ELNEC- For Veterans

END-OF-LIFE NURSING EDUCATION CONSORTIUM

Palliative Care For Veterans

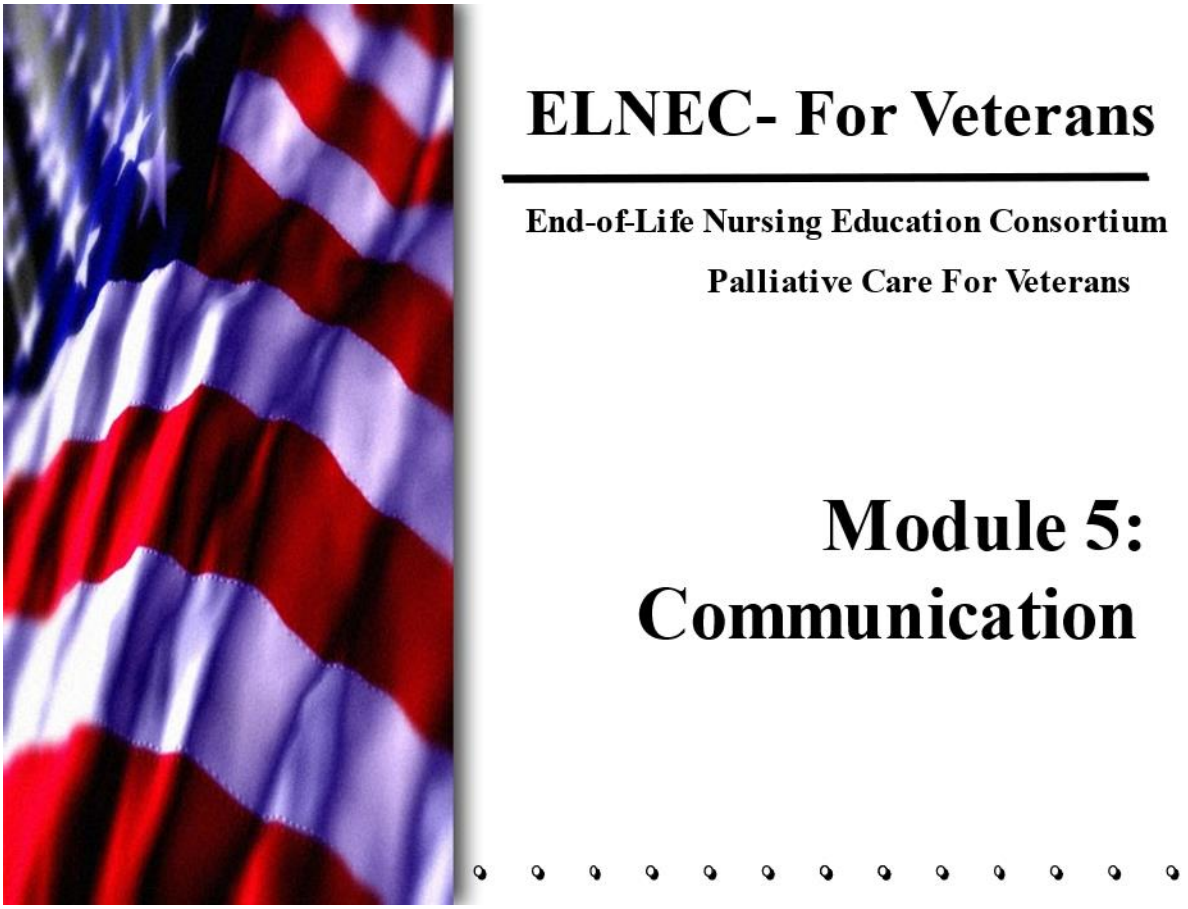
FACULTY GUIDE

Module 5
Communication

The End-of-Life Nursing Education Consortium (ELNEC – For Veterans train-the-trainer program and curriculum was developed by the National ELNEC Project Team, a partnership between the City of Hope (Betty R. Ferrell, PhD, RN, MA, FPCN, FAAN, Principal Investigator) in collaboration with the American Association of Colleges of Nursing with updates undertaken by Carma Erickson-Hurt, DNP, LCDR, USN, RET. Curriculum development and national ELNEC-For Veterans train-the-trainer courses were generously funded by the US Department of Veterans Affairs (original courses and ongoing updates spanning 2009-2023).

Module 5: Communication
Faculty Outline

Slide 1



"Nature gave us one tongue and two ears so we could hear twice as much as we speak."
Epictetus (55 A.D.-135 A.D.)

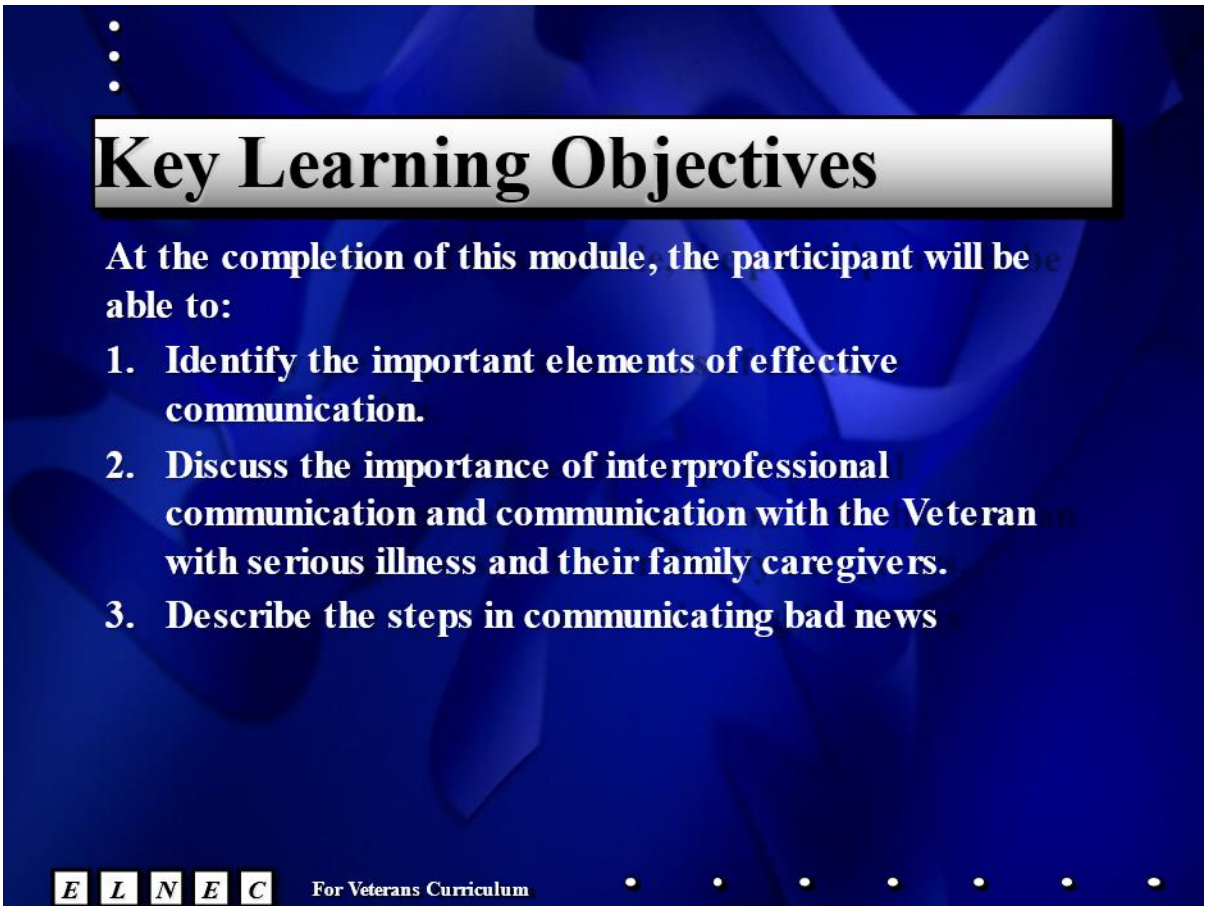
- In the complex and enormous system of the VA, communication can be difficult and sometimes seem almost impossible. Communication is the foundation of excellent palliative care and is an essential requirement to the success of this care (Dahlin & Wittenberg, 2019).

- This module is divided up into 3 sections:
  - Overview of communication
  - Communication techniques: giving "the words"
  - The interprofessional team and family meeting

Teaching Tip:

- This module is intended to be interactive, thus rely less on reviewing PowerPoint slides, and more on role play, viewing good communication through suggested videos, critiquing "not-so-good" communication, etc. Suggested resources include the following:
  - **ELNEC-Communication curriculum** based on the NCP [National Consensus Project for Quality Palliative Care and the eight domains of the clinical guidelines.
  - **We Honor Veterans t**raining videos based on listening and supporting Veterans with PTSD at end of life :https://www.wehonorveterans.org/resource-library/now-available-three-new-training-videos-on-supporting-ptsd-at-the-end-of-life/
  - **The Conversation Project** provides resources for families to use in discussing how they would like to be cared for at the end of their life. http://theconversationproject.org/
  - **Vital Talk** provides free resources (i.e. videos, discussion guides) to assist you in developing excellent communication skills. https://www.vitaltalk.org/resources/

Slide 2

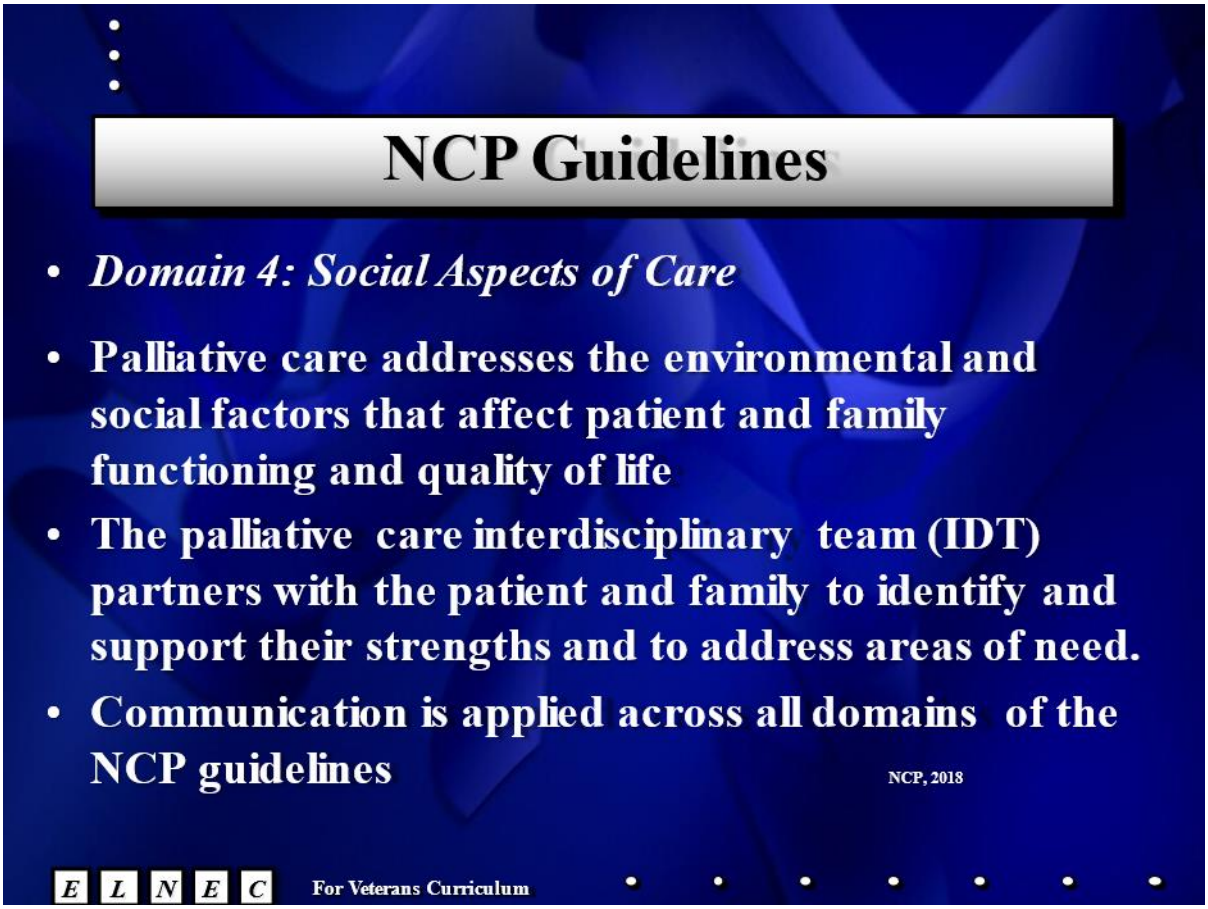


Key Learning Objectives

At the completion of this module, the participant will be able to:

1. Identify important elements of effective communication
2. Discuss the importance of interprofessional communication and communication with the individual with serious illness and their family caregivers.
3. Describe steps in communicating bad news.

