2023

Improving Nursing Comfort in Relation to Difficult Conversations

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Improving Nursing Comfort in Relation to Difficult Conversations

Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Nursing Practice at the University of Kentucky

By

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Lexington, KY

2023

Abstract

Background/Purpose

Conversations between care providers and patients are integral to medicine and are the most performed "procedure" (Luff et al., 2016). In Pediatric Intensive Care Units (PICUs) and Pediatric Cardiac Intensive Care Units (PCICUs), children of all ages with diverse diagnoses and needs are treated for critical illnesses and traumatic events. Therefore, providers frequently have difficult conversations with patients and their families. Pediatric critical care nurses are often invited to participate in these discussions. However, their role during, and after, these conversations is not always clear. The goal of this project was to evaluate the impact of an educational simulation-based intervention on the knowledge and comfort level of pediatric critical care nurses regarding difficult conversations with patients and their families.

Methods

This project was a quasi-experimental study with a one group pre-test-post-test design. A total of 55 pediatric critical care nurses were eligible and invited to participate. Participants completed a pre-test survey that provided demographics as well as established baseline knowledge and comfort level regarding difficult conversations. Participants then listened to a 10-minute voiceover PowerPoint presentation regarding difficult conversations, the critical care nursing role and framework to utilize when having a difficult conversation with a patient or family. This was followed by a simulation experience where participants could apply their new knowledge with a parent actor. The simulation was followed by a debrief opportunity and finally participants completed a post-test survey. Data was analyzed utilizing descriptive statistics, and paired t-tests on Statistical Package for the Social Sciences (SPSS) software.

Results

A total of 26 nurses completed the pre-test survey, voiceover PowerPoint, simulation, debrief and post-test survey. There was a statistically significant increase in knowledge of the nursing role in difficult conversations as well as the individual's comfort level in having such conversations.

Conclusions

The aim of this project was to develop an educational program that included simulation to teach current pediatric critical care nurses about difficult conversations, their role in these conversations and improve their confidence. This project was successful in doing so and demonstrated statistically significant improvement in knowledge and confidence. This project has the potential to dramatically improve the patient/family experience during difficult conversations and involvement in care.

Acknowledgements

I would like to take a moment to thank the individuals who assisted me throughout this project. First and foremost, I am especially grateful to my advisor, Dr. Misty Ellis, for your guidance and encouragement during this process and my time in the program. You challenged me to pursue my full vision of this project which was including simulation. I know that I have been well prepared for my new career path not only didactically but also through the clinical rotations you secured for me and the advice you gave. I am appreciative to Dr. Adrienne Johnston for being excited for and supportive of my project prior to being on my DNP committee. Thank you for being someone with whom I could always share potential ideas or roadblocks and receiving valuable input from you. Thank you to Dr. Holly Chitwood for being part of my DNP committee and for your feedback especially regarding APA citations. Thank you to Dr. Jennifer Dent for consultation on the simulation component of my project and for serving on my DNP committee. I am also grateful to all those at UK's College of Nursing Simulation Center (Drs. Julia Hall and Bonita Moore along with Carol Simpson and AJ Letamendi) who helped coordinate and serve as my parent actors.

To my manager, Stephanie Durbin, I am grateful for your unwavering support and encouragement. I appreciate all you did to help encourage my coworkers to participate in the project and simulation. Your idea of a relief nurse for those working enabled higher participation. Thank you to Dr. Amanda Thaxton-Wiggins for assisting with the data analysis portion of my project. Thank you to Dr. Meghan Marsac for sharing your insight and providing resources when I was beginning to develop this project. I also want to thank Dr. Patricia (Patty) Howard for guiding me through the IRB process and providing invaluable feedback. The

assistance of all these individuals, and others not listed by name, was invaluable. Thank you for sharing your time and expertise and for your support.

Dedication

I dedicate my project in honor of my Grandmom, Velma Rose Ayers Clifton, who was a nurse for 35 years. She was a kind and gentle woman who loved her patients, family, and God immensely. When I graduated with my BSN, she was able to attend and pin me. She was proud of me for deciding to become a nurse though she didn't understand how I choose pediatrics. She was so excited when I decided to pursue my DNP. My Grandmom died from Covid-19 in 2021. While I am deeply sad she is not here to see me complete this milestone, and become Dr. Sarah Clifton, DNP, I know how immensely proud she would be of this accomplishment. My Grandmother, Alice Gardner Marshall, attended my hooding and graduation ceremony in May and my DNP defense in July. I think she was exuding enough pride and love for all my grandparents. I will never be able to adequately express how immensely grateful I am for my family and friends that supported and encouraged me throughout this journey.

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Background and Significance

Problem Statement

Highly specialized intensive care of patients aged 0-21 occurs in pediatric intensive care units (PICUs) and pediatric cardiac intensive care units (PCICUs). Due to the medically and surgically complex illnesses seen in children admitted to the PICU/PCICU, the ICU team, or various other consulting specialties, often have difficult conversations with patients and their families. Pediatric critical care nurses are often included in these difficult conversations and interact extensively with the patient and families before, during, and after the discussions. Beddhard-Huber et al. (2020) stated that while nurses are key to difficult conversations, "they may be reluctant to engage without role clarity, permission to do so, and/or clear tools and relevant resources." Therefore, it is crucial pediatric critical care nurses are provided education and training to help build confidence in their ability to address questions and support the patient and their family.

