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COMFORT™ SM Communication for Oncology Nurses: Program Overview and Preliminary Evaluation of a Nationwide Train-the-Trainer Course

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Abstract

Objective—The COMFORT Communication Course for Oncology Nurses is a train-the-trainer program funded by the National Cancer Institute (R25) that provides nationwide communication training to improve patient-centered communication in cancer care. The purpose of this article is to provide an overview of the program and present an evaluation of three courses.

Methods—The curriculum contains seven modules addressing palliative care communication. Pre-course survey of needs, post-course feedback, and follow-up at 6 and 12 months were used to evaluate the program.

Results—To date, three courses have been presented to 269 nurses from 34 states and Washington D.C. Post-course evaluations showed high satisfaction with course design, content, and faculty. At 12 months, course participants had implemented institution-wide system changes and communication skill building. On average, each nurse trained 37 other healthcare providers.

Conclusions—The COMFORT communication course provides the essential communication skills and tools oncology nurses need to provide quality care across the cancer continuum.

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Practice Implications—Training is needed to prepare oncology nurses with the skills to provide patient-centered communication across the cancer continuum. These skills include training others in communication and implementing process improvement. The COMFORT communication train-the-trainer model is an effective approach to meet this need.

Keywords

Communication skills training; nurse education; cancer care; patient-provider communication

1. Introduction

The recently published American Society for Clinical Oncology/American Academy of Hospice and Palliative Medicine Guidance Statement on high quality palliative care in oncology practice identified the need for palliative care communication skills training for cancer clinicians [1]. Recommendations made in the guidance statement specifically address the need to train oncology clinicians to be able to describe the difference between palliative care and hospice to patients, enabling them to make more appropriate patient referrals. The panel recommendations emphasized the need for continuing education to teach cancer clinicians primary palliative care skills including how to engage in 'honest and compassionate communication about treatment options and their limits in advanced disease' with patients and families. These recommendations identified six specific skills:

1. Assessing patient and family understanding of illness, prognosis and goals of care at diagnosis, disease progression, and with changes in treatment plan
2. Assessing patient and family preferences regarding information and who participates in decision-making
3. Providing details about expectations for disease control and expected effects on symptoms and quality of life
4. Explaining expected length and frequency of treatment
5. Describing frequency of and rationale for disease reassessment
6. Acknowledging and addressing mistakes

Given the frequency of interaction between oncology nurses and patients and their families, it is crucial that oncology nurses possess strong palliative care communication skills in order to provide quality cancer care [2]. However, standards and processes for teaching and implementing communication skills into cancer care are not clearly defined [2]. Studies have demonstrated that communication theory is essential to developing a coherent framework for teaching communication skills, but a number of barriers, including limited time for training and a lack of contextualization, often interfere with the implementation of communication education for oncology nurses [3, 4]. Moreover, adjustments to nurse communication curricula are needed [5] as oncology nurses need a toolkit of basic skills in order to provide tailored patient-centered communication adaptable to patient and family needs [3]. Oncology nurses need communication training that can improve the quality of patient-centered care provided to cancer patients and their families across the continuum of cancer care [6]. The goal of this paper is to provide an overview of a train-the-trainer

communication program for oncology nurses funded by the National Cancer Institute and summarize evaluation for three nationwide courses.

1.1 Background

This project builds on a decade of research by the investigators in palliative care communication that began by summarizing the deficiencies of communication training protocols [7, 8]. This research, using clinical observations of terminal prognosis meetings with dying patients, palliative care team meetings, and semi-structured interviews with palliative care team members, revealed a lack of attention to the patient's ability to understand and accept information, minimal inclusion of family members, and neglect of social, psychological, and spiritual care topics. At the time (10 years ago), communication education and training protocols were unsuitable for team-based delivery structures and had yet to include nurses. Additional research using extensive longitudinal research of patients and families, from the point of diagnosis through death and bereavement, [9] lead to the COMFORT initiative, calling for the development of a new communication curriculum aimed at outlining the basic principles of palliative care communication. COMFORT is an acronym standing for the seven basic principles of palliative care communication. Table 1 provides an overview of the curriculum by module. In early work by the investigators, COMFORT has shown to improve clinician self-efficacy, attitudes toward communication, and reduce providers' apprehension about communication [10–12]. Working with a nurse researcher, and by integrating communication theory into clinical research, [13] the COMFORT communication curriculum was developed for nurses and has become the first theoretically-grounded and evidence-based curriculum for teaching palliative care communication. Subsequent research with the curriculum has shown improvement in nurses' attitudes, comfort levels, and perceived self-efficacy regarding palliative care conversations [14] and improvements in nurse perceived confidence initiating difficult communication topics with family caregivers [15].

