Project Guide
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Contact: Wendy.Anderson@ucsf.edu
Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>SECTION 1: Guide for Workshop Facilitation</td>
<td>3</td>
</tr>
<tr>
<td>SECTION 2: Guide for Rounding with Bedside Nurses</td>
<td>17</td>
</tr>
<tr>
<td>SECTION 3: Materials for Communication Workshop</td>
<td></td>
</tr>
<tr>
<td>A. Workshop objectives</td>
<td>26</td>
</tr>
<tr>
<td>B. Pre- and post-workshop checklists</td>
<td>27</td>
</tr>
<tr>
<td>C. Pre-workshop reflection activity for participants</td>
<td>31</td>
</tr>
<tr>
<td>D. Faculty schedule template</td>
<td>34</td>
</tr>
<tr>
<td>E. Participant schedule</td>
<td>36</td>
</tr>
<tr>
<td>F. Faculty contact list</td>
<td>37</td>
</tr>
<tr>
<td>G. Slides for workshop didactic session</td>
<td>38</td>
</tr>
<tr>
<td>H. “What is Palliative Care” definitions handout</td>
<td>43</td>
</tr>
<tr>
<td>I. Skills and conversations handout</td>
<td>44</td>
</tr>
<tr>
<td>J. Role play case handouts</td>
<td>49</td>
</tr>
<tr>
<td>K. Reference and resource list</td>
<td>52</td>
</tr>
<tr>
<td>L. Reflection session guide</td>
<td>54</td>
</tr>
<tr>
<td>M. Pocket card</td>
<td>56</td>
</tr>
<tr>
<td>N. Pre-workshop participant evaluation</td>
<td>58</td>
</tr>
<tr>
<td>O. Post-workshop participant evaluation</td>
<td>60</td>
</tr>
<tr>
<td>P. Follow-up evaluation</td>
<td>63</td>
</tr>
<tr>
<td>SECTION 4: Materials for Rounding with Bedside Nurses</td>
<td></td>
</tr>
<tr>
<td>A. Patient-Nurse rounding record</td>
<td>67</td>
</tr>
<tr>
<td>B. Rounding time log</td>
<td>69</td>
</tr>
<tr>
<td>SECTION 5: Materials for Train the Trainer Sessions</td>
<td></td>
</tr>
<tr>
<td>A. Stakeholder interview guide</td>
<td>70</td>
</tr>
<tr>
<td>B. Pre-training teaching reflection exercise</td>
<td>71</td>
</tr>
</tbody>
</table>
C. Pre-training survey ................................................................. 74
D. Sample schedules for train the trainer intensive ....................... 77
E. Facilitator pocket card .......................................................... 85
F. Workshop Observation Guide .................................................. 86
G. Post-Workshop Reflection Exercise .......................................... 87

SECTION 6: Reports and Evaluations
A. University of California Health Implementation Executive Summary 88
B. University of California Health Implementation Evaluation Plan 91
Introduction

Welcome!

We are so pleased that you are interested in the IMPACT-ICU program and have found our guide. We assembled this guide for the University of California Health implementation of our program, and provide it as a resource to others who may want to implement similar work at their centers. Below, please find some brief information about the program; please get in touch if we can answer any further questions.

What is IMPACT-ICU?

IMPACT-ICU is a quality improvement program designed to integrate palliative care into the ICU by training and supporting bedside nurses. The program has 2 main components:

- **Communication skills training workshop**: An 8-hour learner-centered workshop trains nurses to facilitate communication about prognosis, goals of care and palliative care among families and physicians. It is taught by a multidisciplinary team of experts in palliative care, critical care, and communication. In role-plays, nurses practice conversations with families, physicians, and in family meetings. A reflection session teaches self-care practices to address nurses’ distress & burnout.

- **Proactive specialty palliative nursing support**: IMPACT-ICU positions bedside nurses to coordinate primary palliative care, including symptom management, family support, and communication about prognosis & goals of care. To support bedside nurses in this role, palliative care advanced practice nurses and nurse educators round regularly at the bedside to coach bedside nurses through the process of screening for and developing a plan to address palliative care needs; they are available for consultation at other times.

We developed a faculty development program to prepare advance practice nurses and nurse educators to implement the program at their centers; this guide includes a description of that program.

Why & How was IMPACT-ICU Developed?

IMPACT-ICU was developed by an interdisciplinary and multi-specialty team at the University of California, San Francisco (UCSF) Medical Center in 2011, in response to requests from critical care nurses for training in communication and increased specialty palliative care support in the ICU. It was refined at UCSF between 2011-2013. Between March 2013-August 2015, the University of California Office of the President’s Center for Health Quality and Innovation Quality Enterprise Risk Management program funded the dissemination of IMPACT-ICU across the 5 University of California Medical Centers:
Davis, Irvine, Los Angeles, San Diego, and San Francisco. A summary of the evolution of this implementation is included in this guide.

**What would I need to implement this at my center?**

We designed this guide to provide the concepts, procedures, and materials you would need to implement this program at your center. For the communication skills training workshop, you would need a team member with experience facilitating small group communication skills trainings using role play. If you have not had this experience, you could gain it through programs described on Page 16 of this guide.

We hope you find this guide helpful, and please reach out if our team can be of help.

Sincerely,

The IMPACT-ICU Team

Contact: Wendy.Anderson@ucsf.edu
Guide for Workshop Facilitation

I. INTRODUCTION

For learners, the most important determinant of the effectiveness and enjoyableness of any communication skills training experience is you -- the facilitator. How you facilitate your communication skills practice sessions during the workshop will determine how engaged the learners are, whether they feel safe learning new skills, whether they identify and learn skills that will help them in their practice, and whether they come away from the experience recommending it to their colleagues. How you facilitate these sessions will also be the main determinant of how you feel about the workshop – good facilitation process connects you to your learners and makes learning how to have these difficult conversations fun for the whole group. We have designed this guide to support you in using the best practices in facilitation, and also to encourage your continued development as a facilitator, so that you can learn from each session to make the next one even better.

Like communicating about serious illness, facilitating is not easy. Also like communicating about serious illness, it is a skill that can be learned, and that you get better and better at with practice and feedback. Outlined below are key steps in the facilitation process, based on research and ours and others’ experience in conducting communication skills training. Each step included here seems to us to really matter, in terms of learner engagement, safety, and acquisition of new skills. We encourage you to try to follow this guide, to test it for yourself, and to come to your own conclusion about essential steps. At the end of the guide, we give some suggestions for continual improvement, and how you might evaluate this guide for yourself.
II. STRUCTURE AND PROCESS FOR EACH ROLE-PLAY SESSION

Each role-play session in the IMPACT-ICU workshop lasts for 60-70 minutes. To maximize learning, we’ve found that dividing it into the following segments seems to help. These are summarized in the table below, and detailed in the text that follows.

Table Recommended Structure for Role Play Sessions

<table>
<thead>
<tr>
<th>Segment</th>
<th>Duration</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>A. Goals/challenges</strong> (5 minutes)</td>
<td></td>
<td>“What challenges do you encounter in talking with (families/physicians/in family meetings) about prognosis, goals of care, and palliative care?”</td>
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<tr>
<td><strong>B. Review conversation goals and skills</strong> (5-10 minutes)</td>
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<td>Review specific goals for the conversation; Review skills to be practiced, getting examples from the group</td>
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<tr>
<td><strong>C. Model role play</strong> (5-10 minutes)</td>
<td></td>
<td>Faculty model skills (don’t need to goal set/debrief faculty for model role play); Direct participants to observe for skills and then report what they observed after</td>
</tr>
<tr>
<td><strong>D. Skills practice</strong> (40 minutes)</td>
<td></td>
<td>See role-play facilitation figure</td>
</tr>
<tr>
<td><strong>E. Take-home points</strong> (5 minutes)</td>
<td></td>
<td>“What are you taking home from this session for the discussions you have in practice?”</td>
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A. Goal setting (5 minutes)

The purpose of this step is to engage the learners in the role-play to come, and show you where their learning edge might be so you can tailor the practice.

