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Module 6: Communication Supplemental Teaching Materials/Training Session Activities
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Module 6

Table 1: Six-Step Protocol for Breaking Bad News

1. Get the physical context right.
 - Privacy
 - Patient comfort
 - No other procedures or activities as a distraction
2. Find out how much the Veteran knows or suspects.
 - The factual content of the Veteran's statements.
 - The style of the Veteran's statements.
 - Emotional content of the Veteran's statements.
3. Find out how much the patient wants to know.
4. Share medical information.
 - Align (Using patient's words and current knowledge).
 - Educate.
 - Give information in small amounts.
 - Use English (not medical jargon).
 - Check reception frequently. (Check that message is being received.)
 - Reinforce the information frequently.
 - Blend concerns and anxieties with that of the patient.
5. Respond to the Veteran's feelings.
6. Plan and summarize.
 - Identify coping strategies of the Veteran and reinforce them.
 - Identify other sources of support for the Veteran.

Reference:

Buckman, R. (2005). Communication skills in palliative care: A practical guide. *Neurologic Clinics*, 19(4), 989-1004.

Module 6

Table 2: Concepts of Effective Communication Within Shared Decision-Making

Principles of disclosure, confidentiality, informed consent, decisional capacity:

- **Disclosure** - Includes:
 - The Veteran's current medical status, including the likely course if no treatment is provided.
 - The interventions that might improve prognosis, including a description and the risks and benefits of those procedures, and some estimation of probabilities and uncertainties associated with the interventions.
 - A professional opinion about alternative therapies available to the patient.
 - A recommendation that is based on the physician's best clinical judgment (Jonsen et al., 2015; Lapine et al., 2001).
- **Confidentiality** - the sensitive personal information about a Veteran such as diagnosis (both physical and mental health conditions). It also includes personal information that a Veteran discloses to a nurse about themselves (gender identity, gender expression, trauma and abuse, etc). This information is traditionally, ethically, and legally guarded by confidentiality. Nurses are obliged to refrain from divulging information obtained from patients and to take reasonable precautions to ensure that such information is not inappropriately divulged by others to whom it might be professionally known (Jonsen et al., 2015).
- **Informed consent** - a legal term
 - When a Veteran consults a health provider for a suspected medical problem, the provider makes a diagnosis and recommends treatment. The provider explains these steps to the Veteran, giving the reason for the recommended treatment, the option of alternative treatments, and the benefits and burdens of all options. The Veteran states their understanding of the information, assesses the treatment choices, and expresses a preference for one of the options proposed by the provider.
 - This represents the practical application of respect of the Veteran's autonomy (Jonsen et al., 2015).
- **Decision-making capacity** - the ability to understand or to make choices
 - A Veteran's capacity to consent to or refuse care requires a patient to:
 - ◆ Demonstrate an ability to understand relevant information,
 - ◆ Appreciate the medical situation and its possible consequences,
 - ◆ Communicate a choice, and
 - ◆ Engage in rational deliberation about one's own values in relation to the recommended treatment options (Jonsen et al., 2015).
- **Advance Care Planning**
 - **Advance care planning** - Individuals are frequently concerned that when crucial decisions must be made about their medical care, they will no longer be capable of participating in those decisions. Advance care planning serves as a solution to this problem. It includes three things: 1) naming another person as their surrogate decision-maker, 2) declaring their preference for life-sustaining measures in a document (advance directive), and 3) completing documents that state their wishes (out of hospital orders for life-sustaining measures. It is essential that Veterans discuss these concerns with their

family and their health care providers; it is also essential that nurses foster such discussions and record them in the Veteran's record (Jonsen et al., 2015).

- **Patient Self-Determination Act** - During recent decades the nature of the professional-patient relationship has shifted from medical paternalism to patient self-determination. This act, established in 1990, requires that all hospitals receiving federal funds (e.g., Medicare/Medicaid) must ask patients at the time of admission whether they have advance directives (Jonsen et al., 2015; PSDA, 1990).
- **Natural Death Acts (also known as Death with Dignity Acts)** are laws, passed by individual states, that:
 - ◆ Affirm a person's right to refuse life-sustaining medical interventions;
 - ◆ Provide mechanisms for patients to exercise those rights;
 - ◆ Outline the situations in which those rights take place.
- **Advance Health Care Directives**- The primary mechanism that Veterans use to make end-of-life decisions. Usually a statement in writing that declares what type of lifesaving medical treatment a patient wants if incompetent or unable to communicate to medical personnel. Two other forms of Advance Directives are the Living Will and Medical Durable Power of Attorney. Both instruments may be limited or broad in declaration of patient's rights (Jonsen et al., 2015).
- **Durable Power of Attorney for Health Care** - A state specific statute authorizing individuals to appoint another person to act as their agent to make all health care decisions after they have become incapacitated. Recognized in some states as a Health Care Proxy.
 - ◆ This person may be a relative or friend. Legal priority is given to the chosen individual, including next of kin.
 - ◆ Most state statutes require that this appointment be made in writing.
 - ◆ Helpful to the health care team because they authorize a specific decision maker, chosen by the Veteran, to make medical decisions on the Veteran's behalf (Jonsen et al., 2015).
- **Court-Appointed Guardian**- a person appointed by a judge to act on behalf of a minor (a "ward" of the court) when the court system has determined that the minor requires protective oversight of person and estate. Guardians can be relatives, friend, or strangers. Most wards live in private homes, hospitals or other institutions and do not have advance directive capabilities. Not all states offer public guardian services. While 40 states have statutory provisions for public guardianship services, many guardianship programs are underfunded or not funded at all.
- **Court –Appointed Conservator**- a person or organization (conservator) appointed by the court to care for an adult (conservatee) who cannot care for him/herself or manage his/her own person or finances. In the state of California, conservators cannot make end-of-life decisions for consevatees without a court order.

