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Nurse–patient communication in palliative care: an evaluation of a communication skills programme

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Good communication between nurses and patients is a central aspect of palliative care. However, evaluation of courses designed to improve nurses' communication skills has been inconclusive. Most courses have concentrated on skills training, although communication training programmes which have been integrated into clinical practice over time and have also focused on attitudes and used a range of teaching methods, have been shown to be effective. A study was set up to evaluate whether a communication skills course which would focus on knowledge, attitudes and skills would improve nurses' communication skills. One-hundred-and-ten nurses completed a 26 h training programme over six months and completed precourse and postcourse audiotape recordings of a patient assessment. An overall statistically significant improvement in assessment skills between pretest and post-test mean total scores ($P < 0.001$) was found, with statistically significant improvements in six of the nine key areas assessed. The nurses reported that although some elements of the programme, such as role play, had been stressful they felt more confident in handling difficult situations. The longer integrated communication skills programme which allows nurses to explore attitudes, raise self-awareness and develop knowledge and skills appears to be effective.

Mot clés: la communication; enseignement, soins infirmiers; études d'évaluation; les soins palliatifs

La communication bonne entre des infirmiers et des patients est un aspect central des soins palliatifs. L'évaluation des cours conçus pour améliorer les techniques de communication des infirmiers, cependant, a été peu concluante. La plupart des cours ont concentré sur la formation pour les techniques, bien que des programmes de cours de communication, ce qui ont été graduellement intégrés dans la pratique clinique et qui ont concentré sur des attitudes et qui ont utilisé une gamme de méthodes pédagogiques, se soient révélés efficaces. On a établi une étude pour évaluer si un cours de techniques de communication, ce qui concentreraient sur la connaissance, les attitudes et les techniques, améliorerait les techniques de communication des infirmiers. Cent-dix infirmiers ont fini un programme de

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formation qui ont duré vingt-six heures, pendant six mois et ont fait des enregistrements d'un évaluation d'un patient sur bande magnétique avant le cours et après le cours. Une amélioration d'ensemble statistiquement significative des techniques d'évaluation était trouvée entre les notes totales moyennes ($P < 0.001$) avant le test et celles après le test, avec des améliorations statistiquements significatives dans six des neuf domaines clés ce qui étaient évalués. Les infirmiers ont rapporté que bien que des parts du programme, par exemple jouer un rôle, aient été stressants, ils se considèrent plus assurés dans des situations difficiles. Le programme de techniques de communication intégré plus long, ce qui permets aux infirmiers d'explorer des attitudes, de croître la conscience de soi et de développer la connaissance et les techniques semble d'être efficace.

Introduction

Effective communication between nurses and cancer patients is a central aspect of nursing care. Health professionals' psychosocial skills not only largely determine patient satisfaction and compliance, but can also positively influence health outcomes.[1]

Increasing patient dissatisfaction with health care is, in part, related to deficiencies in communication.[2,3] Studies in many countries have confirmed that communication problems are common in clinical practice, yet nurses' communication skills with cancer patients have not improved over the past 20 years.[4,5] To communicate effectively it is necessary to master a defined body of knowledge and skills and explore personal attitudes. Communication skills do not automatically improve with experience.[6]

Examples of psychosocial skills needed for effective communication include assessment skills, facilitating skills, techniques for handling difficult questions and good self-awareness. These skills can be defined with behavioural criteria and can be reliably taught and assessed.[7] Helpful attitudes include low levels of anxiety regarding death and dying[5] and an unconditional positive regard for patients.[8] Unfortunately, nurse training has generally been ineffective in teaching clinical communication and there is extensive variability in the quality and intensity of training offered.

In medical training, highly structured programmes in which specific skills are identified, demonstrated, practised and evaluated with supervision, tend to be more effective than less-structured programmes.[9,10] Courses with low student-to-teacher ratios which provide students with multiple opportunities for practice and feedback are also beneficial. Audio and video demonstration tapes, and role play with simulated patients have proved to be effective tools in promoting open communication.[11]

Doctors' training programmes which have documented efficacy[6,12] have all taken an eclectic approach and integrated a communication skills programme into clinical practice over a period of time. In a study using this approach, nurses who had undertaken an integrated programme over a period of time were shown to be better communicators than nurses who had completed condensed three- to five-day workshops.[5] Over the past decade the short workshops have frequently been subscribed to by health professionals working in cancer and palliative care,[13,14] but there is, as yet, a dearth of evidence to suggest they improve nurses communication skills.[15] It was therefore important to evaluate the effects of a longer integrated training approach.

