclosure for an outline of what to expect, risks and benefits.

Link for post-presentation evaluation survey:
https://uarizona.co1.qualtrics.com/jfe/form/SV_djy6OZUYDAvvdvo

Thank you for your consideration to participate. For questions or concerns, please contact David Lup, BSN, RN at dlup@email.arizona.edu

Reminder Email

If you attended the monthly in-service presentation entitled IMPLEMENTING THERAPEUTIC COMMUNICATION STRATEGIES IN HOSPICE CARE AS A PALLIATIVE MEASURE, thank you for participating. If you have not already completed the post-presentation evaluation survey, there is still time. Link:
https://uarizona.co1.qualtrics.com/jfe/form/SV_djy6OZUYDAvvdvo
Completion is voluntary and anonymous.

Thank you for your consideration to participate. For questions or concerns, please contact David Lup, BSN, RN at dlup@email.arizona.edu

"Forward" of Invite Email

My name is David Lup and I am a Doctor of Nursing Practice (DNP) student at the University of Arizona. For my doctoral project, I am conducting a quality improvement project about Implementing Therapeutic Communication strategies in hospice care as a palliative measure. This is an opportunity to learn about communicating more effectively and empathetically with your patients and their families.

If you choose to participate, you will be asked to participate in a short educational presentation during our next monthly in-service meeting on July 8, 2021 and complete a post-survey questionnaire. It will take approximately 30 minutes to participate in the in-service and complete the post-survey. The survey is completely confidential. This project has been approved by Sage Hospice and reviewed by the University of Arizona Institution Review Board

Please see the attached Disclosure for an outline of what to expect, including risks and benefits.

Link for post-presentation evaluation survey:
https://uarizona.co1.qualtrics.com/jfe/form/SV_djy6OZUYDAvvdvo
.
Thank you for your consideration to participate. For questions or concerns, please contact David Lup, BSN, RN at dlup@email.arizona.edu

APPENDIX D:

EVALUATION INSTRUMENTS (HOSPICE CARE POST-SURVEY)

Utilizing Therapeutic Communication in Hospice Care Post-Survey:

Demographic Information:

Fill in the blank accordingly or circle the best answer for the questions below.

I have _____ years of experience as a hospice nurse.

a) 0-2 years b) 3-5 years c) More than 5 years

Prior to this presentation had you ever received formal education or training about utilizing therapeutic communication in hospice care (e.g., coursework, CE, in-service)?

b) Yes a) No

1) Potential patient care benefits brought about via the effective use of therapeutic communication in hospice care include: (check all that apply)
    a. Decreased patient suffering
    b. Decrease family suffering
    c. Improved overall hospice quality of care
    d. Decreased hospice nurse workload

2) Potential patient care failures brought about via the failure to utilize effective therapeutic communication include: (check all that apply)
    a. Increased feeling of guilt, loneliness, and hopelessness for patients and their families
    b. Increased hospice legal liability in the event of service failure
    c. Decrease incidence of hospice benefit revocation and hospitalization
    d. Decreased hospice CAHPS scores for the measure “communication with family”

3) One verbal statement aimed at articulating empathy is:
    a. “I will do my best to make sure you have what you need”
    b. “Being on hospice means you have six months or less to live”
    c. “Dying is a natural part of life, you should not be sad about it”
    d. “I am running late today so I can only stay with you for a few minutes”

4) One fundamental skill aimed at enhancing therapeutic communication during patient encounters is:
    a. Aligning yourself with the patient while acknowledging the reality of the situation.
    b. Trying to complete a hospice visit quickly to minimize the time you are intruding in the patient’s home
    c. Telling patients and families a “white lie” when needed in order to comfort them.

d. Avoiding difficult conversations entirely to minimize suffering.

Perceived knowledge

1) As a result of this presentation, I am more knowledgeable regarding the use of therapeutic communication in hospice care.

Strongly Disagree Disagree Undecided Agree Strongly Agree

2) As a result of this presentation, I feel more confident to use therapeutic communication strategies in my future patient encounters.