- **Surrogate** - A person who is authorized to make a decision on behalf of another who is incapacitated. Traditionally, next of kin have been considered the natural surrogates, and the medical providers have turned to family members for their consent (Jonsen et al., 2015). Substituted judgment - when someone is granted authority to decide on behalf of the patient, that person's decisions must promote the patient's preferences and welfare.

References:

- Jonsen, A., Siegler, M., & Winslade, W. (2015). *Clinical ethics: A practical approach to ethical decisions in clinical medicine*, 8th edition. New York, NY: McGraw-Hill.
- Lapine, A., Wang-Cheng, R., Goldstein, M., Nooney, A., Lamb, G., & Derse, A.R. (2001). When cultures clash: Patient, and family wishes in truth disclosure for dying patients. *Journal of Palliative Medicine*, 4(4), 475-480.
- Patient Self-Determination Act of 1990 (PSDA). Sections 4206 and 4571 of the Omnibus Budget Reconciliation Act of 1990, PL 101-508. Effective December 1, 1991.

Module 6

Table 3: Tips for Communicating with Veterans with Neurocognitive Disorders or Dementia

Environment is important:

- Lighting should be adequate
- Noise should be at a minimum
- Warn the person you are there, don't take the person by surprise
- Stand or sit in front of the person and make good eye contact
- Avoid unnecessary clutter on the floors
- Screen out troubling messages (TV, radio, news)

Treat the older adult with respect:

- Identify yourself
- Call the person by preferred name
- Explain what the task you need to and what you are doing
- Use appropriate tone and volume (~~do not use baby talk~~)

Respond to emotions rather than words:

- Use specific, descriptive language
- Use appropriate gestures
- Touch as appropriate and tolerated

Remember when communicating with older adults with **neurocognitive disorders or dementia** that behaviors often communicate a message for the Veteran and vice versa (Robinson et al., 2020; Smith et al., 2020).

- Smile; use humor.
- Do not argue or confront. Anger can be used to communicate pain, fear or hurt feelings.
- Use positive language.
- Know the older adult, their habits and life story and use it in the conversations. Crying may indicate sadness or frustration. Wandering may indicate they are lost, are looking for a specific room or place, or are hungry.
- You may need to do most of the communication.

References:

- Robinson, L., Wayne, M.S., & Segal, J. (2020). *Tips for Alzheimer's caregivers: preparing for the road ahead and getting the help you need*. Accessed February 21, 2021 from <https://www.helpguide.org/articles/alzheimers-dementia-aging/tips-for-alzheimers-caregivers.htm>
- Smith, M.A., & Segal, J., & Robinson, L. (2020). *Family caregiving: finding caregiver support and making caregiving more rewarding*. Accessed February 21, 2021 from <https://www.helpguide.org/articles/parenting-family/family-caregiving.htm>

Module 6

Table 4: Addressing Goals of Care: REMAP

Addressing Goals of Care: “REMAP”

We designed this talking map to give you a just-in-time route through a complex conversation. Think of it as a series of signposts—you might find that not all apply to a particular patient.

Step	What you say or do
1. Reframe why the status quo isn't working.	You may need to discuss serious news (eg a scan result) first. “Given this news, it seems like a good time to talk about what to do now.” “We’re in a different place.”
2. Expect emotion & empathize.	“It’s hard to deal with all this.” “I can see you are really concerned about [x].” “Tell me more about that—what are you worried about?” “Is it ok for us to talk about what this means?”
3. Map the future.	“Given this situation, what’s most important for you?” “When you think about the future, are there things you want to do?” “As you think towards the future, what concerns you?”
4. Align with the patient’s values.	As I listen to you, it sounds the most important things are [x,y,z].
5. Plan medical treatments that match patient values.	Here’s what I can do now that will help you do those important things. What do you think about it?
EXTRA: Expect questions about more anticancer treatment.	Here are the pros and cons of what you are asking about. Overall, my experience tells me that more chemo would do more harm than good at this point. It’s hard to say that though.
EXTRA: Talk about services that would help before introducing hospice	We’ve talked about wanting to conserve your energy for important things. One thing that can help us is having a nurse come to your house to can help us adjust your medicines so you don’t have to come in to clinic so often. The best way I have to do that is to call hospice, because they can provide this service for us, and more.



Accessed from VITALtalk and can be downloaded free and permission to print and share with others (per VITALtalk). Website: <https://vitaltalk.org/> and *Addressing Goals of Care: REMAP* can be accessed at: <https://vitaltalk.org/guides/transitionsgoals-of-care/> [Accessed February 10, 2021]

Module 6

Figure 1: Listening Exercise

This exercise is intended to give participants/students an opportunity in active listening. Please divide yourselves into groups of two. One of the two partners will be instructed to be the “speaker” to describe a loss that they’ve experienced in their own life. This can be loss of a significant person, loss of some aspects of their own health, loss of a pet, loss of an object/home or any other significant loss in life. The person is asked to talk about this loss for five minutes. The second partner, the “listener,” needs to listen silently for the five-minute period of time. The listener *may not speak at all* during the five minutes.