Slide 3



National Consensus Project (NCP) Guidelines (NCP, 2018):

- Domain 4: Social Aspects of Care
  - *Global*: The palliative care IDT has the skills and resources to identify and address, either directly or in collaboration with other service providers, the social factors that affect patient and family quality of life and well-being.
  - *Screening and Assessment*: The IDT screens for and assesses patient and family social supports, social relationships, resources, and care environment based on the best available evidence to maximize coping and quality of life.
  - *Treatment*: In partnership with the patient, family, and other providers, the IDT develops a care plan for social services and supports in alignment with the patient's condition, goals, social environment, culture, and setting to maximize patient and family coping and quality of life across all care settings.
  - *Ongoing Care*: A palliative care plan addresses the ongoing social aspects of patient and family care, in alignment with their goals and provides recommendations to all clinicians involved in ongoing care.

- Communication is important and an important aspect across all eight domains of the NCP *Clinical practice guidelines for quality palliative care*. Below is a table that illustrates the

application of communication according to the domains [according to the ELNEC-Communication curriculum] (Ferrell et al., 2019).

Module 1 Suggested Supplemental Teaching Material:

Table 1 (in Module 1 Supplemental Teaching Materials): National Consensus Project Domains and Corresponding National Quality Forum Preferred Practices

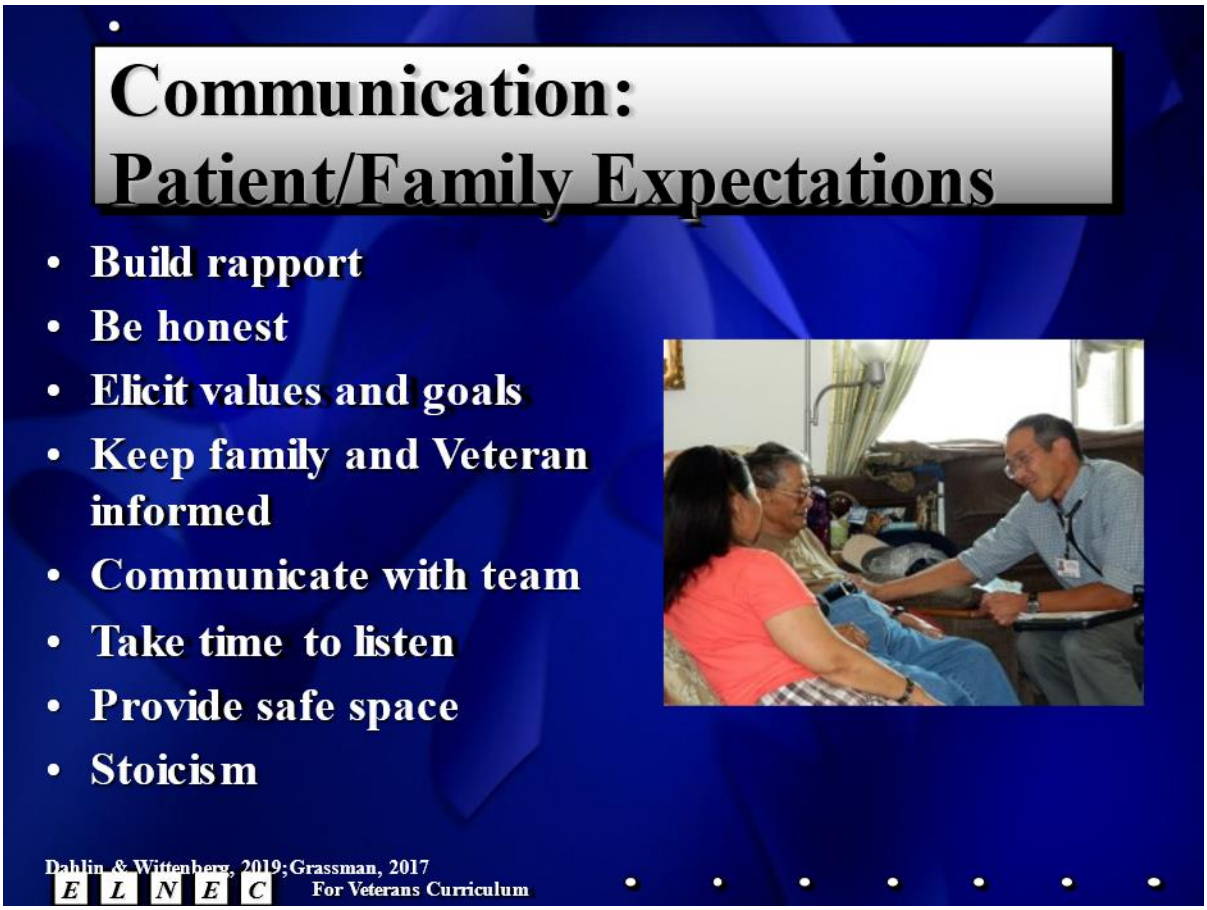
Slide 4

- Nurses assist Veterans and their families establish goals of care, identify important "tasks" to be completed (e.g. a trip, a conversation with a loved one, etc.), discuss barriers to care (e.g. lack of support at home, financial issues, etc.), and accurately communicate this to the interprofessional team.

- Specific standards/documents state the role of nurse communication to Veterans with serious illness
  - American Nurses Association (ANA): Requires nurses to provide care not only to the physical body, but also to address psychological, social, and spiritual/existential needs. This care includes discussing goals of care, describing end-of-life choices and caring for families who are dealing with the loss (ANA, 2016).
  - The American Association of Colleges of Nursing (AACN): Developed palliative care competencies for undergraduate and graduate nursing students in an effort to stress the important role nurses have in this care and the vital responsibility they have in communicating well with patients and their families (AACN, 2016; AACN, 2019).
  - The Hospice and Palliative Nurses Association (HPNA): Developed *Palliative nursing: Scope and standards of Practice* which stresses the importance of being competent in communication throughout the trajectory of a serious illness, at the time of death, and through bereavement care (HPNA 2021).

- National Consensus Project for Quality Palliative Care: *Clinical practice guidelines*: Guidelines to assist with interdisciplinary communication, collaboration with patient/family, development of care plans and goals of care (NCP, 2018).

Slide 5



- Based on the expectations expressed by Veterans/families experiencing life-limiting diseases, it is important to communicate to Veterans and families in the following ways (Dahlin & Wittenberg, 2019):
  - Build rapport with Veterans and families to build trust and understanding
  - Be present
  - Bear witness compassionately
  - Be honest and truthful. This is especially important in Veterans with PTSD, so discussions about death should be done openly and directly. Veterans have faced death before when they were in combat, so clinicians should not use indirect phrases to try to make death more palatable (Grassman, 2017).
  - Elicit and request their values/goals and help as much as possible to achieve these values/goals
  - Keep Veterans and families informed
  - Work with the entire interprofessional team and see that they understand the care plan, that they communicate the goals of care to one another, and that they contribute to its development
  - Listen actively to validate concerns and needs of both Veterans and families/caregivers
  - Provide a safe, quiet, and private place for conversations about death and dying.
  - Stoicism is a component of military culture that tends to long outlast military service. Stoicism can contribute to veterans underreporting their fear, emotional and physical pain, as well as reluctance to

ask for help. Nurses could say, “I know a lot of veterans put on a brave front and don’t want to take pain medication, but pain can consume your energy. You need your energy for other things now.” Encourage veterans not to confuse stoicism with courage by saying, “It takes courage to reach out to connect with others or to ask for help.” (Grassman, 2017)

NOTE: Information that is given in a wise and sensitive manner can promote both the Veteran and family’s ability to act not only now, but in the future and it strengthens the nurse/patient/family relationships (McHugh & Bushman, 2016).

Slide 6

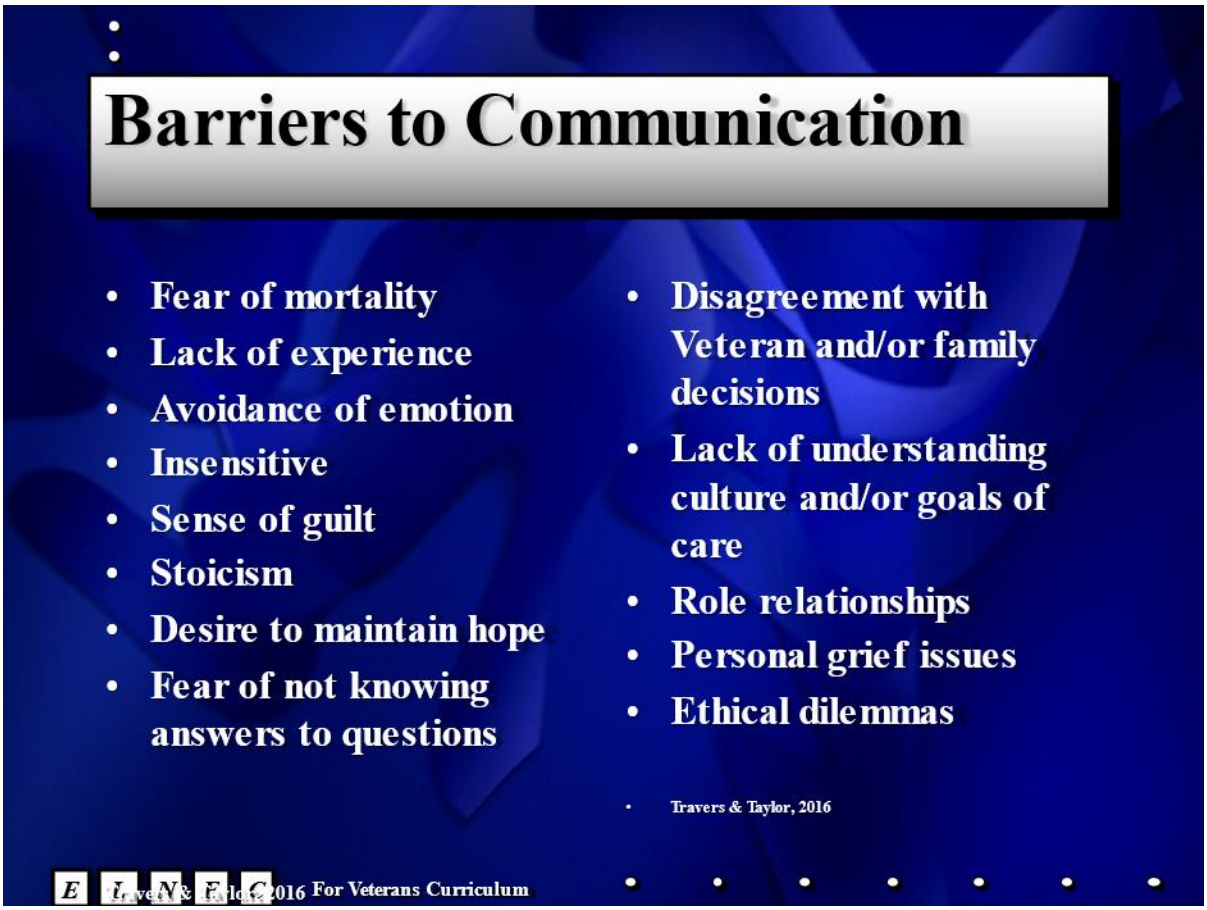
- Nurses are in a unique position to witness and to have conversations with Veterans and their families and to communicate and collaborate with the interprofessional team (Anderson et al., 2017).
  - Through ongoing assessment, determine how much the Veteran/family need/want to know.
  - Initiate family meetings with interprofessional team.
  - Illness can either strengthen family relationships or cause their family strife to surface in unexpected ways.
    - Families with ambivalent relationships (i.e., violence, abuse, divorce, and separation) will have a harder time coping with negative feelings, anger, and guilt.
  - Remember to communicate with children, paying attention to their developmental age. Refer to child life specialists, if available.

NOTE: Further information on family meetings will be provided later in this module.

Slide 7

- Communication is key in order to assess a Veteran's quality of life with or without treatment.
  - What are the prospects, with or without treatment, for a return to normal life? What physical, mental, and social deficits is the Veteran likely to experience if treatment succeeds?
  - Are there biases that might prejudice the provider's evaluation of the Veteran's quality of life? Is the Veteran's present or future condition such that his or her continued life might be judged undesirable?
  - Is there any plan and rationale to forgo treatment? Are there plans for comfort and palliative care?

Slide 8



- Fear of one's own mortality, from both Veteran and healthcare provider perspective, resulting in avoidance of discussing death and dying (Travers & Taylor, 2016).
- Lack of personal experience with death and dying can increase reluctance to discuss this topic.
- Fear of healthcare providers' expressing emotion, such as showing tears, may cause some individuals to avoid difficult topics.
  The healthcare provider's insensitivity, demonstrated by interrupting communication; patronizing; not allowing Veterans/families the opportunity to express their views. Ask a question about combat history in a sensitive way and be willing to hear what others do not want to hear (Grassman, 2009).
- Sense of guilt for failure to cure the Veteran, fear of being blamed for causing death, or guilt at inability to change outcome are real concerns. Society often places unrealistic expectations for cure.
- Desire to support a perception of hope for Veterans and family members. If it is not possible for the Veteran to have full restoration of health, then what other things can bring hope? Always hope for the best but prepare for the worst.
- Fear of not knowing the answer to a question or whether to be honest when answering a question are two significant barriers to open communication.
- Disagreement with Veteran/family decisions can negatively impact further communication.

