Keywords: End-of-life care/ Communication skills/Training

This article has been double-blind peer reviewed

A two-day training course in communication skills for end-of-life care gave healthcare assistants more confidence in discussing death and dying with patients and families

Communication skills training in end-of-life care

In this article...

- The importance of communication skills in end-of-life care
- How a course for healthcare assistants was set up
- The positive effect of training on staff confidence

Author Jodie Morris and Ann Corbett are clinical nurse specialists, end-of-life care, Arden Cancer Centre, University Hospitals Coventry and Warwickshire Trust.

Abstract Morris J, Corbett A (2011) Communication skills training in end-of-life care. *Nursing Times;* 107: 47, 16-17.
Health professionals lack confidence in end-of-life care issues, particularly in communicating with dying patients and their families. University Hospitals Coventry and Warwickshire Trust set up a two-day training course on communication skills in end-of-life care for healthcare assistants. Evaluations showed this increased staff confidence.

Our experiences in end-of-life care services have shown that many health professionals lack confidence in addressing end-of-life care issues, particularly in communicating with dying patients and their families.

It is vital that they understand the basic communication skills needed when caring for this group. Such skills are a national priority; the end-of-life care strategy recommended that communication skills training should be aimed at all staff levels, including for healthcare assistants (Department of Health, 2008).

HCAs provide most day-to-day care on wards and are often faced with emotional situations that they feel they neither can nor should address. In an internal training needs analysis at University Hospitals Coventry and Warwickshire Trust, carried out in 2009, HCAs said they valued end-of-life care education; one of their commonly expressed needs was training on how to communicate effectively with patients and families about dying.

These staff members said they had little or no confidence in their ability to answer questions about death and dying, which meant they avoided discussions with patients and relatives on the subject. They also seemed unable to recognise the powerful impact that listening and the use of silence can have (Buckman, 2000).

Setting up a training course

As a result of discussions with HCAs, the end-of-life care facilitators at UHCW identified a gap in training provision. A two-day advanced communication skills training course was then devised and delivered as a pilot specifically for HCAs.

This innovative course is the first of its kind to be reported in the UK. It is based on the concept of experiential learning from the Connected advanced communication skills training (recognised by the National Cancer Action Team, see tinyurl.com/comms-training).

The aim was to use a mixture of didactic teaching, role play and constructive feedback to give staff the skills and confidence to engage in difficult end-of-life conversations.

The course objectives included enabling participants to:

- Define and understand their own communication style;
- Show an understanding of appropriate/inappropriate body language;
- Listen for and pick up cues;
- Use open questions when appropriate;
- Feel more confident about dealing with patients, relatives or colleagues in emotional/difficult situations and with issues directly related to end-of-life care.

Participants were recruited by distributing flyers throughout the Arden Cancer Network. Although we wanted to attract staff to the course, we decided to allocate places by restricting them to one staff member per area at a time, mainly to preserve confidentiality.

Pre-course questionnaires were sent to participants before the course, which gave us insight into their own perceptions of their communication skills and a baseline to work with.

We felt it was important to hold the courses away from the hospital site in a calm, stress-free setting, so we held it at a local conference centre in Coventry.

Course content

Each course had 10 participants, who were split into two groups of five on the second day. The format is described below.

Day 1:

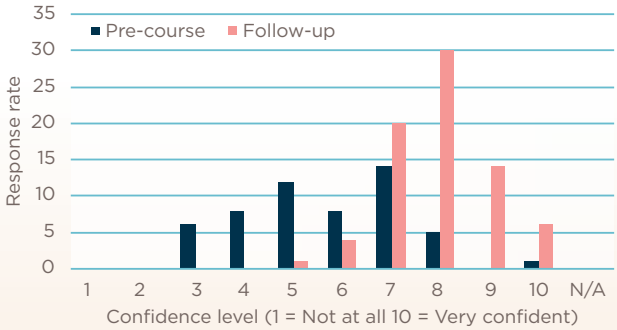
- Ground rules for the course were agreed among the group at the start of the day;
- The facilitators introduced themselves and gave a brief summary of their experience and roles;
- Participants introduced themselves and gave a brief description of their workplace. We asked them to explain why they wanted to attend, what they wanted to gain from the course, and whether they had had any previous communication training;
- The group discussed any fears about the course;
- Participants then discussed communication challenges, which were explored in detail. These were based on difficult issues with

