A standardized Approach to Patient and Family Centered Care

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Atlantic Health: Morristown Medical Center

Suburban Community Teaching Hospital
✓ 600 + Beds
✓ 5000+ employees
✓ Goryeb Children's Hospital
✓ Gagnon Cardiovascular Hospital
✓ Level 1 ACS Trauma center
✓ 30,000 + admissions a year
✓ 90,000 + ED visits
✓ Magnet designation x 3
Intensive Care Units

- Open ICU with required critical care consult
- Surgical ICU
  - 22 Beds: Trauma, Neurosurgical and Surgical
- Medical ICU
  - 10 Beds: Septic, VDRF, Oncological
Background

- 2009 - Open visiting hours BUT:
  - Closed during change of shift and from 2 – 4 PM (quiet time)
  - Families not included during patient care rounds
  - Families asked to leave during change of shift
  - Family meetings on request

**SO......**

How Satisfied Were Our families with Our Approach?
Family Satisfaction Data - 2009

- Low family satisfaction with:
  - MD communication
  - Doctor(s)’ sensitivity to my family member’s needs
  - Flexibility of visiting hours
  - Clear explanations of tests, procedures and treatments
  - Sharing in decisions regarding my family member’s care on a regular basis
  - Sharing in discussions regarding my family member’s recovery
So We Tried……..

· Reviewing the literature and implementing the following:
  · Utilizing Volunteers to support families
  · Eliminated no visiting from 2 – 4 PM
  · Having a family meeting for patients that are with us for longer than 3 days
  · Using an on-line educational program for families
  · Created an ICU information booklet
  · Harp music
  · Chair massage for family members
  · Social worker ran support groups

HOW DID THAT WORK?
Satisfaction of Family Members in 2010

Availability of MD - 47%
Clear explanations of tests, procedures and treatments – 67%
Sharing in decisions regarding my family member’s care on a regular basis – 71%
Sharing in discussions regarding my family member’s recovery- 81%

Nurses availability to speak with me
Honesty of staff
Meeting general needs of family member
Sharing in discussions
Ability to share in care
Support & Encouragement
Sharing in decisions
Clear explanations of tests
Availability of Dr. to speak with me
Not So MUCH………..

- We were still missing the point!

- Some improvement regarding information needs of families
- Continued to have low satisfaction scores on items associated with:
  - Communication
  - Involvement in care
  - Decision making

NOW WHAT?
Patient and family centered care (PFCC) implemented in our Goryeb children's hospital

- ICU nursing staff and manager attended a conference
- Performed an assessment of how PFCC was currently implemented in our ICU
- Held PFCC conferences on site for ICU team
- ICU multidisciplinary work group formed lead by two staff nurses
- Identified PFCC principles that we wanted to become part of our healing culture in the ICU
# Identifying PFCC Principles

<table>
<thead>
<tr>
<th>PFCC Core Principles</th>
<th>MMC Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participation</strong></td>
<td><strong>Care Team rounds</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Nursing rounds</strong></td>
</tr>
</tbody>
</table>
## Identifying PFCC Principles

<table>
<thead>
<tr>
<th>PFCC Core Principles</th>
<th>MMC Initiative</th>
</tr>
</thead>
</table>
| **Respect and Dignity** | • Families can participate in care to the extent to which they feel comfortable in collaborating with the patient care team.  
• We support open visiting hours and welcome all questions and concerns. |
| **Collaboration** | • Shared decision-making between patient/family and healthcare team.  
• Mutual goals will be established for the patient through collaboration with the family, during family meeting, nursing rounds and patient care rounds. |
| **Information Sharing** | • In addition to bedside rounds, the communication boards in the room are utilized to share information and as a means of communicating plan of care.  
• Communicating family priorities |
Research Questions

1) Does an educational video demonstrating the use of a newly developed communication tool and a standardized approach to Patient Family Centered Care (PFCC bundle) improve nurse and physician’s knowledge, beliefs, and attitudes toward PFCC in an adult intensive care unit?

2) Does the use of a newly developed communication tool and a standardized approach to PFCC (PFCC bundle) by ICU nurses and physicians improve patient/family satisfaction?
Study Design and Sample

- Quasi-experimental Study – Pre/Post intervention

- Sample - Surveys were given to:
  - 53 staff working in the ICU at the time of the study: nurses (27), resident and attending physicians (26).
    - This was a sample of convenience and by completing the study survey participants were giving their consent.