Context, Scope, and Consequences of problem

Conversations between care providers and patients are considered the most performed "procedure" (Luff et al., 2016). Delivering bad or unexpected news in healthcare is unfortunately an expected duty of the job for a healthcare provider. Providers and other healthcare personnel may experience emotional distress, nervousness, or discomfort with having to initiate and lead these conversations (Luff et al., 2016). Quality and appropriate communication with patients and family members is essential for clarity and understanding of the critical condition being discussed.

Quality and appropriate communication with the patient and family is key as these conversations form their understanding of the condition and assist them with making difficult

choices (Meyer et al., 2009). Communication becomes more challenging in pediatrics because of the child's developmental stage. Parents can understand and process information at a higher level than a child (Brouwer et al., 2020). Healthcare providers must also navigate the "triangular relationship between the healthcare professionals, parents and the child" (Brouwer et al., 2020). When difficult conversations do not occur in an appropriate manner whether that be timing or approach, it can result in distress and discomfort not only for patients and their families, but also healthcare providers (Brooks et al., 2017).

Regardless of specialty, nurses are a constant presence for the patient and their family. There is often an unverbalized, and at times overwhelming, pressure and responsibility to provide emotional support felt by the nurse. To fulfill this expectation, nurses must gain the knowledge and skills to adequately provide emotional support. Including pediatric critical care nursing staff in difficult conversations not only allows them to stay apprised of the information communicated but also allows them to observe how other healthcare professionals handle difficult conversations. The overall patient and family experience is impacted, positively or negatively, by the nurse's ability to navigate difficult conversations.

Current Evidence-Based Interventions

Several studies established educational seminars for healthcare providers on how to improve communication with families/pediatric patients (Meyer et al., 2009; Tobler, Grant & Marczinski, 2014; Peterson et al., 2016). Other studies focused on improving provider and other healthcare personnel's proficiency during difficult conversations through simulation (Bowen et al., 2020; Peterson et al., 2016). Bowen et al. (2020) discovered the combination of lecture and simulation resulted in increased usage of specific communication skills and improved perceived empathy scores in simulated difficult conversations. Unfortunately, education is not currently

provided to help pediatric critical care nurses with difficult conversations. This project seeks to address this gap by providing education and a simulation opportunity to pediatric critical care nurses.

Purpose/Objectives

The purpose of the project was to develop an educational resource for pediatric critical care nurses to provide support and improve comfort in their role during difficult conversations with patients and their families. There were several objectives for this project:

1. Gather information from nursing staff on their perception of difficult conversations, the role of the nurse and their perceived comfort level.
2. Evaluate whether an intervention was needed to further educate and improve comfort level.
3. Develop an educational PowerPoint and simulation experience.
4. Assess impact of the intervention on nursing comfort with difficult conversations.

Review of Literature

PICOT Question and Search Methods

A literature review was conducted to determine the evidence supporting utilization of educational interventions for improving pediatric critical care nurses' confidence with their role during and after difficult conversations with patients and their families. Using PICO format, the guiding question was: Within pediatrics, how did the use of educational interventions affect pediatric critical care nurses' comfort and proficiency during difficult conversations?

CINAHL and Pubmed databases were utilized. Search terms initially were "pediatrics," "nursing" and "difficult conversations." A total of 22 articles resulted; however, many did not meet inclusion criteria. Therefore, the search term "pediatrics" was removed from the query.

Difficult conversations occur in all areas of nursing and interventions to improve competency and comfort with these conversations do not need to be specific to a certain specialty. 187 articles resulted on PubMed and 65 articles on CINAHL for a total of 252 articles that were published in the last ten years. Articles were included if in the inpatient setting and the goal was focused on improving nursing competency with these conversations. Articles were excluded if they were outpatient or were not focused on interventions for nurses to improve their comfort with difficult conversations.

Synthesis of the Evidence

Upon review of articles discovered during the literature search, there were a total of 13 articles which met criteria. All took place in the hospital setting. Two of the articles were specifically focused on the ICU (Brooks et al., 2017; Felix et al., 2020). Brouwer et al. (2020) focused on what parents would like healthcare professionals to know about their experience with difficult conversations. Katz (2019) focused on difficult conversations within the field of oncology. Three articles focused specifically on palliative care although one was pediatric specific (Beddhard-Huber et al., 2020; Jack et al., 2018; Kerr et al., 2019). Four of the articles focused on nursing students trying to enhance their exposure to and competency with difficult conversations (Jeffers et al., 2022; Kantor & Stadelman, 2020; Little & Bolick, 2014; Thrane, 2020). Boles (2015) discussed avenues of emotional support that best resonated with patients and their families. The last article compared the comfort and competency level of urban versus rural nurses with difficult conversations (Isaacson et al., 2019).

Summary of Evidence

Six of the studies utilized qualitative designs to examine or improve nursing comfort with difficult conversations (Brooks et al., 2017; Brouwer et al., 2020; Isaacson et al., 2019; Jack et

al., 2018; Jeffers et al., 2022; Kerr et al., 2019). The anticipated outcome was that the educational intervention would increase nursing comfort and proficiency. The majority of studies did reflect this with statistically significant improvement.

Isaacson et al. (2019) utilized a cross sectional design to measure nurse comfort with difficult conversations utilizing the C-Cope instrument. Urban nurses reported being less comfortable with palliative and end of life conversations than rural nurses (Isaacson et al., 2019). Unsurprisingly, nurses with more experience reported being more comfortable with difficult conversations (Isaacson et al., 2019). Kerr et al. (2019) examined challenges nursing staff identified as to communicating with patients who have life limiting conditions. Nurses listed limited time, incomplete knowledge about the patient's condition and goals of care as well as lack of confidence with difficult conversations (Kerr et al., 2019). Felix et al. (2021) developed a practical guide as a result of COVID-19 for difficult conversations utilizing the SPIKES framework.