This exercise is intended to provide both an experience in describing loss and in expressing emotions as well as, most importantly, giving an opportunity to listen intently in silence.

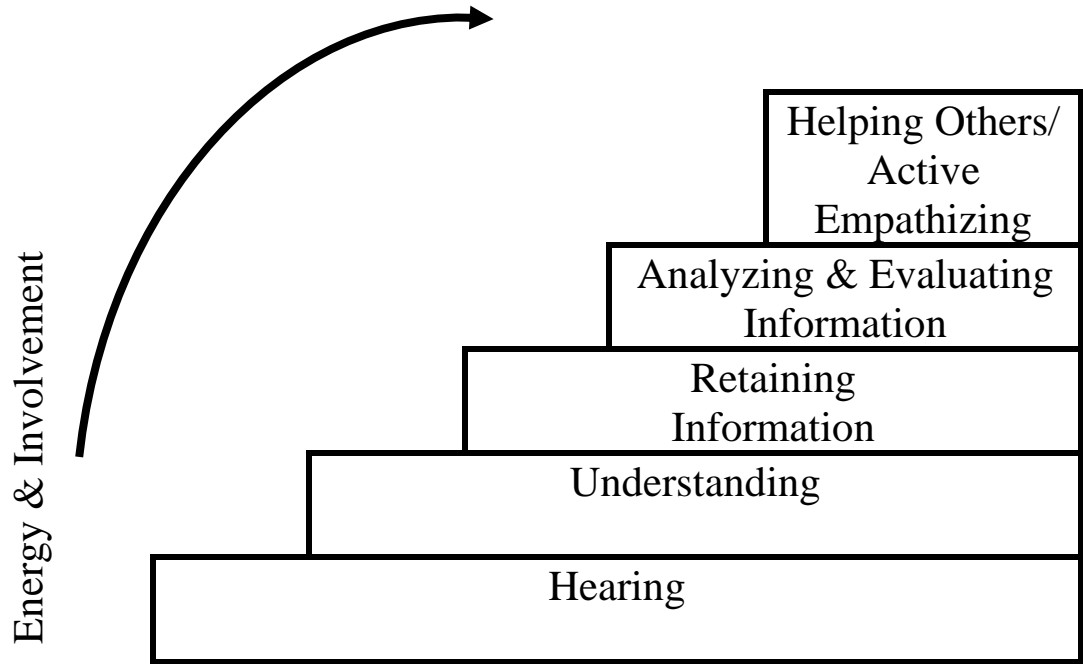
Questions for Discussion:

After completing this five-minute exercise, the following questions may be used to guide discussion with the participants:

1. For the “Speaker”:
 - What did it feel like to describe your loss?
 - How did the listener respond to you?
 - Did you feel that the listener was being attentive?
 - Was there any particular thing that made you feel that the listener was in fact listening to you?

2. 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
Figure 2: Listening Steps



Source:
Ray, M.C. (1992). *I'm here to help; a hospice worker's guide to communication with dying people and their loved ones*. New York, N.Y: Bantam Books.

Module 6

Figure 3: Exercise to Elicit End-of-Life Goals (30 minutes)

This exercise is a way to have participants focus on the importance of communication with Veterans and families as it helps them to define what is important to them at this time in their lives. It helps to clarify their values and end-of-life goals that will guide the interprofessional care plan.

- 1. Create Triads:** Nurse, Veteran, observer 8 minutes

All participants: Read “Questions to Elicit Goals (Mod 6: Figure 2)” and discuss which questions would be most helpful to them as the Veteran being asked and as the nurse asking the questions.

- 2. Role Play:** Ask participants to role play this communication in their triads. Let them know there will be time at the end to discuss the quality and outcome of these communications. 8 minutes

Nurse: Create dialogue using “Questions to Elicit Goals” or similar questions to help the Veteran identify what is important to them at this time in their lives. The Veteran is aware of his/her limited life expectancy.

Veteran: You are a Veteran who is aware of their limited life expectancy and you are beginning to consider what you want to happen during this limited time of your life. Engage in dialogue with the nurse.

Observer: Observe the verbal and nonverbal communication between the nurse and the Veteran. Be ready to describe the quality and outcome of the dialogue.

- 3. Group Discussion:** Facilitate group discussion to address the quality and intensity of this dialogue. Point out how initiating dialogue can assist Veterans and families to identify what is important to them and how we as professional caregivers can then direct our care based on what they have communicated. 10 minutes

Questions to ask to facilitate group discussion.

Patient: What did it feel like to answer these questions? Did they help you to focus on or communicate your priorities?

Observer: Discuss the quality of the communication including the verbal and nonverbal communication between the nurse and the Veteran.

Nurse: What did it feel like for you to have this dialogue?

Source:

The Hospice of the Florida Suncoast, February 2001. Reprinted with permission.

Module 6

Figure 4: Questions to Ask Veterans & Families to Help Them Identify What is Important about Time in Their Lives, Their End-of-Life Goals, Wishes and Plans

Questions for Veterans and Families

- Tell me about yourself.
-
- What do you know about your illness/disease? Is there anything else you would like to know?
-
- What information do you need right now?
-
- How has your illness changed things for you?
-
- How has your illness changed things for your family/those you love?
-
- What matters the most to you? What is most important to you? For your family?
-
- What is helping you the most?
-
- Where are you getting support?
-
- How are you / your family coping with the illness
-
- Can you tell me your family communication style?
-
- Who are important people to be at meetings?
-
- Has your family been through something like this before?
-
- Can you anticipate any potential areas of concern for your family?
-
- Did the patient ever discuss what she or he would want if they became seriously ill?
-
- Did the patient ever complete advanced care planning?
-
- Did the patient ever discuss how he/she defined quality of life in serious illness?
-
- Tell me what your loved one was like?
-
- What was important to him or her?