2. Course Description

2.1 Theoretical Framework for Course Development

With funding from the National Cancer Institute, a two-day course was developed using the COMFORT curriculum. Three frameworks were used to guide course development: 1) Interaction Adaptation Theory; 2) Principles of Adult Learning; 3) Performance Improvement. According to Interaction Adaptation Theory (IAT), patients, families, and clinicians adapt to each other based on the types of verbal and nonverbal messages received and their own changing needs within the interaction [16, 17]. IAT offers an appropriate framework for interactions that take place across the cancer trajectory by positing three conditions affecting message responses: requirements, expectations, and desires [18]. Requirements are based on the needs of the receiver in the interaction, expectations are derived from the social norms within the medical setting and based on prior experiences, and, lastly, desires are based on what the communicator would like to see in the interaction and are often associated with social and cultural norms [18]. IAT provides a framework for understanding the communication process inherent in the COMFORT curriculum [19], with

the goal of teaching a multitude of communication strategies so that nurse communication style can be adapted to the needs of the patient/family.

Principles of adult learning were also used to guide the development, delivery, and dissemination of the COMFORT curriculum for cancer care. The course syllabus, approximately 350 pages, is comprised of lecture content with published peer-reviewed sources, communication tools that provide suggestions for what to say, questions to ask, and how to observe nonverbal communication, and supplemental resources for teaching and evaluation. Clinical nursing faculty and communication researchers are brought together to teach the curriculum. The same faculty were used at all three courses. Teaching methods varied among participating faculty members, including lectures with evidence-based information, small group settings, discussions of challenges, open role-play with feedback, interactive exercises, and audio-visual materials. Participants are also provided with multiple learning resources including lecture notes, USB of training manual, references, and varying books to enhance the interactive process of teaching communication skills.

Finally, the performance improvement approach was used to assist nurses in the development and assessment of patient-centered communication goals for their own institutions. Prior to attendance, nurses were required to identify written patient-centered communication goals for implementing change at their institution. During the course, these goals were refined and revised in order to create specific strategies for implementation. The goal of train-the-trainer communication courses is to develop oncology nurses who would return to their individual institutions, share information with others and cultivate organizational change.

2.2 Course Content and Design

The COMFORT curriculum teaches healthcare providers how to deliver life-altering news, assess patient/family health literacy needs, practice mindful communication, acknowledge family caregivers, and address patient/family goals of care. Each module of the curriculum is grounded in communication theory and includes evidence-based communication skills. The curriculum is designed to give nurses the necessary tools to increase their own communication skills, teach communication skills to colleagues, and implement new processes for patient-centered care at their own institutions. Each course participant receives a print and digital course syllabus containing the following for each module: an overview of communication concepts, communication toolbox, and supplemental sources that consist of recommended evaluation measures and communication tools for process improvement (successful approaches from communication research). Throughout the course, participants are introduced to communication resources including examples of teaching materials, books, pamphlets, films, and mHealth resources. Additionally, nurses receive a print and digital training manual that includes PowerPoint slides, speaking notes, and ways to evaluate communication after training.

The investigators developed a two-day train-the-trainer course organized by the cancer continuum (diagnosis, treatment, survivorship, and end of life) with modules of the curriculum woven into course content. On the first day, nurses were introduced to the history and an overview of the seven COMFORT modules, participated in an activity about the

important role of nursing in cancer care, learning the patient's story (module C), time of diagnosis: being present (module M), communication about treatment: using plain language (module O/O), transitioning to survivorship: discussing quality of life (module O), and keynote lecture on spiritual care communication. On the second day, nurses heard keynote lectures on end-of-life communication (module R), family-centered care (module F), and team communication (module T). In addition, nurses participated in two of four different skills building sessions that focused on delivering life-limiting news, survivorship, family meetings, and spiritual care assessment. Nurse teams were divided so that they could later share course material with each other. During these sessions, actors were present to role-play scenarios so nurses could practice new communication skills. At the end of day two, there was a session on how to teach COMFORT communication modules to others. The curriculum was revised after each course based on feedback from faculty and course participants.