Four articles focused on providing nursing students exposure to and improving their comfort level with difficult conversations (Jeffers et al., 2022; Kantor & Stadelman, 2020; Little & Bolick, 2014; Thrane, 2020). The American Association of Colleges of Nursing (AACN) made changes to the required curriculum for nursing schools placing a greater emphasis on communication, and this went into effect for all schools renewing accreditation after 2019. Additionally, the AACN released a mandate for nursing schools in 2021 requiring exposure to and education on difficult conversations with a newly added focus on palliative/end of life care. These studies resulted in increased confidence and proficiency in nursing students regarding difficult conversations. While beneficial for nursing students, this mandate does not help nurses

currently in practice. Additionally, new nurses still require education regarding this challenging topic and there is no educational program in place for new and current nurses.

Identification of Gap

Clearly, interventions to provide education and improve comfort for nurses during difficult conversations were needed. The literature review revealed that previous studies' proposed interventions had been successful. However, there was not a uniform approach or program for educating and preparing healthcare personnel on difficult conversations. There were few articles focusing on nursing, but most were for providers such as residents. The desired state of practice would include the development and initiation of a program that prepares pediatric critical care nurses for evidence based, compassionate and effective communication during difficult conversations. In addition, this program would increase nursing comfort regarding these conversations. A clear gap in practice was the lack of research and interventions focused on improving nursing staff communication, especially in pediatrics. There was significant research focused on improving provider comfort and competency (Bowen et al., 2020; Brock et al., 2019; Peterson et al., 2016; Tobler et al., 2014). Also, it was encouraging that nursing schools are working to educate and expose nursing students to difficult conversations. However, nurses currently in the workforce likely did not receive this exposure and would benefit from having a similar opportunity.

Proposed Strategy to Address Gap

There is currently little research available looking at nursing comfort during difficult conversations. There is even less research specifically focused on pediatrics. This project sought to close the gap in research by providing an educational program to pediatric critical care nurses which could also be replicated by other pediatric care centers. While pediatric critical care

nurses typically do not lead difficult conversations such as care conferences, they are the staff most frequently interacting with the family and patient after these discussions. To best support families and patients, pediatric critical care nurses should feel confident in their ability to support the family after these discussions as well as address their questions.

Theoretical/Conceptual Framework

The framework selected to guide this project was the IOWA Model. The IOWA model was developed over 25 years ago and is one of the most frequently utilized evidence-based practice models (Duff, 2020). The IOWA model focuses on the healthcare system (patient, provider, organizational structure) to guide evidence-based practice decisions (Titler et al., 2001). Providing education and improving nursing staff confidence during difficult conversations relates to the very areas focused on by the IOWA framework.

The development of the project followed the steps of the IOWA framework as outlined. The first step in the IOWA model is to identify a problem, which in this case was the clear need to educate pediatric critical care nurses on their role in difficult conversations and improve comfort. The second step in the IOWA model is to determine whether the "trigger" is a healthcare organization priority. After discussing with the unit manager, the identified gap in care was large enough to become a priority. The third step of the IOWA model is to identify stakeholders. In this project, stakeholders were identified as nursing staff, nursing manager, child life, palliative care, and psychology colleagues. Discussions occurred with these various stakeholders and garnered support for this project. The fourth step is to perform a literature review, which was completed and validated this project. The final two steps of the IOWA framework include implementing the proposed intervention and evaluating the outcome.

Methods

Design

This study was quasi experimental as subjects were not randomly assigned to groups. The epidemiologic design was cohort as it was a natural experiment on nurses in the PICU. This study used a one group pre-test-post-test design to examine the impact of an educational and simulation-based intervention on comfort of nursing staff during difficult conversations with pediatric patients and their families. The pre-test and post-test surveys were matched utilizing a unique identifier of favorite number and childhood street (for example, 6Locke). This was done to enable comparison of the pre and post intervention results.

Setting

The project took place in the joint PICU/Pediatric Cardiac ICU (PCICU) at Kentucky Children's Hospital (KCH). KCH is a Level 1 Trauma Center with 205 beds. KCH is the regional referral and pediatric care center for central and eastern Kentucky. The PICU/PCICU has a total of 16 beds and nursing staff are cross trained in both units. At the time of the project there were eight ICU attendings and five advanced practice providers. Patient care is additionally managed by residents. Other staff assisting with the provision of healthcare and support include nurses, respiratory therapy, child life, social work, and palliative care.

KCH is a part of the University of Kentucky HealthCare (UKHC) system and shares the mission, goals, and strategic plan. UKHC is an academic medical center whose mission is to be committed to research, education, and patient care. The commitment to these three aspects of academic medicine was in congruence with the proposed project. KCH was developed to expertly care for the pediatric population and this project sought to enhance the quality of care provided at KCH.

Sample

A convenience sample of 55 registered nurses from the PICU/PCICU at KCH were invited to participate in this project. Inclusion criteria for this study were 1) registered nurses, 2) trained to work in the ICU setting, and 3) off orientation. Pediatric nursing staff were excluded if they did not work in the ICUs and if they were still on orientation.