Adapted from, and for further information:

Dahlin, C. & Wittenberg, E. (2019). Communication in palliative care: An essential competency for nurses. In B.R. Ferrell and J.A. Paice (Eds.), *Oxford textbook of palliative nursing*, 5th edition (Chapter 5). New York, NY: Oxford University Press.

Module 6

Figure 5: Brief Communication Role Play Scenarios/Dyads

Communication Role Play Scenarios

Following are some brief role-play scenarios (4) to be done in pairs. The participants are encouraged to reverse roles (health care professional or Veteran/family caregiver). After completing the 10-minute role plays, the participants should discuss:

- 1) What verbal communication strategies were most helpful?
- 2) What verbal communication strategies were least helpful?
- 3) What nonverbal communication strategies were most helpful?
- 4) What nonverbal communication strategies were least helpful?

Role Play #1

Ms. Smith is a 32-year-old Coast Guard Veteran, single mother who was diagnosed one week ago with stage IV ovarian cancer. This is her first follow up clinic visit in which the oncologist will be discussing treatment options with her. You, the nurse, are meeting her for the first time in the exam room while awaiting the oncologist's arrival. Ms. Smith says to you, "Is it true that everyone dies from ovarian cancer?" How do you respond?

Role Play #2

Dr. Martha Rollin is a hematologist caring for a 23-year-old woman (Molly), an Air Force Veteran, with relapsed leukemia. She was medically discharged from the Air Force 2 years ago. Her relapse was discovered when she was having a physical exam due to complaints of fatigue. She believed her exhaustion was due to the stress of her upcoming wedding. It has become apparent to you and all other nursing and medical team members that Molly is declining. However, Dr. Rollin has been reluctant to inform Molly, her fiancé, or her parents of her prognosis. One of the other nurses shared in report that Dr. Rollin once mentioned that Molly reminded her of her own granddaughter and the resident mentioned that Dr. Rollin told him that Molly was one of her longest-term patients. The nursing staff has become increasingly frustrated as they feel Molly, her fiancé, and her parents need to be informed of her status. Late this evening, Dr. Rollin returns to the hospital for a new admission and you decide this is a good time to discuss Molly's care with her.

Module 6
Figure 5 (continued)

Role Play #3

Paulo Rodriquez is a 49-year-old Navy Veteran with a recurrent brain tumor currently hospitalized after experiencing seizures. Paulo was diagnosed at age 44, just after retiring from the Navy after a 20 year career as a corpsman. He has had extensive surgery, chemotherapy, and radiation therapy. Three months ago, the brain tumor team advised Paulo and his family that there were no further treatment options at which time his family took him to Mexico where he has had numerous herbal therapies and traditional folk remedies. He has experienced weight loss, increasing severe headaches, nausea, and now seizures. Following a severe seizure last week, his girlfriend brought him back to the cancer center to seek any new treatments. As Paulo waits in radiology for a scan, you, the oncology nurse, come to see him as you heard he was in radiology. Paulo tells you he is so tired of treatment and being taken far away and just wishes his girlfriend and children would “just let me be at home so I can be with them and my friends.” How do you respond?

Reflective Practice: For after the Role-Play:

Non-judgmentally reflect on your practice for professional development and learning. You might ask:

1. How might previous experiences affect my communication with this Veteran, family, a colleague?
2. What assumptions might I have made about this Veteran/family?
3. Did anything surprise me?
4. Did anything interfere with my ability to be attentive or respectful? Were there points where I felt judgmental about someone in the room?
5. Could I have been more present with and available to this Veteran/family?

Module 6

Figure 6: Recommendations for Conducting a Family Meeting

Prepare for the Meeting

- Ask the Veteran if they want to be at the meeting and which family members they want to attend.
- Coordinate the meeting – space, time, and health care members who will attend.
- Review medical issues and history.
- Discuss the goals of meeting with team.
- Identify which health care member will lead the meeting.
- Discuss which family members will be present.
- Try to minimize distractions: set aside adequate time and seating, turn off pager if possible.

Open the Meeting

- Facilitate introductions for everyone in attendance – who they are and their role in the care.
- Review the medical situation.
- Establish the overall goal of the meeting, by saying something like: *“Today I’d like to make sure everyone understands how [the Veteran] is doing and answer all the questions that you have,”* or *“We wanted to meet today to discuss how [the Veteran] will be cared for at home.”*
- Be prepared for the goals of the meeting to change based on Veteran and family’s desires.

