



## Improving communication with palliative care cancer patients at home – A pilot study of SAGE & THYME communication skills model



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### A B S T R A C T

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**Purpose:** To pilot an evidence-based communication skills model (SAGE & THYME) with UK District Nurses (DNs) who visit patients with advanced cancer early in the dying trajectory. Evidence suggests that DNs lack confidence in communication skills and in assessing cancer patients' psycho-social needs; also that they lack time. SAGE & THYME is a highly structured model for teaching patient centred interactions. It addresses concerns about confidence and time.

**Method:** Mixed methods. 33 DNs were trained in SAGE & THYME in a three hour workshop and interviewed in focus groups on three occasions: pre-training, immediately post-training and two months post-training. Questionnaires measuring perceived outcomes of communication, confidence in communication and motivation to use SAGE & THYME were administered at the focus groups.

**Results:** SAGE & THYME provided a structure for conversations and facilitated opening and closing of interactions. The main principle of patient centeredness was reportedly used by all. Knowledge about communication behaviours helpful to patients improved and was sustained two months after training. Increased confidence in communication skills was also sustained. Motivation to use SAGE & THYME was high and remained so at two months, and some said the model saved them time. Challenges with using the model included controlling the home environment and a change in style of communication which was so marked some DNs preferred to use it with new patients.

**Conclusion:** Training DNs in SAGE & THYME in a three hour workshop appears to be a promising model for improving communication skills when working with cancer patients.

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### Introduction

Patients are living longer with incurable cancer. In the UK, the majority spend their last year at home managed by generalist primary care practitioners, predominantly District Nurses. These patients are known to have high psychological morbidity. Overall, depression and anxiety is around 20–30% (Hotopf et al., 2002) but there are various stages in the disease trajectory when patients are particularly vulnerable (Morse, 1992; White and Mcleod, 2002; Thekkumpurath et al., 2008). Incidence of depression and anxiety

is high at diagnosis and in the following six months, and increases again with advanced and metastatic disease and when the prognosis is poor. Assessing psycho-social needs is required when disease progresses, active treatment stops and until death (Thekkumpurath et al., 2008).

District Nurses (DNs) visit patients with advanced cancer early in the dying trajectory to support them and their families, and build a relationship before hands-on, intimate care is needed at the end of life (Seale, 1992; Austin et al., 2000; Mok and Chui, 2004; Ohman and Sodreberg, 2004; Coffey, 2006; Stolz et al., 2006; Fingfeld-Connett, 2007). DNs are confident and skilled in providing practical support and physical care (Griffiths et al., 2012) and are ideally placed to identify and respond to psychological concerns (Luker et al., 2000; Pateman, 2003; Kennedy, 2005; Griffiths et al., 2010).

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In some studies, DNs report that they have good communication skills and provide skilled psycho-social assessment to cancer patients (Austin et al., 2000; Wright, 2002; Kennedy, 2005). Other evidence suggests however that DNs lack confidence in communication skills and in assessing cancer patients' psycho-social needs; also that they lack time for this work (Dunne et al., 2005; Aitken, 2006; Addington-Hall et al., 2006; Griffiths et al., 2007).

For example in our observation study of palliative home care we found that DNs tend to avoid cancer patients' cues of distress and block exploration of their concerns (Griffiths et al., 2010).

Connolly and colleagues have developed an evidence based communication skills model (SAGE & THYME), taught in a three hour workshop, that addresses concerns about confidence and time (Connolly et al., 2009). SAGE & THYME is a mnemonic that guides the nurse through exploring concerns, patients' own strategies for dealing with them, when to offer advice and when to refer for specialist help (Bandura, 1982; Maguire et al., 1996; McCormack and McCance, 2006). It encourages person-centered interactions by helping the nurse to hold back with premature advice that can close down interactions. SAGE guides practitioners through active listening, THYME through simple patient centred problem solving (Fig. 1). SAGE prompts the nurse to organize the Setting; Ask about concerns; Gather all concerns and Empathise. THYME prompts them to ask the patient who they have to Talk to; whether this Helps; what You (the patient) think would help; what the patient would like Me (the nurse) to do; and finally to End/summarise the discussion.

Nationally, 26,000 health care practitioners have been trained in SAGE & THYME in the UK. It has been evaluated in hospital settings and found to increase nurses' knowledge and confidence (Connolly et al., 2009, 2014). The aim of this study was to explore whether SAGE & THYME has similar utility with District Nurses in the palliative cancer home care and which factors facilitate and hinder its effective use.

## Methods

### Design

Mixed methods study using focus groups and questionnaire survey.

#### SAGE & THYME

Setting: If you notice concern - create some privacy - sit down

Ask: "Can I ask what you are concerned about?"

Gather: Gather all of the concerns - not just the first few

Empathise: Respond sensitively - "You have a lot on your mind"

Talk: "Who do you have to talk to or to help you?"

Help: "How do they help?"

You: "What do YOU think would help?"

Me: "Is there something you would like ME to do?"

End: Summarise & Close 'Can we leave it there?'

Fig. 1. SAGE & THYME model.

### Training

During the study, District Nursing services in four Trusts in North West England took part in SAGE and THYME training. The workshop lasted three hours and included brief taught components, group work and role play. Post workshop, the DNs were given a prompt card to take to patient visits to remind them of the sequence of the model (Fig. 1).

### Recruitment and sample

DNs were recruited by the DN clinical leads in each Trust. Inclusion criteria were: RGN qualified, working as a DN, and more than one patient with cancer on the caseload.

### Ethical approval

Ethical approval was granted by the Local Research Ethics Committee (NRES:Reference 11/NW/0525).

### Focus groups

The DNs were interviewed in focus groups on three occasions: pre-training, immediately post-training and two months post-training. The pre-training and two months post-training focus groups were held at local health centres and the immediately post-training focus group at the training venue. Each group had between 5 and 12 participants. All focus groups were audio-recorded and were 30–90 min in duration.

40 DNs took part in the study, but there was attrition at the different stages. 40 DNs attended the pre-training focus groups, 33 attended the training itself and focus groups held immediately after, and 26 attended the two months post-training focus groups. Five DNs who could not attend the two months post-training focus groups were interviewed individually on the phone. The other two were unavailable. This paper reports findings at each stage.

Focus groups allowed in depth exploration of experiences, and promoted sharing and discussion of ideas (Kitzinger, 1995; Kaufman, 1996; Kreuger, 2008). They were facilitated by two researchers using a topic guide. One of the researchers (JG) led the discussion, and the other researcher (CW) took notes, checked equipment, probed for fuller responses from participants, and ensured that all of the topics had been covered. The guide was flexible to allow participants to introduce other topics of relevance to the discussion. The purpose of the pre-training focus groups was to explore DNs' experiences and challenges of assessing the psycho-social needs of patients (reported in Griffiths et al., 2014), and to ascertain whether DNs perceived a need for communication skills training. The immediately post-training focus groups asked DNs to consider whether SAGE & THYME would be useful in their practice. The two months post training focus groups captured DNs' reflections on the training, whether it needed to be modified in any way, the use and utility of SAGE & THYME in practice, and barriers and facilitators to its use.

### Questionnaires

Three questionnaires were used that had been developed by the Maguire Communication Skills Training Group for use in a previous, hospital based evaluation of SAGE & THYME. The first was an 'outcomes' questionnaire (Table 1, column 1) comprising 19 items about the participant's perceptions of the likely outcomes of their interactions with patients e.g. that asking about concerns or emotions can damage them/be of benefit. Perceptions were rated on a scale of 1–9 from very likely to very unlikely. The second was a

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