2.3 Course Evaluation

Program evaluation includes an assessment of the process, outcome, and impact of the program as shown in Table 2. The process is assessed by a pre-course application that consists of three surveys. Outcome is assessed through post-course evaluation of course content. The impact of the program is assessed with a 6 and 12 month follow-up of post-course goals. Prior to the project, IRB approval was obtained.

2.3.1 Pre-Course Application—Each team completes a pre-course application that includes characteristics of the applicants, their institution, and the patients cared for in the institution. One letter of support from an administrator per team is required as part of the application. These letters of support are used to capture commitment and support from the institution and are used as a baseline enthusiasm for institutional change.

The pre-course application includes three surveys for evaluating institutions: 1) Institutional Assessment; 2) Educational Programs; and 3) Institutional Survey. The Institutional Assessment is a self-rating tool with information about the services and resources available at their institution. The assessment consists of seven categories including: vision and management standards; practices standards; visiting standards; spiritual, religious, and cultural standards; psychological and emotional standards; quality improvement standards; and community network and partnerships. The Educational Programs survey identifies the institution's educational programs offered to healthcare professionals in oncology communication content areas in the past two years. The Institutional Survey is used to identify the teams' perceptions of communication effectiveness with patients across the continuum of care. The survey assesses the team's view of their institution's readiness to change by evaluating the degree of difficulty teams have with certain communication topics. The survey also assesses the team's involvement with breaking bad news and providing prognosis information to patients and family members.

2.3.2 Post-Course Evaluation—Participants are provided evaluation forms immediately following the course. Each team member is asked to rate the clarity of presentations, quality of the content, and the value to them as a clinician/practitioner. Participants are also asked to

provide qualitative comments regarding both positive and negative experiences over the two-day course. Data from the evaluations are used to revise subsequent courses, determine the content most valuable to the participants, and evaluate curriculum content for process and teaching methods.

2.3.3 Post-Course Goals—Team members are asked prior to course attendance to submit three goals for institutional change. During the two-day course, goals are refined and revised as ideas from discussion and networking lead to more specific strategies for implementation. Participants are asked to include the target audience in the goal, method of education if applicable, and comment on the institution's quality improvement program. At the 6 and 12 month follow ups, participants are asked to identify goal achievements and provide a numerical percentage rating of completion. Participants are also asked to report on the number and discipline of those they have trained.

3. Results

3.1 Participants

Two person teams, made up of competitively selected oncology nurses from nationwide cancer centers, participated in one of three COMFORT communication courses. Two hundred sixty nine oncology nurses (140 teams) from 34 states and Washington D.C. participated in a COMFORT course. Sixty-nine percent of the participants were Caucasian and seven percent declined to share their race. The remaining participants consisted of Asian (13%), African-American (5%), more than one race (3%), Hawaiian of Other Pacific Islander (2%), and American Indian or Alaska Native (1%). The majority (91.2%) of the participants were female.

3.2 Evaluation of Institutional Assessment

One hundred five institutions nationwide supported teams for the COMFORT courses. The majority (65%) of the participants came from institutions that were either community cancer centers (33%) or NCI designated cancer centers (32%). The remaining intuitions were ambulatory cancer centers (13%) and other (22%) such as acute outpatient clinics and city teaching hospitals.

The Institutional Assessment survey (Table 3) results reveal each team's institution's available support services and resources to patients, family members, and caregivers and the institutional standards present prior to attending the course. Availability of visiting standards was the highest rated with 85% responding positively, followed by quality improvement standards. Teams reported that institutions routinely obtain feedback from patients and caregivers (80%), have providers available for family meetings (94%) and by phone (91%), and have administrative executive staff support for implementation of initiatives to improve communication (94%). However, staff knowledge of community resources and contact information was less common (57%) as well as the display/distribution of excellent communication (63%). Overall, the availability of psychosocial and emotional standards was the lowest rated with only 68% responding positively. Provider accessibility via email for patients and families was reported as less available than phone (59%), and only 17% have

available video conferencing for communication between providers and patients and their families.