1. Introduce the session topic: “OK, first we’re going to be practicing discussing prognosis and goals of care with family members.”

2. Elicit participants’ challenges in the specific conversation to be practiced: “What do you find most challenging in (discussing prognosis and goals of care with families / working with physicians to address family needs / participating in family meetings)?” You don’t need to go around the room and to get all input from all learners, just take whatever answers are offered. It is helpful to scribe these for the group to see and as a record.

3. To focus this discussion and illustrate the connection between the 3 conversations we are practicing during the day, in the last two role-plays, which continue from the morning role-play, you may want to ask the participants to re-cap what occurred in
the prior role-play: “Now you remember we will be continuing with the same case of Mr. and Mrs. Ames all day. So briefly, could someone in the group recap where we are with Mrs. Ames? What did we learn from her this morning?” [You might ensure that key information about the case is reviewed to frame the next role-play, for example that Mrs. Ames wants information about prognosis, but hasn’t really gotten it; that she is very worried about her husband but feels he is independent and would not want to live in a nursing home.] “Ok great, now we are going to practice talking with Mr. Ames’ doctor about what we learned. Lets run through what our goals will be for this discussion.”

B. Present goals of conversation and skills to practice (5-10 minutes)

The purpose of this step is to focus the learners on what they are trying to accomplish in the role-play conversation, and what skills they will use. Remember they have likely never seen these skills, so you probably can’t review them too much.

- Walk through the skills handout, overviewing goals and skills to be practiced in this session. “Ok, we’re going to be practicing how you might work with the challenges you identified. First, I want to walk you through the goals for this conversation, and the skills we will be practicing to achieve those goals.”

- A nice way to have participants practice some of the skills before role play, especially ones they may not be familiar with such as the NURSE statements, is to have participants give examples of them in the large circle. For example, you might ask, “What emotions do you encounter or struggle with responding to?” “Anger – great. Lets practice some NURSE statements. Can someone give me an example of a Naming response for anger?” “Great – what about a Support statement – can someone give an example of a Support statement to respond to anger?”

C. Model role-play (5 minutes)

The purposes of the model role-play are to: 1) Show learners what they are working toward – so an expert level discussion and use of skills; 2) Engage learners in the process of observing for skills and impact on the recipient.

Note: for the model role play, you can EITHER model only the communication skills, without asking the person playing the nurse to identify a goal beforehand OR you can show how the learner and facilitator will interact by modeling the full cycle of facilitation, beginning with the person playing the nurse identifying their goal and a skill they will use. We have found modeling only the skills to be more effective. Modeling only the skills has the advantage of focusing more on the communication skills themselves. Modeling the entire facilitation cycle has the advantage of showing learners how that will work. Either way, the person playing the nurse in the model role play should not time out or get stuck – the purpose of the model role play is to show a relatively difficult conversation that most participants would not feel comfortable with, which is navigated
well with use of skills from the handout.

1. Describe the roles for the session and introduce model role-play. “For this session, one of you will be playing a nurse, and another a family member. First, we’ll do a model role-play so you can see how you as a nurse might use these skills on the handout to accomplish some of the conversation’s goals. Kathleen will be playing the nurse for the model role play, and Ann will be playing the family member, Mrs. Ames.”

2. Have someone (could be the person playing the nurse in the model role play) read the nurse’s scenario aloud to the group, so that everyone is familiar with the case and what the nurse knows.

3. Before the model role-play starts, make sure that you tell all of the participants to observe closely for any skills on the handout that the nurse used, and what the impact was on the recipient (family or physician). Encourage them to write it down.

4. The facilitator times out the role-play after about 2 minutes. The model needs to clearly show use of skills in the handout, and how they can be used to quickly and effectively achieve the goals of the conversation, e.g. for the family role-play, to get information about family understanding of prognosis, goals of care, and needs for information, as well as provide emotional support.

5. After the model role play, make sure to elicit the participants’ observations on what was learned in the discussion how the skills learned helped us learn that. You don’t need to debrief the person playing the nurse after, you can just go to the participants for their observations: “OK, now what did Kathleen learn as the nurse in that discussion?” “What skills did she use to achieve that?” “What did you notice about the impact of using those skills on Mrs. Ames?” You may want to point out what was accomplished in a 2-minute discussion, given nurses’ concerns about time for these discussions in the middle of their busy workday.

D. Participants practice communication skills (40-50 minutes)

This is the meat of the role-play session – your work with the participants as they practice using the communication skills. The way you interact with the learner playing the nurse determines the effectiveness and safety of their practice. Also, the degree to which you involve the rest of the group determines how much they learn from the session. Using the process below, you can ensure the exercise addresses key aspects of skills training: is learner-focused, includes specific and positive feedback, includes the chance to safely try new skills, and the chance to observe others using new skills.

1. Setting up the role-plays

   • Ask for two volunteers, one to play nurse and the other family member. To get volunteers, it may help to say, “The first volunteer gets it easy – they only have to ask one open-ended question, then I will time you out.” [Note: if you make this
promise, be sure to time them out after the first open-ended question. You can then ask them if they want to go on – they often will. Alternatively, you can set the expectation that everyone will participate, and just go in order around the room.

• When the participant who will play the family member comes up, give them the family member scenario (this handout is only given to participants as they play the family member, it is not read or handed out to the whole group).

• You can give the participant who will play the nurse the nurse scenario handout, but this has already been read aloud before the model so the learner shouldn't need too much time to read. While you are goal setting with the learner, the participant playing the family member can read the family member handout.

• For the supporting roles (family / doctor), you can solicit a new volunteer every 2-3 learners – they don’t need to change with every learner.

• It seems to help participants to focus on communication skills if everyone sits down at the front of the room in their chairs to do the goal setting and stays seated for the debrief and feedback – if they get up, ask them to sit back down.

• Like in a family meeting, the arrangement of the room seems to matter for the role-play. Below is a diagram of what we have used. It seems that the observers participate more if they are close in distance from the role-play. We have found that it is helpful for the facilitator to sit next to and a little behind the participant playing the nurse, in a coaching location. The other faculty should be integrated into the room in a way that they can see the facilitator and be actively involved in the discussion. Attend to the room set-up during the role-play and if it doesn't seem right, pause to re-arrange.

Figure: Diagram of Recommended Room Set-up for Role-Play
• It seems to work best for each new learner who comes up to play the nurse to continue the conversation where the previous learner playing the nurse left off. However, if the discussion comes to an end, you could start over using a slightly different emphasis, based on the learners’ identified challenges.

2. Facilitation process for each learner playing the nurse

Following is a diagram and detailed description of the cycle you will take with each learner playing the lead (nurse) role – note that the timing for each piece is optional (could go longer). We have found that this order of the steps and including all of them improves the quality of the role-play learning.