Strongly Disagree Disagree Undecided Agree Strongly Agree

3) I intend to use the information I learned at the in-service presentation during my future patient encounters

Strongly Disagree Disagree Undecided Agree Strongly Agree

Presentation format

1) The presentation contained the right amount of information, (i.e., not too much, and not too little)

Strongly Disagree Disagree Undecided Agree Strongly Agree

2) The presentation length of time was appropriate

Strongly Disagree Disagree Undecided Agree Strongly Agree

3) I enjoyed the presentation format

Strongly Disagree Disagree Undecided Agree Strongly Agree

Additional comments (free text box):

APPENDIX E:

PARTICIPANT MATERIAL (PRESENTATION OUTLINE)

Presentation Outline

- What is therapeutic communication?
    - Therapeutic communication is a collection of techniques that prioritize the physical, mental, and emotional well-being of patients. Nurses provide patients with support and information while maintaining a level of professional distance and objectivity (Sharma & Gupta, 2021).
- How does therapeutic communication positively impact patient care in hospice?
    - Effective therapeutic communication is essential for promoting better decision-making in end-of-life care and relieving caregiver burden (Walczak et al., 2017).
    - Family and patient preparedness regarding end-of-life anticipation and preparation reduce the burden of care and grief intensity (Nielsen et al., 2017; Roen et al., 2018).
    - Intense caregiver burden and patient feelings of guilt can be addressed by utilizing effective therapeutic communication (Ghesquiere et al., 2019; Lavalley, 2018; Nielsen et al., 2017; Roen et al., 2019; Sulmasy et al., 2017).
    - Studies suggest that building rapport and trust with patients and their caregivers through the implementation of therapeutic communication strategies leads to reduced caregiver burden, depression, anxiety, and guilt for caregivers and patients (Ahluwalia et al., 2018; Fuoto & Turner, 2019; Goldsmith et al., 2020; Sulmasy et al., 2017).
    - Delivering end-of-life hospice education with confidence and empathy helps frame hospice care in a positive light and increases patients' willingness to utilize it (Fridman et al., 2018).
    - Studies show that patients who are informed of their prognosis and engaged in shared decision-making regarding their treatment choices are more likely to request quality of life care focused on symptom management and hospice services (Patel et al., 2016; Roen et al., 2018).
    - Teaching hospice nurses' therapeutic communication strategies increases nurse confidence and satisfaction when engaging in end-of-life communication (Fuoto & Turner, 2019; Goldsmith et al., 2020; Hagerty et al., 2017; Sallnow et al., 2016).
- What are some potential consequences of failure to implement therapeutic communication in hospice?
    - When hospice patients and their caregivers do not have an adequate understanding of the resources available to them during end-of-life, their suffering can be exacerbated (Nielsen et al., 2017; Walczak et al., 2017).
    - Psychological suffering and distress in hospice patients and their caregivers are often of extreme intensity (Ghesquiere et al., 2019; Nielsen et al., 2017; Sulmasy et al., 2017; Walczak et al., 2017). Research shows that even physical complications such as wounds can lead patients and their caregivers into social isolation and depression (Cornish, 2019; Lavalley, 2018).

- When hospice nurses fail to acknowledge and address non-physical areas of suffering, caregiver and patient grief is intensified, and end-of-life care quality becomes less than optimal (Nielsen et al., 2017; Walczak et al., 2017).
- Failing to deliver end-of-life hospice education with confidence and empathy leads to decreased patients' willingness to utilize hospice care (Fridman et al., 2018).