Table 4, the Educational Program survey, presents detailed pre-course data regarding the educational programs offered to healthcare professionals in oncology communication at teams' institutions in the past two years. The most frequent educational programs offered were focused on Team Communication (70%) and Culture (69%), and End of Life Communication (15%). Breaking Bad News (25%), Transition in Care Conversations (24%), and Recurrence Conversations (15%) were the least frequent educational programs offered by institutions.

The Institutional Survey results (Table 5) reveal the teams' perceptions of communication effectiveness with patients across the continuum of care (0=Not Effective; 10=Very Effective), the degree of difficulty teams have with certain communication topic (0=Not Difficult; 10=Very Difficult), and teams' involvement with breaking bad news and providing prognosis information. Across all points on the cancer continuum, participants' perception of communication with patients were least effective at their institutions during bereavement (4.3), when facing end of life (5.1), and through survivorship (5.2). Teams reported having most difficulty handling conflict among patients and their families (5.6), initiating talks with patients about hospice and palliative care topics (5.3), and handling conflict among team members (5.2). In response to yes/no questions, findings showed 35% of the teams are present when bad news is delivered to a patient and 35% deliver the bad news. Lastly, 40% of the teams reported being present when prognosis information is given to a patient.

3.3 Evaluation of Course

Post-course evaluations revealed participants were highly satisfied with the course design, content and faculty. On a scale of 1 to 5 (1 = lowest), participants' overall opinions of the course were positive (4.9), and results showed the course met their expectations and objectives (4.8) and the environment was conducive to learning (4.7). In the comment section on the evaluations, participants identified the strengths of the course as:

> "…very applicable information."
>
> "…evidence-based information about communication skills."
>
> "…self-evaluations to challenge us in all the different areas."
>
> "…made it easy for [us] to teach the ideas so we can implement them and improve the communication skills of our nurses."

3.4 Changes in Structure, Process, and Outcome at 12 months for course 1 and 2

Each team submitted three institutional goals post-course and reported the status of goal completion at 6 and 12 month follow-up. Table 6 categorizes the goal areas of focus and example goals and outcomes at 12-month follow-up for courses 1 and 2. A 95% response rate at 12 months found that 40% of goals were complete, with the remaining 60% in progress. Overall, 185 nurses had trained 6,863 additional healthcare professionals: 505 physicians, 5,267 nurses, 171 social workers, 79 chaplains, and 840 other providers. On average, each nurse trained 37 other healthcare providers.

4. Discussion and Conclusion

4.1 Discussion

Findings from pre-course surveys demonstrate an overall high focus on communication quality across institutions. Still, there is a continued need to address communication support for advance care planning, email access for communication with members of the healthcare team, and ways to increase staff knowledge of community resource information to be shared with patients and families. These are important areas given that cancer patients and families continue to report high unmet informational needs [20, 21] and experience distress and anxiety as a result of poor communication [22–24]. Patients who have low understanding of their cancer journey and low confidence in managing their care are less likely to communicate any concerns to their healthcare providers [25]. While institutions across the nation have prioritized communication, there continues to be a need for communication training that highlights providing information in an understandable and relatable way.

Educational offerings were prolific in the areas of end-of-life communication, yet nurses reported that communication across the cancer continuum was considered least effective at end of life, during bereavement, and through survivorship at their institution. There continues to be a strong need for additional education in communication among nurses working with patients at the end of life [26]. Communication skills training for healthcare providers is the most prudent form of combating problems in cancer communication across the continuum of care [27]. An ongoing educational strategy with continuous development and improvement of communication skills is necessary for improving patient satisfaction and addressing their communication needs [27].