A study was set up to:

- evaluate the effects of a communication training programme for nurses over a six-month period;
- identify the areas of communication with which nurses needed most help;
- identify factors which influence how nurses communicate.

Method

Registered nurses undertaking one of the following courses, in which the long communication training

programme as outlined in Figure 1 was included, were invited to participate in the study:

- Diploma in Cancer Nursing (ENB 237);
- Diploma in Palliative Care (ENB 285);
- Marie Curie Advanced Award in Palliative Care (within the BSc honours degree in Health Studies) (MCAA).

Instruments

Before commencing the course each nurse completed a self-report questionnaire, the Collett and Lester Fear of Death Scale,[16] and an audiotaped nursing assessment. The self-report questionnaire assessed four main areas: demographic information (including, sex, marital status, age and religion); nursing and general educational qualifications; nursing experience; and hobbies and interests.

The Collett and Lester Fear of Death Scale[16] consists of 36 items and uses a six-point response scale to measure respondents' fear of death. However, previous research indicated that the scale in its original form (four subscales underlying 36 scale items) lacked statistical reliability and validity.[17] As a result a factor analysis was undertaken on the scale. The result suggests that only one 'fear of death' conceptual dimension underlies 17 of the scale items. Therefore, 17 of the individual items were summed into a scale in which scores could range from 17 to 102, where higher scores represented higher levels of fear of death.

On the precourse introductory day, each course member received a tape recorder and audiotape together with written instructions about recording a nursing assessment with a patient of their choice to be submitted on the first day of the course. Two further audiotape recordings of a nursing assessment were completed; midcourse (three months after starting the course) and postcourse (three months after course completion). Midcourse the nurses were asked to critique their audiotape in terms of the facilitating and blocking behaviours used and the depth to which the nine key areas of the nursing assessment were covered. Details for the critique were provided in a handout. For the MCAA students this was optional as they were on

Module 1
Submission of audiotape 1
Attitudes to cancer
Impact of serious illness
Perceived communication difficulties
Nonverbal and verbal communication skills
Blocking behaviours
Assessment skills
Autonomy and paternalism
Feedback on audiotape 1

Clinical practice
Practice communication skills
Supervision available
Complete audiotape 2

Module 2
Submission of audiotape 2 and self-critique
Attitudes to death
Assessing anxiety, depression, sexuality
Counselling theories
Informed consent, confidentiality, truth telling
Communication workshop 1 – role play
Feedback on tape 2 and critique

Clinical practice
Practice communication skills
Supervision available
Optional audiotape and self-critique

Module 3
- Body image
- Loss, grief and bereavement
- Spirituality
- Bereavement counselling
- Advanced directives and euthanasia
- Communication workshop 2 – video recording, role play
- Stress and survival in cancer and palliative care
- Optional feedback on audiotape and self-critique

Clinical practice
Three months postcourse
- Diploma summative assessment
  – audiotape 3
  – written critique
- Written feedback

Figure 1 Communication skills programme

a day-release course and there were practical difficulties in nurses obtaining further time off for feedback sessions. Postcourse, the audiotape and self-critique formed part of the course formal assessment and was therefore compulsory.

The communication skills programme

The communication programme is shown in Figure 1. The programme consisted of 26 h of skills and attitude training over a six-month period. Each nurse received personal feedback on their communication/assessment skills for each audiotape as part of the training programme. The individual feedback sessions lasted approximately 20 min.

The rating for each audiotape was carried out by two raters. The rating scale was a revised version of the rating scale used in previous studies.[5,18] It consists of nine key areas, each scored 0–3 according to the criteria laid down for each of the nine areas in the rating manual, giving an overall score of 0–27. The scale has been tested for reliability and validity[5] and a further reliability check between three raters was carried out.

Three separate raters each rated 13 audiotapes chosen randomly, five from the precourse tapes, three from the midcourse tapes and five from the postcourse tapes to assess for possible drift over time. The level of agreement between raters for each of the nine key areas of assessment was measured. More than half (16) of the pair contrasts had high kappa values (0.8 or better), and four rater pairs had complete agreement. An overall percentage agreement was calculated to be 88%.

