Nursing faculty face increasing instructional demands to keep pace with mounting knowledge and competency requirements for student nurses. In the context of nursing practice, tasks and time pressures detract from the high skill and aptitude expectation of communication. The communication, orientation and opportunity, mindful presence, family, openings, relating, and team (COMFORT) curriculum, an acronym that represents 7 basic nursing communication principles, has been introduced into the communication module of the End-of-Life Nursing Education Consortium, which currently provides the only standardized undergraduate and graduate nurse training in hospice and palliative care. This study examines the potential efficacy of the COMFORT curriculum for everyday communication challenges experienced by members of the Georgia Organization of Nurse Leaders. Participants were prompted to describe communication barriers and then apply an aspect of the COMFORT curriculum to this barrier. Responses revealed primary communication barriers with co-workers and patient/families. Nurses predominantly identified directly correlating components in the COMFORT framework (C-communication, F-family) as solutions to the topics described as barriers. Based on confirmation of extant literature addressing generalist nurse communication challenges, there is support for the inclusion of COMFORT across the nursing curriculum to efficiently and effectively teach communication strategies to nurses. (Index words: Nursing faculty; Nursing curriculum; Communication skills; End of life; Palliative care; Generalist nursing training; Team communication; Nurse supervisor) J Prof Nurs 29:388–394, 2013. © 2013 Elsevier Inc. All rights reserved.
employed by schools of nursing should represent essential building blocks for nurse preparation. This article presents pilot work exploring a novel communication training curriculum named COMFORT, an acronym that identifies the basic principles of nurse communication (Wittenberg-Lyles, Goldsmith, Ragan, & Sanchez-Reilly, 2010). Built from evidence-based research in hospice and palliative care settings, the COMFORT curriculum teaches nurses to focus concomitantly on task and relational communication as a way of improving communication and resolving communication challenges.

**Communication Preparation for the Nurse**

Undergraduate coursework addressing end-of-life and palliative care provides nursing students with minimal exposure to communication curriculum, yet large variances in course structure and content across institutions leave nurses with limited communication skills (Palliative, 2007). Nursing students also report too few opportunities to practice communication skills essential to compassionate caregiving (Corless et al., 2009). While end-of-life and palliative care nursing carries a high expectation for nurse communication ability, so do many aspects of nursing practice. Students in an accelerated baccalaureate nursing program reflected in journals that they felt inadequate as leaders, an inability communicating their own credibility, the demand for a wide variety of communication strategies, and the challenge of communicating with a diverse nursing staff (Lekan, Corazzini, Gilliss, & Bailey, 2011).

Professional nurses also report limited communication preparation and considerable discomfort especially during conversations with patients about end-of-life issues (Brown, Wickline, ECOFF, & Glaser, 2008; Brown et al., 2009; Kruijver, Kerkstra, Bensing, & van de Wiel, 2000; Rask, Jensen, Andersen, & Zachariae, 2009; Wilkinson, Gambles, & Roberts, 2002). Nurses are uncomfortable discussing prognosis, hospice care, advanced care planning, and spirituality with patients (Schulman-Green, McCorkle, Cherlin, Johnson-Hurzel, & Bradley, 2005; ZHOU, Stoltzfus, Houlidin, Parks, & SWAN, 2010; Noble & Jones, 2010). They have difficulty facilitating conversations that involve bad news, palliative care issues, and with patients/family members from different cultures (Malloy, Virani, Kelly, & Munevar, 2010; Helft, Charness, Terry, & Uhrliech, 2011). Younger, inexperienced nurses also have discomfort discussing sexual health with patients (Julien, Thom, & Kline, 2010). There are also barriers to communication in their team environment (Hill & Hacker, 2010) and ambiguity about how best to confront a colleague about undesirable behavior (Sivesind, Parker, Cohen, et al., 2003).