Elicit Veteran and Family Understanding

- Ask Veteran and family members questions, such as *“What have you been told about your [the Veteran’s] condition?”*
- After hearing from the Veteran and family, a helpful follow-up question is *“Is there anything that isn’t clear that we can help to explain?”*

Elicit Veteran and Family Values and Goals

- Elicit goals of all these present, especially if multiple perspectives are held.
- Begin with an open-ended question, such as, *“Given what’s gone on, what are your hopes? Or for families for [the Veteran]?”* This may be followed by more specific suggestions for the family: *“sometimes getting home is an important goal for someone. Sometimes seeing a certain family member or friend is an important goal: are there things like this that you imagine are important for you or [the Veteran]?”*
- Understand ethnic and cultural influences on communication styles, family relationships, medical treatments, and end-of-life care by asking: *“Can you please help me to understand what I need to know about your or [the patient’s] beliefs and practices to take the best care of [the Veteran]?”*
- Maintain focus on the Veteran’s perspectives if the Veteran is not able to attend or speak about their wishes. Often this can help to relieve guilt that family members may feel over making decisions. Such questions could include: *“What do you imagine [the Veteran] would have done or wanted in this situation?”* or *“Our goal is not so much to think about what you*

would want or not want but to use your knowledge of [the Veteran] to understand what he or she would want in this situation.”

Module 6

Figure 6: Recommendations for Conducting a Family Meeting (cont.)

Deal with Decisions That Need to Be Made

- Achieve a common understanding of the issues.
- Find out if the patient had made his or her wishes about the decision known by asking, *“Have you or Had [the Veteran] ever discussed what he would want or not want in this kind of a situation?”*
- Reassure Veterans and family members that they are making a decision about what is in the best interests of the Veteran, not necessarily what is in their own best interests.
- Begin with open-ended assessments and then turn to specific interventions if necessary.
- Offer clear recommendations based on Veteran and family goals, by suggesting, for example, *“Given our understanding of the medical situation and what you’ve told us about your or [the Veteran’s] goals, I would recommend not pursuing dialysis.”*
- Seek consensus whenever possible, agreeing on the decision or on the need for more information.
- Use summary statements, such as, *“It sounds like we are coming to an understanding that you or [the Veteran] would not want to continue on the ventilator. Is that how everyone understands his or her wishes?”*
- Consider the possibilities of seeing the decision as a “therapeutic trial” or as a healthcare team recommendation that requires only family assent.
- Check for understanding of the decisions made, by saying something like, *“I want to make sure everyone understands that we’ve decided to...”*

Close the Meeting

- Offer a brief summary of what was discussed.
- Ask for any final questions.
- Offer a statement of appreciation and respect for the family: *“I appreciate how difficult this must be, but I respect everyone for trying so ~~hard to do right by your chooses or [the patient],~~”* or *“I want to thank everyone for being here and for helping to make the difficult decisions.”*
- Make a clear follow-up plan, including plans for the next family meeting and how to contact the health care team.

Follow up on the Meeting

- Document the meeting in the chart.
- Follow up with any information or reassessment agreed upon during the meeting by saying, *“When we last met, you were going to talk with your brother about our meeting. How did that go?”*

Source:

Rabow, M.W., Hauser, J.M., & Adams, J. (2004). Supporting family caregivers at the end of life: “They don’t know what they don’t know.” *Journal of the American Medical Association*, 291(4), 487. Reprinted with permission.

Module 6

Figure 7: Tips for Using Role Play Exercises

Role playing can provide a beneficial educational exercise by allowing persons the opportunity to practice communication skills and techniques in a safe environment. It can also be used to demonstrate and practice the skills needed for performing assessments, conducting care planning sessions, orchestrating family meetings, or giving bad news. Communication is key to good palliative care and the necessary skills can be enhanced via training and practice opportunities.

Reasons to use role play include:

- connecting content to application
- putting a human face on concepts
- building confidence and skills
- encouraging critical thinking
- gaining empathy into the feelings of clients and practitioners
- practicing important skills prior to actual encounters
- energizing the teaching environment
- increasing student confidence and assertiveness.

Role plays enable participants to define problems, develop solutions, try out new behaviors, and get feedback from their peers. Yet, participants' initial reactions to the idea of a role play may be fear, intimidation, ambivalence or total negativity. Such responses are often due to past experiences in which role playing was not well orchestrated. When you choose to use role play as a teaching technique, it is essential that you as facilitator are prepared and organized.

Here are some tips related to preparation, execution, and evaluation of role plays:

1. Acknowledge that role playing may be difficult at times but the potential benefits are worthy.
2. Preparation/Setting the Stage
 - Always know your purpose for using role play. What skills are you trying to teach or reinforce? What do you hope will be the outcomes of the exercise?
 - Provide any necessary instruction prior to the role play. Role plays are for practicing, not learning, new behaviors or techniques.
 - Communicate your teaching purpose to your participants.
 - Create a safe, relaxed environment. Let participants know that perfection is not expected but rather this is an opportunity to "rehearse" important skills prior to actual interactions.
 - Don't force anyone to participate and offer the option to "opt out" at any time during the process. Performing a role play yourself may help put the group at ease.
 - Make the role play realistic to the situations the participants will face. Use actual clinical examples whenever possible.
 - Set the stage. Give clear instructions to the participants and adequate description of the scenario and players.
 - Don't ask participants to role play an attitude without giving them background information. For instance, instead of just describing the role as an angry family member include information about the reason for the person's anger (i.e., he wasn't informed when his mother was moved into another room at the nursing home).

- If you have used the role play before, think about how it went and make improvements if indicated.
- Prepare participants by emphasizing the importance of social interactions for learning.