Analysis of data

The Cohen kappa statistic was used to test the level of agreement for the reliability study. The Wilcoxon test was used to determine differences in the nine individual areas of assessment. Because tests for differences in the nine individual areas are not independent, the Bonferroni method of approximating true probability values was used. To determine differences in nurses communication skills by independent variables the Spearman rank order correlation was used on ordinal data and Mann–Whitney test was used on dichotomy variable. All tests were one-tailed because of the hypothesis in which training can only reasonably be expected to lead to improvement.

Results

Sample

The sample comprised 110 nurses representing 100% participation, 30 nurses registered for the ENB 237; 60 for the ENB 285 and 20 for the MCAA. The mean age was 35 years. Ninety-nine (90%) were female and 11 (10%) male.

The mean number of years since qualification was 11.55 (range 1–37; SD 9.197). The mean number of months in present nursing post was 37.72 (range 1–68; SD 31.60). The positions and places of work of the nurses are shown in Table 1. Forty-one per cent of nurses had at least one nursing qualification in addition to being an RGN. Almost two-thirds (65%) had completed at least one ENB course and for the majority (87%) this was cancer/palliative-related. Approximately two-thirds (67%) also had attended a previous communications skills course, the mean length of which was 6.63 days.

Fear of death was measured by the Collett and Lester Fear of Death Scale[16] with a possible score of 17–102. Fear of death scores ranged from 29 to 89 with a median of 60, a mean of 59.85 and a standard deviation of 12.17, indicating the sample overall had only moderate death anxiety.

Nurses coverage of the key areas of the nursing assessment

The total coverage scores and the scores for each key area for the pretest, midtest and post-test are shown in Table 2. Pretest the nurses were assessed on how well they covered the nine key areas of the

Table 1 Nurses' position and workplace

	n	Percentage
Official position		
Staff nurse	57	52
Community sister	8	7
Ward sister	22	20
Teacher	3	3
Nurse manager	2	2
Specialist nurse	18	16
	110	
Workplace		
Hospital	55	50
Hospice	28	26
Community	9	8
Specialist nurse	18	16
Total	110	

Table 2 Frequency distributions and descriptive statistics for assessment areas in pretest, midtest and post-test

	Coverage							
	None	Poor	Adequate	Good	Mean	Median	Standard deviation	Range
Pretest (n = 110)								
1) Introduction to nursing assessment	0.52	0.17	0.21	0.10	0.90	0.00	1.06	0–3
2) Patient's understanding of admission	0.35	0.31	0.29	0.05	1.10	1.00	0.09	0–3
3) Patient's awareness of diagnosis/condition	0.21	0.24	0.42	0.14	1.50	2.00	0.97	0–3
4) Patient's history of present illness	0.24	0.20	0.47	0.09	1.40	2.00	0.95	0–3
5) Patient's history of previous illness	0.55	0.25	0.18	0.01	0.60	0.00	0.81	0–3
6) Physical assessment of patient	0.03	0.39	0.52	0.06	1.60	2.00	0.65	0–3
Social assessment of patient	0.10	0.44	0.43	0.04	1.40	1.00	0.72	0–3
Psychological assessment of patient	0.46	0.37	0.15	0.02	0.70	1.00	0.78	0–3
Closure of nursing assessment	0.36	0.41	0.20	0.03	0.90	1.00	0.82	0–3
Overall							3.48	2–18
Midtest (n = 70)								
1) Introduction of nursing assessment	0.29	0.20	0.26	0.26	1.50	2.00	1.16	0–3
2) Patient's understanding of admission	0.34	0.19	0.40	0.07	1.20	1.00	1.00	0–3
3) Patient's awareness of diagnosis/condition	0.06	0.09	0.49	0.37	2.20	2.00	0.82	0–3
4) Patient's history of present illness	0.13	0.09	0.46	0.33	2.00	2.00	0.97	0–3
5) Patient's history of previous illness	0.61	0.19	0.16	0.04	0.60	0.00	0.90	0–3
6) Physical assessment of patient	0.06	0.27	0.59	0.08	1.70	2.00	0.71	0–3
7) Social assessment of patient	0.07	0.33	0.53	0.07	1.60	2.00	0.73	0–3
8) Psychological assessment of patient	0.20	0.34	0.30	0.16	1.40	1.00	0.99	0–3
9) Closure of nursing assessment	0.31	0.37	0.24	0.07	1.10	1.00	0.92	0–3
Overall							3.30	5–21
Post-test (n = 110)								
1) Introduction to nursing assessment	0.07	0.09	0.33	0.51	2.30	3.00	0.91	0–3
2) Patient's understanding of admission	0.30	0.14	0.45	0.12	1.40	2.00	1.04	0–3
3) Patient's awareness of diagnosis/condition	0.04	0.05	0.37	0.54	2.40	3.00	0.76	0–3
4) Patient's history of present illness	0.05	0.09	0.55	0.32	2.10	2.00	0.76	0–3
5) Patient's history of previous illness	0.41	0.30	0.22	0.07	1.00	1.00	0.96	0–3
6) Physical assessment of patient	0.06	0.25	0.50	0.18	1.80	2.00	0.81	0–3
7) Social assessment of patient	0.05	0.41	0.43	0.12	1.60	2.00	0.75	0–3
8) Psychological assessment of patient	0.22	0.32	0.27	0.19	1.40	1.00	1.04	0–3
9) Closure of nursing assessment	0.25	0.31	0.34	0.11	1.30	1.00	0.97	0–3
Overall							3.75	6–23