As a result of ineffective communication processes, nurses experience moral distress, emotional burnout, and work-related stress (Davis, Kristjanson, & Blight, 2003; Ragan, Wittenberg-Lyles, Goldsmith, & Sanchez-Reilly, 2008; Turner et al., 2009). Low self-awareness of verbal and nonverbal communication, fear of own death, and poor task orientation decrease communication effectiveness for nurses (Tay, Hegney, & Ang, 2010) and often result in missed opportunities for patient/family communication (Boyd, Merkh, Rutledge, & Randall, 2011; Helft et al., 2011).

Despite the plethora of research on nurse communication needs, there is still an absence of communication protocols specifically designed to meet the unique role of the nurse. Currently, the End-of-Life Nursing Education Consortium (ELNEC; 2010) is the only ongoing standardized nursing curriculum in the United States with a dedicated and annually revised communication module. The ELNEC, a train-the-trainer course, is a collaboration of the City of Hope and the AACN, providing quality care to patients and families undergoing end-of-life challenges (Malloy, Paice, Virani, Ferrell, & Bednash, 2008). Recently, the ELNEC–Veterans Affairs communication module was revised to incorporate the COMFORT model.

**COMFORT Curriculum for Nurses**

COMFORT is designed to assist nurse clinicians with the practice of biopsychosocial and patient-centered communication. The COMFORT model was developed from empirical research on practitioner communication training in palliative care, family communication at the end of life, and discourse between hospice and palliative care staff and patients and families (Goldsmith, Wittenberg-Lyles, Rodriguez, & Sanchez-Reilly, 2010; Ragan et al., 2008; Villagran, Goldsmith, Wittenberg-Lyles, & Baldwin, 2010). Additional evidence contributing to the development of the COMFORT principles comes from (a) 3 years of teaching and evaluating a medical school elective on geriatric and palliative care, (b) ethnographic data from a palliative care facility, (c) ethnographic data from an inpatient hospice, and (d) focus group data from interdisciplinary care teams (Ragan et al., 2008; Ragan & Goldsmith, 2008; Wittenberg-Lyles, Greene, & Sanchez-Reilly, 2007; Wittenberg-Lyles, 2006).

COMFORT is not a linear guide, an algorithm, a protocol, or a rubric for sequential implementation by nurse clinicians but rather a set of holistic principles that can be used concurrently and reflectively in the care of patients/families with life-limiting illness. For this reason, COMFORT could be integrated across all course work in nursing preparation. More specifically, COMFORT can exist as an addition to already in place curricular structures and can serve to integrate communication concepts across the curriculum.

Informed by multiple goals theory, communication interaction is seen as the exchange of ideas around a task and the exchange of ideas around a relationship. In essence, multiple goals theory determines that every...
message possesses two levels of meaning: the content level and the relationship level (Tracy & Coupland, 1990; Ragan, 1990). In professional contexts, these can be referred to as the task and relationship levels. Message content generally concerns the tasks of communication—for example, instructing, diagnosing, managing, directing, encouraging, supporting, and so forth. Relationship refers both to how people interpret the content of messages and how they understand their shared connection.

The COMFORT curriculum is grounded in a narrative approach to communication and champions relationships among nurse, patient, family, and team members to create a collaborative environment for integrated care from diagnosis to death. Although the curriculum is grounded in evidence-based research in hospice and palliative care settings, we were interested in exploring the applicability and perceived usefulness of the curriculum to nurses in a leadership role. Our aim was to execute research that evaluates a communication framework for nurse education using nurse leaders as participants. Specifically, we questioned (a) what communication challenges are present for nurses and (b) to what extent can COMFORT promote solutions to these challenges?

**Method**

**Setting**

Georgia Organization of Nurse Leaders (GONL) is a body of nurse supervisors and managers with a six-part mission to (a) design the future of patient care and delivery, (b) create healthful clinician environments, (c) supply the workforce, (d) offer leadership, (e) create an engaged membership of Georgia state nurse leaders, and (f) position nurse leaders as valued health executives. Their vision includes innovating nurse leadership and their organization’s activity centers on nurse education, research, policy advocacy, and information resources (Georgia Hospital Association, 2011). GONL is divided into eight regional districts. Hospitals represented by nurse leaders include critical access hospitals, psychiatric hospitals, and rehabilitation hospitals. The setting for our data was the annual district meeting of the GONL for the northeast region. Hospitals represented by the nurse leaders from this district include four 0- to 49-bed hospitals, five 50- to 149-bed hospitals, and one more than 400-bed hospital (Georgia Hospital Association, 2011).