- Short, embedded videos
  - Rapport Savings account: https://www.vitaltalk.org/rapport-savings-account/
  - Approaching uncertainty: https://www.vitaltalk.org/approaching-uncertainty/
  - When patients say "I'm a fighter": https://www.vitaltalk.org/when-patients-say-im-a-fighter/
  - Radical acceptance: https://www.vitaltalk.org/radical-acceptance/
  - Dealing with angry patients: https://www.vitaltalk.org/our-weekly-tip-rolling/
- What are some therapeutic communication strategies I can use during my patient encounters?
  - Nurse statements for articulating empathy (VitalTalk, 2020)
    - Naming: "It sounds like you are frustrated"
      - Notes: In general, it may turn down the intensity a notch when you name the emotion.
    - Understanding "This helps me understand what you are thinking"
      - Notes: Think of this as another kind of acknowledgment but stop short of suggesting you understand everything (you don't)
    - Respecting "I can see you have really been trying to follow our instructions"
      - Notes: Remember that praise also fits in here e.g. "I think you have done a great job with this"
    - Supporting "I will do my best to make sure you have what you need"
      - Notes: Making this kind of commitment is a powerful statement
    - Exploring "Could you say more about what you mean when you say that…"
      - Notes: Asking a focused question prevents this from seeming too obvious
  - Three fundamental skills (VitalTalk, 2020)
    - Tell me more "Tell me more about…"
      - Use when you are not sure what someone is talking about (rather than jump to an assumption).
    - Ask-tell-ask "What do you think about…" "Here's what the tests show" "Does that make sense…?"
      - Related to Assess-Knowledge- Respond in SPIKES. Think of this as one unit of information transfer
    - "I wish" statements "I wish I could say that the chemo always works"
      - Enables you to align with the patient while acknowledging the reality of the situation

APPENDIX F:

PROJECT TIMELINE

Completion Date	Planning	Pre-Implementation	Implementation	Evaluation
May 1, 2021	Submit proposal to project chair			
May 5, 2021 – May 10, 2021		Solidify site. Obtain authorization letter.		
May 20, 2021		Obtain proposal approval from chair		
May 25, 2021		Schedule Proposal Defense Presentation with committee members		
June 12 -19, 2021		Proposal Defense Presentation		
June 25, 2021	Make committee revisions to proposal			
June 27, 2021	Submit to College of Nursing Research Committee			
July 12, 2021		Obtain IRB approval		
July 21-28, 2021			IMPLEMENT Collect Data	
August 1, 2021 – September 1, 2021				Analyze Data
October 9, 2021 – November 1, 2021				Final Defense Presentation of Project Results Executive Summary provided to Hospice owners

APPENDIX G:

LITERATURE REVIEW GRID

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
Candy et al. (2011)	Hospice care delivered at home, in nursing homes and in dedicated hospice facilities: a systematic review of quantitative and qualitative evidence	A systematic review of quantitative and qualitative evidence	Eighteen comparative evaluations and four thematic papers were identified. Quantitative evidence, mostly of limited quality in design, showed that hospice care at home reduced general health care use and increased family and patient satisfaction with care. Main themes in the qualitative literature revealed that home hospice services support families to sustain patient care at home and hospice day care services generate for the patient a renewed sense of meaning and purpose.	Evidence why home-based hospice care is better than in facility.
Choi et al. (2013)	Factors that affect quality of dying and death in terminal cancer patients on inpatient palliative care units: perspectives of bereaved family caregivers	Journal article	The perception of appropriate timing of referral, use of a community based PCU, and higher quality of cancer care as assessed by the Care Evaluation Scale were associated with good dying and death in all domains of the Good Death Inventory.	The good quality of end-of-life care in a PCU improves the quality of dying in terminally ill cancer patients. The data have the potential to guide the development of interventions aimed at achieving a good quality of dying for patients with terminal cancer.
Clayton et al. (2007)	Randomized controlled trial of a prompt list to help advanced cancer patients and their caregivers to ask questions about	Randomized controlled trial	A total of 174 patients participated (92 QPL, 82 control). Compared with controls, QPL patients and caregivers asked twice as many questions (for patients, ratio, 2.3; 95% CI, 1.7 to 3.2; $P < .0001$), and patients discussed 23% more issues covered by the QPL	Providing a QPL and physician endorsement of its use assists terminally ill cancer patients and their caregivers to ask questions and promotes discussion about prognosis and end-of-life issues, without