- Patient / Family members consisted of a sample of convenience and identified as those that completed and returned the survey.
  - Study participants were informed that by completing and returning the surveys they were consenting to participate in the study.
Study Intervention

- Patient and Family Centered Care Bundle:
  
  - **ASCEND communication tool:** A newly developed communication tool (utilizing the ASCEND model) to be used by patients/families and healthcare providers (Knops, 2010)
  - **Communication boards:** To communicate and collaboratively identify patient care goals with families
  - **Nursing rounds:** Inclusion of patients/families into bedside nursing report
  - **Patient care rounds:** Inclusion of patients/families into daily interdisciplinary patient care rounds
  - **Family participation in care:** Inviting family members to assist in routine daily care and incorporating family when there is mutual agreement of specific tasks (ie. mouth care, daily bathing, turning and repositioning)
Study Intervention

- Educational Video for the ICU health care team
  - Skits that demonstrated the implementation of the PFCC bundle:
    1. An introduction to the ASCEND model of Communication
    2. Demonstration of admission nurse interacting with family, explanation of PFCC to family members
    3. Demonstration of nurse utilizing communication boards in patient's room to collaborate in patient care goals

![Plan for the Day Image](image-url)
Study Intervention (continued)

4. Demonstration of family inclusion in interdisciplinary patient care rounds. And nursing shift report

5. Demonstration of inviting family members to assist in routine daily care and incorporating when there is mutual agreement of specific tasks (ie. mouth care, daily bathing, turning and repositioning).

Education of staff and implementation of the PFCC bundle occurred over 3 months.
ASCEND Model of Communication

**A guide to communicating with your medical team**

**ASCEND**
- Anticipate
- Summarize
- Concern
- Explore/Explain
- Next Steps
- Document

**Anticipate**
- Think of questions beforehand, bring pen and paper for notes
- Prepare to listen by turning off phones/electronics, sitting down
- Consider bringing a friend or family member

**Summarize**
- Asking for a summary can help you understand the big picture before details are discussed
- Summarize in your own words to ensure you have understood correctly

**Concern**
- Share one or two of your biggest concerns early in the visit – let us know what to address

**Explore/Explain**
- Explore the risks and benefits of any recommended tests or treatments
- Ask us to explain things in another way if you do not understand something
- Help us understand your goals

**Next Steps**
- Know what the plan is and how you can follow up after the visit

**Document**
- Write down important information and questions
- Write names and contact numbers

**PALLIATIVE CARE**
at Morristown Memorial Hospital
Talking with Patients and Families

**ASCEND**
- Anticipate
- Summarize
- Concern
- Explore/Explain
- Next Steps
- Document

**Anticipate**
- Determine who should participate and what should be discussed
- Introduce yourself, allow patient/family to prepare for discussion

**Summarize**
- Have the patient/family summarize current treatment and condition before you present new information

**Concern**
- Acknowledge the concerns of family/patient

**Explore/Explain**
- Explore patient/family goals and expectations for treatment
- Explain medical information without using jargon
- For options of uncertain benefit, define an appropriate “trial of treatment”

**Next Steps**
- Define a plan, including how to address conflict or uncertainty

**Document**
- Document what was discussed and what the plan will be and why
Study Methodology (continued)

- **Adult Provider Beliefs and Practices (APBP) survey** was used to measure healthcare providers' knowledge, beliefs, and attitudes regarding PFCC pre and post intervention.
- Surveys were placed on survey monkey for one month pre and one month post implementation.

- The 65 questions cover 8 sub-domains:
  - Integration of patient and family-centered care (2)
  - Environment (9)
  - Training and Education (13)
  - Policies and Practices (7)
  - Supportive Practices for the Patient and Families (3)
  - **Working and Communicating with the Patient and Families** (8)
  - Support for Working with Patients and Families (7)
  - Working with Family Advisors (16)

- The survey is not scored:
  - Responses are based on a 7-point Lickert scale from strongly disagree = 1 to strongly agree = 7 and not applicable.
Study Methodology