3. Execution

- Be enthusiastic about the experience!
- Ask for volunteers.
- Be constantly mindful of the responses and behaviors of the participants and intervene if someone is having difficulty. Immediately address problems or feelings in a supportive manner. Never embarrass or criticize a participant.
- Using name tags or props to identify the persons in the scenario may help persons to assume the identity of the role they are playing and help the audience to keep the players straight.
- Feel free to use “time out” when the role play is becoming too emotional, is floundering or is not going in the direction you had hoped. Just taking a break may help, but it might also be a good time to move to evaluation.
- Set a time limit. Using a timer may help keep participants on task. Role plays that are allowed to go on and on are generally not useful. Five to ten minutes is usually long enough; it is preferable to break longer scenarios into smaller scenes so that the group maintains focus.
- Allow the participants to ask for help from the audience if they get stuck. Or assign the participant a partner who they can ask for help during the role play.
- Give everyone an equal opportunity to participate but don’t force participation.
- Emphasize the role and contribution of each participant including the observer. Explain all roles before the start of the role play.
- Fun is allowed but making fun or ridiculing someone is not.
- Respect the privacy of the participants and remind participants not to share information outside of the group.

4. Evaluation

- Evaluation and discussion are essential. Discussion should be tied to the original objectives for the role play. Allow sufficient time for this part of the experience.
- Feedback should be immediate, specific, relevant, and achievable.
- Encourage constructive rather than destructive criticism.
- Ask the “actors” to comment first on the role play first. Start with the person in the “hot seat.” It is much less threatening to evaluate oneself than to accept the criticisms of other, and often the main players are very aware of what went well and what could have been done better.
- Focus on positives first (what went well) during the evaluative stage. Reframe criticisms as opportunities for improvement.
- If appropriate, re-enact the role play.
- Close the role-playing session by summarizing the experience.

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Module 6

Figure 8: Progressive Role Play

Progressive Role Play Lena and Royce

Brief Overview: Lena is 56 years-old, and Air Force Veteran, married, and has two grown children who live out of state. Lena served 4 years in the Air Force and worked in supply. Lena lives with her husband, Royce, 64, in rural America, 75 miles from the nearest hospital. Lena worked for 20 years as a bookkeeper after getting out of the Air Force, but went on disability over two years ago. Royce worked as an electrician, but due to health issues, he went on disability last year. Because of their illnesses, they have been mostly homebound, except to go to medical appointments. Their finances have been extremely limited. Below, is an outline of issues Lena and Royce are currently experiencing.

Lena

- When Lena was 35 years of age, she was diagnosed with systemic lupus erythematosus (SLE) and placed on various medications (i.e. high doses of NSAIDs, hydroxychloroquine, various corticosteroids, cyclophosphamide, methotrexate, and belimumab). These medications and disease have caused numerous side effects, including gastric bleeding, kidney and heart problems.
- Five years ago, she was diagnosed with type 2 diabetes and hypertension.
- Within the past two years, she has been experiencing symptoms of both cardiac and kidney failure. She has been on dialysis 3x/week for the past six months, which entails driving to the nearest dialysis center, 50 miles away—each way.

Royce

- Five and a half years ago, Royce was diagnosed with emphysema 5 ½ years ago.
- He, too, has hypertension and was diagnosed two years ago with chronic lymphocytic leukemia (CLL). His quality of life is poor.

Scene I: Homecare Visits

Overview: On a weekly basis, Melissa, a registered nurse, makes a homecare visit to both Lena and Royce. Melissa has been concerned about Lena and Royce for some time, as both of their conditions are chronic and slowly deteriorating. Neither have an advanced directive.

Lena has a foot wound that Melissa has been assessing closely for the past 3 weeks. Lena's diabetes has complicated the wound from healing quickly.

Yesterday, Melissa noted that Lena's blood pressure was extremely high (196/124) and her pulse rate was 136. She gained six pounds in the last week. Lena was unable to go to dialysis the

previous day, because she was feeling poorly. Melissa calls the dialysis center and makes plans for Lena to go to dialysis this afternoon.

The following day, Melissa comes by to see Lena and Royce. Lena's blood pressure is down significantly. She asks Lena and Royce if they have thought about their goals of care. She confides that she is concerned that they do not have an advanced directive. This scene begins with that conversation.

ROLES (for Scene I):

- **Melissa:** Shares concern about Lena and Royce not having an advanced directive. She has never heard them articulate their goals of care. She is unclear if anyone has given them enough information to discuss goals of care. Melissa leaves information for them to read about advance directives and states she will talk with them when she returns in a day or two.
- **Lena:** States she has not thought much about it but thinks it's a pretty good idea to consider.
- **Royce:** Says he just wants "nature to take its course." States he is fed-up with the healthcare system. His doctors don't talk. It takes him forever to get an appointment. "I guess I will just die here at home."

Scene II: Trips to Trouble—ER and ICU Admissions

Lena and Royce read the advanced care planning information but were hesitant to make some of the decisions required to complete the advance care planning document. Four nights ago, Lena fell and broke her hip and shoulder which resulted in a trip to the ED. Upon arriving to the ED, she was found to be in great pain, dyspneic, tachypneic, and fearful/anxious as to who would care for her husband while she was in the hospital.

Three months prior, an echocardiogram showed an ejection fraction of 35-40% three months ago. Her vital signs were out of range, including a blood pressure of 186/110 (hypertensive for 10 years). She was taken from the ED to the operating room. From the OR, Lena was taken to the Post-Acute Care Unit where they were unable to wean her from the ventilator. She was then transferred to the ICU for STAT dialysis and ventilator management.

When the ambulance came to take Lena to the hospital, Royce had a neighbor follow the ambulance to the ED. Upon seeing his wife in great distress, he became anxious, dyspneic, secondary to his emphysema, and was treated for anxiety/dyspnea in the ED. He was released a couple of hours later and returned home.

