A Novel Approach on Breaking Bad News NONPF 2014

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End of Life Care in the Acute Care Setting

- ICUs historically save lives
- Technology provides more options for patients
- At times, conflicting with patient's wishes
- Goals of care may change
- Curative mode changes to comfort measures
- Sometimes the mode never changes, but the patient expires despite all efforts
- Who is there to explain it all?



SECTION TITLE |

Where are the gaps?

- Expansion of role as APNs without proper preparation
- Crowded curriculums
- Lack of qualified educators
- Negative attitudes toward death/dying
- Lack of resources
- All lead to difficult communication and possible conflicts in goals of care



SECTION TITLE

AG-ACNP Program at Drexel University

- Hybrid program with online and on-campus visits
- End of life care/communication incorporated into curriculum
- On campus intensives
 - ✓ High fidelity simulation
 - ✓ Standardized patient experiences
 - ✓ Workshops
 - ✓ Procedures in critical care



SECTION TITLE 1

Importance of Delivering Bad News Experience

- Death leaves lasting memories for those left behind
- First experience breaking bad news can be constructively evaluated
- Provides the students with a "first" experience without involving a grieving family
- Allows for mistakes without the lasting impressions
- Skills are learned in this "safe" environment



SECTION TITLE |

Objectives of Breaking Bad News Learning Experience

- Observe and discuss the meaning of a 'good death'
- Experience delivering bad news in a combined high fidelity simulation and standardized patient encounter.
- Participate in a debriefing session with roundtable discussion based on common themes from reflective journaling.
- Describe examples of prior experiences in practice with delivering bad news and end of life decisions



SECTION TITLE | 2

Sequence of Breaking Bad News Experience

- Watched Evan Mayday's Good Death video
 Pre-brief of high-fidelity simulation experience
 Underwent case scenario of an unsuccessful resuscitation of a 'code blue'
- Directly led to adjacent room where they were tasked with delivering news of unsuccessful resuscitation to the family member (patient's daughter).

- of unsuccessful resuscitation to the family member (patient's daugnter).

 5. Reflective journaling

 6. Debriefing and round table discussion regarding experience, themes extracted from journaling and past experiences.

 7. Incorporated standardized patients into beginning of reflective roundtable discussion



Case Scenario

- Roger G is an 80 year old type 1 diabetic. He has experienced many complications associated with his diabetic mellitus. He has peripheral vascular disease and is legally blind.
 In addition, he receives hemodialysis three times a week. He was admitted with an

- acute MI 12 days ago from home Mr. G's hospitalization has been complicated by a cascade of complications including cardiogenic shock and respiratory failure. Over the past 2-3 days the patient has stabilized. The medical team has discussed moving Mr. G. to an acute rehab after the weekend given the patient was functional

- at home and doing well.

 His morning labs are WNL save for a Na of 126 and a chronically elevated BUN/Cr.
 You are being called to the bedside for a 'code blue'.
 The patient is a full code, there is no living will or power of attorney. He is widowed and has one grown daughter who he lives with and is his next of kin.



Reflective Journaling

"When I reflect on this experience it surprised me how real it

"I have seen so many physicians breaking news to families in such a cold, uncompassionate matter-of-fact way"

"This exercise helped me feel confident when I have to do this on my own one day"



Reflective Journaling

"I felt helpless when I first arrived on the scene since there was not much backup"

"I was uncomfortable speaking to the daughter because I wasn't sure which words to use."

"It was difficult to say or explain what had happened" $\,$

"I kept wanting to say 'passed' because using the word 'dead' or 'died' was really hard"



Themes derived from student journaling

- Didn't know what to say
 Torn in trying to explain what happened
 Felt helpless
 Uncomfortable situation
 Felt pulled: Didn't agree with coding patient vs. honoring wishes of Fetr pulled: Didn't agree with coding patient vs. nonoring wishes or patient
 How far do we go? Felt badly that we 'gave up'
 Comparing: prior experiences with physicians in similar situations
 Being in charge was hard
 Hard to control self when speaking with family



Standardized Patient General Feedback to Group

- They appreciated strong eye contact
- Some physical contact was positive- hand holding or shoulder
- Wanted a calm and direct approach
- Many different approaches were evident to SP's
- Smiling was perceived as a negative
- 'Passed' and 'expired' are confusing terms
- Authentic connection vs. feeling abandoned
- Fill up space with talking vs. silence



SECTION TITLE | 2

Key Points of Roundtable Discussion

- Viewing death as a failure
- Discussing death is easier when the provider has a relationship with the patient/family
- Paying attention to the non-verbal behavior of the spouse
- Providing a death that is good for the patient
- How we are providers take care of ourselves after a difficult day



SECTION TITLE

Faculty Roles and Implementation

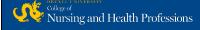
- Emphasize the importance of securing a safe environment
- Understand that for some students this will be emotional, be prepared to handle that
- Anticipate religious and cultural differences
- Make sure that the team understands that the focus is not on the resuscitation process
- Keep the case simple
- Properly train the SP



SECTION TITLE

Future Direction

- Collaborative approach using psych mental health colleagues and students to participate in the simulation experience.
- Interdisciplinary education with medical school students
- Development of a online based 'delivering bad news' educational series
- Further data collection from this years students



SECTION TITLE

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