WEBER STATE UNIVERSITY

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Improving Communication at the End of Life

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ABSTRACT

Death is universal to all life, yet it is a topic that makes individuals deeply uncomfortable. As a result, the medical community poorly communicates imminent death to patients and families. Better education to the medical community about real chances of survival and the frequency and level of disability following various insults could go a long way to alleviate those problems. The purpose of this project is to propose better education to medical professionals regarding rates of survival as well as the adverse sequelae of many life-saving measures. This knowledge will lead to exploration for the feasibility of improving their skills at then communicating that information to patients and their families to make the most informed decisions about their ongoing care.

PICO QUESTION

How does an educational program for family members of patients in peri-arrest situations regarding the long-term survivability of their condition improve familial ability to honor end-of-life decisions during the peri-arrest period?

LITERATURE REVIEW

A review of the literature found that:

- Patients and families rarely have a good understanding of their, or their loved one's health [1, 2, 3, 4].
- The nursing role is underutilized not well understood in peri-arrest, end-of-life situations [2, 5, 6, 7, 8, 9].
- Families' comfort after death is tremendously influenced by the communication/teaching that happened before the death [1, 2, 4, 5, 9, 10].

Better educating all involved in the realities of morbidity and mortality and in how to then convey that information can result in a culture change in hospitals. The education empowers nurses to take a more active part in end-of-life discussions and giving patients and their families a better understanding of the expected course. This in turn will give surviving families comfort and relieve anxiety about decisions made in extremis.

PROJECT METHODOLOGY

The ideal educational offering for this subject matter would include significant discussion, collaboration, and simulation (3), covering:

- Realistic survival rates and both immediately and to hospital discharge for various potentially fatal insults.
- Role play and discussion of how best to have some of these difficult conversations.

Unfortunately, the current situation of increased stress and burnout associated with the pandemic requires the use of other formats that do not require added time requirements for staff. The project has been requested for presentation at:

- Utah Emergency Physicians at a group meeting at a date and time to be determined.
- Excellence in Trauma Care Conference October 7, 2022.

Plan and Development

Both presentations will be live and in person as well as virtual and will be presented with multi-media augmentation through PowerPoint or related slide show.

The basic structure of the talk has been developed through various master's class assignments but will be altered for audience and time available.

Special attention has been paid to research regarding effective presentation, which will include a variety of methods to engage the audience.

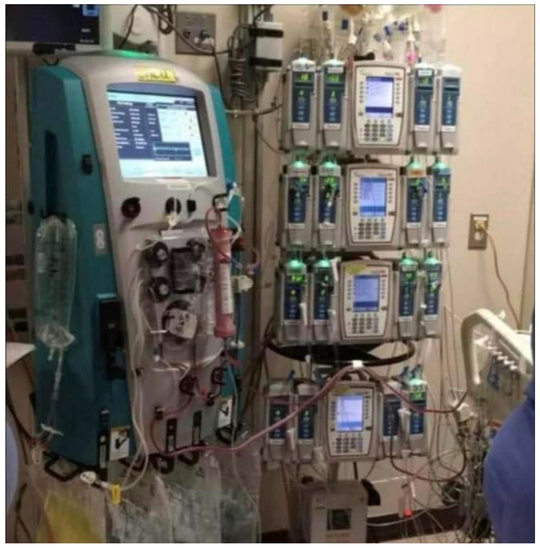

Figure 1

Evaluation

Evaluation for the effectiveness of the talk for Utah Emergency Physicians will be done through pre and post talk surveys.

Evaluation for the talk at The Excellence in Trauma Care Conference is done through the conference organizers.

Outcome

The best outcome after the presentation would be to see a change in the practice of those who attending to be more willing to engage in difficult, uncomfortable conversations with patients and families regarding the realities of the likely future and more awareness of not only quantity but quality of life.