Procedure

IRB Approval

Institutional Review Board (IRB) approval from UKHC was received prior to beginning the study. A letter was sent to the IRB from the PICU/PCICU Nursing Manager to demonstrate organizational support and buy-in from a key stakeholder. There were no patient charts utilized or reviewed. The results of the surveys are kept in a secure location on a password protected laptop. The data will be securely stored for six years and then will be destroyed using university guidelines for data security.

Evidence-Based Intervention

The evidence-based intervention was developed after discovering the current practice for preparing pediatric critical care nurses for difficult conversations could be improved and standardized. An integrative review of the literature revealed a clear gap/lack of research within pediatric critical care. The intervention involved several components: 1) a 5 minute online pre-test survey, 2) a 10 minute voiceover PowerPoint regarding difficult conversations, 3) a 10-15 minute simulation opportunity with a parent actor, 4) a 10 minute post simulation debrief, and 5) a 5 minute online post-test survey.

Pre-surveys and Post-surveys

The pre-survey established demographics for participants including age, ethnicity, years of being an ICU nurse and whether they had received prior education on nursing role and difficult conversations. The pre-survey was completed prior to participants viewing the voiceover PowerPoint and asked several questions utilizing the Likert scale to establish baseline knowledge and comfort with difficult conversations. The link for the pre-survey was sent out a month prior to the intervention. Participants were instructed to complete the pre-survey prior to viewing the PowerPoint. The post-survey evaluated changes to knowledge and comfort level with difficult conversations in addition to assessing perception of the voiceover PowerPoint and simulation. Differences between the pre-test and post-test were used to assess the effectiveness of the intervention. See Appendices B & F for complete surveys.

Voiceover PowerPoint

The voiceover PowerPoint was developed from reviewing research studies on difficult conversations. The PowerPoint established what difficult conversations are, the role of pediatric critical care nurses in difficult conversations, impact on pediatric critical care nurses, taught the SPIKES framework, and what matters to families. Difficult conversations include more than a decline in patient status as they can also involve test results, diagnoses, and procedures. Difficult conversations can involve telling the patient/family a nasogastric tube (NG) for feeding or another peripheral intravenous line (PIV) is needed. While seemingly routine for healthcare providers, these can be distressing for the patient and their family. Little & Bolick (2014) make a key point that the recipient is the one who determines what bad news or a difficult conversation is and not the one relaying the information.

In the PICU/PCICU at KCH, nurses are frequently included in difficult conversations and planned care conferences. As the family processes, the nurse is a constant presence throughout the shift and can be asked follow-up questions. If a pediatric critical care nurse is unsure of how to interact, they may engage in blocking behaviors which includes changing the subject or ignoring emotional cues. A study by Kennedy Sheldon, Hilare, and Berry (2011) found that healthcare providers recognized 57% of socioemotional cues but only acknowledged and explored them with the patient and their families 22% of the time. Poor communication skills can result in nurses experiencing burnout, low personal accomplishment, cynicism, and emotional exhaustion (Ramirez at al., 1995; Robins, Meltzer & Zelikovsky, 2009). Nurses and other health providers are already at increased risk for burnout and emotional exhaustion. Therefore, it is crucial for pediatric critical care nurses to feel comfortable and competent during difficult conversations as it impacts them personally and the quality of care for families and patients.

The SPIKES framework acronym stands for Setting, Perception/Perspective, Invitation, Knowledge, Empathy/Emotion, and Summary/Strategy. SPIKES is an evidence-based practice framework that assists healthcare professionals in providing distressing information in an organized manner. The SPIKES framework consists of six steps that allow the user to achieve the goals of a difficult conversation. It also fosters an environment where patients and families can react as needed. The six steps are to establish what the patient/family knows and their readiness for bad news, provide information in an easily understood manner, decrease isolation and emotional impact news may have on the recipient, and develop a strategy/future treatment plan with family/patient. Utilizing the framework can help reduce distress for nurses by allowing

them to feel more confident in their ability to clearly, and empathetically, discuss information. See Appendix C for SPIKES framework image.

Simulation

The simulation brought an opportunity for the University of Kentucky's College of Nursing Simulation Center to assist in providing advanced education to KCH's pediatric critical care nurses utilizing a real-life scenario with a parent actor. Prior to participation in the simulation, participants confirmed they completed the pre-survey and viewed the voiceover PowerPoint. The simulation scenario was created by the project lead for participants to have the opportunity to implement what they were taught in the voiceover PowerPoint.

The scenario involved a teenage boy, J.R. who lost control of an ATV, hit a tree, and was not wearing a helmet. He was unresponsive and intubated at the scene. He coded twice enroute to the hospital. Participants were told a care conference had occurred where family was told of the events enroute and the results of CT and video EEG showing J.R. had suffered a severe brain injury and was unlikely to recover. Family had been asked to think about next steps. The parent actor was instructed to appear visibly distressed and to wait and see if the nurse would acknowledge it. The goal of the simulation was for participants to recognize and engage in the difficult conversation, ideally utilizing the SPIKES framework.

After the simulation concluded, there was a simulation debrief using the Promoting Excellence and Reflective Learning in Simulation (PEARLS) tool. PEARLS encourages self-assessment of performance, facilitates focused discussion, and allows for further education and feedback for the participant. See Appendix D & E for the detailed simulation scenario and debrief tool.