- Lack of humility or sensitivity about the Veteran's/family's cultures may lead to poor communication.
  - Lack of knowledge and/or understanding of the Veteran's and family's views of health, illness, death and dying. end-of-life goals, wishes, or needs may lead to inappropriate decisions being made. The decisions may not respect the values, culture, and goals of Veterans and families.
- Cultural norms that influence the nurse/physician relationships may present engrained barriers to collaborative communication.
- Personal grief and loss issues of the nurse (e.g., loss of a family member or pet, dissolution of a marriage, loss of dreams, unaddressed cumulative loss/grief).
- Ethical concerns, which may lead to disagreements between Veterans, family members, or healthcare providers related to care, are difficult to discuss but should be addressed openly and, if necessary, with the assistance of an ethics consultation team/ethics committee.

STOP & CONSIDER:

Which of the barriers listed on this slide do you see most frequently in your practice?

Slide 9

Frequently, we speak with Veterans and families about difficult issues and the "fix" seems so obvious to us. Yet, many times, people just want us to listen to their pain, its inconvenience, and it's destruction. Often our role is not to try to fix it. They need us to just listen and "bear witness."

Suggested Video:
It's Not About the Nail: https://www.youtube.com/watch?v=yWcEhtg7W3s

Discussion Questions for the Video:

- What was verbally communicated?
- What was non-verbally communicated?
- How did you know the listener was not complying with the request of the one talking?

Slide 10

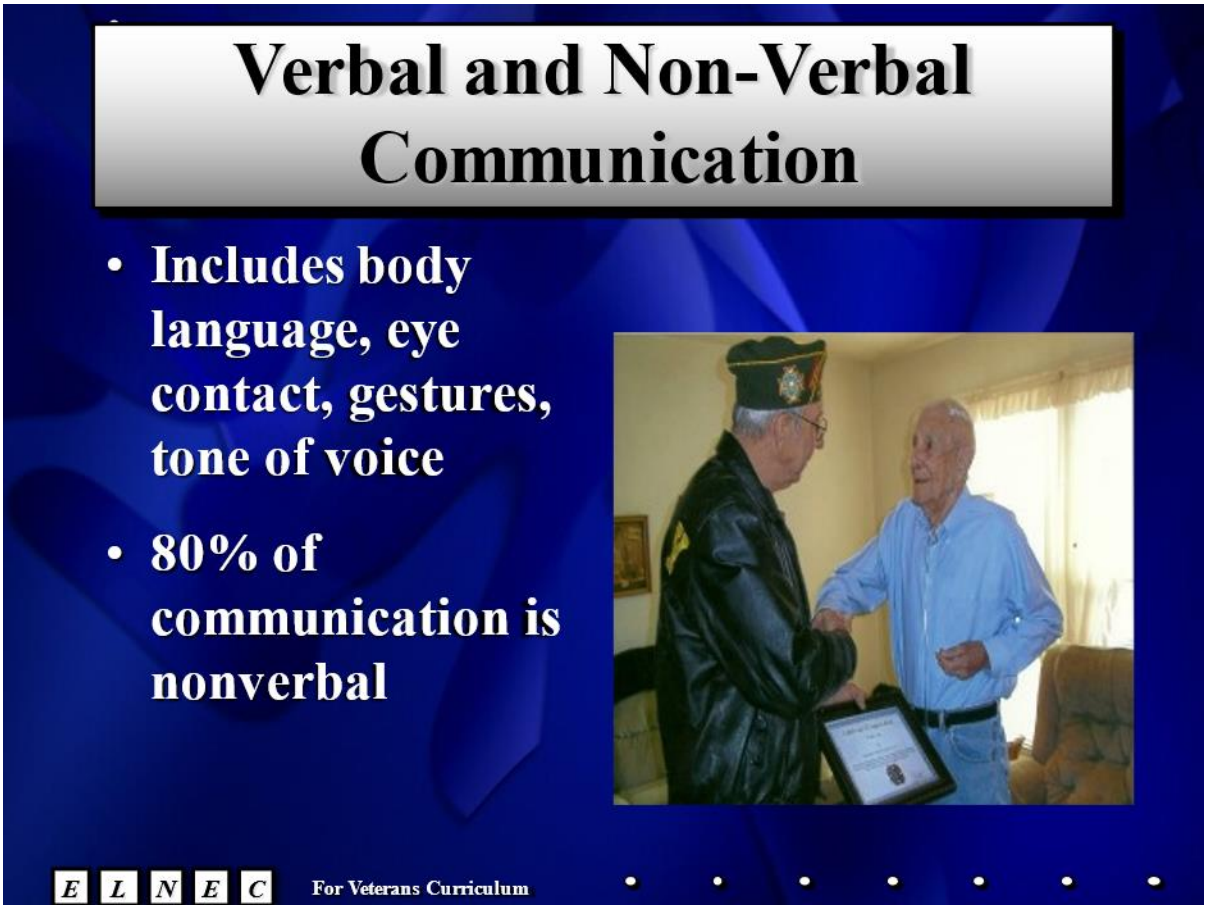
- The family caregiver carries an enormous burden. While attention is always given to the Veteran, the caregiver may be suffering from physical and psychological pain, social isolation, and spiritual angst—yet frequently the healthcare profession fails to notice or assess the family caregiver.

- How do you start a conversation with the caregiver? First of all, pay attention, listen, bear witness, and ask the right questions (Dahlin & Wittenberg, 2019; Goldsmith, 2016):
  - What is going on that takes away from your time with (name of Veteran)? (Ask about status of job, other family members).
  - Describe what it is like at home. Are you able to assist with his/her daily care? Tell me what a typical day looks like for you.
  - With your job, are you able to provide the care he/she needs? Or, do you think you will need outside help? (Ask if the Veteran's care is interfering with their work).
  - Do you or your family need help financially or help with insurance? What help is available if you need it?
  - Who holds the insurance, you or (name of Veteran)? Is the Veteran "enrolled" in the VA? What does this mean in terms of making decisions?
  - What experiences are most important/meaningful to you?

- What fears/worries do you have about the illness?
- What do you hope for your family?
- What kinds of needs do you and your family have?
- Do you have a support system? If so, please describe (e.g. family, friends, neighbors—living near/far?)

*The VA has an extensive program for caregivers, including information, resources, and support. Financial support may also be available to those who quality. More information can be found on the **VA Caregiver Support Program** on the VA website*: https://www.caregiver.va.gov/

Slide 11

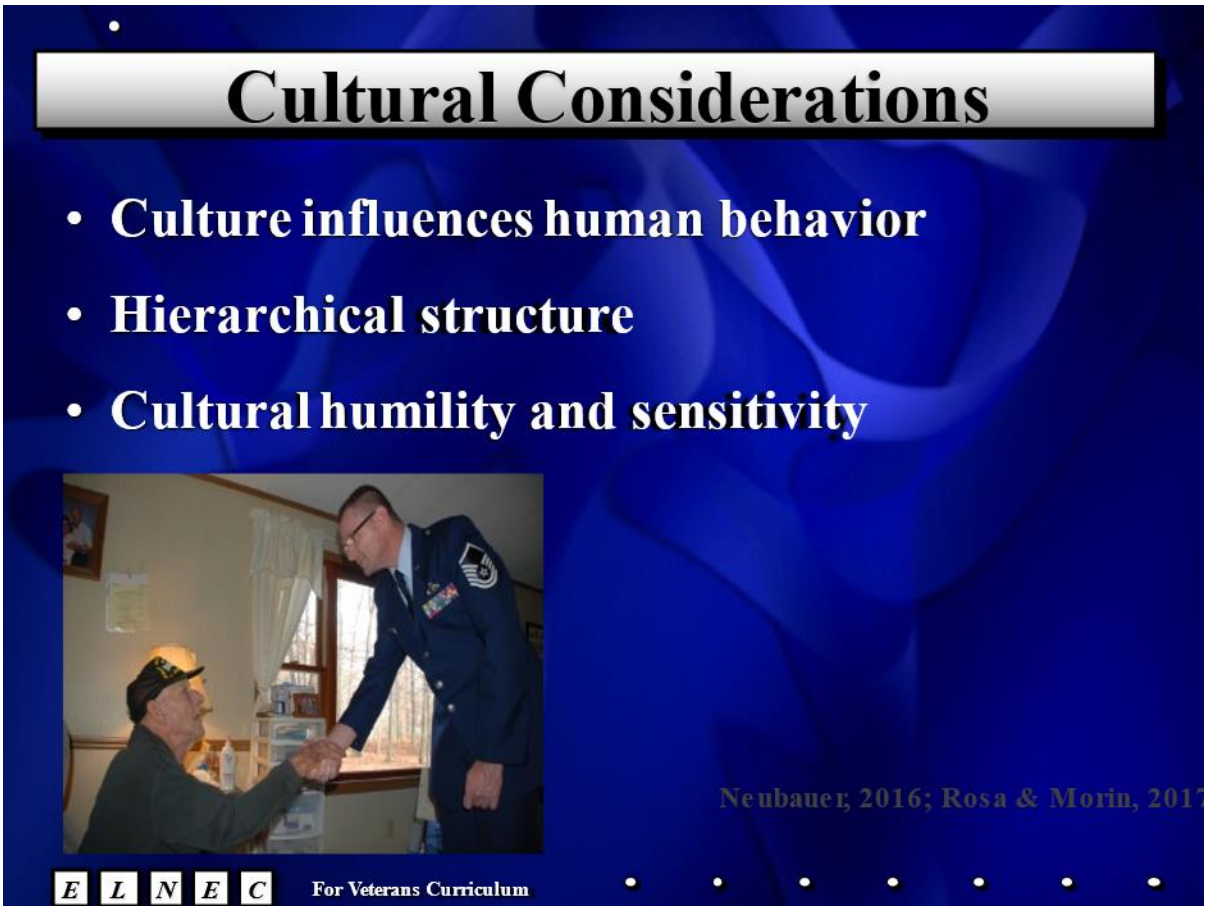


- Communication includes verbal and non-verbal messages. Eighty percent (80%) of communication is non-verbal. This includes body language, our presence, tone of voice, and mannerisms (Dahlin & Wittenberg, 2019).
  - Body language (leaning in, absence of distracting movements)
  - Eye contact (maintaining)
  - Gestures (nodding)
  - Voice intonation
  - Physical "comfort zone"
  - Military symbols and gestures (uniforms, patches, hats, stickers, memorabilia in the home). The salute is a military custom between service members typically signaling acknowledgement of respect to a superior rank. Veterans will also salute the flag.
  - Veterans may carry additional expectations from military service (e.g., having a "squared away" appearance, communicating in a direct style, being prompt) (McCaslin et al, 2021)
- Examples of verbal communication
  - Avoid interruptions
  - Establish purpose of visit/meeting
  - Encourage participation
  - Solicit beliefs, values, and preferences. Military service usually inspires a sense of pride, belonging, loyalty, and brotherhood/sisterhood known as *esprit de corps.* This is why many veterans feel a sense of comfort and connection with other veterans, even with those from

different branches of service or from different eras (Burek, 2018). Veterans share a common set of values, which guide and motivate their behavior, and they may continue to hold these values long after taking off the uniform

- Elicit/validate emotions
- Ask about family and social context
- Provide sufficient information
- Provide clear, jargon-free conversation and explanations
- Validate understanding
- Offer reassurance, encouragement, and support
- Listen
- Be present and "bear witness"

Slide 12



- Culture influences human behavior
  - Impacts communication, family structure/involvement, healthcare decision-making Health inequities and disparities prevent individuals from seeking care or receiving care