- To measure patient/family satisfaction the Critical Care Family Satisfaction Survey (CCFSS) was used.
- The CCFSS is mailed one month post-ICU discharge.
- Validity and reliability for CCFSS was extensively evaluated by Wasser (Wasser et. al. 2001)

- The survey has 5 subscales of:
  - Assurance
  - Information
  - Proximity
  - Support
  - Comfort

- The survey is 20 positively worded items, with a lickert scale of: 5 = very satisfied, 4= satisfied, 3 = not certain, 2 = not satisfied and 1 = very dissatisfied.
Results:
Research question 1

Does an educational video demonstrating the use of a newly developed communication tool and a standardized approach to Patient-Family Centered Care (PFCC bundle) improve nurse and physician’s knowledge, beliefs, and attitudes toward PFCC in an adult intensive care unit?

- Survey data was entered in SPSS version 19.
- A Wilcoxon signed ranks test was used to determine if there was a difference between the pre and post APBP survey items.
- There were no statistical differences in the pre and post survey results.

BUT......
Results

- While not statistically significant, the responses (mode) moved from a negative response to a positive response within the sub-domain of policy and procedures.

<table>
<thead>
<tr>
<th>Policies and Practice Sub-domain</th>
<th>Pre-implementation Mode</th>
<th>Post-implementation Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 = strongly disagree</td>
<td>5 = agree</td>
</tr>
<tr>
<td>Q 27. Families should be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>encouraged and supported in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being present and participating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>in medical /teaching rounds.</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Q 28. Families should be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>encouraged and supported in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being present and participating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>during nurse change of shift.</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Q 29. Families should have the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>option of being present and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>supporting the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>during medical procedures.</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
# Results

- There was also an increase in staff’s sensitivity to environmental needs of families related to questions in the Environment sub-domain.

## Environment Sub-domain

<table>
<thead>
<tr>
<th>Question</th>
<th>Mode Pre-implementation (strongly disagree = 1 to strongly agree = 6)</th>
<th>Mode Post-implementation (strongly disagree = 1 to strongly agree = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.5. There is adequate space and facilities for families within the clinical area to sit comfortably at the patient’s bedside.</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Q 6. There is adequate space and facilities for family within the clinical area to consult in private with care providers.</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Q 10. There is adequate space and facilities for families within the clinical area to make private telephone calls.</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>
Results:
Research Question 2

2) Does the use of a newly developed communication tool and a standardized approach to PFCC (PFCC bundle) by ICU nurses and physicians improve patient/family satisfaction?

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Pre-implementation (JAN-MAR)</th>
<th>Post-implementation (JUL-SEP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 18-34 n (%)</td>
<td>3 (2%)</td>
<td>7 (6%)</td>
</tr>
<tr>
<td>Age: 35-59 n (%)</td>
<td>68 (48%)</td>
<td>51 (47%)</td>
</tr>
<tr>
<td>Age: 60+ n (%)</td>
<td>71 (50%)</td>
<td>51 (47%)</td>
</tr>
<tr>
<td>Unit Type – ICU n (%)</td>
<td>91 (61%)</td>
<td>79 (71%)</td>
</tr>
<tr>
<td>Unit Type – MICU n (%)</td>
<td>57 (39%)</td>
<td>33 (29%)</td>
</tr>
<tr>
<td>Days in Unit – 0-3 n (%)</td>
<td>64 (49%)</td>
<td>40 (39%)</td>
</tr>
<tr>
<td>Days in Unit – 4-7 n (%)</td>
<td>38 (29%)</td>
<td>37 (36%)</td>
</tr>
<tr>
<td>Days in Unit – 8-10 n (%)</td>
<td>12 (9%)</td>
<td>10 (10%)</td>
</tr>
<tr>
<td>Days in Unit – &gt; 10 n (%)</td>
<td>16 (12%)</td>
<td>16 (16%)</td>
</tr>
</tbody>
</table>
Results

- A Chi square test was used to determine if there was a statistically significant difference in pre and post satisfaction data.
- There were no statistically significant differences in the pre and post satisfaction data.