Measures and Instruments

Data collected from the online surveys was both qualitative and quantitative utilizing Qualtrics, which is a data collection software. A pre-test survey was sent out to participants prior to the education and simulation component of the project. The post-test survey was provided immediately after completion of the simulation. Demographic measures obtained during this study were age, gender, ethnicity, and years of nursing practice. Knowledge of the nursing role in difficult conversations and comfort level before and after the intervention was assessed utilizing Likert scale questions, with response options ranging from 1) "strongly disagree" to 5) "strongly agree." Prior education on the nursing role in difficult conversations and satisfaction with the various intervention components was also assessed using Likert scale questions.

Data Analysis

There were no sections skipped on the pre-test or post-test survey by participants. However, there were two pre-surveys that could not be matched with two post-surveys as individuals incorrectly remembered or did not remember their unique identifier. Therefore, the data from these two individuals was omitted from analysis. Frequency distribution or means and standard deviations were used to summarize survey items, as appropriate. Paired t-tests were used to determine changes in understanding nursing role and comfort with difficult conversations. SPSS software was utilized with an alpha level of less than or equal to .05 indicating statistical significance results.

Results

While there were 55 ICU nurses eligible for participating in this project, 26 completed the pre-survey, voiceover PowerPoint, simulation, and post-survey. As mentioned above, two individuals did not correctly remember their unique identifiers, yielding 24 sets of pre-test and

post-test surveys for data analysis. The following data is shown in Table 1 in the Appendix. The sample was predominately female (91.7%), and white non-Hispanic (95.8%). 54.2% of participants were between the ages of 21 and 29 which shows engagement and investment of younger nurses. However, there was about an equal split in years of experience as a nurse. 37.5% of participants had 0 to 2 years of experience and 41.7% had been a nurse for 5 or more years. There was a vested interest between new and experienced nurses in improving their knowledge base and comfort level in difficult conversations.

Participants' knowledge of nursing role and level of comfort with difficult conversations significantly improved after viewing the voiceover PowerPoint and the simulation. Knowledge regarding the nursing role in difficult conversations improved from a pre-intervention mean score of 3.79 (SD = 0.78) to a post-intervention mean score of 4.54 (SD = 0.51; $p < .001$, see Table 2). Comfort level of participating in difficult conversations increased from a pre-intervention mean score of 3.21 (SD = 1.02) to a post-intervention mean score of 4.42 (SD = 0.5; $p < .001$). Comfort interacting with and answering questions from patients and their families improved from a pre-intervention mean score of 3.42 (SD = 0.88) to a post-intervention mean score of 4.13 (SD = 0.45; $p = .003$).

The final table in the Appendix (Table 3) contains descriptive summary of other questions from the pre-survey and post-survey. On the pre-survey, participants were asked if they had previously received education on the nursing role in difficult conversations utilizing the Likert scale. The mean score was 2.21 (SD = 0.78). Therefore, participants did not have much if any prior education on difficult conversations. The rest of the questions in Table 3 were from the post-survey and evaluated satisfaction with the various components of the intervention. The voiceover PowerPoint was found to be helpful/informative with a mean score of 4.71 (SD =

0.55), and simulation exercise was found to beneficial with a mean score of 4.54 (SD = 0.59). Participants were asked if they felt that the education provided valuable information and training and should be considered for future nursing orientation and the mean score was 4.75 (SD = 0.53). The final question was if they believed quality of patient and family care would be improved because of the intervention and the mean score was 4.50 (SD = 0.51).

Finally, Table 4 contains the responses from the post-survey where participants could leave additional feedback or comments. This was voluntary and the survey could be submitted without completing this final section. Comments left included "very informative simulation," "brought awareness to the lack of education and formal training," "project was well thought out and will certainly be adding this to my nursing care," "experiences in this simulation cover what every nurse will deal with in their career," "SPIKES is easy to remember and reference when having difficult conversations," and "as a PICU nurse who has these hard conversations often, this simulation was very beneficial."

Discussion

The goal of this project was to develop an educational opportunity for pediatric critical care nurses at KCH to learn about nursing role in difficult conversations, the SPIKES framework, implement their new knowledge in a simulation experience, and evaluate the impact of the intervention on participants. Statistical analysis of the impact of the voiceover PowerPoint and simulation opportunity revealed statistically significant satisfaction and improvement as demonstrated above and in the tables provided below. The outcomes of this project align with those of several other studies utilized during the literature review process. The qualitative data in Table 4 further supports the utilization of simulation in addition to education.

At the time of the literature review and development of this project, there were no published studies examining the impacts of these interventions on pediatric critical care nurses. There were several studies on neonatal intensive care unit (NICU) and pediatric oncology nurses. Most of the studies focused on critical care providers such as residents. Therefore, this may be the first project examining impact of education/simulation opportunity on nursing comfort with difficult conversations in pediatric critical care.

Moving Forward

Since the completion of the project, numerous participants have shared the continued positive impact this project had on their nursing practice. Two participants had extremely difficult situations and conversations almost immediately afterward. They shared their continued increased comfort and even improved confidence in their ability to engage with the families. Several keep the SPIKES framework on their phone and review it prior to entering a potentially difficult conversation. The project lead is considering returning to the IRB and seeking approval to add a 6-month follow-up survey.

The nursing manager has expressed a strong desire to implement this project as part of the training for new nurses and potentially continued education for current nurses in PICU/PCICU. The project lead will be working with the manager and unit education specialist on the rollout of this program. There is potential to collaborate with other pediatric hospitals in the region which would allow for replication and greater sample size to further assess impact. This project could also be expanded to include all pediatric nurses. Additional education and scenarios could be added to cover when the conversation is occurring with the pediatric patient, unexpected diagnosis, different types of test results, navigating difficult conversations when

there is a language barrier, etc. This project has the potential to positively impact all healthcare providers and their relationships with patients and families.