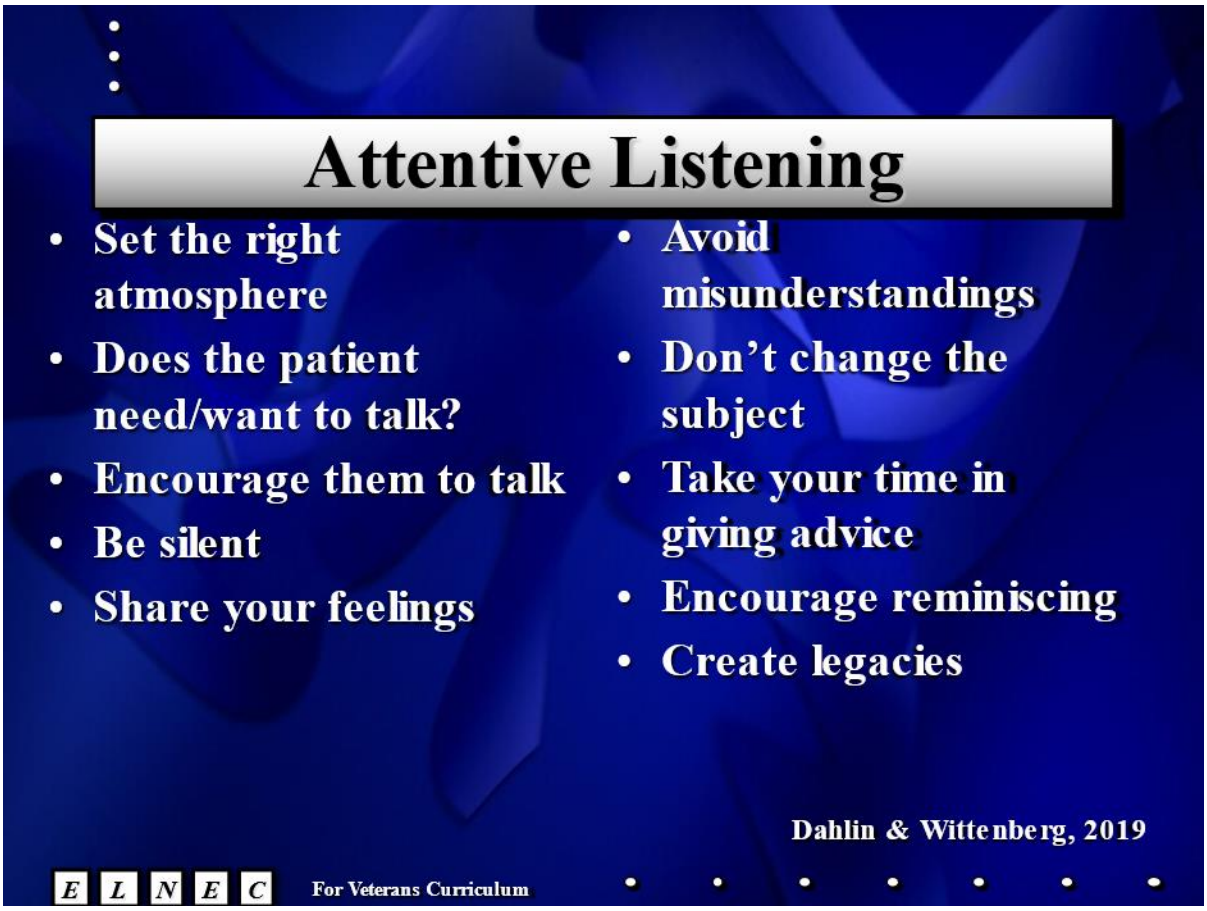
- Hierarchical structure
  - Hierarchy allows structural racism throughout health care.
  - Hierarchy guides communication and decisions
  - Racial /ethnic discordance between the healthcare provider and Veteran/family results in less open communication. This can result in Veterans being given fewer choices and less control (Neubauer et al., 2016).

- Cultural sensitivity and humility (Rosa, 2019; Rosa & Morin, 2017)
  - Shift focus from:
    - Cultural competency
      - Identify differences (i.e., cultural/religious groups, death-related beliefs, practices, rituals, traditions)
    - Seeking cultural understanding
      - Value Veteran/family experience
      - Ask
- Ask questions, listening to the veteran's story will help to establish rapport and help to put the

veteran at ease. (Burek, 2018). Never say "I understand" to a veteran. This phrase, even when said with empathy, may cause a veteran to withdraw or become angry. One cannot "understand" unless they have been there. Respect and trust can be elicited with other empathetic statements or questions, such as "How was that for you?" or "I can't imagine what that was like for you" (Burek 2018).

- Starting from a fresh understanding:
  - Ongoing active process involving:
    - Curiosity and mindful respect
    - Reflection on practice and interactions
    - Flexibility
  - "Where were you born and raised?"; "What language do you prefer to speak?"; "Are there cultural norms for a male or female caregiver?"; "Do you have any foods you would especially enjoy, or that you would especially like to avoid?"
  - Military questions: "What branch were you in?", "When did you serve?", "What was your job in the military", "Where were you stationed?", and "Were you deployed?" (More on military history assessment in culture module)

Slide 13



- Is this a good time to talk with the Veteran/family?
- Are you comfortable to talk - Does the Veteran need any pain or symptom medications first?
  - If so, be sure that you are sitting comfortably, as well as the family.
  - Sit down on "eye-to-eye" level.

- Is this the right time to talk?
  - Ask the Veteran and family caregivers for permission before engaging in a lengthy conversation
  - They may be exhausted and not ready for conversation.
  - Veteran and family may feel over-loaded with information from the team.
  - Perhaps a social worker was just in and spent some time with the Veteran and family and has no further need to talk at this time.
  - Assess the situation.

- Don't anticipate what may be said—LISTEN!

- Encourage communication by (Dahlin & Wittenberg, 2019):
  - Nodding one's head;

- Comments like "I see," or "Tell me more";
- Repeating 2-3 words from their last sentence, "… you were shocked by the diagnosis";
- Reflecting, "So you mean that …" or, "If I understand what you are saying, you are feeling …"

- Listen as you are providing the attention to a good friend who is sharing his/her concerns, heart, and joys.

- Don't change the subject—this can be a natural response we often use to avoid difficult conversations.

- Take your time in giving advice.
  - Try not to give advice, if at all possible, unless asked
  - If you do give advice, do it unassumingly
    - "Have you thought about …"
    - "When I went through this with my friend, mother, etc. I found this to be helpful …"

- Encourage reminiscing, let them tell their story—this is a powerful reassurance that their lives had meaning.

- Create legacies (e.g., audio snippets on smart phones to be downloaded, scrapbooking, leaving a letter to be read on a special occasion, etc.).

- "Thank you for serving our country" is a small thing to say, but it can make a big impact. It requires sincerity, however; words become trite and perfunctory when they don't come from personal exploration and development of awareness of the sacrifices Veterans have made.

- Acknowledge families of veterans. They, too, have often been through hardships and made sacrifices, especially if the Veteran has/had PTSD.

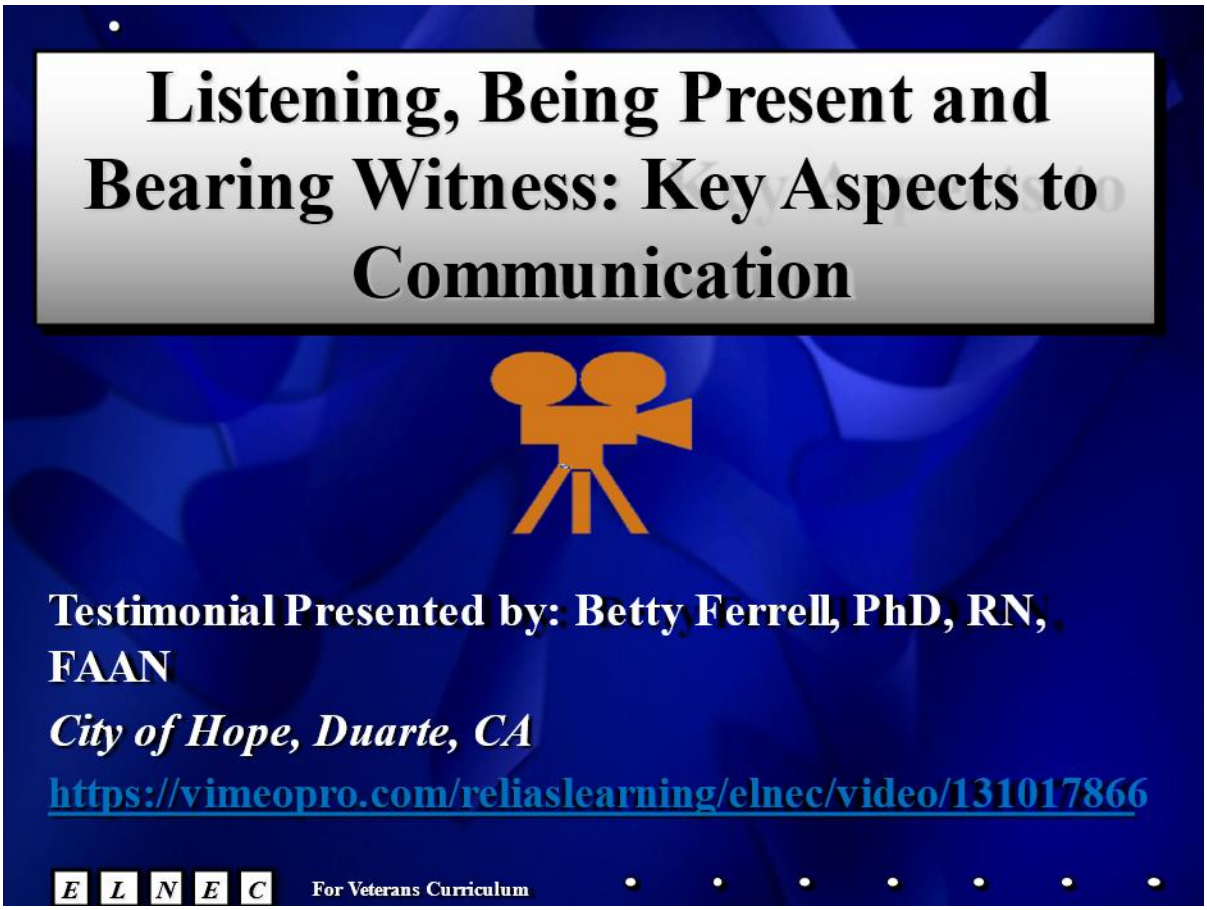
- It's never too late to say, "I'm sorry for how you were treated when you came home," to a Vietnam Veteran as their suffering was never validated (Grassman, 2015).

- Avoid the politics of war. Whether the war was won or not, whether a war is just or unjust, does not change what soldiers went through, the sacrifices they made. In fact, losing wars or fighting in wars they come to believe are unjust, makes the sacrifices that much more difficult to bear (Grassman, 2009).

<u>Module 6 Suggested Supplemental Teaching Material</u>:

Figure 2: Listening Steps

Slide 14



- Mindful presence involves a nurse being nonverbally present for Veteran and family members while also being attentive, in the moment, nonjudgmental, intuitive, and empathic" (Adler, 2017).

- Communication does not consist of only words and gestures, but also includes a "relational dimension" where attitudes, feelings, intentions, and care are presented. Providing gestures such as rubbing a patient's hands/back with lotion, reading to them, reminiscing about a special occasion or introducing the interprofessional team to the patient by not referring to them by their diagnosis—all of these activities help to reconnect patients to things that are important to them (du Pré & Foster, 2016).

- Mindfulness is sometimes referred to as "heedful interrelating." This is the opportunity to be aware of one's self, others, personal relationships, and what is going on in the world around you. It is important to have an open mind and to receive new ideas and ponder different perspectives.

- In communication, it is vital that you are mindful of other's perspective and why they may feel the way they do. Being mindful means to have sincere curiosity and look at a variety of perspectives and not to debate an issue that you may disagree with (du Pré & Foster, 2016).

Suggested Video:

Listening (testimonial): https://vimeopro.com/reliaslearning/elnec/video/131017866

Slide 15

LET'S PRACTICE … Listening Exercise

- Time 5 minutes: Two people
  - One listens without interrupting
  - One speaks about a loss (for 5 minutes)

Questions for Discussion: After completing this five-minute exercise, use the following questions to guide discussion with the participants:

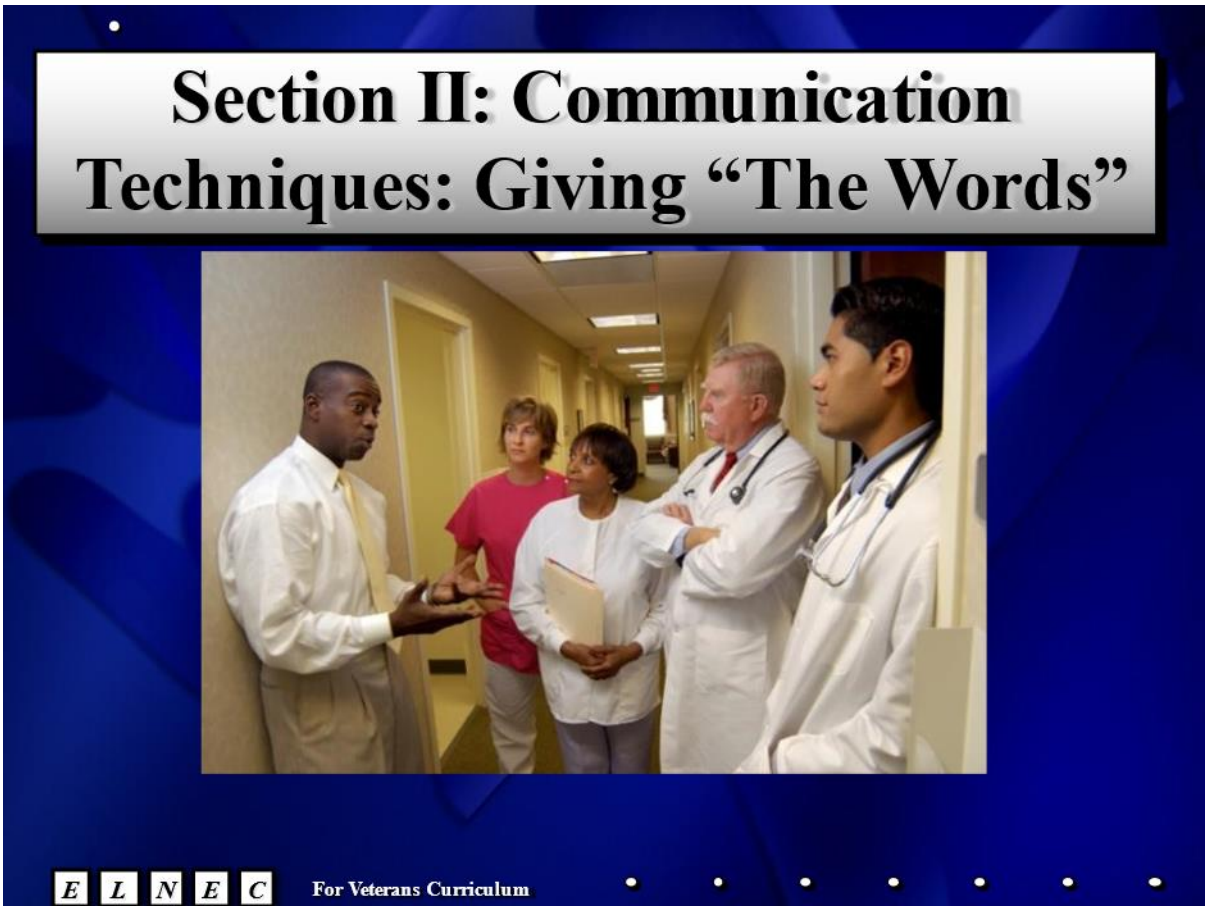
- For the "Speaker":
  - What did it feel like to describe your loss?
  - How did the listener respond to you?
  - Did you feel that they were being attentive?
  - Was there any particular thing that made you feel that they were, in fact, listening to you?
- For the "Listener":
  - How did it feel for you to listen in silence for five minutes?
  - Did the five minutes seem short or long?
  - What aspects of the telling of the story of loss were most significant to you?
  - What did you learn from this experience of attentive listening?