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
	prognosis and end-of-life care		(95% CI, 11% to 37%; P < .0001). QPL patients asked more prognostic questions (ratio, 2.3; 95% CI, 1.3 to 4.0; P = .004) and discussed more prognostic (ratio, 1.43; 95% CI, 1.1 to 1.8, P = .003) and end-of-life issues (30% v 10%; P = .001). Fewer QPL patients had unmet information needs about the future (21 = 4.14; P = .04), which was the area of greatest unmet information need. QPL consultations (average, 38 minutes) were longer (P = .002) than controls (average, 31 minutes). No differences between groups were observed in anxiety or patient/physician satisfaction.	creating patient anxiety or impairing satisfaction.
Clayton et al. (2008)	Sustaining hope when communicating with terminally ill patients and their families: a systematic review	Systematic review	This review suggests that the issues surrounding hope in this context are complex. Despite the lack of unanimity among researchers regarding the definition of hope, findings suggest that balancing hope with honesty is an important skill for health professionals (HPs).	Many patients seem to be able to maintain a sense of hope despite acknowledging the terminal nature of their illness. Patients and caregivers mostly preferred honest and accurate information, provided with empathy and understanding. Many different sources of hope were identified in this context in broad aspects of life, not just the medical situation. HPs need to recognize this spectrum of hope and appreciate that patients may simultaneously hope for 'cure' while

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
				acknowledging the terminal nature of their illness. HPs may help patients to cope with their terminal prognosis by exploring and fostering realistic forms of hope that are meaningful for the particular patient and their family.
Clayton et al. (2019)	Hospice nurse identification of comfortable and difficult discussion topics: associations among self-perceived communication effectiveness, nursing stress, life events, and burnout	Survey analysis	Nurses were generally experienced (median 9 years, range <1–46 as a registered nurse; median 3 years, range <1–23 as a hospice nurse), reporting overall Effective/Very Effective communication skills (85.6%); 70% desired more communication training. As nursing stress increased perceived overall communication effectiveness decreased (rs = −0.198; p 0.012). As burnout increased overall effectiveness (rs = −0.233; p 0.002) and effectiveness with difficult topics (rs = −0.225; p 0.003) decreased. Content analysis revealed 9 categories considered both comfortable and difficult to discuss; contextual comments provided fuller explanation (e.g., providing general information on the Dying Process was comfortable, discussing Dying process during patient death was	Hospice nurses perceive themselves as effective communicators yet want additional training. Perceived communication effectiveness is associated with burnout and stress.

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
			difficult). Seven additional categories (e.g., Denial) were deemed uniquely difficult.	
Dingley et al. (2017)	Caregiver activation and home hospice nurse communication in advanced cancer care	Prospective observational design	Caregiver communication that reflected activation included demonstrating knowledge regarding the patient/care, describing care strategies, expressing opinions regarding care, requesting explanations of care, expressing concern about the patient, and redirecting the conversation toward the patient.	Nurses prompted caregiver activation through focused care-specific questions, open-ended questions/statements, and personal questions.
Epstein et al. (2005)	Measuring patient-centered communication in patient-physician consultations: theoretical and practical issues	Qualitative	Patient-centered communication (PCC) is widely endorsed as a central component of high-quality health care (Committee on Quality of Health Care in America, 2001), but it is not clear what it is, upon what theories it is based, or how to measure it. Too often, the terms patient-centeredness, patient-centered care and PCC are used interchangeably. In our view, patient-centeredness should be reserved to describe a moral philosophy with three core values: (1) considering patients' needs, wants, perspectives and individual	Evidence regarding the nature of patient-centered communication; what it is, and why is it effective.

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
			experiences; (2) offering patients opportunities to provide input into and participate in their care; and (3) enhancing partnership and understanding in the patient–physician relationship (McWhinney, 1995). The term patient-centered care refers to actions in service of patient-centeredness, including interpersonal behaviors, technical interventions, and health systems innovations. there may be an elusive trans-contextual 'way of being' that defines the essence of PCC—a unifying principle. Such ways of being might include attentiveness (Epstein, 2003), critical curiosity (Fitzgerald, 1999), informed flexibility (Duffy et al., 2004) and presence (Epstein, 1999).	
Han et al. (2018)	Communicating caregivers' challenges with cancer pain management: an analysis of home hospice visits	Deductive content analysis	From 63 hospice nurse visits, 101 statements describing caregivers' pain management challenges were identified. Thirty percent of these statements pertained to communication and teamwork issues. Twenty-seven percent concerned caregivers' medication skills and knowledge. In 52% of the cases, nurses responded to caregivers' pain	Family caregivers (FCGs) of hospice cancer patients face significant challenges related to pain management. Addressing many of these challenges requires effective communication between FCGs and hospice nurses. To optimize hospice patients' comfort and reduce caregivers' anxiety and burden related to pain management, hospice nurses

