Honoring Patient Wishes

Nurses’ communication skills key to helping patients achieve end-of-life goals

by Anna Mariani Reseigh

Hearing the voice of the customer (VOC) is a goal for many industries. For example, auto companies perform extensive research into what customers would want in the look, feel and performance of their vehicles. The hotel industry strives to provide accommodations that meet the needs of travelers with comfort and conveniences such as Wi-Fi internet access. In contrast, the VOC is not being heard in the healthcare industry when it comes to end-of-life (EOL) care.

Patient preferences are not being met

Desired EOL care is not being realized by patients. The U.S. medical model strives to prolong life by using a wide array of procedures, such as intubation, feeding tubes, catheters, cardiopulmonary resuscitation and tests. In contrast, the goal of a peaceful death is preferred by patients, according to findings of a national survey of more than 2,500 patients old enough to qualify for Medicare.¹ Respondents’ reported preferences included:

- When presented with a hypothetical terminal illness, 86% preferred to die at home and only 9% preferred to die in a hospital.
• 83.9% did not want potentially life-prolonging drugs that would make them feel worse all of the time.

• 71.7% preferred palliative drugs even if they might be life-shortening.

• 87.4% stated they would not want to be put on a ventilator if it would extend their life one week.

• 77.4% would not want to be put on a ventilator even if it extended their life one month.

Sadly, these preferences are not being acknowledged. According to an analysis of 20% of Medicare claims in 2009, the site of death for over 52% of Medicare beneficiaries age 66 and older was an acute-care facility or nursing home.\(^2\) The site of death only provides information on where the person was at the time of death. It does not describe the EOL experience. The Medicare claims were further analyzed for the 90 days prior to death for a more accurate picture of the EOL experience: 69.3% were hospitalized, 29.2% had intensive-care unit (ICU) admissions, 42.8% had nursing home admissions, and 11.5% had three or more hospital admissions.\(^3\) These data show that while a majority of people prefer to die at home, a majority of people are in an institutional setting at the time of their death or during the 90 days prior to their death.

**Hearing the VOC**

The need for excellent communication skills is universal in nursing care, but it’s especially important during EOL care. While doctors may inform patients of their terminal illness or poor prognosis, they spend little time with their patients. Nurses are the constant presence in the
clinical setting and are often the ones who spend critical time with patients to help them understand their diagnosis and treatment options and to help them determine EOL goals.

For example, an anxious spouse has been waiting in the ICU lobby. She goes to her husband’s nurse to seek his or her advice as she has been asked to consider a ventilator withdrawal for her husband who had a massive aneurysm. In another example, a nurse working the night shift enters the room of a patient newly diagnosed with late-stage ovarian cancer. The terrified patient asks the nurse, “Am I going to die from this?” Nurses should be available and willing to be the resource that patients and families seek in these situations.

Skilled communication between the patient and nurse is needed to identify patient wishes, and nurses providing care to the dying must be trained in skillful communication methods. Good communication is a key to recognizing physical and psychosocial concerns, listening to expressions of loss and grief, and identifying ethical and spiritual concerns. The skill of communication requires intense education and practice.

When a patient initially receives a bad diagnosis or poor prognosis, a nurse is actively involved in providing information, clarifying medical information, and listening as the patient and his or her family evaluate treatment options. Most patients and their family members are fearful of dying, pain, unrelieved symptoms and abandonment. Nurses should be available and willing to listen to patient and family concerns, and encourage communication among families and with doctors.

A necessary process improvement
Nurses report a need for training in skilled communication in the context of EOL care. The transition from curative-based care (for conditions where a cure is considered achievable) to EOL care can be difficult for patients and their families, and U.S. Medicare data supports the assumption that lack of education and accompanying discomfort among nurses in discussing EOL with patients and their families may negatively impact this transition.

A curriculum focused on communication at EOL can give nurses the skills to meet the needs of their patients. While training opportunities exist in a variety of settings and delivery models, the challenge is to convince healthcare institutions to prioritize them. Communication skills are needed not only by hospice nurses, but all nurses that serve an elderly population, including those who work in medical and surgical settings, rehabilitation, extended care, long-term acute care, community health, and home care.

As patients grow older and approach EOL, an often confusing and frightening array of options for care are presented to them. As they face these difficult decisions, nurses’ roles are critical. Skilled communication can help patients realize their preferences for EOL care, and help healthcare act on and hear the VOC.

References


3. Ibid.


6. Ibid.

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