Module 6 Suggested Supplemental Teaching Material:

Figure 1: Listening Exercise

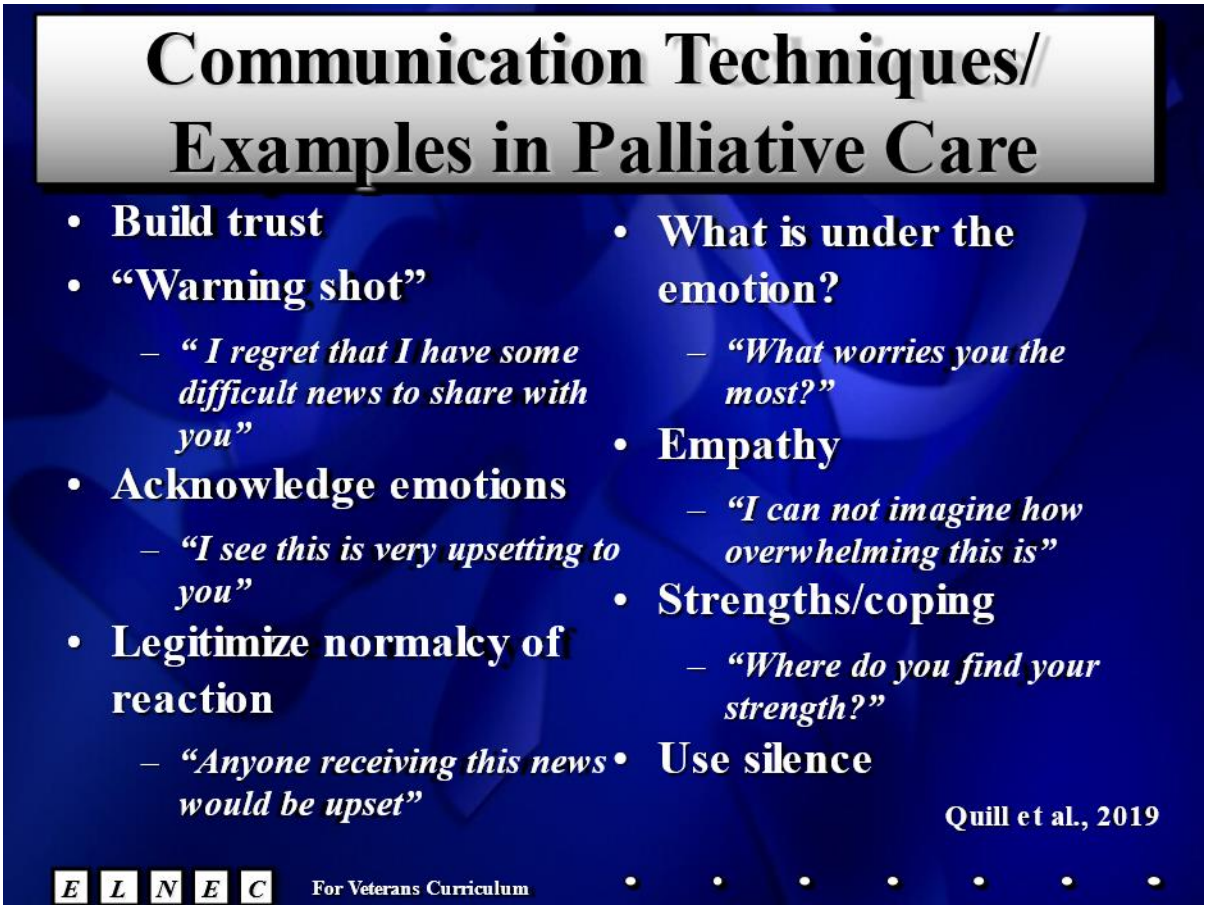
***This Concludes Section I**

Slide 16



- **Section II: Communication Techniques—Giving "The Words"**
- Though listening and being present are key components of communication, words help to clarify, dismiss myths, provide comfort, and understanding. This section will assist in learning how to start and maintain excellent communication. How do you begin to communicate?
- Having key words and/or phrases in mind can be helpful.
- Remember, once you ask a question, truly listen. Avoid the mistake of considering what your next question will be while the Veteran and/or the family is responding.
- Be present, mindful, and be willing to "bear witness" in a sincere and empathetic manner.

Slide 17

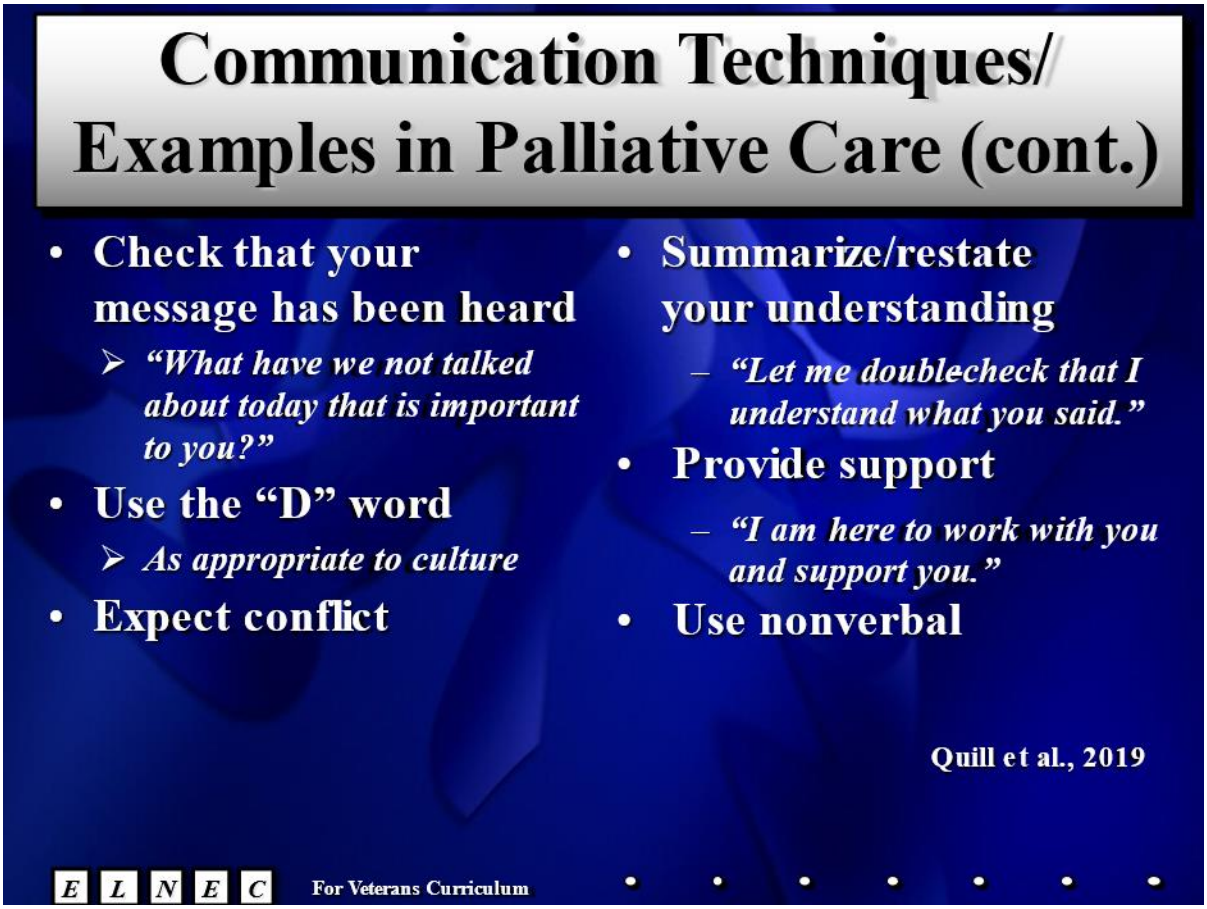


- It is helpful for members of the healthcare team to understand basic communication techniques, especially when speaking with seriously ill Veterans and their families.

- Building trust with the Veteran and family is vital. This can be done humbly by encouraging them to talk, listening, demonstrating respect, and not forcing them to make hasty decisions.

- Other techniques include:
  - Providing a "warning shot".
  - Acknowledging emotions that they may be expressing.
  - Legitimizing the normalcy of the reaction.
  - Exploring what is under the emotion.
  - Empathizing.
  - Exploring what their strengths and past coping strategies are.
  - Using silence: After a Veteran/family has received bad news, be prepared for silence. It is generally uncomfortable to sit through silence. However, this allows time for them to process what they have heard. Don't be tempted to fill in the silence with more medical facts, future diagnostic tests, etc. (Quill et al., 2019).

Slide 18



- Other communication techniques and examples used in palliative care include:
  - Checking that what was said was heard/understood.
  - Using the word "dying" as appropriate to the Veteran/family's culture.
  - Expecting conflict: To prevent or lessen conflict, remember to actively listen, express/explain your view, reframe your statements (if necessary), and agree to brainstorm with the Veteran/family/team.
  - Summarizing and restating what has been understood.
  - Providing support to Veteran and family.
  - Identifying and using nonverbal communication: Ask for clarification when the nonverbal contradicts the verbal (e.g., crying, poor eye contact, etc).

- Examples of nonverbal communication for healthcare team: Attentive listening, eye contact and touching (when culturally appropriate) are examples of nonverbal behavior (Quill et al., 2019).

Slide 19

- Empathy has been defined as "the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner." (Miriam Webster, nd; accessed July 24, 2022 https://www.merriam-webster.com/dictionary/empathy)

- Empathy for others is a critical competency for healthcare professionals to possess. Empathy involves three dimensions (du Pré & Foster, 2016):
  - Attending to the emotions of another (relational)
  - Understanding the emotions (cognitive)
  - Responding to the emotions (communicative)

- The acronym NURSE, showcases how one can articulate empathy in a therapeutic way (Back et al., 2008):
  - **N**aming: "It sounds like you are frustrated."
  - **U**nderstanding: "This helps me understand what you are thinking." Beware: Do not leave the impression that you understand everything the patients is talking about, because you cannot.

- **R**especting: “I can see you have really been trying to follow our instructions.” This is an opportunity to use praise.
- **S**upporting: “I will do my best to make sure you have what you need.” This statement shows your commitment to assist.
- **E**xploring: “Could you say more about what you mean when you say that…”

NOTE: The acronym *NURSE* can be downloaded from *Vital Talk* at**:**
http://vitaltalk.org/guides/responding-to-emotion-respecting/

Slide 20

- Communication strategies to facilitate end-of-life decision-making with Veterans (Dahlin & Wittenberg, 2019).
  - The nurse should be willing to both initiate and engage in discussions about issues relating to care at the end of life.
  - Use words like "death" and "dying" in discussions with the dying Veteran and their families.
  - Maintain hope and be specific about what there is hope for (e.g., pain/symptom control, a good death, a chance to resolve issues with family). *[Show Vital Talk video[Is there any hope?]:* https://www.vitaltalk.org/topics/reset-goals-of-care/*]*
  - Clarify benefits and burdens of treatment option(s).
  - Ensure that consistent information is being given by all healthcare providers.
  - These conversations can be difficult, as they may change at various transition points on the illness trajectory.