Figure: Diagram of Facilitation for Group Communication Skills Practice

1a. Welcome Learner
   a. Thank you for volunteering
   b. Review conversation goals

1b. Learner Goal
   a. Specific learner goal
   b. Select skill to reach goal
   c. Direct observers to goal/skills

2. Role Play

3a. Time-Out: Success
   a. Check in with learner:
      • Met goal
   b. Brief general (+) feedback to learner
   c. Specific (+) feedback from observers, other faculty, facilitator

3b. Time-Out: Stuck
   a. Check in with learner:
      • Table edge for later discussion
   b. Brief general (+) feedback to learner
   c. Specific (+) feedback from observers, other faculty, facilitator

4a. Close Learner’s Practice
   a. Thank you
   b. Take home points

4b. Brainstorm Edge
   a. Learner ideas
   b. Ideas from observers, other faculty, and facilitator
**Step 1a: Welcome the learner to the role-play**

- Thank the learner for volunteering, and remind them what the goals of the conversation are: “Thank you so much for volunteering Rebecca. As you remember, the things we are working on in this discussion are: eliciting family understanding of prognosis and goals of care and providing emotional support.”

**Step 1b: Identify the learner’s goal and the skill they will use to achieve it**

This step is crucial to making the role-play learner-centered and skill-based. It is helpful to separate the goal – which is what they want to accomplish in the conversation – from the skill/tool they will use to get there. As the facilitator, you should prepare the learner for success. If you think their goal is not appropriate, feel free to re-direct it: “I think it is important for us to ask Mrs. Ames what she understands about her husband’s prognosis. It might be a hard question to lead with though, as you are the just meeting her. Could we start with maybe just asking how she is doing today?” Or feel free to help them choose a different skill to help achieve their goal: “You said you wanted to provide emotional support. Open-ended questions can do that – I’d like to suggest that you also consider using a NURSE statement – would that be ok?”

a. From among the goals of the conversation, let the learner choose what they’d like to focus on / where they’d like to go next. “Rebecca, what would you like to focus on in this practice?” “What would you like to achieve with Mrs. Ames?”

b. Then help them choose a skill to achieve this goal: “Great, so you want to focus on providing emotional support. Let’s look at your purple skill sheet – what skill would you like to use to provide emotional support? A NURSE statement, great, do you feel prepared to do that?”

c. Instruct the observers to watch for the skill and effect, and remind them to write down words said as you will be asking them afterward: “We’ll have the observers in the group watch for how you respond to emotion.”

**Step 2: Role-play (approx. 2 minutes)**

- Let the learner start the role-play when they are ready: “When you’re ready, go ahead and get started.”

- Let the role play go until the learner seems stuck to you, they call a time out, or they have used their skill and had a chance to see its effect

- Take notes about specific skills used and their effect, in addition to concerns or opportunities missed

- If you or learner has not called time-out by about 2 minutes, it is good to stop and check in. Even if the discussion is going well, transitioning through too many topics makes it is hard for you and the observers to remember what happened for feedback
Steps 3a and 3b: Debrief learner (approx. 5 minutes)

Note that the contents of Step 3a and 3b are pretty similar, with the difference being your and the learner’s assessment of whether the practice was successful in meeting the goal the learner set using the skill they identified to use. Debrief as follows to assess the learner’s perspective:

a. **Check in with learner:** Remind the learner of their goal: “Your goal was to use a NURSE statement – how do you feel you did?”
   - If the learner feels a **success** (3a), you can go directly to positive feedback.
   - If the learner identifies a **stuck / problem / concern / edge** (3b), briefly clarify/restate/reflect what the edge was: “You said you didn’t know what to say when she cried – can you say more about that?” Once you and the learner agree about any edge / stuck point, table that for later discussion: “Ok, we’ll come back and talk about that [edge].” It may be that the learner meets their goal, then goes on to get stuck on another issue – you can still debrief as follows, and might let the learner go back in to address the stuck point.

b. **Brief, general positive feedback from facilitator:** briefly assure the learner that you felt they did well, “I thought you did a lot of things well.”

c. **Specific positive feedback from observers, other faculty, and facilitator:** Get positive feedback from the group: “I thought you did a lot of things well. Could we hear from our observers about what went well in that encounter? What skills did Rebecca use? What was their impact?” It is best for group engagement if you can get this feedback from the observers. Other faculty are good sources for this too. Often the best facilitation is making the points you wrote down on your sheet by getting others to say them. If no one identifies a point you want to make, make it but see if you can then hand it back to the group for more discussion. “I noticed Rebecca also used great non-verbal skills – did anyone else notice anything about non-verbals?”

If the learner feels they succeeded, and you agree, then you would proceed to Step 4a (closing) after positive feedback. If the learner identified a challenge / edge / stuck point, then go to 4b to brainstorm how to address it.

**Step 4b: Brainstorm about how to address edge**

If the learner did get stuck / timed-out, you should give them a chance to try something differently and feel a success. After positive feedback, you can lead a brainstorming session about how to proceed.

a. **Learner ideas:** Turn back to the learner, and remind them of their edge, and ask for ideas they have about how to address it. “So, Rebecca, you got stuck when she kept asking questions again and again. Let’s take a minute to think about how to deal with that. Do you have any thoughts?” “Respond to emotion - that’s a great idea.”
b. Ideas from observers, other faculty, facilitator: “Can we also get some ideas from the group?” “What other ways could you respond to multiple questions?” Again, it’s best to first go to observers, then other faculty, then you last to foster group discussion.

**Step 1b, Round #2**

Now return to Step 1b for the learner to practice again: “OK Rebecca, you’ve gotten some great suggestions. Would you be willing to try one in another brief practice to see how it works? Which would you like to try?”

**Step 2, Round #2**

Let the learner go back into role-play, timing out pretty soon after they have used their new skill, so they do feel a success.

**Step 3a, Round #2**

Here you might just check in with the learner (and probably not the group) after you time them out – “How did that feel?” Hopefully they felt a success. Then you can ask them what they’ll take home, and rotate to a new learner.

**Step 4a: Close Learner’s Practice – 1 minute**

After the learner has succeeded (or had 2 turns), thank them and rotate learners – you might ask the learner for a take home point: “What will you take home from this?”

**Notes / other situations:**

- **If the learner feels a success but you don’t think they met their goal / have concerns:** Here is where your excellent facilitator skills come into play! In the debrief (Step 3), after positive feedback, you could test to see whether you can get the learner to identify an edge: “Mrs. Ames seemed pretty sad – she kept saying how discouraging it all was. How did you feel about that?” If you can get the learner to identify your concern as an edge, e.g. “Now that you mention it that was a bit uncomfortable, I didn’t know what to say,” you can go to Step 4b for brainstorming about how to address it. The trick is not to call the learner out without them opening the door to getting suggestions about how to address something differently.

- **If the learner feels stuck, but you felt they did really well:** You don’t have to have them go back into skills practice – you could use the group to give feedback and to re-frame how the learner felt. “I actually thought you responded beautifully – could we get some feedback from the group?” “I think sometimes you just need to sit with the sadness an not try to fix it – that’s exactly what you did.”
• *If the learner doesn’t feel a success on the second try at skills practice:* Probably don’t make them go in a 3rd time, as it may be distressing and take away others’ turns. If the learner and you don’t feel good about their final practice, then you could do some brief brainstorming with them about what they might want to try next time. “So it sounds like you ended up being comfortable with the silence, but then got stalled at what to say. That’s pretty normal. What might you try next time? I often find that NURSE statements are helpful. Might you try that next time?”

E. Conclusion – take home points (5 minutes)

After the last learner finishes role-play in each session, take 5 minutes to close the session. The purposes of this step are: 1) for you to hear what the learners are taking home, which is important feedback for your teaching, and 2) for the learners themselves to consolidate what they have learned in the session. It also helps to very enthusiastically thank all of the participants for their participation – remember they are doing very hard work and they really appreciate you noticing that.

