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Innovations in Simulation

Evolution of a Hospice Scenario: Manikin to SP and More

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Abstract: This article describes the evolution of a hospice simulation over time. Based on student evaluations and faculty observations, a manikin-based simulation was converted to a standardized patient simulation, and videos of faculty performing the scenarios and modeling caring behaviors were developed. As their "ticket into class," students wrote a brief reflection of the caring behaviors they saw used in the recorded nurse/patient interactions. After these changes, students reported that they found the experience to be valuable in a number of ways, including reduction of presimulation anxiety and increasing their sense of being prepared for both the simulation and real-life patient care.

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Nursing students often receive little education about providing end-of-life care for dying patients (Carman, 2014; Gillan, van der Reit, & Jeong, 2014). However, almost half of nursing students in a recent national study experienced the death of a patient while in clinical; these students reported no debriefing by their clinical instructors or other faculty about these experiences (Heise, Wing, & Hullinger, 2018). This lack of preparation and lack of debriefing may have a negative impact on students, patients, and their families and potentially impact the ability of a future nurse to provide quality care to a dying patient (Heise et al., 2018; Peters et al., 2013).

Common methods of teaching end-of-life content include lectures, seminars, and small group discussions and visits to local hospice centers (D'Antonio, 2017), although few evaluations of these methods have been published to date. It is incumbent on nurse educators to provide education for this care, yet textbooks and most nursing curricula continue to provide little information on the subject (D'Antonio, 2017; Gillan, van der Riet, & Jeong, 2014). This article reports the evolutionary development and improvement of a death and dying simulation experience for nursing students in a community health course.

Carman suggested that a combination of didactic information and practical application in simulation would be an effective way to provide some end-of-life preparation (2014). In a simulation, facilitators are able to create a consistent and controlled environment giving students a

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certain level of control and the ability to call timeouts should they feel overwhelmed or uncertain about how to proceed. Students are also relieved of the concern about harming or having a negative emotional impact on an actual patient or their loved ones.

Key Points

- Nursing students receive little formal education about providing end-of-life care for dying patients.
- Simulation relieves student concerns about causing a negative emotional patient or family impact.
- Faculty modeled caring behaviors for the dying simulated patient and family.

The Robert Morris University nursing program has included didactic and simulation pedagogies on death, dying, and hospice care for a number of years. Simulation educators regularly evaluated all scenarios for opportunities to improve the quality general, and the hospice, death, and dying simulations were no exception.

First Iteration of the Hospice Scenario Experience

Death, dying, and hospice curricula are housed in the community nursing course for senior-level undergraduate nursing students, in our program. The two scenarios discussed in this article were embedded in a 4-hour lecture that included live simulations broadcast into the classroom. The scenarios were designed using the International Nursing Association for Clinical Simulation and Learning Standards of Best Practice: Simulation[SM] (Standards of Best Practice: Simulation[SM], 2016) and were conducted in a Society for Simulation in Healthcare–accredited simulation center by a Certified Healthcare Simulation Educator.

Presimulation Activities

Student preparation for the class consisted of various reading assignments. This included the only paragraph in the assigned textbook regarding hospice nursing. Hospice and Palliative Nurses Association (HPNA) teaching sheets (https://www.stjosephhomehealth.org/resources/hpna-teaching-sheets/) were also on a preparatory reading list and focused on communication with the seriously ill patient and the patient's family members and what to expect in the final days of life.

Student learning objectives for the two scenario activities were (a) discuss own feelings of discomfort in working with dying patients and families, (b) identify the psychosocial needs of the family/caregivers in end-of-life and hospice care, (c) identify physical care needs of the hospice patient with regard to pain, nausea, and bowel habits, (d) develop a plan of care for the hospice patient, and (e) effectively communicate with patients and families in a hospice setting. Students were to review written case introductions of the scenarios. The first scenario involved a standardized patient (SP), and the second was manikin based. Students were to prepare a care plan for use with the patient and family presented in the SP scenario.

On the day of the class, content on Kübler-Ross' stages of grief (Kübler-Ross & Kessler, 2014) was reviewed to prepare for speaking with the family. Cultural considerations and traditions around death and dying from a geographic and religious perspective were discussed. Students were encouraged to share examples from their own experiences, both personal and professional. Communication skills included in the Hospice and Palliative Nurses Association teaching sheets were reviewed and discussed. The didactic session ended with an overview of hospice and palliative care.

Scenarios

Two students then volunteered to participate in each of the scenarios. The remaining 25 to 30 students observed this interaction via live feed to the classroom. The first faculty-developed scenario included an SP portraying a single mother of a teenage daughter. The mother, with end-stage ovarian cancer, had recently entered hospice care. A pair of students interviewed and assessed the patient in her simulated home setting for approximately 15 minutes.