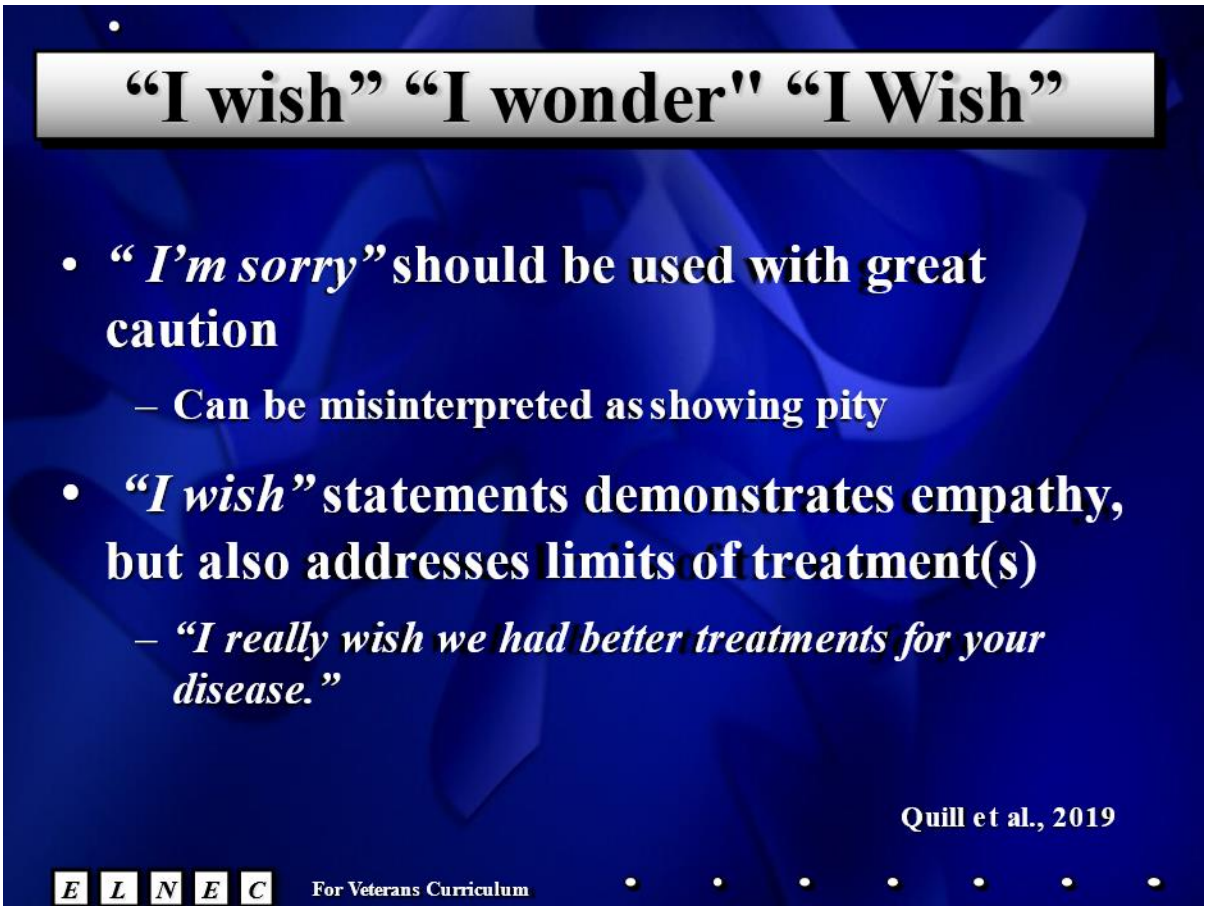
Module 6 Suggested Supplemental Teaching Materials:

Table 2: Issues of Communication and Shared Decision-Making
Table 4: Addressing Goals of Care: REMAP
Figure 3: Exercise to Elicit End-of-Life Goals
Figure 4: Questions to Ask Patients & Families to Help Them Identify What is Important about Time in Their Lives, Their End-of-Life Goals, Wishes and Plans

NOTE: What about communicating with your patients who have dementia? See Table 3: Tips for Communicating with Adults with Neurocognitive Disorders or Dementia.

Suggested Video:
Is There Any Hope [VitalTalk]: https://www.vitaltalk.org/topics/reset-goals-of-care/

Slide 21



- When Veterans express a wish for something that is likely unrealistic, we can use "I wish, I worry, I wonder" statements to acknowledge their hopes, providing honest statements about prognosis, and offering strategies to help them meet their stated goals. (Quill et al., 2019).

  - **"**I wish" statements have a very different connotation from "I'm sorry" which can be misinterpreted as invoking pity.
  - "I wish" denotes empathy, but also shows that there are limits to treating the illness.
  - Examples of saying this is,
    - "I really wish we had better treatments for your disease."
    - "I wish I did not have to give you this information."

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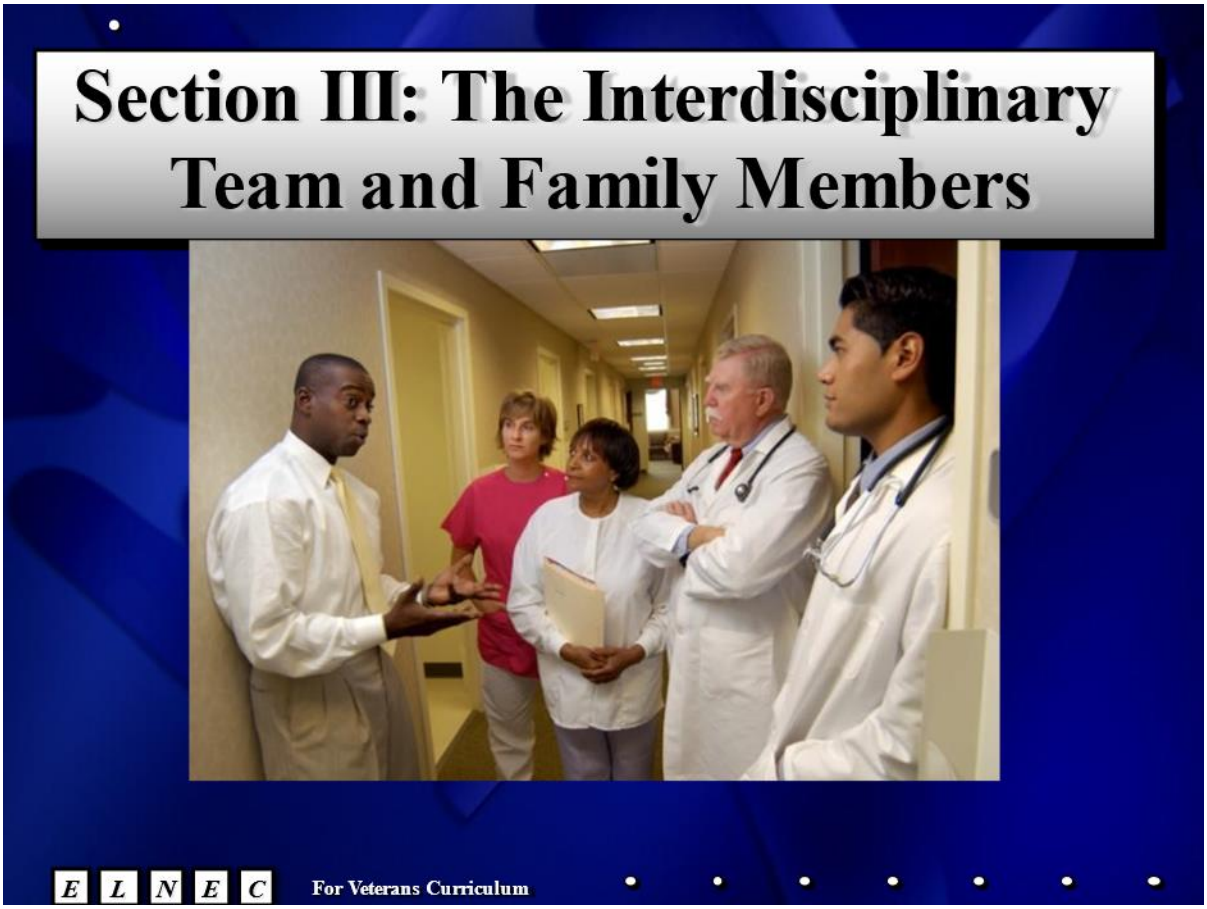
- Caring for seriously ill Veterans every day is difficult and overtime, can cause fatigue, both physically and psychologically. Nursing leaders must be aware of this and be dedicated to coaching and encouraging their staff. This is important in order for your staff to continue to grow and in turn, to provide better care for patients and their families.
- Let's debrief:
  - Do you currently have a coach/encourager?
  - Are you a coach/encourager to your staff?
  - What was technically involved in this conversation?
    - "good listening skills,"
    - "body language encouraged conversation-the coach was available to listen to staff member,"
    - Coach asked nurse what her opinion was versus the coach just giving it.
      - This 3+ minute video show how just a few minutes of listening, being present and "bearing witness" can empower and encourage nurses to do this important and sacred work.

Suggested Video:
Coaching: Supporting Primary Palliative Care at the Bedside: http://vitaltalk.org/topics/coaching/

***This Concludes Section II**

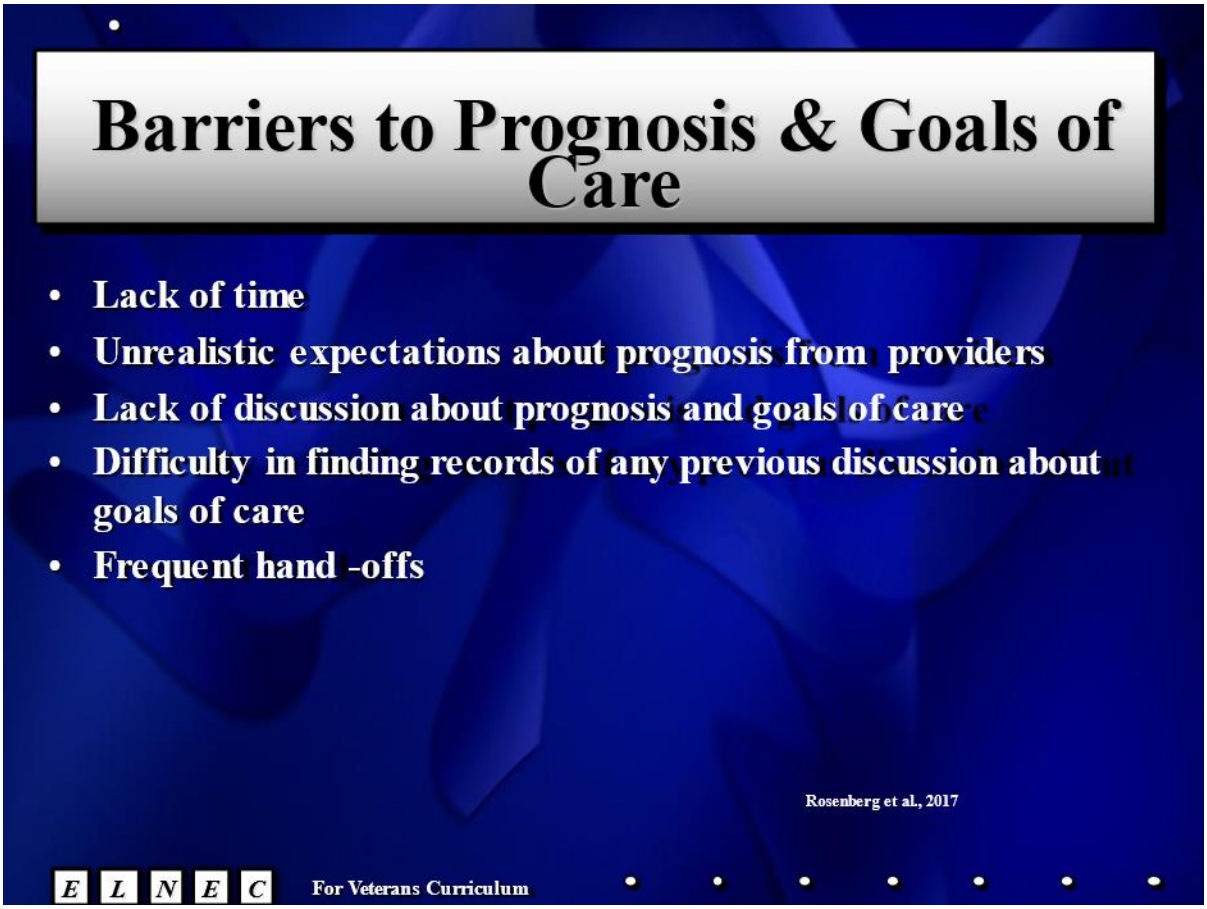
Slide 23



- This final section will highlight the importance of working with the family and interprofessional team in providing the most compassionate care possible, through exquisite communication.

- Expect conflicts along the way. Use them as opportunities to grow and learn.

Slide 24



- As acute care nurses, we sometimes feel frustrated with other healthcare professional colleagues when their patients do not know and understand their prognosis and /or have not been given opportunities to develop/articulate their goals of care.

- In one study of 332 hospitalists (Rosenberg et al., 2017), representing 43 states, showcases barriers physicians experience when discussing prognosis and goals of care with their seriously ill patients:

- Lack of time
- Unrealistic expectations about prognosis from providers
- Lack of discussion about prognosis and goals of care
- Difficulty in finding records of any previous discussion about goals of care
- Frequent hand-offs

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- Family meeting or conference:
- The family meeting is a gathering of the patient and family caregiver as well as other members of the interprofessional team involved in the Veteran's care, as appropriate.