Figure 2

THEORETICAL FRAMEWORK

The framework used for this project was the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) model. This framework provides a direction for investigating clinical questions starting with a population, intervention, comparison, outcome (PICO) question. It continues with tools for appraising evidence, both research and non-research. The JHNEBP model then has a tool for synthesizing the gathered evidence. The next step is presenting the evidence and proposed practice change to the affected and interested parties. At this point, the logistics of cost and potential change of physical resources need to be addressed and ideally overcome.

CONCLUSIONS

Better education to medical personnel results in better education to patients and families which results in better quality of life for all involved.

REFERENCES

1. Barndt, S. N. (2018). Death in trauma: The role of the ACNP in patient advocacy and familial support in end-of-life care decision-making. *Journal of Trauma Nursing, 25*(3), 171-176. https://doi.org/10.1097/JTN.0000000000000363
2. Kim, S., & Tak, S. H. (2021). Family members' knowledge and attitude toward life-sustaining treatment decisions for patients in the intensive care unit. *Journal of Hospice and Palliative Nursing, 23*(3), 256-263. https://doi.org/10.1097/NJH.0000000000000750
3. Papadakos, C. (T)., Stringer, T., Papadakos, J., Croke, J., Embleton, A., Gillan, C., Miller, K., Weiss, A., Wentlandt, K., & Giuliani, M. (2020;2021;). Effectiveness of a multiprofessional, online and simulation-based difficult conversations training program on self-perceived competence of oncology healthcare provider trainees. *Journal of Cancer Education, 36*(5), 1030-1038. https://doi.org/10.1007/s13187-020-01729-x
4. Sullivan, S. S., da Rosa Silva, C. F., & Meeker, M. A. (2015). Family meetings at end of life: A systematic review. *Journal of Hospice and Palliative Nursing, 17*(3), 196-205. https://doi.org/10.1097/NJH.0000000000000147
5. DeSanto-Madeya, S. & Safizadeh, P. (2017). Family satisfaction with end-of-life care in the intensive care unit. *Dimensions of Critical Care Nursing, 36* (5), 278-283. DOI: 10.1097/DCC.0000000000000262.
6. Ghezelsefli, Z., Ahmadi, F. & Mohammadi, E. (2020). End-of-life care provided for cancer patients. *Holistic Nursing Practice, 34*(4), 210-220. DOI: 10.1097/HNP.0000000000000391.
7. Kim, H., & Kim, K. (2020). Palliative cancer care stress and coping among clinical nurses who experience end-of-life care. *Journal of Hospice & Palliative Nursing, 22*(2), 115-122. DOI: 10.1097/NJH.0000000000000624.
8. Velarde-García, J. , Pulido-Mendoza, R. , Moro-Tejedor, M. , Cachón-Pérez, J. , Palacios-Ceña, D. & (2016). Nursing and end-of-life care in the intensive care unit. *Journal of Hospice & Palliative Nursing, 18*(2), 115-123. doi: 10.1097/NJH.0000000000000217.
9. Webb, J., & Guarino, A. J. (2011). Life after the death of a loved one: Long-term distress among surrogate decision makers. *Journal of Hospice and Palliative Nursing, 13*(6), 378-386. https://doi.org/10.1097/NJH.0b013e318222b089
10. Scharf, B., Zhu, S., Tomlin, S., Cheon, J., Mooney-Doyle, K., Baggs, J. G., & Weigand, D. (2021). Feasibility of an intervention study to support families when their loved one has life-sustaining therapy withdrawn. *Journal of Hospice and Palliative Nursing, 23*(1), 89-97. https://doi.org/10.1097/NJH.0000000000000717

Figures

1. Rebecca [@RNRebeccaLove]. (2022, April 5). *Pictures can be worth a thousand words – this one is worth a #million. This is what #nurses do, here a.*[Tweet; photo] https://twitter.com/RNRebeccaLove/status/1511311753749147654?t=gO7EzpZs4nUZaZyArvPHJg&s=03
2. iStockphoto.