To keep the observing students engaged in viewing the scenario, they were given the task of identifying the patient's stage of grief according to Kübler-Ross' staging and to identify a question that they would like to ask the patient. Debriefing using the Advocacy-Inquiry method (Rudolph, Simon, Rivard, Dufresne, & Raemer, 2006) was used, taking 20 to 30 minutes. The SP joined the group to give feedback during this time.

The second scenario involved feuding family members arguing over an unresponsive patient, portrayed by a manikin, who subsequently dies during the scenario. The family members, played by nursing students as embedded actors, received brief scripts guiding them to portray siblings who were at odds with each other over advanced directives and religious beliefs. Two nursing students entered the room to interact with these family members. This scenario lasted 15 minutes on average. The same Advocacy-Inquiry debriefing method and timeframe were used for this scenario.

Debriefing

In postsimulation, all students debriefed as a group, facilitated by the instructor. The session began with an emotional debriefing of the learners, inquiring, "How did that go for you? How are you feeling?" This was followed by a discussion of therapeutic communication with families under stressful circumstances. Objectives of the scenario included identifying the psych social needs of the family and patient and effectively communicating with the family. However, the debriefing often focused on students'

questions regarding the management of family discord during the scenario. The family discord often derailed the debriefing and did not align with the actual planned scenario objectives.

Student Evaluations of the Scenario Experience

Students' written evaluations of the simulations reflected continued anxiety and a perceived lack of preparation for interacting with hospice patients. Some expressed discomfort in talking with a patient about death. Students clearly expressed a preference for the SP hospice simulation over the manikin experience. The manikin scenario did not provide a relatable death experience for many participants. Some felt it difficult to suspend disbelief because of the fact that a soulless mechanical body was "dying."

Faculty Thoughts on the Scenario Experience

Students were expected to prepare before they came to class. However, faculty could not discern if student discomfort with the subject matter or a lack of preparation kept discussion to a minimum. Few students seemed prepared or willing to engage in the conversation. Faculty realized they needed a more engaging way to confirm that students had indeed completed the assigned prework.

In addition, serious shortcomings in the family dynamic scenario were identified. The scripted family conflict proved to be too challenging for the students asked to function as embedded actors. Portrayals by students varied according to both acting and emotional skill level, providing an inconsistent outcome from class to class. Simulation facilitators observed students sitting at a distance from the patient, if they sat at all. Student care providers were stilted in their conversations and avoided physical contact, such as touching a shoulder or hand, of either the patient or family members. Finally, the relative lack of fidelity in using a manikin to die in a scenario was accentuated on more than one occasion, by a supposedly deceased patient (manikin) having an errant eye pop open, confusing students and causing nervous laughter, ultimately misdirecting the overall goal of the scenario as facilitators watched students dissolve into giggles at the end of the manikin "death." These spontaneous and unpredictable events potentially limited the effectiveness of the simulation and achievement of desired outcomes.

Evaluation of the Revised Hospice Scenarios

The manikin scenario had been inherited from a prior instructor. A new faculty member ran the manikin scenario six times during one academic year. Student-written evaluations were reviewed at the conclusion of that year. Evaluations revealed students' anxiety and sense of feeling unprepared for therapeutic communication with hospice patients. As a result, both faculty and the simulation facilitator began to investigate methods to improve presimulation student preparation and the overall simulation experience.

On deeper discussion and reflection, the team realized that students often did not have the context or baseline skill for these difficult conversations. For most high-level nursing skills, students are often prepared by readings, lecture, and live or video demonstrations by nurse experts. Yet for this scenario, faculty expected students to apply reading and lecture content in the absence of any prior skill demonstration or practice.

Scenario Revisions Based on Feedback and Reflection

The approach to improving the learning experience was three-fold. The precourse reading requirements remained, and a conscious decision was made to replace the dying manikin in one of the scenarios with an SP. The team adapted the second scenario of the three-scenario Julia Morales and Lucy Grey National League for Nursing Advancing Care Excellence for Seniors cases to replace the manikin death scenario (National League for Nursing, 2019). This National League for Nursing unfolding scenario is that of a same-sex couple in their 60s with Julia as the patient with lung cancer; Lucy is her partner. In this scene, Julia is near death and nonresponsive; the students interact with Julia's partner, Lucy. The age of the couple was modified when a casting call for an older female of color yielded only women in their 20s and 30s. An embedded actor of color was paired with a Caucasian SP.

The idea for a presimulation exemplar video was borne somewhat serendipitously. During a debriefing session with the class and SP, students were asking questions about how one would begin a conversation with a new hospice patient. The facilitator, with the agreement of the SP, demonstrated a conversation with the standardized hospice patient live in the classroom. Students responded positively to this experience.