5 key points

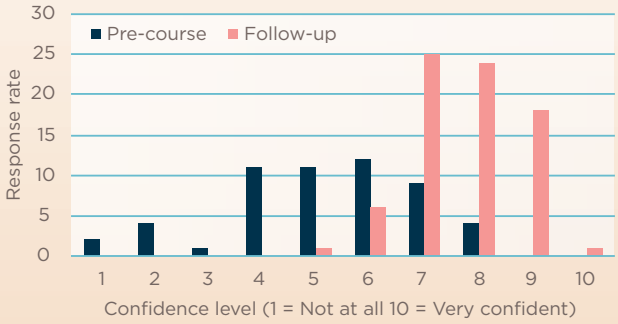
1. **Health professionals lack confidence in communicating with dying patients and their families**
2. **Training in communication skills should be aimed at staff at all levels**
3. **Healthcare assistants value education on end-of-life care**
4. **Didactic teaching, role play and constructive feedback can increase staff skills and confidence**
5. **Staff need ongoing training to empower them and improve end-of-life care**

FIGS 1 AND 2. **EVALUATION QUESTIONS**

How confident are you that you can recognise (and acknowledge) patient cues?



How confident do you feel about working with the patients or relatives agenda before intergrating your own?



patients, relatives or colleagues;
- The type of emotion was highlighted, such as anger or denial. All the issues discussed were written on flipcharts;
- Participants took part in ice-breaker exercises, followed by didactic teaching outlining an evidence base on the importance of good communication;
- The next session focused on basic communication skills, looking at verbal and non-verbal skills;
- At the end of the day, participants chose a scenario they wanted to re-enact the following day, which would ideally be one from their own working experience that involved a communication issue they had found difficult.

Day 2:
- The course facilitators gave a brief overview of the day and introduced two actors who would take part in the scenarios;
- Participants were asked if they wanted to continue with their choice or change their scenario;
- The groups were split into two groups of five, each with an actor and facilitator;
- Once in separate rooms, the first participant in each group started by giving a brief outline of their scenario;
- The facilitator gathered more details to set the scene. The actor and facilitator then identified the challenging emotion away from the group, and the most beneficial way of working through this was discussed and a plan formulated;
- The role play was filmed in short clips and replayed to the group. Constructive feedback from participants focused on giving examples of skills and strategies learnt from the didactic teaching on day 1;
- This format was repeated for all participants, allowing them to learn from other scenarios;
- To complete the day, the groups joined together and reflected on the two days to establish whether they had achieved their learning outcomes.

Although all participants were apprehensive about the videoed role play, they all felt this was the courses's best learning tool.

Evaluation

We devised three evaluation questionnaires for participants:
- Pre-course questionnaire completed before the course;
- Post-course questionnaire completed at the end of day 2;
- Follow-up questionnaire completed 12 weeks after the course.

The pre-course evaluation created a baseline of confidence levels to measure against the two post-course questionnaires. We used open and closed questions and Likert scales to measure satisfaction.

No staff made any negative comments, verbally or written, during the courses.

One post-course question was: Did the course fulfil your expectations previously outlined? Were your main goals met? Below is one typical response:

"Have taken many good points away with me that I hope will help in my work and everyday life. Good course. Felt at ease. Fun and interactive."

The pre-course and follow-up questionnaires were compared using graphs. Figs 1 and 2 represent six courses, each with 10 participants.

After completing the course, the scores for how confident participants felt about recognising (and acknowledging) patient cues increased from an average of four to eight (Fig 1). This suggests staff had increased confidence in recognising and acknowledging patient cues.

Scores for how confident participants felt about working with patients' or relatives' agendas before integrating their own rose from an average of five to eight (Fig 2).

Changes since the course

The course's success showed it needed to be part of the regular teaching programme at UHCW, incorporated in end-of-life care training. We are working to secure funding to run it in 2012. We also felt it should be offered to band 5 staff nurses and this year ran four band 5 courses.

We used participant feedback to reflect on the experiential learning on day 2, and realised that splitting the group may have adversely affected the learning experience for some. We tried a smaller intake of eight, keeping them as a whole for both days; after trialling this for two courses the learning experience seemed to improve.

Conclusion

The success of the course has highlighted the need for communication training at this level. Using reflective practice and videoed role play has proven to be the most beneficial learning experience for participants. **NT**

Funding for this project was provided by Coventry and warwickshire Workforce Locality Stakeholder Board.

References

Buckman R (2001) Communication in palliative a practical guide. *Neurology Clinics;* 19, 4, 989-1004.

Department of Health (2008) *End-of-life Care Strategy: Promoting High Quality Care for All Adults at the End of Life.* London: Stationery Office. tinyurl.com/endoflife-strategy

Al Grant