nursing assessment. The scores were low in total and in every key area, particularly in the areas of psychological assessment: 46% of nurses did not attempt to assess how the patient was feeling, 52% did not introduce themselves or state the purpose of the assessment, 55% never covered patients' history of previous illnesses and 35% of nurses did not ascertain patients' understanding of their admission. Nurses were most likely to undertake the physical assessment of the patient with 52% of nurses achieving an adequate physical assessment. Overall the assessments were physically orientated and superficial. There was little structure to most of the assessments. This resulted in an enormous amount of repetition with some audiotapes lasting over an hour.

Midtest the coverage scores improved in total and in every key area except patients' history of previous illness. The nurses still appeared reluctant to cover the patients' understanding of admission and few were able to close the assessment satisfactorily. Fifty-two per cent of the nurses satisfactorily introduced themselves and gave the purpose for the assessment, 46% of nurses undertook an adequate to good psychological assessment, 58% of nurses assessed patients awareness of their diagnosis or prognosis, with 37% also eliciting how patients felt about the diagnosis or prognosis. There was a general improvement in the assessment structure, the audiotapes were shorter, indicating the nurses were using their skills more effectively.

Post-test the improvement in the total coverage score in every key area was maintained except in the areas of psychological and social assessment both of which remained the same. However, post-test 56% of nurses undertook an adequate to good psychological assessment in comparison to 17% of nurses pretest. Similarly 55% of nurses post-test undertook an adequate to good social assessment compared to 47% pretest. However, this was lower than in the midtest, where 60% of nurses scored an adequate to good coverage score. The smallest improvement pretest to post-test was in the physical assessment. Pretest 58% of nurses provided adequate to good coverage which improved to 68% post-test. Statistical tests were undertaken to identify whether any of the pretest, midtest and post-tests scores were statistically significant.

Pretest, midtest and post-test differences in nurses coverage scores

The overall mean total coverage scores increased from 10.1 in the pretest to 13.3 in the midtest to 15.3 in the post-test. These increases were significant from pretest to midtest ($P < 0.0001$), midtest to post-test ($P < 0.0001$) and from pretest to post-test ($P < 0.0001$).

Differences in the nine individual areas of assessment are shown in Table 3. Even using the conservative Bonferroni estimate, six out of the nine key areas for the pretest to post-test differences were statistically significant. The most pronounced areas of improvement included introduction, patients' awareness of their diagnosis or prognosis, history of present illness and psychological assessment. The greatest teaching impact appears to have occurred between the pretesting and midtesting occasions particularly on the following areas: psychological assessment, patients' awareness of diagnosis/prognosis and history of present illness. These improvements also appear to have been sustained over time to post-test.