  - **Attendance** – The Veteran should be asked if they want or are able/to attend. The Veteran should be asked which family members they wish to attend. The surrogate decision-maker should be included
  - **Purpose** of the meeting may be the following: discussion of the condition of the Veteran and realistic treatments and trajectory of the condition, goals of care, advance care planning, consistent information for decision-making, identify areas of discord, and other strategies.
  - **Goal** is to improve communication about care of the serious illness and decision-making (Gentry, 2016).

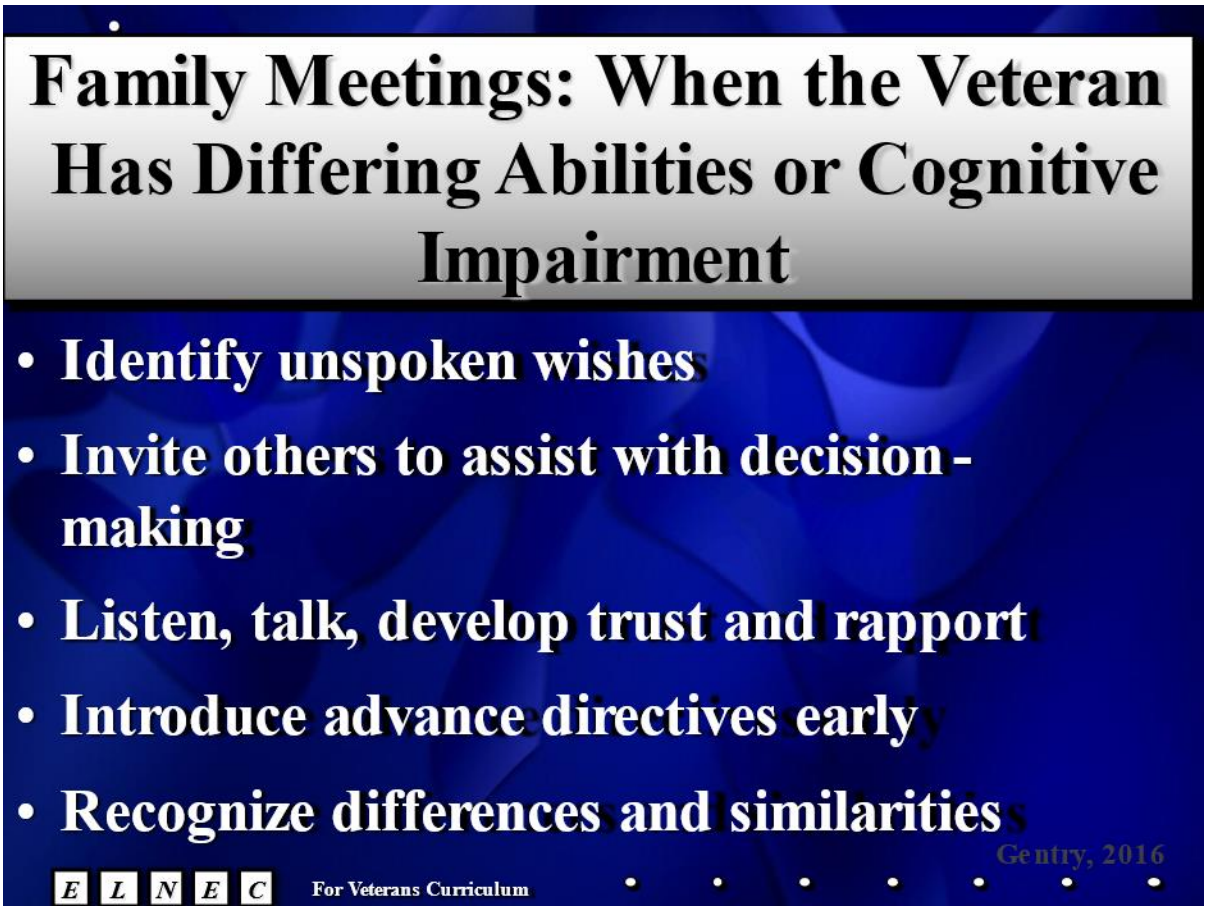
- Barriers to breaking bad news during family meetings include:
  - Healthcare providers' lack of knowledge and experience
  - Lacking a holistic view of the family

- Family's unwillingness to discuss/recognize the decline of their loved one
- Lack of privacy
- Lack of time
- Cultural differences
- Language challenges
- Cognitive impairment (patient and/or spouse/partner/caregiver)

Module 6 Suggested Supplemental Teaching Materials:

Table 1: Six-Step Protocol for Breaking Bad News
Table 2: Issues of Communication and Shared Decision-Making
Figure 6: Recommendations for Conducting a Family Meeting

Slide 26



- The life expectancy for adults with differing abilities has expanded over the years and is now within 5 years of the general population. This has resulted in an increased frequency of death from age related illnesses such as cancer, heart disease, and chronic lung disease (Ellison & Rosielle, 2015).

- Many Veterans with differing abilities or cognitive impairments will have legal guardians (often, but not always, family members) who have decision-making responsibility. Yet, some adults with developmental disabilities or cognitive impairments will be able to express their values and wishes. These must be accommodated as much as possible by surrogates and members of the healthcare team (Ellison & Rosielle, 2009).

- Communication with family and caregivers should include (Gentry, 2016):
  - Assisting family and/or caregivers to identify if there are any unspoken wishes their loved one may have displayed (e.g. self-removing their feeding tube multiple times)
  - Identifying and inviting trusted family, friends, physicians, nurses, and caregivers to assist with decision making
  - Taking time to listen, talk, develop trust and rapport with family members, patients, and caregivers

- Introducing palliative care and advance directives early. Ask parents/caregiver, “what might be the next potential admission?”
- Recognizing the differences and similarities of both the general population and those with differing abilities or cognitive impairments

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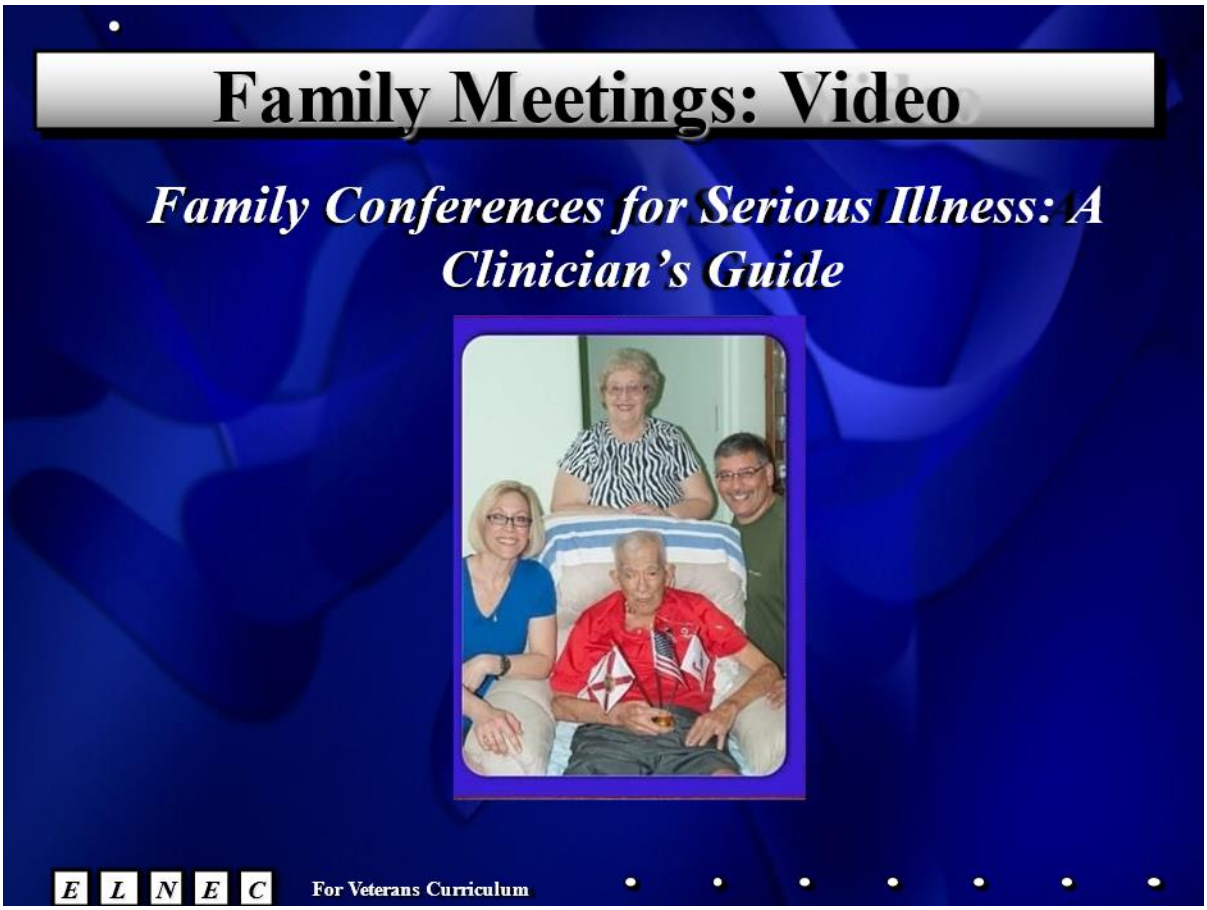

This is an excellent short video (4 minutes, 47 seconds) that outlines seven important aspects of holding a family meeting: *Family conferences for serious illness: a clinician's guide* [https://www.vitaltalk.org/topics/conduct-a-family-conference/] also has a clinician quick guide worksheet that can be downloaded at https://www.vitaltalk.org/guides/family-conference/ [Both accessed July 24, 2022]

- Pre-meet: Get team together before the meeting to make sure everyone is on the same page.
- Introduce: Hold the conference in a private place, introduce all who are present, and make a plan.
- Assess: Learn about what the family's perspective is of the Veteran's illness.
- Update: Give up-dates in parts. Provide pauses so family can think about what you have said and ask questions. Use language the family understands. End with giving "the big picture."
- Empathize: When families understand, they may become emotional. Acknowledge this.
- Prioritize: What is important to your loved one?
- Align: Align medical plan to the Veteran's values.

STOP AND CONSIDER:

- What has been your experience in attending family meetings?
- Of the seven aspects of holding a family meeting described above, which does your team do best?
- What areas can be improved upon?