While nurses reported receiving training in team communication, the majority of these programs emphasized processes aimed at improving patient safety rather than improving collaboration. The emphasis on content focusing on collaboration is pivotal. Teamwork is one of the generalist competencies for oncology nurses, including the ability to identify conflicts, engage in effective problem-solving among team members, and utilize effective therapeutic communication skills with patients and families as well as with colleagues [28]. Educational programs for nurses that address these content areas are needed. Systemic barriers to goals of care conversations include obstacles to team communication, especially for sharing information across services and between specialties, with variation in documentation systems delaying workflow and care coordination [29].

A major curricular gap identified through pre-course surveys and curriculum development is in survivorship communication. Educational program offerings were least likely to be provided for recurrence conversations and have been identified recently as most critical to quality survivorship care planning. One third to one half of cancer survivors report suboptimal patient-centered communication [30]. Recent research has identified gaps in this area, noting that cancer survivors are not given detailed communication about follow-up care, lifestyle recommendations, or social and emotional needs [31]. Future curriculum content development should address how nurses should relay news of recurrence and initiate discussions about quality of life that include physical, psychological, social, and spiritual well-being domains.

Post-course goals showed that nurses opted to partner with palliative care to improve communication. Successful integration of oncology and palliative care requires relationship-building across specialties [32]. Integration of palliative care and oncology requires oncology nurses to have solid interprofessional skills for successful collaboration and processes in place to ensure frequent communication [33]. Findings presented here suggest that the COMFORT train-the-trainer program in communication provides a way to bridge these relationships and foster collaboration.

Overall post-course evaluations demonstrate that nurses feel equipped to return to their institution and teach communication to other healthcare providers. While the long-term effect of the program is not yet known, a 95% response rate at 12 months and early goal results indicate success with meeting nurses' learning needs and resulting in institutional changes. Institution-wide changes are taking place to improve communication through process improvement and the successful training of other healthcare providers in communication. Still, project evaluation is limited by a lack of understanding about the barriers to goal implementation, treatment fidelity of the curriculum, and a lack of behavioral outcomes of individual course participant communication.

4.2 Conclusion

To date, three of the four planned courses have been held. The goal of these courses is not only to facilitate dissemination of the curriculum, but also to allow curriculum revision and add tools identified by nationwide nursing audiences. As new and evolving patient populations make skilled healthcare communication essential, the contemporary work of the COMFORT$^{TM\ SM}$ Communication Curriculum is offered to assist nurses in meeting patients' and families' needs. Once all four courses have occurred, the next step will be to adapt the curriculum for online learning thus making the curriculum more widely available to low resource facilities and enabling more nurses to be trained per institution.

4.3 Practice Implications

Collectively, the COMFORT$^{TM\ SM}$ communication curriculum is aimed at teaching nurses to get to know the patient's life story, support the family caregiver, take care of the patient's/caregiver's heart, mind, and body, and view communication as a process involving patient, family caregiver, and healthcare team. The nurse's ability to return to their institution, champion quality communication skills, and implement institutional change to improve communication is critical. Teaching others about COMFORT$^{TM\ SM}$ communication is an important first step toward patient-centered care. The train-the-trainer model for communication training appears to be a viable and promising strategy for teaching communication across the cancer continuum. Train-the-trainer is less costly than traditional on-site training methods and allows instruction to be tailored to address the institution's least effective communication practices across the cancer continuum.

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Highlights

1. Provides an overview of a train-the-trainer communication program to improve patient-centered communication in cancer care.
2. Identifies services, resources, and educational programs offered at participants' institutions.
3. Identifies nurses' perceptions of communication effectiveness with patients across the continuum of cancer.
4. Presents an evaluation of the three nationwide communication courses for oncology nurses.
5. Argues that potential gaps exist in communication education curriculum content and nurse's communication role.