Table 3 Pretest, midtest and post-test differences in individual areas of assessment

	Pretest vs midtest	Pretest vs post-test	Midtest vs post-test
1) Introduction to nursing assessment	**	****	****
2) Patient's understanding of admission	NS	*	NS
3) Patient's awareness of diagnosis/condition	***	****	n.s.
4) Patient's history of present illness	***	****	NS
5) Patient's history of previous illness	NS	NS	NS
6) Physical assessment of patient	NS	NS	NS
7) Social assessment of patient	NS	NS	NS
8) Psychological assessment of patient	****	****	NS
9) Closure of nursing assessment	NS	**	NS
Overall	****	****	****

*P ≤ 0.05; **P ≤ 0.01; ***P ≤ 0.001; ****P ≤ 0.0001 (or better); NS, not significant.

Table 4 shows a frequency distribution of changes between pretest, midtest and post-test. The majority of nurses had assessment scores that increased between testing occasions. Between the pretest and midtest, improvement occurred for more than three-quarters of nurses (79%), from midtest to post-test improvement occurred for 70%, and between the pretest and post-test improvement occurred for 90% of nurses. It can therefore be concluded that following communication skills training, nurses were able to carry out a more in-depth assessment of patients' concerns.

Differences in nurses communication skills between nurses

Nurses who had qualified more recently had higher pretest and post-test scores than nurses who had qualified less recently ($P < 0.05$). Nurses with at least one nursing qualification aside from RGN had significantly lower post-test scores than nurses with no other nursing qualifications. Nurses with more nursing qualifications tended to have lower post-test scores than nurses with fewer nursing qualifications ($P < 0.05$) Females had slightly higher post-test scores (mean = 15.61) than the males (mean = 12.73) ($P < 0.05$). However, it must be noted the male sample was very small. Younger nurses tended to have higher scores on pretest ($P < 0.05$) and post-test scores ($P < 0.01$) than older nurses. Age was unrelated to any of the change score variables.

Religion was unrelated to pretest and post-test scores; however, on average, Protestants scores increased from midtest to post-test by 1.3, compared to an increase of 3.7 for Catholics ($P < 0.05$). There was a small positive correlation between frequency of religious attendance and score increases between the midtest and post-test ($P < 0.05$). Those who attended religious services weekly had score increases between the midtest and post-test of 3.48, compared to 1.33 for those attending 'occasionally', 1.91 'infrequently', and 0.25 for non-attendees.

Nurses who had previous communications training in the form of the three- to five-day workshops were compared to nurses who had had communications training of a different length and nurses who had had no previous communications training. There were no significant differences on any of the communications outcome variables.

Pretest scores for hospital nurses (mean 10.11), hospices nurses (mean 10.43) and district nurses (mean 10.00) were higher than for the specialist nurses (mean 8.7) ($P < 0.06$). However, these differences did not reach levels of statistical significance.

There was no significant difference in post-test scores or on pretest to post-test levels of improvement according to whether nurses had a midtest or only pretest and post-test.

Table 4 Frequency distribution of changes from pretest to midtest to post-test

	n	Percentage
Pretest to midtest (*n* = 70)		
Score increased	55	79
Score stayed the same	4	6
Score decreased	11	16
Pretest to post-test (*n* = 110)		
Score increased	99	90
Score stayed the same	5	5
Score decreased	6	6
Midtest to post-test (*n* = 70)		
Score increased	49	70
Score stayed the same	3	4
Score decreased	18	26

Course evaluation

The written evaluation indicated that the majority of nurses found the communication component was the most important aspect of their course. However, the course evaluations suggest that the training may not always have been comfortable as the following examples show. Two questions were asked:

1) Q: How have you found the communication skills training?
   A: I think it was very useful to do it over a long period so that when I went back to my clinical area I was able to think about the techniques that we'd discussed and it made me more aware of picking up cues and reflecting things back to patients more than I did, instead of just taking in what they said and making my own assumptions.
   A: The tapes we have just done I found really useful for picking up what I do wrong and I think that I give too much of my own advice

really. I didn't realize I did this but you notice it listening to the tapes and there really is no point in giving all that information.

2) Q: What haven't you liked about it?
   A: I think exposing myself professionally really – thinking I was doing things OK and realizing there's a lot of things I've been doing not very well. I suppose I felt there were areas I could certainly improve on. I think I've really benefited from it.
   A: The self-critique, being strict with yourself and listening to what you are saying and picking yourself up. It was very difficult.

Discussion

The communication skills training programme appeared to be very acceptable to students, indicated by 100% participation. The overall agreement was that the audiotape recordings, self-critique and feedback sessions were the most valuable aspects of the course with role play also proving very important.