**Participants**

Supervisory/Managerial nurses attending the annual GONL district meeting were invited to participate in this study during the second portion of their annual seminar. Of the 28 nurse leaders in attendance, 21 consented as participants. All nurses were female, Caucasian, with a mean age of 47 years (31–59). Half of them held bachelor of science in nursing degrees (50%), followed by associate degrees of nursing registered nurses (RNs; 25%), licensed practical nurses (LPNs; 15%), and other graduate education (10%). One participant did not provide demographic information. Participants were not asked to provide specific organizational titles; all serve in a supervisory or managerial capacity to qualify for membership in GONL.

**Data Collection**

An educational program about the COMFORT model was held during a 90-minute session (Table 1 for an overview). Participants were oriented to the study, the

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<th>Table 1. Overview of the COMFORT Communication Curriculum</th>
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<td><strong>The COMFORT model</strong></td>
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format of the session, and their protected rights as participants. Next, participants were given a piece of paper and 15 minutes to record (a) communication challenges in their day-to-day work setting and (b) a specific instance/scenario in which communication was a barrier in their work. Following this, a presentation detailing the tenets of COMFORT was provided and included 30 minutes of interactive discussion with participants. Next, participants were given another piece of paper and invited to apply COMFORT to engage the specific communication challenge they had written about earlier in the session. Finally, participants were asked to rank the seven elements of COMFORT from most important to least important.

Data Analysis
Written responses were transcribed and then analyzed using an iterative process of theme analysis composed of four distinct grounded theory phases (Creswell, 1998; Strauss, 1987). Stage 1 included open coding in which we identified unrestricted chunks of texts that suggest a theme. At this point in the process, interpretations are tentative, and categories and their linkages to other themes were not addressed. Phase 2 involved integration in which previously identified themes were connected, collapsed, or associated. In Phase 3 the categorization of information units were clarified, enabling Phase 4 in which interpretive claims were construed (Lindlof & Taylor, 2002; Strauss, 1987). To establish validity, the authors analyzed the data independently. The authors then met to reconcile discrepancies in integration and categorization through a process of iterative reading and discussion. Finally, both researchers confirmed the selection of interpretive claims.

Results
To investigate nursing communication challenges, the focus of Research Question 1, nurses identified both general and specific communication barriers in their jobs. Of the 21 participants who consented to the study, 3 opted not to identify a communication challenge in their work setting. Responses from 18 participants overwhelmingly identified communication with co-workers and patients' families as the most barrier-filled circumstances.

Communication Challenges With Co-Workers
The most predominant theme among this group of nurse leaders pointed specifically at challenging communication instances with physicians, staff and teams, and the larger context of employees in their organization. Nurses described resistance in getting physicians "involved more closely with all ancillary departments for more complete assessment" and having to work with physicians who were "uncomfortable discussing death/dying/comfort care with patients and families." One nurse summarized her frustration over the lack of adequate communication with physicians:

On a daily basis, we are constantly trying to get physicians to listen to us regarding care of our patients and what we think that our patients need in order to promote care. Our physicians tend to turn a deaf ear to us and have said to us that they do not have time to listen to us.

Difficulty in attending to patients/families who want time with the physician were also reported as a communication challenge, as one nurse explained: "The MD is usually in a hurry. The units are so busy that the staff don't have enough time to sit down and really talk/listen to the patient/family."