BUT......
## Results

<table>
<thead>
<tr>
<th>Survey Data n (% Satisfied**)</th>
<th>%Satisfied 2010</th>
<th>%Satisfied Pre-Implementation Jan – March 2011</th>
<th>%Satisfied Post-Implementation July – Sept. 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 2 (Availability/doctor)</td>
<td>(47%)</td>
<td>114 (80%)</td>
<td>92 (85%)</td>
</tr>
<tr>
<td>(N = 348)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 12 (Sharing decisions)</td>
<td>(71%)</td>
<td>116 (88%)</td>
<td>94 (92%)</td>
</tr>
<tr>
<td>(N = 330)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 23 (Pastoral care support)</td>
<td></td>
<td>93 (87%)</td>
<td>69 (93%)</td>
</tr>
<tr>
<td>(N = 259)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 28 (ICU/Status, website)</td>
<td></td>
<td>35 (73%)</td>
<td>45 (96%)</td>
</tr>
<tr>
<td>(N = 133)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 29 (Explanations for tests, procedures, ad PFCC)</td>
<td>(67%)</td>
<td>62 (79%)</td>
<td>65 (88%)</td>
</tr>
<tr>
<td>(N = 215)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 30 (Participation/rounds)</td>
<td></td>
<td>75 (79%)</td>
<td>67 (84%)</td>
</tr>
<tr>
<td>(N = 249)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 32 (Goals, expectations)</td>
<td></td>
<td>95 (83%)</td>
<td>87 (91%)</td>
</tr>
<tr>
<td>(N = 295)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Conclusion

- Implementation of the PFCC bundle and educational strategies have demonstrated a positive impact on creating a healing culture.

- This educational approach provides a consistent message regarding the PFCC philosophy of the ICU and tools used to support that philosophy.

- We hope to see continued improvement in our family satisfaction scores as we continue this approach.

- Next steps are to see if this approach can be replicated in other settings.
Impact of a Collaborative Re-structuring of New Hire Hospital Orientation on Employee Engagement
Background

- Centers for Medicare and Medicaid Services (CMS) introduced Value Based Purchasing (VBP) in preparation for 2013 changes (CMS, 2011).
- VBP links payment to clinical care, selected hospital acquired infections and patient experience (CMS, 2011).
- Key metrics:
  - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPHS)
  - Core Measures
Challenges

• Shifting current cultural paradigm:
  – patient satisfaction,
  – employee satisfaction, and
  – generally good outcomes to one that promotes excellence in patient experience, employee engagement, and quality outcomes (The Beryl Institute, 2010)

• Moving from patient loyalty to experience
  – HCAHPs measures frequency of behaviors from the patient’s experience
  – One person can influence outcomes
How Do We Achieve Top Decile Metrics?

• Employee engagement

• Research shows that employees who were previously not engaged and were given to managers who communicated that they were not managing average performers but potential stars, productivity and performance of those employees increased 30 – 150%.
One Strategy for Building the Culture

• On-boarding of new employees
  – Evaluate current curriculum in orientation
  – Assure it transmits the type of culture that is fostered
  – Educate individuals on Organizational goals and how they assist in achievement
  – Incorporate Senior Staff to assist with key messages
Our Journey

• Opening a new facility
• Reviewed current curriculum
  – Augmented with quality, patient safety, quality outcomes using 5 Pillar approach (Studer)
• Required managers to preview
• Required all staff to attend
• Hold leadership/staff accountable
Measurement

- Professional Research Consultants (PRC) annual survey
- Combination of satisfaction and engagement questions
Results

• The ANOVA output demonstrated a statistical significance for Employment Engagement mean scores among hospitals (p<0.01) with Mt. Pleasant having the highest mean score, at the 0.05 level of significance.

• Employee engagement overall results placed Mt Pleasant Hospital at the 99.4\textsuperscript{th} percentile for the vendor database (consisting of over 500 hospitals).
## HCAHPS Comparisons