The son, Thomas, who runs his own business and lives 250 miles away is unable to come at this time. The daughter, Emily, has been estranged from her family for the past five years.

After successfully pinning her hip and shoulder, Lena was transferred to the ICU, where she received daily dialysis and was extubated three days post-op. The intensivist asked for a palliative care consult for Lena. After reviewing Lena's chart, the palliative care team contacted Lena's cardiologist and nephrologist about future treatments for Lena. Both physicians stated that Lena had always been hesitant about completing an advance directive and never wanted to

sign a DNR. Both agreed that her health was failing, and the chronic co-morbidities would worsen over time. They both believed that palliative care was a good option for her.

A couple of days later, Lena was transferred to the Acute Observation Unit (AOU), where the palliative care team saw her. Lena's AOU nurse, Eric, who just completed his 6-month new graduate program, was concerned about a palliative care consult. "She doesn't need hospice right now. She has been easily extubated and is hemodynamically stable." The palliative APRN spoke with Eric and clarified the difference between hospice and palliative care. Eric feels that everyone is giving up on Lena and that she should still not sign a "DNR." He states, "no one has spoken to her about a ventricular assist device (VAD) or consulted about her high blood sugars. Today, the palliative APRN has come to meet with Royce and Lena. Eric has requested to attend, too, so he can learn more.

ROLES (for Scene II):

- **Lena:** Listens but confused as to what palliative care is. She knows she can no longer take care of Royce. Explores where they should go. "I know we can't go home again."
- **Royce:** Very worried about finances. He knows he can no longer take care of Lena.
- **Palliative Care Physician:** Reiterates how ill they both are but wants them to make choices of where they want to live. "We want to honor your wishes."
- **Palliative APRN:** The nurse realizes that it is important to speak frankly to Lena and Royce, so they have enough information to make a good choice. "You cannot go back home to live—your care has become too complicated." Is firm about the importance of stating "goals of care." She assures them that they will continue to work with them and will not abandon them.
- **Eric (Acute Observation Nurse):** Upset. He chooses to attend the meeting to learn more about palliative care. Says very little and does not challenge the palliative APRN. Eric wants to make sure that Lena and Royce understand everything the palliative care team says.

Scene III: Regrets

Lena has now been moved to the Rehabilitation Center next door to the hospital and today the palliative APRN will stop by to see Lena again. Lena requested this visit, as she was having some spiritual/existential anxiety.

Since Lena was discharged from the ICU, she has said that she needs to start going back to the Methodist church. Since they have been married, they have not attended church. "I do believe in God and I have lots of forgiveness to ask Him for."

The palliative APRN asks Lena about her family support.

ROLES (for Scene III):

- **Lena:** Lena confides that she and her husband had not spoken to their 32-year-old daughter, Karen, in five years. "My husband and I had to cut-her-off because she has been so irresponsible most of her adult life. "We have gone into great debt to bail her out numerous times. She has four children by four different fathers." "She has a history of drug abuse, but

we have heard from friends that she went to rehab about six months ago and is trying to get her life back together.” “ I really miss her...I need her.....I love her.” “I am so torn, but just don’t have the nerve to call her.” “Her father was always much more angry about this than I was, but I have always honored his request that we not see her anymore.” Lena shares her angst regarding daughter’s behavior, but now wants to re-connect with her.

- **Palliative APRN:** Include in this conversation with Lena about:
- Forgiveness
 - Why this is important to Lena
 - Why this is important to Karen and her future
 - How to orchestrate the call/visit to Karen

Group Discussion:

1. Talk about Lena and Royce having multiple healthcare providers they have been seen in various clinics and healthcare settings (internists, nephrologist, endocrinologist, cardiologist, oncologist, chemotherapy nurses, pulmonologist, homecare nurses, etc):
 - a. Is it appropriate to wait until this point to start discussing goals of care, advance directives, etc?
 - b. What is the nurses’ role in promoting palliative care in these settings? Discuss the important role of communication in these various settings.
2. Ideally, at what point should palliative care have been introduced to Lena? To Royce?
3. What were the positive roles that nurses played throughout this role play in promoting palliative care?
4. Do you currently provide care to a “Lena” and a “Royce?”
 - a. If so, what resources do you have to promote palliative care for them?
 - b. Who are your palliative care champions?
 - c. Can you think of people at your institution that you can communicate with in an effort to promote palliative care?

Module 6

Figure 9: Encounter Example: Situational Role Plays

Directions for Presenter:

Following the didactic portion of Module 6, attendees will join in 3's or 4's, depending on the encounter example. Participants should introduce themselves to each other, quickly read over the encounter example, and then proceed to role play the situation described with one participant serving as an observer.

After 5-10 minutes of role-playing, the scene and its communication challenges, and finally successes can be discussed within the small group.

Communication (3 Roles: 1 nurse, Stan's wife, observer)

Stan, a 42-year-old Army Veteran admitted to the hospital for end-stage Leiomyosarcoma and resulting third episode of sepsis, has opted for palliative care and a do not attempt (DNAR) resuscitation order. Stan's father tells the oncology nurse in ICU, "This is so much harder to do than I ever imagined." Stan's wife then asks the nurses, "What will happen next? What do we do?"