• At the end of each role-play session, thank the participants and elicit their take home points: “Ok, we’re going to conclude this role-play session. I really want to thank everyone for your engagement in the session and thoughtful observations, and for participating – I know it can be intimidating. To close this session, I’d like to take a minute to hear your take home points. What are the main things you will take home from this session?”). It is helpful for someone to scribe these as well. As at the beginning of each session, you can just take whatever answered are offered - no need to go around the room and have everyone give one.
## Table: Facilitation Pearls and Pitfalls

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<tr>
<th>Pearls</th>
<th>Pitfalls</th>
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<tr>
<td>• Bracket each role play session and each participant’s practice with goal setting and the beginning and take-home points at the end.</td>
<td>• Glossing over the skills. You cannot review the skills enough – say them, practice them, call them out over and over again. Copy them on purple paper. Most participants are not familiar with them.</td>
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<tr>
<td>• Make sure that the model role-play illustrates an expert-level example of the discussion being modeled and uses the key skills.</td>
<td>• Letting your learner begin skills practice without a clear and achievable goal and a skill that will accomplish it.</td>
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<td>• Link skills practice to challenges learners experience in practice. “Jen, what do you struggle with in these discussions?”</td>
<td>• Letting learners go too long in role-play. Most learners are more anxious than they appear. Also, if conversation continues for a long time, it is hard to recall and discuss and learn from what happened earlier.</td>
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<tr>
<td>• Time out after the learner has achieved their goal so they can experience a success.</td>
<td>• Letting learner leave role-play without getting positive feedback, or letting observers give suggestions instead of positive feedback.</td>
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<td>• After a time out, first check in with the learner.</td>
<td>• Providing your detailed feedback first after participant times out. It takes the chance away for your observers.</td>
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<td>• Use the skills we are teaching the participants with your learners (e.g. empathy, open-ended questions, etc.).</td>
<td>• Lecturing or telling participants what you want them to learn or take home. See whether you can get them to say it.</td>
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<td>• Talk less, elicit more. The best facilitators elicit key points from participants and other faculty.</td>
<td>• Using very general questions to elicit positive feedback from observers, e.g. “how did you think that went?” Elicit positive and skill-focused feedback specifically: “What did John do well? What skills did he use? What was there effect?”</td>
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<td>• Encourage participants to use a variety of skills: “I’ve really enjoyed the practice of open-ended questions. Would anyone be willing to practice using a NURSE statement to respond to emotion?”</td>
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<td>• Frequently voice your appreciation of the hard work the learners are doing.</td>
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III. CONTINUING YOUR DEVELOPMENT AS A FACILITATOR

The process of becoming an expert facilitator parallels that which is outlined above for learners. And as we experience in our clinical practice, we never stop learning about how best to communicate with patients and families – each experience teaches us something. Similarly, the best facilitators don't perceive that they have completed their mastery, instead they use each experience to get better and better. Below we describe some key points about using the process we use with learners to ensure that we as facilitators learn from every teaching experience.

A. **Set concrete goals and skills for each role-play session:** For your own growth, and so that your co-facilitators can better give you feedback, it helps to set a goal and describe how you will achieve it. This is similar to how we prepare learners before their practice. For example, if you want to focus on learner engagement, you could use the skill of asking open-ended questions of the group. It’s best to pick one goal per role-play session, as we ask learners to do, so you can really focus on it. Tell your co-facilitator what your goal is before the session.

B. **Do a systematic debrief at lunch and after the workshop:** Have someone debrief you as a facilitator the same way you would debrief a learner.

C. **Have your co-facilitators observe you and take notes about each of the following areas:**

1. **Learner engagement:**
   - How engaged were the learners in the session and role-play?
   - What did the facilitator do to engage the learners?
   - What things made the learners seem less engaged, or made it hard to tell whether they were engaged?

2. **Learners’ goals:**
   - Were the learners’ goals clear?
   - What did the facilitator do to elicit the learners’ goals?
   - What was the consequence when the learners’ goals were or were not clear?

3. **Learner trying new or recommended skills:**
   - Did the learner(s) try new or recommended skills?
   - What did the facilitator do that encouraged the learner to try a new or recommended skill?
   - What seemed to discourage the learner from trying a new or recommended skill?

4. **Learning edge:**
   - Where was the participants’ learning edge – where they were challenged but still comfortable?
   - Did the facilitator help to clarify the learning edge for the learner? If so, how?
5. Feedback:
   • What kind of feedback did the learner get from the other participants? The facilitator?
   • How did the facilitator modulate feedback from the observers?
   • What kind of feedback seemed most helpful and why?
   • What effect did the feedback have on the learner’s performance?

6. Take home points:
   • Was it clear what the learner was going to take home from the session?
   • What did the facilitator do to encourage learners to state their take home points?
   • What effect did stating these take home points seem to have on the learner and session?
References and Resources:


9. American Academy on Communication in Healthcare (AACH). Offers training in communication at regularly scheduled conferences, as well as train the trainer programs and a range of professional development activities and support: http://www.aachonline.org/

10. Oncotalk Website. Developed to support a communication training program for oncologists. Has videos of communication skills, and also has learning modules for teachers: https://depts.washington.edu/oncotalk/index.html

11. VitalTalk. Developed from the Oncotalk investigators. A nonprofit with the mission of nurturing healthier connections between patients and clinicians. They specialize in developing and facilitating advanced communication skills courses and faculty training courses focused on balancing honesty with empathy when discussing serious illness and end of life care. They offer in person training courses and train-the-trainer (facilitator training) programs, as well as on-line learning. http://www.vitaltalk.org/
Guide for Rounding with Bedside Nurses

I. Goal of the IMPACT-ICU Project and Purposes of Rounding

The central goal of the IMPACT-ICU project is to educate and support bedside ICU nurses to identify and work with colleagues to address palliative care needs for their patients in 3 domains:

1) Symptom management
2) Family emotional support
3) Communication about prognosis and goals of care

The IMPACT-ICU workshop defines a role for nurses in family support and coordinating communication about prognosis, goals of care and palliative care among ICU clinicians and families. To support nurses as they work to accomplish the role defined for nurses in the communication workshop, advance practice nurses or nurse educators with expertise in palliative care and critical care round in 2 targets units of each medical center. The nurse leaders also lead the communication workshop, and serve as palliative care consultants and educators at their medical centers. Thus, the rounding is an opportunity to develop and reinforce relationships between the IMPACT-ICU nurse leaders and the critical care bedside nurses.

The goal of the rounding is to support nurses in real time in their work on the unit in identifying and addressing palliative care needs for their patients. In the target ICUs at each medical center, we are encouraging bedside nurses to lead primary palliative care assessment for their patients, to coordinate the provision of primary palliative care by the ICU clinicians to meet identified needs, and to suggest a palliative care consult when primary palliative care has not met a patient’s needs.

The specific purposes of the rounding are:

1) To assist the beside nurse in identifying and addressing palliative care needs for the patient currently under his/her care
2) To reinforce the central role of the beside nurse in coordinating communication about prognosis, goals of care, and palliative care
3) To provide support and education to the bedside nurse for palliative care issues

II. Frequency and Structure of Rounding

Rounding frequency was originally specified at twice per month in each target unit, however for some sites, a different frequency has worked better. For example, some leaders round every week, and others round every day. Some have rounded in the evening to support nurses working nights. Others have coordinated their rounds with ICU or palliative care team rounds in the units. We encourage you to tailor the rounding
schedule to your and your units’ needs, so long as you meet the commitment we made to our funders of spending a total of 8 hours rounding in each target units per month.