Table 1

The COMFORT$^{TM\ SM}$ Communication Curriculum

Module	Communication Theory/Framework	Communication Skills Building
C*ommunication*	Narrative Medicine	Learning the patient's story Recognizing task and relationship practices
O*rientation & Options*	Health Literacy Cultural Humility	Gauging health-literacy levels Understanding cultural humility
M*indful Communication*	Mindfulness	Engaging in active listening Understanding nonverbal communication Being aware of self-care needs
F*amily*	Family Communication Patterns Theory	Observing family communication patterns Recognizing caregiver communication patterns Responding to the varying needs of family caregivers
O*penings*	Relational Dialectics	Identifying pivotal points in patient/family care Finding common ground with patients/families
R*elating*	Multiple Goals Theory Problematic Integration Theory	Realizing the multiple goals for patients/families Sharing hope and exploring uncertainty
T*eam*	Groupthink Theory	Developing team processes Cultivating team structures Distinguishing successful collaboration from group cohesion

Table 2

Overview of Program Evaluation

Process	Outcome	Impact
Pre-Course Application (Institutional Assessment, Educational Programs, Institutional Survey)	Post-Course Evaluations	
Pre-Course Goals	Post-Course goals	Goal follow-up at 6 and 12 months post-course

Table 3

Institutional Assessment Completed Prior to Course (n= 140 teams*)

Item	Criteria	% of institutions responding Yes (n=140*)
Vision and Management Standards (75%)	**1** Administrative executive staff support implementation of initiatives to improve communication	94%
	2 Education resources are designed to support development of competencies and practices in communication	69%
	3 Display/distribution of patient feedback of excellent communication (such as bulletin board with patient comments)	63%
Practice Standards (71%)	**1** Advance care planning support available and plan communicated	71%
Visiting Standards (85%)	**1** Policies for treatment and care settings clearly explained (safety procedures, visiting hours)	88%
	2 Inpatient visitor policies clearly explained	81%
Spiritual, Religious, and Cultural Standards (73%)	**1** Interpreter available and process for referral is clear	92%
	2 Chaplain/spiritual care provider available and process for referral is clear	86%
	3 Written materials available for treatment options	87%
	4 Written materials available in different languages	79%
	5 Video available to explain treatment options and procedures	41%
	6 Computer access with Internet available for patient/families	67%
	7 Complementary or integrative therapies are discussed with patients	65%
	8 Families have access to library for additional resources	65%
Psychosocial and Emotional Standards (68%)	**1** Palliative care team is available and referral process is clear	80%
	2 Providers are accessible via email for patients & families	59%
	3 Providers are available for family meetings with patients & families	94%
	4 Providers are available for phone conversations with patients & families	91%
	5 Video conferencing with providers is available for patients & families	17%
Quality Improvement Standards (80%)	**1** Routine feedback from patients, family caregivers, and community partners is obtained	80%
Community Network and Partnerships (72%)	**1** Referral process for community resources in place	87%
	2 Staff knowledge of community resources & contact information is current	57%

*2 teams' responses missing

Table 4

Educational Programs Survey Completed Prior to Course (n= 140 teams*)

Educational Programs for Healthcare Professionals in Oncology Communication Content Areas	**% of institutions indicating "yes" to educational offering in past two years (n= 140 teams*)**
Breaking Bad News	25%
Health Literacy	33%
Culture	69%
Being Present/Mindfulness	50%
Support for Family Caregivers	48%
Goals of Care Conversations/Patient-Centeredness	39%
Transition in Care Conversations	24%
Team Communication (e.g. shift handoff & safety)	70%
Diagnosis (e.g. assessment & evaluation of patient understanding)	45%
Treatment Conversations (e.g. shared decision-making)	33%
Survivorship Care Planning	38%
Recurrence Conversations	15%
End of Life Communication	60%
Grief/Bereavement	49%

*7 teams' responses missing

Table 5

Institutional Survey Completed Prior to Course (n= 140 teams*)