Practice and Education Implications

This project's findings have the opportunity to impact how current and future pediatric critical care nurses at KCH are educated and therefore positively impact their practice. As previously discussed, there was statistically significant improvement in comfort with difficult conversations. In fact, this project has already made a positive impact on the practice of the nurses who participated. Prioritizing the education of pediatric critical care nurses in their role in difficult conversations and providing tools like the SPIKES framework is crucial, thereby enhancing the practice of pediatric critical care nurses and improving quality of care.

Limitations

There are several limitations that are important to highlight and discuss their potential impact on this project. The overall participation of 26 pediatric ICU nurses and attainment of 24 pre-surveys and post-surveys matched is a small sample size, which can impact the generalizability of this project's results. There were 55 eligible nurses which means slightly less than half participated. While multiple incentives and accommodations were made, such as the provision of a relief nurse taking their assignment for 30 minutes to allow participation during a workday, not many accommodations were able to be made for nightshift nurses. The latest time slot for simulation was 4:30 P.M. Future consideration could be given to offering later time periods for night shift.

An additional limitation in participation may have been location and ease of parking. The intervention took place in the Simulation Center at UK's College of Nursing. While it is located on the same campus as KCH and is a 5–10 minute walk via a covered pathway, it is still outside

of KCH. If participants were unable to combine the simulation day with a workday, they had to come in on an off day, requiring additional time for their commute, parking, and taking a shuttle to campus. This also requires additional childcare for those with children. Participants were informed they were welcome to bring their children and one did.

The project lead has been a nurse in the PICU/PCICU at KCH for 3 years and knows the sample population well. It is possible the project lead's position in the unit could have had an impact and bias responses from participants. To minimize this, the project lead emphasized voluntary participation and strict anonymity of the surveys.

Conclusion

PICUs and PCICUs are full of challenging situations and difficult conversations happen every day. Tasks that healthcare providers deem as simple and straightforward may be overwhelming and difficult for the patient and their family. As a reminder, the recipient determines what is bad news and not the one providing the information (Little & Bolick, 2014). Regardless, these conversations inform the patient and family about the patient's condition and will guide their decisions. These discussions are crucial, and nursing plays a key role in ensuring the family's comprehension and comfort.

As determined through the literature review, not much education is provided to pediatric nurses regarding difficult conversations. Furthermore, there were no studies focused on pediatric critical care nurses. This project sought to address the gap discovered in literature and in practice regarding pediatric critical care nurses. After evaluating current PICU/PCICU nurses' knowledge and comfort level with difficult conversations, an educational module was developed in conjunction with a simulation opportunity to teach current pediatric critical care nurses about difficult conversations, their role, and improve their confidence. The intervention was successful

and demonstrated strong statistically significant improvement in pediatric critical care nurses' knowledge and confidence.

Pediatric critical care nurses' knowledge and comfort level with difficult conversations must be prioritized as it impacts the quality of care provided and the relationship developed between the nurse and patient/family. Nurses are at an increased risk for burnout and emotional exhaustion. Not being well-prepared to engage in difficult conversations with families/patients further increases risk for burnout and emotional exhaustion and a lack of self-confidence. This deficiency may prevent pediatric critical care nurses from developing resiliency and potentially cause them to leave the ICUs or bedside altogether. Provision of education and tools for pediatric critical care nurses to successfully engage with families and patients in difficult conversations is essential for the provision of quality care and protection of our nurses on the front line of caring for our patients and their families.

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Tables

Table 1: Descriptive Summary of Demographic Characteristics ($N = 24$)

	n (%)
Age	
21-29	13 (54.2%)
30-39	6 (25.0%)
40-49	4 (16.7%)
60-69	1 (4.2%)
Gender	
Female	22 (91.7%)
Male	2 (8.3%)
Ethnicity	
Hispanic/Latino	1 (4.2%)
White/Caucasian	23 (95.8%)
Years of Being an ICU Nurse	
Less than a year	3 (12.5%)
1-2 years	6 (25.0%)
3-4 years	5 (20.8%)
5-10 years	7 (29.2%)
Greater than 10 years	3 (12.5%)
Number of Difficult Conversations Participated In	
1-5	7 (29.2%)
5-20	9 (37.5%)
> 20	8 (33.3%)

Table 2: Paired t-test Summary of Likert Scale Questions ($N = 24$)

Question	Pre-intervention mean (SD)	Post-intervention mean (SD)	*p*
1. I know what my nursing role is when difficult conversations are occurring with patients and their families. After reviewing the educational PowerPoint and attending the simulation, I better understand the nursing role during difficult patient/family conversations.	3.79 (0.78)	4.54 (0.51)	<.001
2. I feel comfortable participating during difficult conversations. After reviewing the educational PowerPoint and attending the simulation education, I feel more comfortable being part of difficult conversations.	3.21 (1.02)	4.42 (0.50)	<.001
3. I feel comfortable interacting with and answering questions from patients and their families following a difficult conversation. Because of the educational PowerPoint and simulation, I feel more comfortable interacting with and answering questions from patients and their families after a difficult conversation.	3.42 (0.88)	4.13 (0.45)	0.003

Note: Response options ranged from 1) "Strongly disagree" to 5) "Strongly agree"