Rounding structure was originally designed so that the rounding nurse leader would touch base with every patient on the unit to assess whether they met target criteria. We originally designed these target criteria to identify patients who should receive a primary palliative care assessment. In the first 5 months of rounding, we learned that about 40% of patients in each unit met at least one of the pre-defined criteria. Now that we have established about how many patients nurse leaders will focus on during rounds, it is not necessary to record your assessment of every patient. It is acceptable to focus on patients or nurses with the greatest need. You will track the number of patients you discussed in detail with the bedside nurse during rounds by completing a patient-nurse rounding record.

III. Engaging Bedside Nurses’ During Rounds: Challenges and Best Practices

In the 5-month rounding pilot phase, the nurse leaders encountered identified and navigated challenges for conducting rounds and engaging bedside nurses during rounds. They identified best practices for making the rounds most effective. By in large, the rounding during the pilot phase was extraordinarily well received by beside nurses in the target units. Beside nurses have become familiar with the nurse leaders and the rounding, and are becoming familiar with the primary palliative care assessment process and the role we have defined in the project for the beside nurse in communication about prognosis, goals of care, and palliative care.

The challenges and best practices for navigating them identified during the pilot phase are outlined below.

<table>
<thead>
<tr>
<th>Challenges Encountered</th>
<th>Best Practices to Navigate Challenge</th>
</tr>
</thead>
</table>
| Nurse leaders have many other responsibilities; it’s hard to make the time to round. | • Set a specific time each week, or block off times on your calendar for each month.  
• Tell the nurses when you will be there.  
• Meet someone to help you with rounds.  
• Spend only the minimum amount of time required (8 hrs per month per unit), unless you really have more time to spend.  
• Do a quick survey of target units for patients most likely to have palliative care needs – round on those patients first.  
• Don't see every patient / nurse if you don't have time – focus on those most in need. |
### IMPACT-ICU INTEGRATING MULTIDISCIPLINARY PALLIATIVE CARE INTO THE ICU

| Nurses are unfamiliar with the project and rounding process. | • Attend staff meetings to introduce the project and rounding.  
• Post fliers about IMPACT-ICU with your photos on them.  
• Hand out the rounding record to nurses so they can complete key rounding questions before rounds.  
• Spend your interaction time with the nurse explaining the project and purpose of rounding (and ask for feedback).  
• Keep rounding – they will get to know you. |
| --- | --- |
| Nurses are busy, often especially when they are caring for seriously ill and thus eligible patients. | • Skip the nurse who is busy, and come back at the end of rounds if possible  
• If possible, choose a time of the day to round that is less busy – you could get feedback from nurses in the unit about when this might be  
• Get permission first from nurses before launching into screening – and don’t insist on rounding with them if they don’t have time.  
• Say that the you will only take a few minutes; be good on your word  
• Hand out a “911 card” to nurse with your/others’ contact info. Offer to provide support at another time |
| Completing the rounding process and questions feels like “just another thing for the nurses to do”. Nurses don’t seem very enthusiastic about rounding. | • Focus the interaction on your relationship with the nurse.  
• Make the interaction learner-centered, e.g. what frustrates the nurse? What does he/she struggle with? How is he/she doing today?  
• Get feedback on what would be useful.  
• Don’t force the nurse to participate – ask for permission to check back with them next time you round. |
| Nurses express frustration with physicians, and feel burdened that the entire onus for change is put on them. | • Active listening, empathy.  
• Help nurses to focus on what they can do rather than what they can’t (i.e. providing support to families, listening, relaying information to MDs, etc.)  
• Respect the great work they are doing for their patients and families.  
• Invite nurses to partner with us to make things better - attend the IMPACT-ICU workshop, or help with the next one if they have already attended.  
• Work with unit and medical center leadership to address nurses’ concerns; tell nurses that we are doing this. |
IV. Completing the Patient-Nurse Rounding Record

The purposes of the rounding record are to:

1) To standardize and guide the interaction between the nurse leader and the beside nurse during rounds and
2) Document key information about the patient and nurse
3) Describe the support provided to the patient and nurse by the nurse leaders

The rounding record is divided into 7 sections. The purposes of these sections, as well as any specific instructions, are detailed below.

PATIENT INFORMATION

Purposes:

- Track patients who were impacted by rounding
- Track patient needs and nurse challenges by primary service

Instructions:

- Complete Name, medical record number, age and sex or use patient sticker
- Complete hospitals and ICU admission dates, indicate whether palliative care service is already consulting on patient, and indicate patient’s primary service (what service is the patient’s attending).
- Note that you only complete a rounding record if the patient has a serious illness (Step 1 below). Many nurse leaders find it helpful to stamp sheets before rounds to be prepared, but you would not save / enter sheets for patients without a serious illness.

STEP 1: Identify Patients to Screen for Palliative Care Needs

Purpose:

- Identify patients who are suffering from a serious illness and so should be screened for palliative care needs.

Instructions:

- Original 6 target criteria have bee collapsed into 1 question: “Does your patient have a serious illness?” Pose this question to the bedside nurse, using the bullets to help him/her think through the definition of a serious illness. The goal is that nurses would think through this process with their other patients when you are not there.
- If in doubt about whether the patient qualifies as having a serious illness, lean toward screening the patient in Step 2.
- If the patient does not have a serious illness, then you do not complete a patient-nurse rounding record.
• Please check one box documenting the primary serious illness category.
• If you already have a trigger tool in use in your unit (e.g. UC Irvine), it is acceptable to use this trigger tool to identify patients for nurses to perform as assessment. Please document the primary serious illness category.

STEP 2: Screen for and Develop Plan to Address Palliative Care Needs

Purposes:
• Assist beside nurse in performing a primary palliative care assessment
• Ensure that a concrete plan is developed and documented to address any identified needs

Instructions:
• For patients who have a serious illness, guide the bedside nurse through the primary palliative care assessment, but asking them the indicated questions to assess domains of symptom management, family distress, and communication.
• If the nurse identifies any needs for a patient, make sure that you and the nurse come up with a concrete plan to address those needs, whether through primary palliative care or a consultation. Please check the appropriate box to document your plan for all patients where a need was identified. If no needs are identified you do not need to check a box.
• The goal is that nurses will learn from your interactions how to perform the assessment and develop plans to address identified needs, so that they can do this for patients when you are not there.
• Even if the nurse did not identify palliative care need for their patient, you can still document support you provided to them in Step 4, e.g. around symptom assessment or another issue.
• Regarding identifying needs, we have had the question: “Most of my patient’s family members are emotionally distressed.” That is true – research has shown that around 80% of family members suffer from anxiety or depression when a patient is in the ICU and seriously ill. Similarly most patients also suffer from uncontrolled symptoms, and most families experience inadequate communication about prognosis and goals of care. So encourage nurses to identify these frequently needs so that you can help them develop a plan to address them.

STEP 3: Bedside Nurse’s Involvement in Communication

Purposes:
• Reinforce the key role of the beside nurse in coordinating communication about prognosis, goals of care, and palliative care among families and clinicians
• Identify and help nurses to navigate barriers to achieving this role
Instructions:

- Assess the nurses’ involvement in communication about prognosis, goals of care, and palliative care with the patient’s family, physicians, and in family meetings using the indicated questions.
- Please be sure to pose Question 4 to all nurses and document any barriers.
- If the bedside nurse answers “no” to questions 1-3, indicating that they have not been involved in communication, then at least one barrier should be checked indicating why they have not been involved. Barriers can and should also be documented for nurses who responded “yes” to questions 1-3.

STEP 4: Support and Education Provided to Bedside Nurse

Purpose:
- Document the range of palliative care-related issues about which nurse leaders provide bedside nurses with support and education

Instructions:
- Use this space to document all the great support and education you provided to the nurse during your interaction with them. Please check off at least one box per patient-nurse record.

