Family Conversation Scenario Design Tool for Simulations

Instructions: *This tool can help script disclosure conversations or change-of-shift reports by generating role play scenarios for simulation training. The goal is to ensure that conversations with families occur consistently.*

*Before the role play, the facilitator should choose **one to several** complementary variables in each category and reveal the following information to each participant:*

- ***Medical staff:** situation, location, group participants, and patient demographic*
- ***Family:** Patient demographic, parent personality, and parent response*

The facilitator may use the tool on page 2 to evaluate participants. Medical staff should fill out page 3 before a role play about a disclosure conversation. Medical staff should review the outline on pages 4-5 before a role play about a change-of-shift bedside report. Participants should consider the content of the conversation: what should be said and what should NOT be said.

Simulation Variables

Situation

- Near miss
- Adverse event due to system issue
- Patient identification mix-up
- Difficult Diagnosis
- Adverse event due to error
- Breach of confidentiality
- Problem undetected prenatally
- Adverse event due to hazard of high-risk therapy
- Staff change-of-shift handoff

Stage of Disclosure

- Preliminary Disclosure
- Ongoing disclosure
- Final Meeting

Location

- Bedside in open pod with others
- Bedside in **a** private room
- Conference room

Participating Family Members

- Parent(s)
- Parent(s) plus grandparents
- Foster parent(s)

Participating Hospital Staff (Identify person who will lead the conversation)

- Nurse
- Social worker
- Physician/NNP
- Interpreter
- Specialist/Pharmacist
- Hospital Administrator

Parent Demographic

- Age: In his/her teens
- Has no higher education
- DHS is involved
- Non-English speaker
- First couple of days in the NICU
- Complications during home birth
- Age: In his/her twenties
- Well-educated/researched
- NAS (illicit vs. pain)
- Developmentally challenged
- In the middle of a NICU stay
- Unexpected admission
- Age: In his/her thirties or older
- Medically trained
- Domestic abuse is suspected
- Previous NICU experience
- Almost ready for NICU discharge
- Prefers alternatives to medical intervention

Parent Demeanor

- Not very engaged
- Very passive, agreeable, and calm
- Desires only minimal information
- Overly positive
- Very engaged
- Strong patient advocate
- Aggressively negative
- Short-tempered
- Experiencing post-partum depression
- Needs lots of info, and has many questions
- Has been educated multiple times but still doesn't understand

Parent Response

- Speechless
- Angry
- Shows signs of guilt
- Agreeable
- Scared
- Tearful
- Confused
- Nervous
- In denial
- Overwhelmed
- Blaming
- Friendly

Developed at VON ONSITE at OHSU for Disclosure PBP, May 2014

Simulation Measurement

This rubric was inspired by and uses portions from Dr. JoDee M. Anderson's Behavioral Assessment Tool (BAT). There are five categories of skill level, 0-4 (poor to excellent, or novice to expert). As you watch the simulation, make tick marks under the number which best describes the behavior observed. At the conclusion, summarize your assessment by circling the number that best describes the participant's performance in relation to the characteristics listed (the number with the greatest tick marks). This is a behaviorally anchored rating system (BARS). Remain specific to the behavior observed.

1. Verbal Communication

Approach to family is demeaning, or abrubt; does not appear prepared for the conversation; does not ask any questions; fails to react to evolving conversation; does not offer an apology, even if appropriate; uses words unfamiliar to listener; creates confusion with a disorganized or contradictory explanation; voice is either too soft or too loud; "talks down" to the family.	Language and approach are professional most of the time; may ask 2 to 3 important questions during the conversation; may not recognize preditable situations but adapts to evolving conversation; if appropriate, offers an apology; explains important information but does not consider family's ability to understand; tone of voice varies from soft to loud but audible by others in conversation; keeps unnecessary conversation to a minimum.	Language and approach are professional at all times; asks pertinent questions; is not surprised by predictable situations or evolving conversation; if appropriate, offers a sincere apology; presents important information succinctly and builds on what the family understands; speaks clearly and can easily be heard by others; clarifies vague communication; accurately restates family's message; promises to follow up.

Poor (0 points) Novice	Partially Acceptable (1 point)	Acceptable (2 points) Competent	Above Average (3 points)	Excellent (4 points) Expert

2 Empathetic Listening

Interrupts or cuts family off. Makes no effort to understand family's communication; hurried; does not pay attention to family's emotions or primary concerns; becomes defensive, disagreeable, or detached.	Listens without interrupting but appears to be focusing thoughts elsewhere; regards family with a caring attitude; displays some understanding of family's perspective, needs, or emotions; does not recognize family's intentions behind questions or words.	Listens without interrupting and concentrates on family's words and intentions; demonstrates a caring attitude and an awareness of family's primary concerns, needs, and emotions; responds with empathy; non-judgmental; non-defensive.