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
			management challenges with a validating statement. They provided information in 42% of the cases. Nurses did not address 14% of the statements made by caregivers reflecting pain management challenges.	need to assess and address caregivers' pain management challenges during home visits. Communication and educational tools designed to reduce caregivers' barriers to pain management would likely improve clinical practice and both patient- and caregiver-related outcomes.
Kim et al. (2015)	Association between the emotional status of family caregivers and length of stay in a palliative care unit: a retrospective study	A semistructured interview was employed to collect data for a retrospective cohort study	The median LOS was 18 days. A multivariate analysis with adjustment for potential variables revealed significant differences in LOS according to cancer type and time since cancer diagnosis. The denial/angry FC category was independently associated with a shorter LOS (vs. acceptance, adjusted hazard ratio (aHR) 2.11; 95% confidence interval (CI), 1.11-4.03).	We found that terminally ill cancer patients who were referred late had FCs who were in denial or were angry about the anticipated death of their loved one. The emotional status of FCs should be considered when patients with terminal cancer are referred to palliative care
Kissane et al. (2006)	Family focused grief therapy: a randomized, controlled trial in palliative care and bereavement	A randomized, controlled trial	The overall impact of family focused grief therapy was modest, with a reduction in distress at 13 months. Significant improvements in distress and depression occurred among individuals with high baseline scores on the Brief Symptom Inventory and Beck Depression Inventory. Global family functioning did not change.	Family focused grief therapy has the potential to prevent pathological grief. Benefit is clear for intermediate and sullen families. Care is needed to avoid increasing conflict in hostile families.

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
			Sullen families and those with intermediate functioning tended to improve overall, whereas depression was unchanged in hostile families.	
Lee et al. (2015)	Discussions of physical, spiritual, and emotional needs during home hospice care	Observational, longitudinal, multisite study of hospice nurse home visits.	Physical care discussions dominated visit communication (75%; SD=19.1), with psychosocial/emotional (4.1%; SD=7.7), spiritual (0.5%; SD=2.2), and other discussions (20.4%; SD=7.2) (e.g., silence, family members talking to each other, chitchat) comprising the rest of the visit.	Physical care discussions dominated visit communication between hospice nurses and caregivers/patients by a large margin. Second was psychosocial/emotional and spiritual.
Oliver et al. (2018)	Shared decision making in home hospice nursing visits: a qualitative study	Qualitative study	The most commonly used element was defining a problem, and the least used element was the assessment of patient and family understanding. Hospice staff can benefit from a more purposeful shared decision-making process and a greater focus on assessment of patient and family understanding and ability to implement plans of care.	Shared decisions between health care providers and patients and families are replacing the traditional physician-driven plans of care. Hospice philosophy recognizes the patient and family as a unit of care and embraces their role in decision making.
Oczkowski et al. (2016)	Communication tools for end-of-life decision-making in ambulatory care settings: a	Systematic review and meta-analysis	The use of structured communication tools may increase the frequency of discussions about and completion of advance directives, and concordance	Communication tools to assist with EOL decision making

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
	systematic review and meta-analysis		between the care desired and the care received by patients. The use of structured communication tools rather than an ad-hoc approach to end-of-life decision-making should be considered, and the selection and implementation of such tools should be tailored to address local needs and context.	
Parker (2007)	A systematic review of prognostic/end-of-life communication with adults in the advanced stages of a life-limiting illness: patient/caregiver preferences for the content, style, and timing of information	Systematic review	Although there were individual differences, patients/caregivers in general had high levels of information need at all stages of the disease process regarding the illness itself, likely future symptoms and their management, and life expectancy and information about clinical treatment options.	Patient and caregiver information needs showed a tendency to diverge as the illness progressed, with caregivers needing more and patients wanting less information. Patients and caregivers preferred a trusted health professional who showed empathy and honesty, encouraged questions, and clarified each individual's information needs and level of understanding. In general, most patients/caregivers wanted at least some discussion of these topics at the time of diagnosis of an advanced, progressive, life-limiting illness, or shortly after. However, they wanted to negotiate the content and extent of this information.