STEP 5: Surrogate Contact Information

Purpose:
- Identify surrogates for family satisfaction survey

Instructions:
- Please provide telephone numbers for family members who we can contact after the patient’s discharge or death to administer the satisfaction survey.
- You do not need to talk with the surrogate.
- Please record at least 2 numbers for 2 family members if possible. Please compete from all available sources e.g. room white board, nurses notes, medical record – where you would be most likely to find a number if you needed to contact a surrogate.

STEP 6: Patient Outcome Data

Purposes:
- Track patient outcomes including length of stay and discharge disposition
- Track the percentage of seriously ill patients who received palliative care consultation during the hospitalization
Instructions:

- This section is completed using the electronic medical record after the patient has been discharged from the hospital or died.
- Please indicate date of death or discharge and discharge disposition – this is most easily found in the discharge summary.
- Please indicate whether palliative care was consulted on the patient at any time during the hospitalization. This could be found in your own palliative care service records, or by the presence of at least one “Palliative Care” consultation note in the notes/consults section of the electronic medical record.

V. Completing the Rounding Time Log

The purpose of the rounding time log is to document the time the nurse leaders spend rounding in the ICU for the IMPACT-ICU project. Please keep a rounding log for each month. Each time you round, please complete:
- The date you rounded
- The ICU you rounded in
- Your name
- The time you spend rounding (in minutes)

For each target unit, the time spent for each month should total to at least 8 hours = 480 minutes (you do not need to record total).

VI. Data Entry

The rounding log and patient information sheets are entered on-line through the redcap system. Please enter them as follows:

1) Rounding log – please enter on a monthly basis to document all rounds conducted during that month

2) Patient information sheet – please enter after the patient has died or been discharged from the hospital, after this information has been entered on the hardcopy. Some have found it helpful to batch looking up outcome data and data entry, as follows:
- Create 3 folders for patient information sheets:
  (a) Patient still in hospital
  (b) Patient discharged / died – not yet entered
  (c) Entered into database
- After rounds, place records that have all information completed except for “Step 6: Patient Outcome Data” in folder (a).
• Specify a weekly time for the nurse leader or a designee who has HIPAA training and access to the medical record to look up all patients in folder (a) in the electronic medical record.
• Complete outcome data for patients who have been discharged or died, and place these sheets in folder (b).
• Enter sheets in folder (b) into the database, transferring them to folder (c) as they are entered.
VII. Recommended Reading

The following articles are great resources for you as nurse leaders and also for your bedside nurses:

   
   Great thought piece about why some things are slow to change in medicine, and how they are changed one relationship at a time.

   
   Reviews common symptoms and frequency for patients and family members. Would be really helpful in educate nurses about symptom assessment. Note that the frequencies recorded by bedside nurses in our pilot phase were much lower – meaning nurses are probably under-reporting patient’s symptoms or family distress.
WORKSHOP OBJECTIVES

Overall Workshop Objectives
1. Define palliative care and the bedside nurses’ role in primary palliative care communication
2. Assess family understanding of prognosis and goals of care
3. Collaborate with physicians to address family needs
4. Advocate for family informational and emotional needs in multidisciplinary family meetings
5. Employ protective practices to cope with the stresses of work in the ICU

Objectives By Section

The Nurses’ Role in Communication about Prognosis, Goals of Care, and Palliative Care
1. Describe the ethical and professional responsibilities of nurses to families.
2. Detail how nurses can facilitate communication about prognosis, goals of care, and palliative care among families and providers.
3. Define palliative care, including primary and consultative models.

Communicating with Families about Prognosis and Goals of Care
1. Clarify goals for a nurses’ discussion with a family member about prognosis and goals of care.
2. Introduce key communication skills for eliciting families’ perspectives and providing emotional support.
3. Practice and observe colleagues using communication skills to elicit family understanding of prognosis and goal of care and provide emotional support.

Working with Physicians to Address Family Needs
1. Clarify goals for a nurses’ discussion with a physician about family needs.
2. Introduce key communication skills for eliciting physicians’ perspectives, clearly presenting information, and collaboratively developing a plan to address family needs.
3. Practice and observe colleagues using communication skills to elicit physicians’ perspectives, clearly present information, and collaboratively develop a plan to address family needs.

Participating in the Family Meeting:
1. Clarify overall goals of family meetings and goals for nurses’ participation in family meetings.
2. Introduce key communication skills for ensuring that family’s information and emotional needs are met during a family meeting.
3. Practice and observe colleagues using communication skills to introduce key topics discussed, ensure families understand presented information, and provide families with emotional support.

Reflection session
1. Gain a greater understanding the hidden costs of work as an ICU bedside nurse
2. Process some of our own experiences
3. Explore protective practices to address and prevent burnout and compassion fatigue
PRE- AND POST-WORKSHOP CHECKLISTS

To-Do’s - Before the Workshop

3-12 months before workshop:
- Set workshop date and reserve rooms – 1 large (approx. 25 people) + private and confidential space for faculty lunch debrief (approx. 10 people)
- Set up continuing education credits

2-3 months before workshop:
- Get the word out with emails to potential participants, posting flyers
- Open registration
- Create waiting list

1-2 months before workshop:
- Request/order any needed materials (see list on following page)

2-weeks before workshop:
- Email participants who are registered. In this email we include: 1) a welcome, 2) information about location and schedule, 3) anything you want participants to bring (lunch, water, snacks, materials you will not provide such as pens or notebooks), 4) a pre-workshop exercise (included in appendix), 5) request that they release their spot if they cannot come, so that someone on the waiting list can attend

1-2 weeks before workshop:
- Meet with your team to review who will do what in workshop and discuss facilitation goals
- Order coffee/refreshments
- Prepare folders and other materials for the workshop day (see list below and materials in appendices)

1-week before workshop
- Participant reminder email – with request to release spot to someone on waiting list if anyone cannot come
Materials to have on hand / Order before each workshop:

- Folders
- Mailing labels to print front of folder
- Colored paper to make particular materials in folder stand out, e.g. light purple for “purple skills handout”
- Composition books/journals for faculty and participants
- Greeting cards that participants address to themselves that include a reminder to themselves – then we mail them to them a month or so later
- Post-it poster boards for scribing goals, challenges and take-home points
- Markers for the post-it poster boards
- Laminate pocket cards with skills and communication bundle

Folder Preparation

*So that you can pair each participant’s pre-, post-, and 3-month evaluations, we recommend pre-numbering pre-and post-evaluations with each participant’s ID and putting participants’ names on the folder with the corresponding ID*

*Below is the list of materials we put in each folder (in order from front to back)*

<table>
<thead>
<tr>
<th>Left side</th>
<th>Right side</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pocket card</td>
<td>Pre-workshop evaluation (pre-numbered)</td>
</tr>
<tr>
<td>Faculty contact list</td>
<td>Nurses’ role slides – copied 6 slides per page</td>
</tr>
<tr>
<td>Participant schedule</td>
<td>Palliative care definition handout</td>
</tr>
<tr>
<td>Reference and resource list</td>
<td>Role play intro slides - copied 6 slides per page</td>
</tr>
<tr>
<td></td>
<td>Skills and conversation handouts – for role play</td>
</tr>
<tr>
<td></td>
<td>sessions (copied on light purple paper)</td>
</tr>
<tr>
<td></td>
<td>Post-workshop evaluation (pre-numbered)</td>
</tr>
</tbody>
</table>
Materials to Bring to the Workshop

Materials for Faculty:
- Faculty guide
- Completed faculty schedule
- List of participants / sign-in sheet for continuing education, with assigned number for pre-post evaluation
- Slides for nurses role and introduction to role play morning didactic