Table 3: Descriptive Summary of Satisfaction (N= 24)

Question	*Mean* (SD)
1. I have received prior education on the nursing role during difficult conversations.	2.21 (0.78)
2. I found the voiceover PowerPoint to be helpful/ informative.	4.71 (0.55)
3. I found the simulation exercise to be beneficial.	4.54 (0.59)
4. I feel this education provided valuable information and training and should be considered for future nursing orientation.	4.75 (0.53)
5. The quality of patient and family care will be improved because of this intervention.	4.50 (0.51)

Note: Response options ranged from 1) “Strongly disagree” to 5) “Strongly agree”

Table 4: Qualitative Summary of Additional Feedback

I thought this was a very informative simulation that brought awareness to the lack of education and formal training that nurses have regarding having difficult conversations with families.
I thought this project was well thought out. I will certainly be adding this into my nursing care.
I felt this simulation and prevention was very beneficial, I feel that the SPIKE acronym should be presented in orientation and annually to PICU nurses.
Not just orientation but ONGOING for nurses, yearly or every few years. And adding the residents, fellows and attendings to this would be really helpful.
Very helpful for new grad nurses 6 to 12 months after starting in PICU.
Adding difficult conversation simulations to orientations or nursing school courses would be beneficial for nurses and patients.
The experiences in this simulation cover what every nurse will deal with in their career, so approaching it with some framework to use is definitely beneficial to the field.
I think this training would be very beneficial to our new nurses. I think it should be offered about 3-6 months after completion of orientation.
I think allowing us to familiarize ourselves with the scenario a bit more would be beneficial.
Great project. Thank you for the hard work that will benefit our patients and families and nursing staff.
I like how the education used the framework SPIKES. It is easy to remember and reference when having difficult conversations.
As a PICU nurse who has these hard conversations often, this simulation was very beneficial. Sarah was very professional and did a great job explaining the simulation both before and after.
I think a simulation like such would be beneficial for all nurses to participate in during school or orientation!

Appendices

Appendix A: Informed Consent

To KCH ICU Nurses:

Researchers at the University of Kentucky are inviting you to take part in a survey and simulation intervention about nursing comfort during and after difficult conversations with patients and their families. Those receiving this letter have met the inclusion criteria for the study- ICU nurses at KCH who are not on orientation. This intervention seeks to improve nursing comfort with difficult conversations. Although you may not get personal benefit from taking part in this research study, your responses may help us understand more about nursing comfort with difficult conversations. Some volunteers experience satisfaction from knowing they have contributed to research that may possibly benefit others in the future. Increased comfort and knowledge of role could decrease emotional distress of nursing staff as well as improve quality of care of patients and their families. Those who choose to participate will be asked to fill out a short pre-test survey, listen to a 10-minute voiceover PowerPoint, attend a short simulation experience, and complete a post-test survey.

If you do not want to be in the study, there are no other choices except not to take part in the study.

The survey/questionnaire will take about 5 minutes to complete. Although we have tried to minimize this, some questions may make you upset or feel uncomfortable and you may choose not to answer them. If some questions do upset you, we can tell you about some people who may be able to help you with these feelings.

Your response to the survey is anonymous which means no names, IP addresses, email addresses, or any other identifiable information will be collected with the survey responses. We will not know which responses are yours if you choose to participate. Your pre-and post-test surveys will be matched utilizing a unique identifier, such as favorite number and the street you grew up on (i.e. 6Locke), that you will provide on both surveys.

We hope to receive completed questionnaires from about 55 people, so your answers are important to us. Of course, you have a choice about whether or not to complete the survey/questionnaire, but if you do participate, you are free to skip any questions or discontinue at any time. You will not be penalized in any way for skipping or discontinuing the survey. Completion of the pre-survey will serve as acceptance of informed consent.

Please be aware, while we make every effort to safeguard your data once received on our servers via Qualtrics, given the nature of online surveys, as with anything involving the Internet, we can never guarantee the confidentiality of the data while still en route to us.

If you have questions about the study, please feel free to ask; my contact information is given below. Thank you in advance for your assistance with this important project. Please have the attached survey completed within the next three weeks.

Sincerely,

Sarah Clifton
College of Nursing, University of Kentucky
PHONE: 615-585-8201
E-MAIL: secl227@uky.edu

Advisor
Misty Ellis
College of Nursing, University of Kentucky
Phone: 502-803-0419
Email: misty.ellis@uky.edu

If you have complaints, suggestions, or questions about your rights as a research volunteer, contact the staff in the University of Kentucky Office of Research Integrity at 859-257-9428 or toll-free at 1-866-400-9428.

Appendix B: Pretest survey

Demographic Questions

1. Please insert your favorite number and childhood street here. This will be used as the identifier to match pre-test with posttest surveys
2. How old are you?
    a. 21-29
    b. 30-39
    c. 40-49
    d. 50-59
    e. 60-69

3. What gender do you identify as?

4. What is your ethnicity?
    a. American Indian/Alaskan Native
    b. Asian
    c. Black/African American
    d. Hispanic/Latino
    e. Native Hawaiian/Pacific Islander
    f. White/Caucasian

5. How long have you been a nurse in the ICU?
    a. Less than a year
    b. 1-2 years
    c. 3-4 years
    d. 5-6 years
    e. 7-10 years
    f. Greater than 10 years
6. Approximately how many difficult conversations have you witnessed and engaged in as a nurse?
    a. 0
    b. 1-5
    c. 5-20
    d. >20