**MPH 2012 YTD Comparison to VBP Benchmark and Achievement**

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>MPH 2012</th>
<th>VBP Benchmark</th>
<th>VBP Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain was ALWAYS well controlled</td>
<td>87.95</td>
<td>77.9</td>
<td>68.75</td>
</tr>
<tr>
<td>Staff ALWAYS explained meds</td>
<td>79.43</td>
<td>70.42</td>
<td>59.28</td>
</tr>
<tr>
<td>Patients ALWAYS received help</td>
<td>82.88</td>
<td>77.69</td>
<td>61.82</td>
</tr>
<tr>
<td>Doctors ALWAYS communicated well</td>
<td>89.76</td>
<td>88.95</td>
<td>79.42</td>
</tr>
<tr>
<td>Patients were ALWAYS given recovery info</td>
<td>85.88</td>
<td>89.09</td>
<td>81.93</td>
</tr>
<tr>
<td>Nurses ALWAYS communicated well</td>
<td>86.2</td>
<td>84.7</td>
<td>75.18</td>
</tr>
<tr>
<td>Hospital environment</td>
<td>73.12</td>
<td>77.67</td>
<td>62.8</td>
</tr>
<tr>
<td>Patients who gave overall rating of 9 or 10</td>
<td>82.99</td>
<td>82.52</td>
<td>66.02</td>
</tr>
</tbody>
</table>
Conclusions

• Employees need to connect to the mission/purpose of the organization
• Individual connection should begin at the time of entry into the organization
• It is the responsibility and role of the leaders to assist all employees in understanding the importance of their piece in the overall puzzle and to foster an environment where employees value what they do and recognize the importance of their individual contributions.
Practice Implications

• On-boarding should be focused on the type of culture desired with emphasis on expectations, mission, and values (this led to a change in overall System orientation)
• Creating an engaged culture results in improved outcomes and elevated patient experience scores.
• Changes to health care with reimbursement contingent on value-based outcomes, heightens the need to have all staff contributing to the outcomes to achieve success.
Practice Implications

• Creation of methods to assist staff in connecting to how their actions make a difference.

• Maintain an engaged environment through creative mechanisms allowing staff to make changes and/or corrections as needed and have input into decisions.
### Results-Satisfaction Questions

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>.148&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3</td>
<td>.049</td>
<td>1.205</td>
<td>.308</td>
</tr>
<tr>
<td>Intercept</td>
<td>5738.131</td>
<td>1</td>
<td>5738.131</td>
<td>139920.881</td>
<td>.000</td>
</tr>
<tr>
<td>hospital</td>
<td>.010</td>
<td>1</td>
<td>.010</td>
<td>.247</td>
<td>.620</td>
</tr>
<tr>
<td>Year</td>
<td>.122</td>
<td>1</td>
<td>.122</td>
<td>2.970</td>
<td>.086</td>
</tr>
<tr>
<td>hospital * Year</td>
<td>.016</td>
<td>1</td>
<td>.016</td>
<td>.399</td>
<td>.528</td>
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<td>Error</td>
<td>12.467</td>
<td>304</td>
<td>.041</td>
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<tr>
<td>Total</td>
<td>5750.746</td>
<td>308</td>
<td></td>
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<tr>
<td>Corrected Total</td>
<td>12.615</td>
<td>307</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> R Squared = .012 (Adjusted R Squared = .002)
## Results - Engagement Questions

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
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</thead>
<tbody>
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<td>.054</td>
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<td>.008</td>
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<td>Intercept</td>
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<tr>
<td>hospital</td>
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<td>2</td>
<td>.054</td>
<td>6.058</td>
<td>.008</td>
</tr>
<tr>
<td>Error</td>
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<td>21</td>
<td>.009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>508.228</td>
<td>24</td>
<td></td>
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</tr>
<tr>
<td>Corrected Total</td>
<td>.295</td>
<td>23</td>
<td></td>
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</tr>
</tbody>
</table>
## Results - Engagement Questions

<table>
<thead>
<tr>
<th>Question (8 questions)</th>
<th>Roper 2011</th>
<th>St Francis 2011</th>
<th>Mt Pleasant 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q92: I have a sense of fulfillment in my job.</td>
<td>4.51</td>
<td>4.47</td>
<td>4.54</td>
</tr>
<tr>
<td>Q93: I am committed to investing my thoughts and ideas into [hospname].</td>
<td>4.56</td>
<td>4.52</td>
<td>4.72</td>
</tr>
<tr>
<td>Q94: I look forward to coming to work [hospname].</td>
<td>4.48</td>
<td>4.49</td>
<td>4.64</td>
</tr>
<tr>
<td>Q95: I care about the success of [hospname].</td>
<td>4.75</td>
<td>4.72</td>
<td>4.89</td>
</tr>
<tr>
<td>Q96: I feel a sense of ownership in [hospname].</td>
<td>4.44</td>
<td>4.43</td>
<td>4.72</td>
</tr>
<tr>
<td>Q97: I enjoy my job.</td>
<td>4.60</td>
<td>4.59</td>
<td>4.70</td>
</tr>
<tr>
<td>Q98: My work is rewarding.</td>
<td>4.59</td>
<td>4.58</td>
<td>4.65</td>
</tr>
<tr>
<td>Q99: I am emotionally committed to [hospname].</td>
<td>4.55</td>
<td>4.57</td>
<td>4.70</td>
</tr>
<tr>
<td>Mean</td>
<td>4.56</td>
<td>4.55</td>
<td>4.70</td>
</tr>
</tbody>
</table>
Broadening Cultural Sensitivity at the End-of-Life: An Interdisciplinary Educational Program Incorporating Critical Reflection