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
Roen (2018)	Resilience for family carers of advanced cancer patients-how can health care providers contribute? A qualitative interview study with carers	Qualitative, semi-structured, individual interviews with family carers of advanced cancer patients were performed until data saturation.	Four main resilience factors were identified: (1) being seen and known by health care providers-a personal relation; (2) availability of palliative care; (3) information and communication about illness, prognosis, and death; and (4) facilitating a good carer-patient relation.	Health care providers may enhance carers' resilience by a series of simple interventions. Education should address carers' support needs and resilience. Systematic assessment of carers' support needs is recommended. Further investigation is needed into how health care providers can help carers and patients communicate about death.
Sallnow et al. (2016)	The impact of a new public health approach to end-of-life care: a systematic review	A systematic review employing narrative synthesis. Both meta-ethnography and the use of descriptive statistics supported analysis.	Eight articles were included in the analysis. Three main themes emerged from the meta-ethnography: making a practical difference, individual learning and personal growth and developing community capacity. The quantitative findings mapped to the meta-ethnography and demonstrated that engaging communities can lead to improved outcomes for carers such as decreased fatigue or isolation, increase in size of caring networks and that wider social networks can influence factors such as place of death and involvement of palliative care services.	Evidence exists for the impact of community engagement in end-of-life care. Impact assessment should be an integral part of future initiatives and policy makers should recognize that these approaches can influence complex issues such as carer support, community capacity, wellbeing, and social isolation
Totman et al. (2015)	'You only have one chance to get it right:' a	A qualitative study using semi-	Participants' experiences of being a caregiver and of professional support	Existential psychology provides a theoretical perspective from which to

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
	qualitative study of relatives' experiences of caring at home for a family member with terminal cancer	structured interviews. Transcripts were analyzed thematically using the Framework approach.	were highly varied. The analysis generated 15 themes which were organized into a framework based on Yalom's four 'existential conditions': responsibility (e.g. 'being the linchpin of care'; 'you only have one chance to get it right'), isolation (e.g. 'being on my own', 'being held in mind'), death (e.g. 'knowing but not knowing') and meaningfulness (e.g. 'giving something back', 'acceptance and gratitude'). Healthcare professionals were perceived as influential in both helping and hindering relatives in meeting the challenges they faced.	understand the psychological complexity of the emotional challenges home caregivers face and a framework which may usefully inform research and clinical practice. Professionals' attentiveness to caregivers' needs can have powerful effects in assuaging anxiety, reducing isolation, and enabling relatives to connect with the meaningfulness of caregiving.
Walczak et al. (2017)	Encouraging early discussion of life expectancy and end-of-life care: a randomized controlled trial of a nurse-led communication support program for patients and caregivers	A parallel group randomized controlled trial design	Communication support program recipients gave significantly more cues for discussion of prognosis, end-of-life care, future care options and general issues not targeted by the intervention during recorded consultations but did not ask more questions about these issues or overall. Oncologists' question prompt list and question asking endorsement was inconsistent. Communication support program recipients' self-efficacy in knowing what questions to ask their doctor significantly	Given the importance of clarifying prognostic expectations and end-of-life care wishes in the advanced cancer context, the communication support program appears to be an effective and well-received solution to encourage early information seeking related to these issues though, its long-term impact remains unclear.

Pub. Year Author's Last Name	Title of Publication	Type of Study	Main Outcomes or Findings	Support for and or Link to Project
			improved at follow-up while control arm patients' self-efficacy declined. The communication support program did not impact patients' health-related quality-of-life or the likelihood that their health information or shared decision-making preferences would be met. Satisfaction with the communication support program was high.	

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