Perception of Communication with Patients at Institution Across Continuum of Care		
Scale: 0=Not Effective to 10 =Very Effective	**Mean**	**Range**
At time of diagnosis	6.3	0–10
During treatment	6.6	0–10
Through survivorship	5.2	0–10
At recurrence	6.2	0–10
Facing end of life	5.1	0–10
At time of death	5.3	0–10
During Bereavement	4.3	0–10
The Degree of Difficulty the Team has with the Following:		
Scale: 0=Not difficult to 10 =Very Difficult	**Mean**	**Range**
Determining how the patient and family like information shared with them	3.2	0–10
Evaluating your own communication with patients and families	3.9	0–9
Evaluating your own communication with colleagues	3.9	0–9
Telling others when you observe or have concerns about errors in care	4.7	0–10
Keeping regular communication with other providers about patient transfers/transition in care	3.7	0–10
Sharing information during interdisciplinary team meetings	2.9	0–10
Initiating talks with patients about hospice and palliative care topics (e.g. prognosis, bad news, death)	5.3	0–10
Handling conflict among patients and family	5.6	0–10
Handling conflict among team members	5.2	0–10
Discussions with patient/family about spirituality (e.g. existential distress)	4.3	0–9
Discussion with patient/family about cultural concerns (e.g. beliefs, traditions, rituals)	3.9	0–9
Discussions with patient/family about financial concerns	4.3	0–9
	% of institution responding Yes	
When bad news is given to a patient:		
Are you present?	35%	
Do you deliver the news?	35%	
Is a colleague with you?	34%	
When prognosis information is given to a patient:		
Are you present?	40%	
Do you deliver the news?	8%	
Is a colleague with you?	33%	

* 6 teams' responses missing

Table 6

Examples of Participant Goals and Outcomes at 12 month Follow-Up

Category	Goal	Outcome
Training colleagues	Compile most applicable PowerPoint slides into a presentation. Teach nurses this information during staff meeting. Monitor HCHAP scores.	We compiled a presentation covering a very shortened version of what we learned during the two-day conference. We also emailed our PowerPoint to each nurse/nursing aid in our unit in case someone missed staff meeting, or if they wanted to reference back to what we taught. We saw some improvement in HCHAP scores, with “Nurses listen carefully to you” going from 86%–90%. Overall nurse communication score at 92% at 12 months.
Institution-wide training (system change)	Expand individualization of plan of care, using the question "what do I need to know about you as a person to give you the best care possible?" to be measured by review of plan of care within computerized charting system.	Education provided to inpatient nursing staff of unit regarding the above question for individualization of plan of care. All nursing staff uses this question on admission in adult patient profile in EMR to be sure we are addressing the patient’s specific preferences. Weekly chart audits show increase from approximately 30% to 90% of patient’s care plan individualized to reflect patient centered goals.
Institution-wide training (communication skills building)	To incorporate an education session on communication for oncology nurses in the quarterly Oncology Orientation for new hire nurses (inpatient and outpatient) to measure satisfaction of the educational session	Three modules (Mindful Communication, Openings and Orientation & Options) scheduled in all quarterly Oncology Orientation programs for inpatient and outpatient nurses at uptown sites. 69 nurses participated in these programs. Consistent positive program evaluations from participants.
Needs Assessment	Administer the communication assessment tool to patients/families on one floor to capture baseline data on patient/family perceived communication patterns	Assessment tool crafted from “The Effective Listening and Interactive Communication Scale (ELICS), A Self-Assessment Scale of Listening and Communication Skills”. An institute wide palliative care needs survey also went out to NP staff who reported they lacked comfort and confidence in basic communication skills about difficult conversations.
Partnering with Palliative Care	Assess staff understanding and perception of palliative care and enhance knowledge base using COMFORT tools	We asked staff to write down what palliative care means to them on an index card and turn it in. This was to get a baseline for teaching. We held an ELNEC in-service introducing COMFORT communication tools to the GYN/ONC, ICU and Assessment Center staff, as well as our NICU PC team. We performed an in- service at our annual Nursing Skills Day regarding COMFORT communication. Based on the information obtained on the index cards at the 6 month assessment, we have been able to eliminate communication barriers. Palliation is a word that has become normal on our unit. We will continue to offer theses inservices and plan to increase the use of the COMFORT communication into the inservices. We plan to do “mini” inservices at staff meetings and skills days to engage staff in the use of COMFORT communication.
Self-Care	Develop educational sessions to "train the trainer" and establish staff champions to facilitate education and disseminate changes to our inpatient oncology staff	We developed a workgroup that includes 8 unit nurses. Out of these 8 there are 2 leaders. They meet monthly on various days so that everyone is able to attend. The peer support workgroup has been success. The most recent peer support group was hosted at one of the facilitators homes where they discussed different stressors faced on the unit and how to cope with those stressors.