Poor (0 points) Novice	Partially Acceptable (1 point)	Acceptable (2 points) Competent	Above Average (3 points)	Excellent (4 points) Expert

3. Nonverbal Communication

Openly distressed; does not recognize or respond to family's nonverbal cues (word choices, tone, body language); turns body away from family; stands during the conversation, or if sitting, leans away from speaker and keeps arms and legs folded; Looks away or down often; uses inappropriate facial expressions.	May appear flustered at times but maintains self-control; recognizes or responds to some nonverbal cues. May turn body toward the family or lean in somewhat but keeps arms folded. Appears distracted or disinterested. Makes minimal eye contact; nods in agreement sometimes; uses appropriate facial expressions.	Maintains composure; correctly interprets nonverbal cues and responds in a way that increases communication; asks additional questions if a cue is unclear; faces body toward speaker, leans in, sits forward on chair, and keeps arms unfolded; makes good eye contact; nods in agreement; uses mirroring facial expressions.

Poor (0 points) Novice	Partially Acceptable (1 point)	Acceptable (2 points) Competent	Above Average (3 points)	Excellent (4 points) Expert

Disclosure Conversation Planning Worksheet

Instructions: *Prompt, compassionate, and honest communication with the patient and family following an incident is essential. Every unit should develop a unit-specific guideline about which types of incidents merit disclosure. To ensure that proper disclosure of patient safety events occurs consistently, use this worksheet to script the conversation just before meeting with the family.*

Here are some questions to consider:

- How can you personalize the conversation to this particular family?
- What behaviors, words, or actions are you planning?
- How can you bridge the gap between what the family hears (or is able to process) and what you believe you are communicating?
- What will you do to follow-up or check in with the family in the coming hours or days?

1. What stage of disclosure is this? (preliminary disclosure, ongoing disclosure, final meeting)

2. Where will this conversation take place?

3. Which family members will be present?

4. Which medical staff should be present? (physician / NNP / RN / specialist / pharmacist / social worker / interpreter / administrator / other)

5. Who is the best person to lead this conversation?

6. What needs to be disclosed? What behaviors, words, or actions are you planning for the communication?

7. What do you know about the family?

8. How do you expect the family to respond?

9. What questions do you expect to be asked? Who will you bring into the conversation if you are not able to answer them?

10. How do you plan to follow up with the family? What will happen and who will do it?

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Change-of-Shift Bedside Report Outline

Process: Pre-Bedside Report (begins 1 hour prior to shift change)

Job and Role: Offgoing and oncoming nurses

Notes:

MAJOR STEP "What"	KEY POINTS "How"	REASONS "Why"
1. Check in on patients (1 hour prior to shift change)	1.1 Inform patient / family that change of shift will happen within the hour 1.1.1 Set expectations for bedside report 1.2 Ask patient if they want to participate 1.3 Address patient needs (5Ps): 1.3.1 Pain 1.3.2 Potty 1.3.3 Position 1.3.4 Possessions 1.3.5 Pumps 1.4 Prepare patient room for next shift 1.4.1 Restock key items as needed 1.4.2 De-clutter room	Eliminate non-urgent interruptions for nurses during shift handoff
2. Transfer of Knowledge (RN Handoff note)	2.1 Complete RN transfer of knowledge note in Epic	Complete note will help to facilitate bedside report This is key information that oncoming RN will see prior to bedside report
3. Obtain Shift Assignment	3.1 Per unit protocol	
4. Area Readiness Huddle (3 min)	4.1 Attend and contribute to Area Readiness Huddle 4.2 If needed, obtain relevant information from the Charge RN	To identify and escalate abnormalities
5. Preparation (7 min)	5.1 Oncoming nurse reads written handoff note 5.2 Off-going nurse finds oncoming nurse for shift change	

Process: ICU Bedside Report

Job and Role: Off-going and oncoming nurses

Notes:

MAJOR STEP	KEY POINTS	REASONS
1. Warm Welcome	1.1 Introduce the oncoming nurse and tell the patient something confidence building about him/her. 1.2 Connect on a personal level. *Off-going nurse should tell something personal about the patient to the oncoming nurse.* *Tell me who you have here with you today.* 1.3 Update the white board.	Patient knows who nurse is why they are there. Establish relationship with patient/family early. Manage up and instill confidence in the oncoming nurse.
2. Safety & Comfort Checks	2.1 Alarms, emergency supplies 2.2 ADL/Activity Status 2.3 Examine LDAs (drip checks) & Wounds 2.4 Discuss pain & symptom management 2.5 Perform unit specific focused assessment, prn	Establish baseline between both nurses and ensure patient is safe at the beginning of each shift.
3. Discuss Plan	3.1 Current/relevant diagnosis and co-morbidities. Utilize bedside computer. *3.2* Review the patient and clinical goals from previous shift and acknowledge unresolved issues. *Ask patient if anything was missed.* 3.3 Develop plan of the day and plan of the stay with patient *Identify some new goals now* ***OR*** *let patient know when nurse will return to identify new goals* 3.4 Acknowledge existing psych/social issues 3.5 Reminder of upcoming tests and procedures	Promote patient / family engagement and continuity of care. Set up trust with patient (to follow through). Limit personal judgments on patients' situation / condition.
4. Patient Questions	4.1 Ask patient / families what questions and concerns they have *"What is your #1 concern today?"* *Reassure patient*	Engage patient / family in care; reduce anxiety; establish trust.
5. Fond Farewell	5.1 Off going nurse says goodbye 5.2 Oncoming nurse shares timeframe for return	To be able to acknowledge bond and give closure to patient and nurse.
6. Documentation Verification in EMR	6.1 Additional computer data review (as needed).	Ensure accurate and complete nursing notes. Validate transfer of knowledge.