Pre-Intervention Questions:

The following questions will be utilizing the Likert scale. Please select the option that fits your level of agreement for the following questions or statements. (1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree)

1. I know what my nursing role is when difficult conversations are occurring with patients and their families
    1 2 3 4 5

2. I feel comfortable participating during difficult conversations
   1 2 3 4 5
3. I feel comfortable interacting with and answering questions from patients and their families following a difficult conversation.
   1 2 3 4 5

4. I have received education on the nursing role during difficult conversations.
   1 2 3 4 5

Appendix C: SPIKES Framework

(Baile et al., 2000)

Appendix D: Simulation Sheet Provided to Simulation Center/Parent Actor

Statement prior to simulation with prebrief:

I have attempted to provide you with a realistic parent interaction in a patient care situation. Your overall role is to treat the simulation as a real clinical experience as you interact with the environment, family and patient. Treat the simulated patient and parent as you would in practice. Be open to learning through simulation realizing that this is a safe learning environment.

Objectives:

1. Identify the nursing role in difficult conversations
2. Utilize effective therapeutic communication during difficult conversations with families
3. PICU RN will demonstrate increased knowledge of therapeutic communication following the education provided
4. Use SPIKES framework

Date of Simulation:

Estimated Time: Approximately 15-minute scenario with 10-15-minute debriefing

Simulators Used: Simman

Personnel: Simulation specialist, family member role played,

Equipment:

Simulated patient	Colorful blanket	Bedside items
Subdued lighting	PIV with MIVF	MAR
Stable, normal vitals on monitor		Intubated

Scenario:

Jacob Right is a 15-year-old boy who was four wheeling with his friends over the weekend. It appears he lost control of the ATV while going around a curve and he crashed headfirst into a tree. He was not wearing a helmet. Friends called 911 immediately. Upon arrival, J.R. was a GCS of 3 and did not have a pulse. CPR was initiated and ROSC was obtained after 15 minutes and 2 rounds of epi. He was intubated at the scene. Pupils were fixed and dilated. He was airlifted out and coded in the air for 20 minutes and given 3 rounds of Epi before ROSC. Upon arrival to the hospital, he was sent for CT which showed significant cerebral edema and loss of differentiation between grey and white matter. Video EEG was initiated and demonstrated minimal brain activity initially but now shows none.

You are the nurse taking care of J.R. and his family. Mom (or dad depending on who actor is that day) is in the conference room and the attending just informed them of the result of the CT and video EEG. The parent has been told that unfortunately J.R. has suffered a severe brain injury and is unlikely to recover. Parent has been asked to think about how they want the medical team to proceed.

It is a few hours later and the mom is crying at the bedside. You come in to do your cares and the mom looks at you and says "I just don't understand. I don't understand how we got here or half of what the doctor was saying. Is he saying my son is dead?

	Findings	**Correct Step**
Initial Frame: Patient lying in bed Family member at bedside sitting in chair: Distraught **Wait for a few moments to see if nurse will recognize and acknowledge the situation/your distress** "I just don't understand. I don't understand how we got here or half of what the doctor was saying." "I can see he is still breathing, and I laid on his chest earlier and I can hear his heart beating. But they said he is dead."	VS: BP 100/70, T 98, R 12, P 100, O2 sat 95% Eyes closed No response to pain No verbalization	Hand hygiene Introduce self Identify patient Assess patient noting priorities: LOC Pain VS Lungs Heart Abdomen Extremities IV site Communicate therapeutically with family member: Listen carefully; note verbal & nonverbal cues; use open ended questions, pauses & silence; be

"I don't know what I will do without Jacob." "I just don't know what to say. I feel so helpless."		available; answer questions; be supportive. Comfort measures: oral care, promote skin integrity, positioning, oral suction

Appendix E: Simulation Debrief

Debriefing:

How do you feel?

What went well? (can notice things that they did too. Tell me what you were thinking?)

I noticed you did xx. Tell me what you were thinking when you did this?

If you had to do the scenario over again, would you do anything differently?

Were you able to use the SPIKES framework while talking with the mom? How did it feel to use it?

Do you feel that you were therapeutic in your communication? If so, provide example(s)?

Do you feel at any point you were nontherapeutic or struggled with communication?

What will you take away from this experience?

**Please remember to complete the evaluation of the simulation on the provided lab computers following the debriefing*

Appendix F: Posttest survey

Please insert the same identifier you used on the pre-test (favorite number and childhood street) here. This will be used as the identifier to match pre-test with posttest surveys.

The following questions will be utilizing the Likert scale. Please select the option that fits your level of agreement for the following questions or statements. (1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree)

1. After reviewing the educational PowerPoint and attending the simulation, I better understand the nursing role during difficult patient/family conversations.
   1 2 3 4 5
2. After reviewing the educational PowerPoint and attending the simulation education, I feel more comfortable being part of difficult conversations.
   1 2 3 4 5
3. Because of the educational PowerPoint and simulation, I feel more comfortable interacting with and answering questions from patients and their families after a difficult conversation.
   1 2 3 4 5

4. I found the voiceover PowerPoint to be helpful/informative.
   1 2 3 4 5

5. I found the simulation exercise to be beneficial.
   1 2 3 4 5
6. I feel this education provided valuable information and training and should be considered for future nursing orientation.
   1 2 3 4 5
7. The quality of patient and family care will be improved because of this intervention.
   1 2 3 4 5
8. Please add any additional commentary or feedback you have regarding the intervention.