To hand-out as participants arrive:
- Name tags (for faculty and participants)
- Journals / composition books for reflection sessions (one each participant)
- Pens
- Folder for each participant with workshop materials

To hand-out during role-play sessions:
- Role Play #1: Communicating with Families about Prognosis and Goals of Care (nurse + family member parts)
- Role Play #2: Working with physicians to address family needs (nurse + physician parts)
- Role Play #3: The Family Meeting (nurse + physician + family member parts)

To hand-out during taking it home session at end of day:
- Greeting cards (one each participant) that participants address to themselves that include a reminder to themselves – then we mail them to them a month or so later

Other Materials:
- Post-it poster boards for scribing goals, challenges and take-home points
- Markers for the post-it poster boards
- Computer to show slides; project or adaptor for projector if needed, power cables
To-Do’s - After the Workshop

1-week after workshop:
☐ Review and enter pre- and post-workshop evaluations and goals, challenges, take-home points scribed during session
☐ Meet with team to review how workshop sent and plan any changes for next session

1-month after workshop:
☐ Mail greeting cards (that they completed and self-addressed) to participants

3-months after session:
☐ Distribute and collect completed follow-up evaluation surveys
PRE-WORKSHOP REFLECTION ACTIVITY

Email this activity to the registered participations 2-weeks before workshop. It is for participants’ own preparation – they don’t hand it in to you. You can remind participants of this activity at the beginning of the workshop in the goal-setting section, though you wouldn’t ask for specific details unless offered, e.g.: “We asked you to do a reflection activity before the session to prepare for today. In thinking about that activity and your clinical practice, what challenges do you encounter in discussing prognosis, goals of care, and palliative care with families and other clinicians?”
Pre-Workshop Reflection Activity
We are delighted that you will be participating in our upcoming workshop, “Communication about Prognosis, Goals of Care, and Palliative Care.” We designed the following questions to help you reflect on your prior experiences and prepare you for the workshop. Before you arrive at the workshop, please take 15-20 minutes to work through following questions. This exercise is for your purposes only; we will not ask you to turn it in. Thank you in advance and we look forward to working with you!

Please recall a specific patient experience that highlighted for you the importance of communication about prognosis, goals of care, and palliative care. Use the following questions as a guide to reflect on this experience and its impact on you.

1. How involved were you with the care of this particular patient? How connected did you feel to the patient? What helped or hindered this relationship?

2. How connected did you feel with the family? What helped or hindered this relationship?

3. Were the patient’s goals of care (as defined by the patient and/or family) clear to all members of the team? Were the family, nurse, and other clinicians “on the same page?” What was the impact of this?

4. Were you involved in a family meeting or other communication with the patient, family, and other clinicians about prognosis and goals of care? How did you feel about this communication and your level of involvement?
5. Was the palliative care consultation service involved? If so, what was the impact of the consult? If not, how do you think this service might have helped?

6. How did caring for this patient impact you? What did you take home, both positive and negative, from the experience?

7. What challenges do you face when addressing prognosis, goals of care, and palliative care with a patient’s family?

8. What challenges do you face in discussing prognosis, goals of care, and palliative care with other clinicians?

9. What challenges do you face to your involvement in family meetings?

10. What would you most like to get out of this workshop?
**Faculty Schedule Template:** Complete before each workshop in the planning meeting to specify who will do what in each workshop.

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Activities / Notes</th>
<th>Faculty/Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:15-9:00</td>
<td>Set-up</td>
<td>• Check projector, slides, materials, last minute issues</td>
<td>All</td>
</tr>
<tr>
<td>9:00-9:10</td>
<td>Sign-in and</td>
<td>• Welcome participants: sign-in, hand out folders with pre-evals as they enter</td>
<td>Jenica</td>
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<td>10 min</td>
<td>Pre-evaluation</td>
<td>• Collect pre-evals</td>
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<tr>
<td>9:10-9:20</td>
<td>Welcome and</td>
<td>• Welcome and background of session (given by bedside nurse)</td>
<td>Ann</td>
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<tr>
<td>10 min</td>
<td>Introduction</td>
<td>• Faculty introductions (see contact list in folder) – introduce selves – focus on qualifications</td>
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</tr>
<tr>
<td>9:20-9:50</td>
<td>Goal setting,</td>
<td>• Participant introductions – go around the room, introduce self and challenge/goal</td>
<td>Kathleen P.</td>
</tr>
<tr>
<td>25 min</td>
<td>objectives,</td>
<td>• Review IMPACT-ICU project &amp; workshop objectives/activities (in slides)</td>
<td>Wendy</td>
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<tr>
<td></td>
<td>schedule</td>
<td>• Review contents of participant folder</td>
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<td></td>
<td>overview</td>
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<tr>
<td>9:50-10:20</td>
<td>The Nurse’s</td>
<td>Case Scenario, Didactic, Discussion (in slides)</td>
<td>Kathleen T.</td>
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<tr>
<td>30 min</td>
<td>Role in</td>
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<td>Kathleen P.</td>
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<td>Discussing</td>
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<td>Susan</td>
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<td>and Palliative</td>
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<td>Care</td>
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<td>10:20-10:35</td>
<td>Overview of</td>
<td>Rationale for 3 conversations (slides)</td>
<td>Wendy</td>
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<tr>
<td>15 min</td>
<td>role play</td>
<td>Rationale for role play (slides)</td>
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<tr>
<td></td>
<td>activities</td>
<td>Review “purple sheet” skill handout</td>
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<tr>
<td>10:35-10:45</td>
<td>Break</td>
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<tr>
<td>10:45-11:55</td>
<td>Communicating</td>
<td>• 5 min Elicit participants’ challenges</td>
<td>Facilitator:</td>
</tr>
<tr>
<td>70 min</td>
<td>with Families</td>
<td>• 5-10 min walk through skills handout</td>
<td>Kathleen T</td>
</tr>
<tr>
<td></td>
<td>about</td>
<td>• 5 min Model discussion</td>
<td>Model role play:</td>
</tr>
<tr>
<td></td>
<td>Prognosis and</td>
<td>• 50 min Large group role play + discussion</td>
<td>Nurse: Susan</td>
</tr>
<tr>
<td></td>
<td>Goals of Care</td>
<td>• 5 min Elicit take home points</td>
<td>Mrs. Ames:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ann</td>
</tr>
<tr>
<td>11:55-12:00</td>
<td>Check-in</td>
<td>• How was role-play?</td>
<td>Kathleen T and</td>
</tr>
<tr>
<td>5 min</td>
<td></td>
<td>• Questions about working in role play? 3 conversations model?</td>
<td>all</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specific skills?</td>
<td></td>
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<tr>
<td>12:00-12:45</td>
<td>Lunch</td>
<td>Participants Together</td>
<td></td>
</tr>
<tr>
<td>45 min</td>
<td></td>
<td>Faculty Check-in/Debrief</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Title</td>
<td>Activities / Notes</td>
<td>Faculty</td>
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<tr>
<td>12:45-1:45</td>
<td>Working with physicians to address family communication needs</td>
<td>• 5 min Elicit participants’ challenges</td>
<td>Facilitator: KP/Michelle Model role play:</td>
</tr>
<tr>
<td>60 min</td>
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<td>• 5 min Walk through skills handout</td>
<td>• Nurse: Kathleen T</td>
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<td></td>
<td></td>
<td>• 5 min Model discussion</td>
<td>• Doctor: Susan</td>
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<td></td>
<td>• 40 min Large group role play + discussion</td>
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<td></td>
<td></td>
<td>• 5 min Elicit participants’ take home points</td>
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<tr>
<td>1:45-2:45</td>
<td>Participating in the Family Meeting: Advocating for Family Informational and</td>
<td>• 5 min Elicit participants’ challenges in participating in family meetings</td>
<td>Facilitator: Denah Model role play:</td>
</tr>
<tr>
<td>70 min</td>
<td>Emotional Needs</td>
<td>• 5 min Walk through skills handout</td>
<td>• Nurse: Kathleen P</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 5 min Model discussion</td>
<td>• Mrs. Ames: Ann</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 50 min Large group role play + discussion</td>
<td>• Doctor: Susan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 5 min Elicit take home points</td>
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<tr>
<td>2:45-2:55</td>
<td>Break</td>
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<tr>
<td>10 min</td>
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<tr>
<td>2:55-4:05</td>
<td>Reflection Session</td>
<td>Writing about a case – hand out journals</td>
<td>Susan</td>
</tr>
<tr>
<td>70 min</td>
<td></td>
<td>Sharing Discussion</td>
<td>Kathleen T</td>
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<tr>
<td>4:05-4:15</td>
<td>Break</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
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<tr>
<td>10 min</td>
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<tr>
<td>4:15-4:30</td>
<td>Taking it Home Feedback Post-Evaluation</td>
<td>• Q&amp;A</td>
<td>Kathleen P.</td>
</tr>
<tr>
<td>30 min</td>
<td></td>
<td>• Discussion – take home point for each participant</td>
<td>Wendy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Greeting cards – plan for use of new skill</td>
<td>Jenica: collect evals + cards</td>
</tr>
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<td></td>
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<td>• Complete + collect post-evaluation forms</td>
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<tr>
<td>4:30-5:30</td>
<td>Faculty Debrief</td>
<td>-------------------------------------------------------------------------------------</td>
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<tr>
<td>30-60 min</td>
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<td>All</td>
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</table>