In addition to nurse–physician communication issues, overall organizational communication flow was identified as a challenge. Motivating employees to "read and understand memos and signage" was described as difficult and time consuming. Given that nurse participants were responsible for ensuring communication between co-workers, problematic workplace communication focused on "relay of communication" to staff "who need to know" and how project information is sometimes not "communicated to key individuals." In addition, organizational morale was identified as a key communication concern, as one nurse explained:

With many changes in our future as a hospital and healthcare providers, it has been very difficult to communicate to staff their value and worth to our system, to encourage retention of seasoned/veteran staff members.

Communication Challenges With Families
Communicating with families, most frequently in terminal illness contexts, was recognized as a challenging barrier. Having to "relay or explain to a family" about a patient's care, status, or disease "when something goes wrong" was considered difficult. Nurses described the daunting task of having to explain medical prognoses and procedures in "terms that are understandable." One nurse explained how she learned to do this:

"More times than not, I have to rely on my personal religious beliefs to explain some situations. I have, with time, become very comfortable [with] discussing death, dying, and poor prognosis situations, especially with asking family members about DNRs. However, this is difficult for most nurses (going against what our purpose seems to be) and for physicians.

This nurse articulates not only a challenging communication task but also characterizes the looming attitudes and perceptions that reinforce the difficulty of this task. One nurse noted that she lacks the ability "to predict the best method of delivery with patients of all different education and socioeconomic backgrounds."

Participants also considered facilitating family communication formidable. Nurses reported that their role often included family mediation and assisting with decisions about care. Extenuating circumstances within a patient's case created family communication barriers that required nurses to intervene. For example, one nurse
shared that she had a 16-year-old [patient] “admitted with a massive abdominal tumor—the family thought she was pregnant even though she denied sex.” These difficult communication situations consisted of multiple family members and ongoing bad news. In addition, nurses also described communication efforts necessary to help family members with acceptability of prognosis and care planning. One nurse recalled:

On one occasion I had a patient who was undergoing chemotherapy for breast cancer who needed extra support in her home…her daughter felt that offering this type of service was indicating that she was unable to care for her mother, therefore making her angry. I had great difficulty expressing to the daughter that I was trying to help her mother as well as her.

**Efficacy of COMFORT**

To investigate how exposure to the COMFORT model can promote solutions to nurse-identified communication challenges, the goal of Research Question 2, nurses were asked to apply COMFORT to their communication challenge and to rank order the COMFORT principles. Nurses ranked C-communication (n = 14, 66%) as a primary resolution tool. The C in COMFORT espouses nurses to consider the relational function of their communication in addition to the tasks that must be completed to achieve excellent patient care. Next, F-family communication (n = 7, 33%) was considered second most important among COMFORT components. Family caregivers are emphasized in COMFORT, with specific attention given to understanding the family caregiver as part of a family system.

However, when asked to apply COMFORT to their communication challenge, nurses most often identified T-team as a resource. One nurse specifically identified daily patient care conferences as a point of improvement for team communication. Another participant realized that a potential solution to her communication challenge was to understand “the need to include the team in the effort…and overall understanding [of] the importance of looking at each member of the team as a person.”

Nurses also described an awareness of C-communication and the need to balance relational communication, especially when working with patients and families. Recognizing that their list of clinical tasks sometimes superseded their own emphasis on communicating caring, nurses articulated that “allowing time and opportunity for questions, clarifications” and enabling “ongoing dialog to reiterate concepts” could resolve challenges. Nurses recognized the need “to repeat and go back over everything if needed” and “to let the patient and family ask questions.” One nurse summarized: “Using the steps of COMFORT, I can learn the importance and value of including lots of family and friends and the need for repetition [to convey] a more understanding manner.” Overall, team and the communication principles of narrative nursing emerged as a result of the COMFORT presentation and prompted many of the nurses, most practicing for at least two decades, to reconsider longstanding communication choices in their own bedside and supervisory practice.

**Implications and Discussion**

Nursing faculty must identify curricular tools that will empower students to face the complexities of nurse–team communication, family communication, and staff communication in the midst of an increasingly long list of competencies. Although this study involves practicing nurse leaders from one state, it demonstrates the promise of the COMFORT curriculum as an integrative tool for faculty to use when teaching communication skills training. Embedding COMFORT into courses such as pharmacology, anatomy and physiology, maternity and obstetrics, pediatrics, acute care, and more would mark a shift toward the integration of communication as an integral, adaptive, and prime clinical skill.