The study provided strong evidence that the inter-rater reliability of the communication skills rating score was high. Overall, the nurses scores increased significantly from the pretest to midtest, pretest to post-test and midtest to post-test. Although there was an increase in each of the nine key areas only very small mean increases were seen for physical and social assessments. One possible reason for this could be that at pretest, most nurses had some coverage of these areas. Thus, the scope for improvement was less than for areas where more nurses had no coverage. This suggests nurses felt much happier assessing the physical and social areas at pretest even though coverage was superficial. The training did improve the depth of assessment in these areas but not significantly. Areas with the largest improvement were areas which had the highest proportion of nurses at pretest with no coverage. Few nurses assessed patients awareness of their diagnosis and prognosis or the psychological impact of the illness pretest but most were able to cover these areas post-test. This suggests the training had most effect on the emotionally laden areas and nurses felt more confident to address these areas after training.

In spite of variation in levels of improvement for individual areas of assessment, the vast majority of nurses increased their scores. These increases were most noticeable between the pretest and post-test: 90% of nurses had increases in their scores and less than 6% had scores that decreased with 4% remaining the same. It cannot be ignored that for 10% of nurses the training had little effect or in some cases nurses' performance worsened.

These findings are consistent with previous research.[5] There appears to be a small number of nurses who, regardless of training cannot or perhaps do not want to change their way of communicating. These nurses adopt one of two strategies: either they just give information or they keep very much to their agenda and ignore all patients' cues.[5] These strategies prevent them exposing themselves to patients' emotional worries and concerns. Discussions with the nurses using these strategies suggests they do not want to get involved with patients' emotional reactions as it causes them too much stress and they would rather leave this area of care to other colleagues. They must be respected for this honesty.

The training effect was least strong between the midtest and post-test where 70% of nurses increased their scores but about one quarter decreased their scores. The reason for this could be that the midtest was completed when training was in progress whereas the post-test score was completed when the nurses were back in their own clinical area. This raises the question of whether the improvements would be maintained over a longer period of time or would the nurses revert to their previous practices. Further research is currently being undertaken to test the longer term effect of the communication skills training.

The positive training effect on nurses' communication skills, which was sustained over a three-month period, appears to have been for almost all nurses regardless of their individual characteristics. There were, however, some small but significant relationships between communications training and pretest and post-test scores. In particular, nurses who had qualified more recently were, pretest and post-test, more effective communicators than those who had qualified less recently. This finding is heartening in that it suggests one of two things: preregistration nurse communication training has improved or newly qualified nurses have not yet had the chance to become socialized into bad habits.

Not surprisingly, age was similarly related to pretest and post-test scores, such that nurses who were younger were more effective communicators than older nurses. Females were also slightly better communicators at the post-test than males though the percentage of males in the study was small (10%). In summary, the best communicators were those who had qualified more recently, and were younger and female. However, these relationships, while statistically significant, were weak. The fact remains that for the most part, all nurses benefited from the training and the benefit was sustained into their working environments.

The results of this study should be viewed with caution as the sample, to an extent, was self-selected in that the nurses had not specifically chosen to just do a communication skills course but they had elected to undertake a course to increase their knowledge in cancer and palliative care. A worrying finding of this study was that the specialist nurses were no better communicators pretest than any of the other nurses. A requirement for specialist posts is postbasic training in the speciality and communication skills. Most specialist nurses in this sample had undertaken communication workshops. Furthermore, the nurses who had completed short condensed workshops were no better communicators pretest than the nurses who had only preregistration basic training. This indicates short training courses may not improve communication skills, whereas the results of this study demonstrate that if nurses integrate a communication skills programme with sessions on training and knowledge of cancer/palliative treatments and care they do improve. The longer course enables people to review their own skills and gives them the opportunity to critique, with support, their performance over a period of time. Role play although stressful can be beneficial in giving students the opportunities for practising situations they found difficult. Longer courses appear to develop greater group cohesiveness such that experiential learning like role play does not become so threatening.

In this study the areas the nurses needed most help with were the emotionally loaded areas such as patients' awareness of their diagnosis and prognosis, handling difficult questions, psychological assessments and dealing with patients' and families' emotions such as anger and denial. The study has provided strong evidence that these skills can be taught and the integrated training approach appears to significantly improve nurses confidence in tackling these essential areas of care.

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