A literature search was completed to investigate the possible use of demonstration videos as presimulation preparation. The use of expert modeling videos before simulation to improve performance, judgment, and professional caring behaviors in nursing students was documented in the literature (Coram, 2016; Jarvill, Kelly, & Krebs, 2018; Kardong-Edgren et al., 2015; Lasater, Johnson, Ravert, & Rink, 2014). Providing expert models of goal performances might shorten the time required to acquire the desired behaviors (Clark & Mayer, 2008). However, the use of expert models in hospice scenarios was not reported in the literature at this time. Based on this information, two videos of nurse experts interacting with simulated hospice patients were developed for students.

Faculty hypothesized that students were unaware of how to demonstrate caring behaviors with this patient population. To address this need, selected behaviors listed in the Health Communication Assessment Tool (Pagano, O'Shea, Hetzel-Campbell, Currie, Chamberlain, & Pates, 2015) were turned into a simple list of verbal and nonverbal behaviors for students to review (see Table).

Observing an expert performance video allowed students to develop a preliminary cognitive representation before trying it on their own. Simplifying the objectives and decreasing the intense interpersonal family dynamics of the old scenario allowed for a more meaningful and useful debriefing. The debriefing discussion became more focused on the student experience of communication with a patient and loved one in the hospice setting. The revised simulation objectives were simplified to include (a) effectively communicate with patients and varying family structures in a hospice setting and (b) practice health communication behaviors with patients and families at the end of life.

Table Taken From the Health Communication Assessment Tool

Professional Caring Behaviors

- Introduced her/himself to the patient (and/or family).
- Shook the patient's and/or family's hand.
- Explained the reason for her/his visit in the appropriate terms.
- Used positive communication including a smile to encourage interactions.
- Maintained eye contact when talking with patient and/or family.
- Communicated what she/he was about to do before to doing it.
- Asked the patient or family if it was okay to touch patient before doing a procedure or test (blood pressure, auscultation, IV, NG, and so forth).
- Touched patient appropriately.
- Spent the majority of time near the patient.
- Sat when talking or educating patient.
- Listed more than talked.
- Consistently leaned toward the patient or family member who was speaking.
- Effectively educated the patient and/or family about the procedure, disease, and/or treatment.
- Asked questions to encourage feedback and enhance clarity.
- Recognized and responded appropriately to patient's and/or family's nonverbal and verbal behaviors (frowns, tears, hysteria, silence, and so forth).
- Used appropriate vocal tone and volume for the situation.
- Avoided judging patient/family behaviors (re: economic status, abuse, drug use, sexual orientation, religion/cultural differences, and so forth).
- Spend equal or more time on psychosocial aspects of patient/family care as on clinical (biological) aspects.
- Inquired about patient's/family's feelings regarding situation.
- Recognized conflict and tried to gain information and find opportunities to minimize it.
- Maintained, enhanced, or developed an interpersonal relationship with patient and/or family (via communication and professionalism).
- Avoided health care jargon (vital signs, respiratory, and so forth).
- Avoids jargon.

Source: Pagano et al. (2015).

Evaluation

Students had varying reactions to the two different faculty communication styles portrayed in the videos. All students were able to identify multiple health communication behaviors from the Health Communication Assessment Tool list, demonstrated by the faculty. When students then interacted with the SPs in the scenarios, facilitators noticed that students often began conversations with the patient using wording nearly identical to what they had heard in the videos. This demonstrated the impact of providing expert demonstrations of communication behaviors for novice learners. Students developed their own communication styles as the simulation progressed while continuing to use various communication behaviors.

During debriefing, both simulation participants and observers gave feedback on their observations of the simulation. Frequently, the observing students were able to identify the use of health communication behaviors more clearly and easily than the students who actually participated in the simulation. Although participants used health communication behaviors, they were less aware than observers that they had done so. Students sat nearer to the patient and family member and provided more touch and caring behaviors than in the previous semesters.

Students described a decrease in anxiety before and during the simulation when compared with prior classes. Students also reported feeling better prepared for this simulation and a sense of real-life applicability when compared with past students' experiences.

Conclusion

As part of a continuous quality improvement process, both anecdotal and written student feedback were used as a guide to improve preclass student preparation, fidelity, and outcomes of a hospice simulation experience. Consulting with colleagues and reviewing current literature provided optimal solutions. As a result of this project, students were able to identify key health communication behaviors in hospice scenarios. Using an application-based preclass preparation, a method to ensure that students completed preclass work, and a conversion from a manikin to an SP as a dying patient, served to increase the quality, fidelity, and value of the experience for students as they themselves reported.

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