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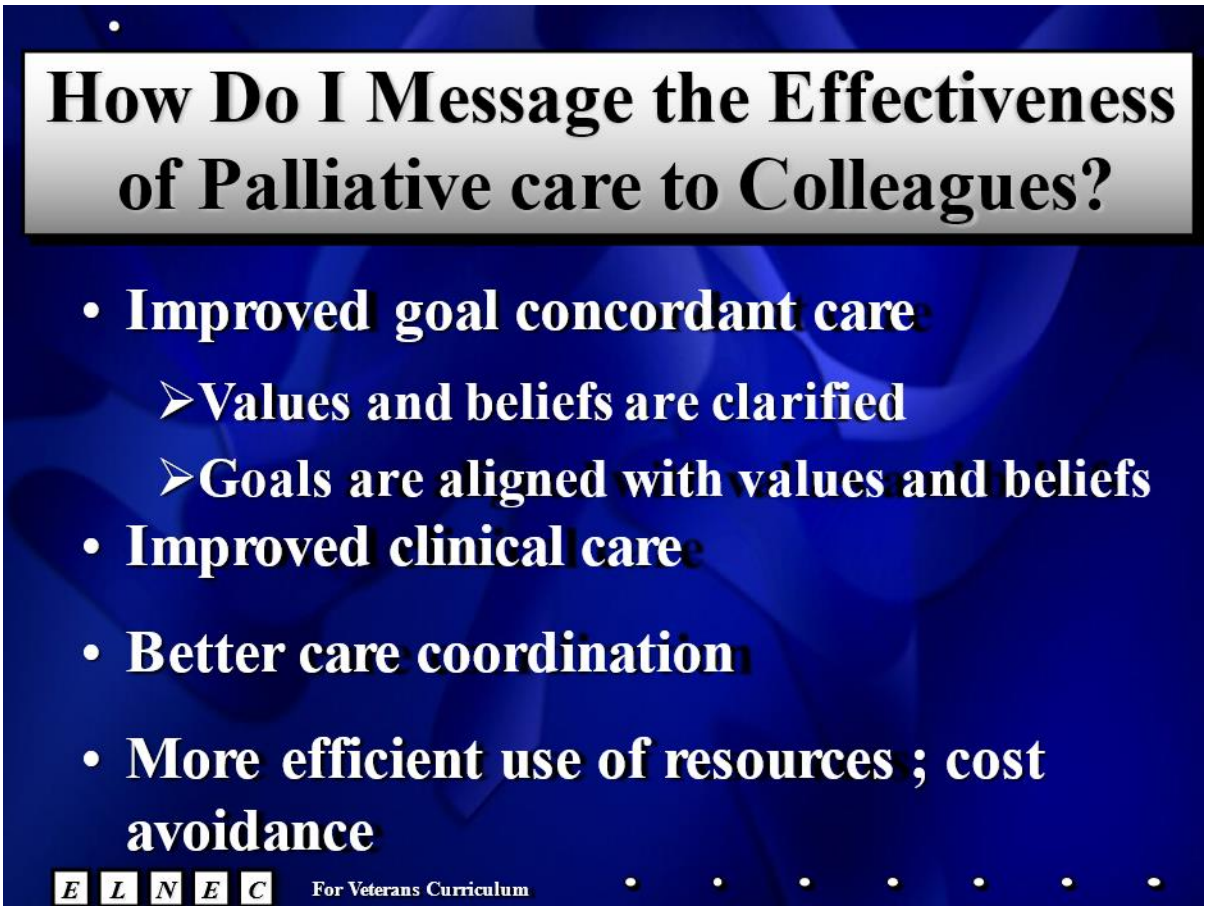
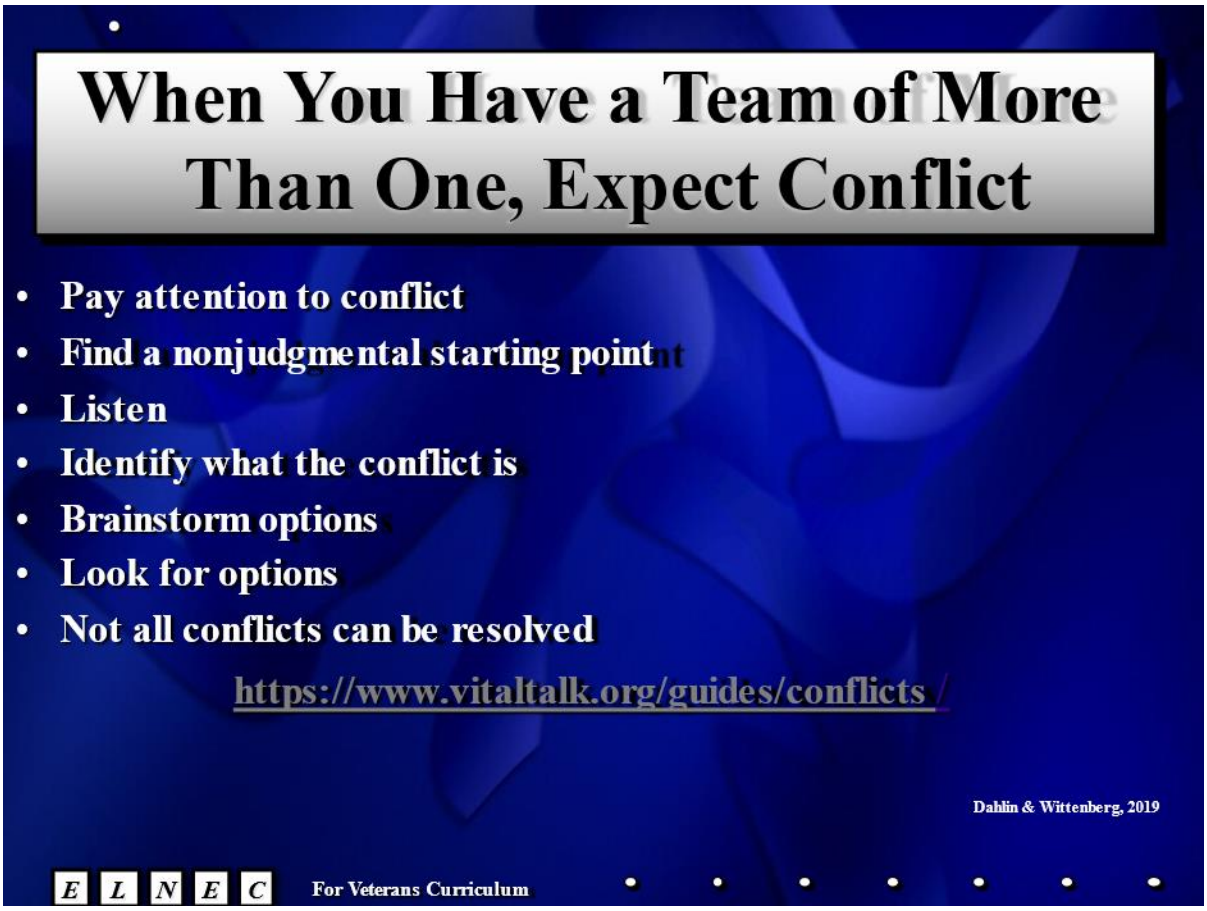


- Improved goal concordant care – values and beliefs are clarified and goal is aligned with them
- Improved clinical care: assess and manage symptoms, help to establish goals of care, and provide assistance to caregiver.
- Better care coordination: Possibly reduce readmission by providing home care and/or out patient care. Assist in enrolling patients in hospice, when appropriate.
- More efficient use of resources: Reduce use of ICU/ED units and cost avoidance: Multiple studies have shown that palliative care can not only saves money but improve care for Veterans and family. (Smith et al., 2014). However, this is not a discussion with Veterans and families as they will think we do not want to spend money on their care.

Slide 29

- Inter-team communication is essential (Dahlin & Wittenberg, 2019).
  - The interprofessional team's goals should be consistent with those of the Veteran/family.
  - Communication among team members should occur on a daily basis.
  - Communication between nurse and physician is critical.
  - The process of collaborative communication supports decision-making between nursing and other disciplines.
  - Collaboration recognizes the unique abilities and knowledge of each professional.
  - Documentation in the medical record or written communication should demonstrate team member roles and goals.
  - Regularly scheduled team meetings are an appropriate tool for carrying out excellent communication—**benefits the Veteran, family, and team.**
  - Expect differing opinions and some conflict—when more than one person is caring for a Veteran, there will always be differing perspectives.

Slide 30



- Expect conflicts to occur. Be prepared for them. Here are some steps to help defuse conflicts (Dahlin & Wittenberg, 2019):
  - Pay attention to the conflict: This must be done internally. You may feel anger, irritation, boredom. Watch body language (eyes rolling, sideway glances, etc). It is not wise to ignore conflict, as it will probably reemerge later.
  - Find a nonjudgmental starting point: "Can we talk about what's happening here?" Raise the issue without attacking those involved. Don't judge. Create space for the other person.
  - Listen to their story: "Tell me your perspective on this." Listen and give the person your full attention. As you listen, don't start preparing your arguments.
  - Identify what the conflict is about, and articulate it as a shared interest: "So, here is my take on the situation." "It appears that we both are interested in the care of Patient X……"
  - Brainstorm options: "Could we list a couple of options, then spend a minute talking about the pros and cons?"

- Look for options that recognize the interests of all involved: "I understand how this meets your interest in ____." "Perhaps we should consider ___ as a good marker of whether we are going in the right direction?"
- Remember that some conflicts cannot be resolved: Not all conflicts have a solution that everyone can agree upon. So, in some cases, it is important to "agree not to agree."

- Identify your own emotions and try to describe them, not display them.
  - Check that the conflict is not about "YOU"—about you "getting your own way";
  - Be prepared that you may disagree with the decisions of patient/family;
  - After the patient/family members have been provided all the information/options, it is their responsibility to make the decision they think is best.

- **Remember, that you are an advocate. Always keep the Veteran and his/her family's best interest in mind.**
  - When nurses and physicians do not communicate, it is the Veteran who suffers. Negative or disruptive physician/nurse relationships are characterized by negative outcomes.
  - Skilled communication and true collaboration are essential standards of care to ensure patient advocacy and safety.

NOTE: A guide to know what to say at different steps in a conflict in order to defuse conflicts can be downloaded from the Vital Talk website at: https://www.vitaltalk.org/guides/conflicts/ [Accessed July 24, 2022]

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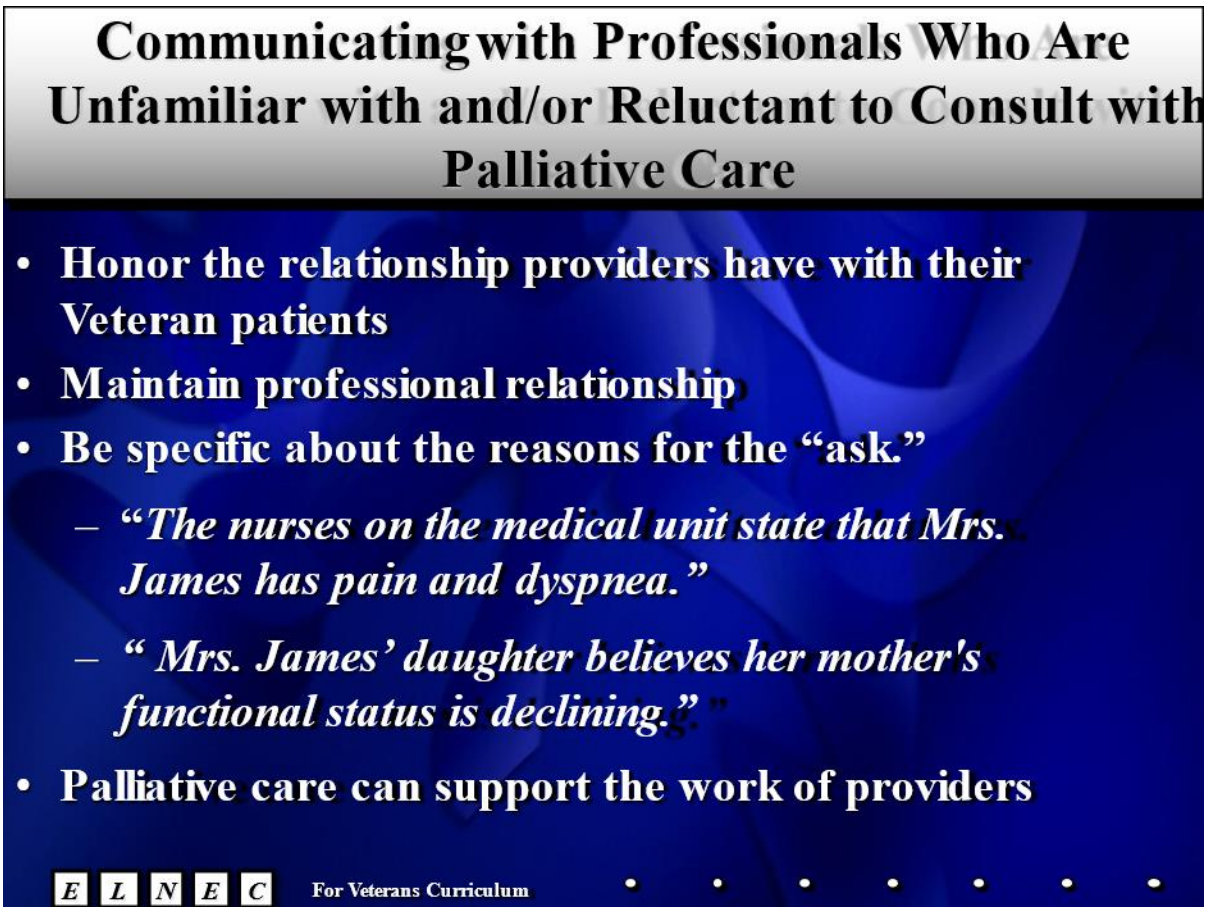

- As advocates for Veteran, nurses have multiple opportunities to assess Veteran for palliative care. This can be challenging when nurses speak with providers (including physicians, nurse practitioners, physician assistants and others) who are unaware or not interested in palliative care services. Ways to assist in having these conversations include:
  - Acknowledge and honor the relationship providers have with their Veteran patients. *"What a great benefit for X to have the continuity of care you have given them."*
  - Always maintain a very professional relationship with the provider (no exception to this rule). Never become angry (even though the provider may be disrespectful and/or disagreeable). Respect and honor their requests for what you can and cannot do with their Veteran patient.
  - Be specific about the reasons for the "ask." Build the case for why this provider should consider a palliative care consult. For example, *"The nurses on the floor state she has pain and dyspnea." "When the nurses turn her, she reports pain." "The Veteran and her daughter feel functional status is declining." "I'm wondering if in the clinic setting you ever talked about goals of care?"*
  - Clearly state what palliative care can do. For example: *"We will focus on pain and symptom management. We will work with you and communicate all of our recommendations directly to you."*

- Palliative care can support the work of attending physicians, hospitalists, nurse practitioners, physician assistants, other providers, and nurses. “We work/collaborate WITH you. We do not TAKE over.”

Slide 32

- Communication is a complex process in all circumstances, but becomes truly challenging in advanced disease.

- Remember that each team member's main objective should be to **ADVOCATE** for what he/she believes is in the Veteran's best interest/wishes.

- True advocacy has been achieved when the Veteran and family have a primary role in the plan of care.

- The nurse's role is to promote clear open communication among team members and the Veteran and family.

- Ongoing assessment of communication outcomes is vital.

SUMMARY:

*"Words are both better and worse than thoughts; they express them and add to them; they give them power for good or evil; they start them on an endless flight, for **instruction** and **comfort** and **blessing**, or for injury and sorrow and ruin."*
Tryon Edwards (1809–1894)

- Communication is vital for excellent palliative care.

- May your words be used for:
  - Instruction
  - Comfort
  - Blessing

Module 6 Suggested Supplemental Teaching Materials:
Figure 5: Brief Communication Role Play Scenarios
Figure 7: Tips for Using Role Play Exercises
Figure 8: Progressive Role Play
Figure 9: Encounter Example: Situational Role Play
Figure 10: Nurse-Family Conversation Goals/Skills Guide
Figure 11: Nurse-Family Conversation: Study & Discussion Guide

***This Concludes Section III**