Orientation and Opportunity (4 roles: 1 nurse, David, Nanette, & observer)

David is a 42-year-old gay man from the Philippines in the oncology clinic with Hepatitis C. He served 20 years in the Navy as a cook. David, estranged from his family for many years, has recently reconnected with his sister Nanette. At the clinic, a nurse (Laura) explains a new protocol and potential side effects to them. Once alone, Nanette shares her strong belief with David that a local Philippine doctor could offer alternative herbal treatments. As Laura re-enters the room, she detects high tension and a change in mood.

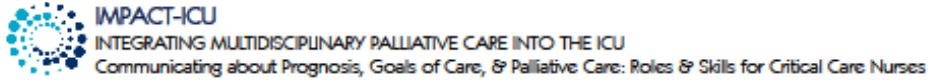
Family (3 roles: 1 nurse, Janice, observer)

Mr. Long, a 77-year-old Vietnam Veteran is a widow. He is admitted to the Oncology Care unit with advanced prostate cancer and intractable back pain. His two children, Ben and Janice, both arrive from out of state. Ben insists that his father be immediately transferred to a comprehensive cancer center while Janice is adamant that their father would rather be at home instead. Janice sits clutching her father's hand, sobbing, and says to the nurse, "I will have my husband fly in and carry Dad out of here!"

Module 6

Figure 10: Nurse-Family Conversation Goals/Skills

Conversation Goals & Skills guide to use with the video: Nurse/Family Conversations (an *IMPACT* Video) which can be found on the VitalTalk website at: <http://vitaltalk.org/topics/the-3-conversations/>



NURSE-FAMILY CONVERSATION

Conversation goals:

- Elicit family needs, understanding of prognosis
- Elicit patient values, goals, preferences
- Suggest plan to address family needs

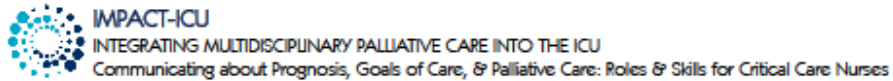
Skills to Practice	Examples
<p>Open-ended questions</p>	<p>Determine family’s understanding and perspectives on prognosis: <i>“What do you understand about your mom’s medical situation?”</i> <i>“What have the doctors said about what to expect?”</i> <i>“What information about prognosis would be helpful to you?”</i> <i>“What is your sense of what the prognosis might be?”</i></p> <p>Understand patient and/or family’s definition of quality of life and thus values and goals of treatment: <i>“What are you hoping for?”</i> <i>“What worries you the most?”</i> <i>“Could you tell me a little about what Jane is like?”</i> <i>“What would be most important for her right now?”</i> <i>“What would Joe think about the treatments he’s getting now?”</i> <i>“What kind of things does Tony enjoy?”</i></p> <p>THEN LISTEN! (using skills below)</p>
<p>Tell me more</p>	<p>Family: <i>“I don’t understand why everyone keeps telling us she’s not responding - when I squeeze her hand she squeezes back.”</i> Nurse: <i>“Tell me more about that.”</i></p>
<p>Reflection</p>	<p><i>“So, if I understand correctly, it seems like you and the doctors aren’t on the same page, is that right?”</i> <i>“It sounds like you have a lot of questions for the doctors.”</i></p>
<p>NURSE</p>	<p>Family: <i>“I’m afraid to even think that Stan might not recover.”</i> Nurse: <u>N</u>ame: <i>“It’s a scary thing to think about.”</i> <u>U</u>nderstand: <i>“I can understand how that would be scary.”</i> <u>R</u>espect: <i>“You have been so strong.”</i> <u>S</u>upport: <i>“We’re here to support you.”</i> <u>E</u>xplore: <i>“What are you afraid will happen?”</i></p>

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Module 6

Figure 11: Nurse-Family Conversation: Study & Discussion Guide

Study & Discussion guide to use with the video: Nurse/Family Conversations (an *IMPACT* Video) which can be found on the VitalTalk website at: <http://vitaltalk.org/topics/the-3-conversations/>



Nurse-Family Conversation: Study & Discussion Guide

I. Review goals and suggested skills for this conversation on the Skill and Conversation Handout. The conversation goals are:

- Elicit family needs, understanding of prognosis
- Elicit patient values, goals, & preferences
- Suggest a plan to address family needs

II. Have a paper and pen and the Skill and Conversation Handout ready. As you watch the video, respond to the following questions:

- What emotions do you see or hear Frank express? Write specific phrases or non-verbal behaviors you see in the video.
- What skills does Tawnya use to respond when Frank expresses emotion? Give specific phrases or non-verbal expressions from the video. How do her responses seem to affect Frank?
- What skills does Tawnya use to assess Frank's understanding of his wife's situation and to get a sense of what he might need? Give specific phrases from the conversation.
- What skills does Tawnya use to learn more about Sandra's values, goals, & preferences? Give specific phrases from the conversation.
- What skills does Tawnya use to suggest a plan to address Frank's needs? Give specific phrases from the conversation.

III. Take-aways

- What did we learn about Sandra and Frank that we didn't know before?
- Thinking ahead to the next time we see Sandra's doctor, what information will be key to share and what might we ask for?

IV. Reflection

- Reflect on a recent patient and family you've cared for. What was challenging for you in communicating with this family?
- What skills did you see here that might help meet a similar challenge in the future?

V. Practice

- Watch the video again, pausing after Frank speaks to practice responding in your own words using the skills you've learned.
- Choose a skill to practice with a patient or family the next time you are working in the ICU. Notice how the patient or family reacts and debrief this with a friend or colleague.

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