Similar to prior research, this study found that communication with physicians represents a dominating communication barrier for nurses. In a recent study of intensive care nurses, 34% of respondents identified physicians as the largest barrier, and 30% named communication as the most needed change (Festic et al., 2010). However, communication barriers were often described as a result of organizational structure. Organizational limitations and barriers have been identified as the central cause for nurses to suffer from time constraints and a lack of autonomy (Brown et al., 2008). Nurses were centrally concerned about the communication they experienced with their co-workers and organization and identified these communications as possessing the most limitations and barriers.

In response to these issues, nurses in this study referenced the need for a team or team communication facilitation/training. This outcry is a trend in other nursing studies seeking ways to improve nurse interaction and experience with other nurses and team members (Kinniman & Bleich, 2004; Jansen, 2008). A study exploring the specific communication complaints between RNs/LPNs and nursing aides found that communication complaints were most common around issues of mentoring, expressing respect, and sharing empathy. Recommendations from this particular study include a multidisciplinary undergraduate training tool (Rubin, Balaji, & Barcikowski, 2009).

Limitations of this work include the homogenous sample of Caucasian females. The impact of supervisory roles also predicates needs in this population that might be unique to those with supervisory nursing duties. Most particularly, this group of nurses might be more aware of team and organizational dynamics than a bedside-only nurse. The small sample size for this study does not affect our results negatively because this work is qualitative in method and intent and, thus, does not seek to generalize themes to all nurses. The study reveals the demographic of nurse leaders in rural Appalachia and, thus, might be a valuable resource in examining ways to enrich nursing at
community-based care centers that are not systematically examined like those in a larger research care center.

**Future Applications**

This study explored communication challenges experienced by nurses in leadership roles in order to explore the potential of the COMFORT curriculum and its integration into undergraduate and graduate programs of study. Results from this study suggest that COMFORT may have utility for nurse training programs. Nurses readily applied an aspect of COMFORT to their described communication challenge. Notably, C-communication was most commonly chosen as the most useful module with F-family ranked as the second most useful. When applying COMFORT, nurses expressed the need for a change in their own communication patterns. Nurses were able to reflectively consider the role their communication patterns play in producing negative outcomes in the goals they pursued with those at their job. These findings suggest that COMFORT content creates awareness of the participant’s own communication practices and has potential for changing communication behaviors.

Disseminating COMFORT as a curricular training program for nurses in developed modular components with correlated data collection is the next phase of development for this framework. A modular teaching curriculum will extend nurse communication beyond the pervasive view of nurse as educator. Specifically, this COMFORT training initiative includes seven modular course units based on a theoretically grounded curriculum for teaching palliative nursing communication skills appropriate for all nursing levels and specialties (Wittenberg-Lyles, Goldsmith, & Ragan, 2010a). Program modules expanded from COMFORT are available through the efforts of an applied book project and CE Central (Wittenberg-Lyles, Goldsmith, Ferrell, Ragan, 2012). These components, recently developed into modules, can function together or separately with a full array of teaching materials and exercises.

The demand on nurses to communicate effectively is never ending. Pivotal communication from a nurse impacts the memory of a family, the work environment for a colleague, the culture of an organization, and a team’s effectiveness. Nursing opportunities for communication arise during task-related care, education about illness, following delivery of bad news, discussion of spiritual and religious concerns, during collaboration with physicians and other providers, and in response to physical and psychological suffering (Malloy et al., 2010). The real challenge lies in describing moments in which the nurse does not communicate or moments in which all stakeholders in the care milieu place little value on the communication skills of nurse clinicians. Nurse educators know this pressure and note the growing need to find communication tools that will support and train nurses in the skill areas of team, end of life, and organization. COMFORT curriculum testing indicates a hopeful tool for supporting communication in these areas and those of culture, health literacy, and presence.

**References**