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Ed Wilgus, PhD

Generously supported by the Beryl Institute & the Salem Health Foundation
More than 50% of deaths in the US occur in hospitals

Team members on the Oncology Unit recognized an opportunity to improve the patient experience of their terminally ill population

A “Compassion Committee” was created to provide an avenue to ensure delivery of more culturally sensitive care within Oncology as well as the greater hospital.
STUDY AIMS

To expand the awareness and comfort of clinicians caring for patients and families with diverse cultural beliefs and practices at the end of life (EOL).

Primary Research Question
Does a bundled education and critical reflection intervention focused on culturally-sensitive EOL care improve clinician’s:

- Level and perceptions of cultural competence
- Knowledge, attitudes, comfort, and satisfaction in caring for culturally diverse patients & families
INTERVENTION

**PHASE I:** Cultural Competence End-of-Life Inservice

- Definition of cultural competence, and importance to service excellence

- Evidence-based culturally-sensitive protocol for assessing EOL preferences

- EOL beliefs, practices & preferences of 3 cultures: *Latino, Russian & Micronesian*
INTERVENTION

**PHASE II: Critical Reflection Sessions**

‘*Critical reflection*’ is the honest exploration and questioning of long-standing assumptions, beliefs and values that are developed through many social influences without awareness (Matthew-Maich et al., 2010)

Critical reflection stimulates us to:
- Seek further evidence and answer new questions
- Consider alternate ways of looking at experiences
- Thoughtfully analyze and understand one’s reactions, actions & future actions
PHASE II: Critical Reflection Sessions

- Two hour small group session
- 6-8 team members with a facilitator
- Self-reflection guide
- Group discussion structured around ethnically diverse EOL case studies
## Description of Sample

<table>
<thead>
<tr>
<th></th>
<th>N = 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>50% &lt;age 40</td>
</tr>
<tr>
<td>Gender</td>
<td>84% female</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>87% Caucasian</td>
</tr>
</tbody>
</table>
| Religion/ Spirituality          | - 78% Christian  
                                 | - 9% Agnostic   
                                 | - 13% Atheist  |
| Highest Education              | 56% Bachelors or higher |
| Discipline                     | - 71% RNs  
                                 | - 7% Social work  
                                 | - 7% Chaplains  
                                 | - 3% each: Physician, RT, Nutrition Services, Pharmacist, Volunteer |
RESULTS

- Cultural Competence – Group profile
- Cultural Knowledge
- Frommelt Attitudes toward Caring for the Dying (FATCOD)
- Comfort Providing EOL Care
RESULTS:
Level of Cultural Competence

Continuum of Intercultural Sensitivity
Milton Bennett - Developmental Model of Intercultural Sensitivity, 1993

- Defense
  Strong defense of one's own world view
- Minimization
  Trivializes differences; focuses on similarities
- Adaptation
  Capable of taking the other's point of view and communicating accordingly

Group's Developmental Orientation
- Acceptance
  Recognizes and values differences

Group's Perceived Orientation
# RESULTS:

**Perceptions of Cultural Competence**

<table>
<thead>
<tr>
<th>Knowledge &amp; Competence Perceptions</th>
<th>Pre-Post Responses</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competence</strong> in cultural EOL situations</td>
<td>67% to 79%</td>
<td>Minimal</td>
</tr>
<tr>
<td>Understanding EOL beliefs of <em>Latino culture</em></td>
<td>17% to 53%</td>
<td>3-Fold</td>
</tr>
<tr>
<td>Understanding EOL beliefs of <em>Micronesian culture</em></td>
<td>4% to 26%</td>
<td>4-Fold</td>
</tr>
<tr>
<td>Understanding EOL beliefs of <em>Russian culture</em></td>
<td>8% to 37%</td>
<td>6-Fold</td>
</tr>
<tr>
<td>Effectiveness in providing <em>patients</em> with culturally sensitive EOL care</td>
<td>25% to 63%</td>
<td>2-Fold</td>
</tr>
<tr>
<td>Effectiveness in providing <em>families</em> with culturally sensitive EOL care</td>
<td>25% to 68%</td>
<td>2-Fold</td>
</tr>
</tbody>
</table>

+Rated at Level of ‘Good’ on 5 point scale: 1- Very little to 5 - Very good
### RESULTS: Cultural Knowledge

<table>
<thead>
<tr>
<th>Cultural Knowledge Test</th>
<th>Baseline Score (N=31)</th>
<th>Post Score (N=25)</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td><strong>Cultural Knowledge Test</strong></td>
<td><strong>18.81 (3.04)</strong></td>
<td><strong>19.28 (2.79)</strong></td>
<td>.55</td>
</tr>
<tr>
<td>(Possible score = 0-25)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Paired t-test p>.05

**Sample items:**
- Health is typically seen as a gift from God in the Micronesian population. *(True or False)*
- When ill, Russian patients often prefer hard, cold or chilled foods. *(True or False)*
RESULTS:
Attitudes Toward Caring for the Dying+

<table>
<thead>
<tr>
<th>Frommelt Attitudes toward Caring for the Dying</th>
<th>Baseline Score (N=31)</th>
<th>Post Score (N=25)</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Possible score = 30-150)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td>Frommelt Attitudes toward Caring for the Dying</td>
<td>134.74 (8.37)</td>
<td>133.52 (9.66)</td>
<td>.64</td>
</tr>
</tbody>
</table>

*Paired t-test p>.05

Sample items:
• Death is not the worst thing that can happen to a person.
• Dying persons should be given honest answers about their conditions.

*Rating scale = 1- Strongly disagree to 5 - Strongly Agree
### RESULTS: Comfort Providing End of Life Care

<table>
<thead>
<tr>
<th></th>
<th>Baseline Score (N=31)</th>
<th>Post Score (N=25)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Possess Necessary Knowledge &amp; Skills to Provide Culturally Sensitive EOL Care</strong></td>
<td>3.10 (.94)</td>
<td>3.79 (.91)</td>
<td>.03*</td>
</tr>
<tr>
<td><strong>Comfort with Culturally-Sensitive EOL Care</strong></td>
<td>3.52 (.89)</td>
<td>4.18 (.68)</td>
<td>.01*</td>
</tr>
<tr>
<td><strong>% Cases in Last Month Effectively Provided Culturally-Specific EOL Care</strong></td>
<td>65.06 (38.71)</td>
<td>65.63 (44.43)</td>
<td>.93</td>
</tr>
</tbody>
</table>

*Paired t-test p<.05

*Rating scale = 1 - Strongly disagree to 5 - strongly agree
LIMITATIONS & RECOMMENDATIONS

• Small sample size – Replicate study with larger group of interdisciplinary clinicians

• Design qualitative study to interview patients/families to discern impact of education and critical reflection on their perceptions of cultural sensitivity at EOL
IMPLICATIONS FOR PRACTICE

- Ongoing cultural diversity education that encourages staff to critically examine and reflect on one’s attitudes, values & biases is vital for a high quality health care experience of multicultural patients/families

- Promote “Culture Vision”, an online program available to staff on the Salem Health intranet, for review prior to caring for patients of diverse populations

- Use reliable internet resources for the translation of printed information

- Ensure ongoing organizational commitment to provide high quality culturally & linguistically appropriate services

- Promote diversity throughout the organization by hiring & retaining multicultural & multilingual staff
CONCLUSION

Becoming culturally competent to effect a positive patient experience at the end-of-life is a process that needs nurturing for nurses and other health care professionals to evolve along the intercultural continuum towards a state of “Adaptation”
An elderly lady was in the doctor’s waiting room one afternoon. Another woman approached her as she was nearing the end of a magazine and asked, “Are you finished?” The first woman replied, “No, I’m Swedish.”
REFERENCES