**Rooms:**
All day: C130
Faculty lunch: S168

**Refreshments:**
AM: 2 pots of coffee and 2 pots of tea to arrive by 8:30am
PM: 2 pots of tea to arrive by 2:45pm for reflection session

**Timekeeper for day:** Kathleen Puntillo
**Lead debriefs at lunch and after workshop:** Kathleen Puntillo and Michelle Milic

**Faculty/Staff:** Enter faculty/staff who are assisting with workshop here

**Visiting/observing:** Enter visiting faculty/observers here
Communicating about Prognosis, Goals of Care, and Palliative Care: A Workshop for Critical Care Nurses

Participant Schedule

**Morning**

9:00-9:10  Sign-in and pre-evaluation
9:10-9:20  Welcome and introduction
9:20-9:45  Goal setting and workshop overview
9:45-10:15  The nurse’s role in discussing prognosis, goals of care, and palliative care
10:15-10:30  Introduction to role play
10:30-10:40  Break
10:40-12:00  Role Play #1: Eliciting family perspectives and needs
12:00-12:45  Lunch

**Afternoon**

12:45-1:45  Role Play #2: Working with physicians to address family needs
1:45-2:45  Role Play #3: The family meeting
2:45-2:55  Break
2:55-4:05  Reflection Session: Coping with the stresses of work in the ICU
4:05-4:15  Break
4:15-4:50  Taking it home
4:50-5:00  Feedback and post-evaluation
Communicating about Prognosis, Goals of Care, and Palliative Care: A Workshop for Critical Care Nurses

UCSF Faculty Contact Information

<table>
<thead>
<tr>
<th>NAME</th>
<th>EMAIL ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wendy Anderson MD MS Hospital Medicine &amp; Palliative Care</td>
<td><a href="mailto:Wendy.Anderson@ucsf.edu">Wendy.Anderson@ucsf.edu</a></td>
</tr>
<tr>
<td>Susan Barbour RN MS WOCN ACHPN Palliative Care Service</td>
<td><a href="mailto:Susan.Barbour@ucsfmedctr.org">Susan.Barbour@ucsfmedctr.org</a></td>
</tr>
<tr>
<td>Rev. Denah Joseph MS MFT Palliative &amp; Spiritual Care</td>
<td><a href="mailto:Denah.Joseph@ucsfmedctr.org">Denah.Joseph@ucsfmedctr.org</a></td>
</tr>
<tr>
<td>Michelle Milic MD Pulmonary &amp; Critical Care</td>
<td><a href="mailto:mmilic@medicine.ucsf.edu">mmilic@medicine.ucsf.edu</a></td>
</tr>
<tr>
<td>Kathleen Puntillo RN PhD, FAAN, FCCM Physiological Nursing</td>
<td><a href="mailto:Kathleen.puntillo@nursing.ucsf.edu">Kathleen.puntillo@nursing.ucsf.edu</a></td>
</tr>
<tr>
<td>Kathleen Turner RN, CHPN, CCRN-CMC Clinical Nurse III, 9/13 ICU</td>
<td><a href="mailto:Kathleen.Turner@ucsfmedctr.org">Kathleen.Turner@ucsfmedctr.org</a></td>
</tr>
</tbody>
</table>
Discussing Prognosis, Goals of Care, and Palliative Care: What is the Nurse's Role?

Case Study: Mr. P

Mr. P is a 58 year old man with refractory AML who has been hospitalized for the past month. He has cardiomyopathy from chemotherapy, and was receiving dialysis to manage his volume status. Last night he became hypotensive, so is being transferred to the ICU for CRRT. He walked into the hospital, but is now unable to get out of bed because of pain and edema. He has also developed altered mental status.

Case Study

You are the nurse admitting Mr. P to the ICU. What is your role in discussing prognosis, goals of care, & palliative care?

► With his family?
► With his other clinicians?
► What is special about your perspective as his nurse?

"The Silence of Death"

- Silence around serious illness & dying
- Families often have overly optimistic expectations for patients' recovery
- Consequences of silence:
  - Clinicians can't support patients and families
  - Families can't prepare, make decisions that are consistent with patient's wishes

Responsibilities of Nurses

"Nurse’s primary commitment is to the patient"
- American Nurses Association Code of Ethics

"Nurse’s over-riding loyalty is to the patient"
“Omission of information may be detrimental to interests of patient”
- United Kingdom Central Council for Nursing

Responsibilities of Nurses

"Nurse's responsibility is to work on the patient's behalf and serve diligently as a moral agent and advocate, especially when the patient has limited or no decision-making capacity.”
- American Association of Critical-Care Nurses
Nurses In the Middle

Challenges
- Nurses often find themselves between patients/families and physicians
- High risk for moral distress

Opportunities
- Nurses are patient’s closest provider
- “Shuttle” diplomacy: a powerful position

What are occasions and venues for nurses to discuss prognosis, goals of care, and palliative care?

Standing Outside the Circle

Nurse Observing ICU Rounds

Lessons from CRBSIs
- Efforts to decrease catheter-related bloodstream infections
  - Infection rates did not decrease until nurses became involved, spoke up to physicians
- Similarly, it is unlikely that palliative care will be effectively integrated into ICUs without active engagement of nurses
What is Palliative Care?
- Specialized care for people with serious illnesses
- Relief from the symptoms, pain, & stress of serious illness, whatever the diagnosis
- Goal is quality of life for patient & family
- Appropriate at any age and stage of illness
- Provided with curative or life-prolonging treatments

Primary Palliative Care
- Primary palliative care
  - Provided by patient’s primary clinicians
  - All ICU clinicians provide palliative care to patients and families
  - A main focus of this workshop and project
- Specialty palliative care
  - Provided by palliative care consult team
  - Interdisciplinary team with specialized training and certification

Primary ICU Palliative Care Assessment & Treatment:
- Symptom management
- Family support
- Communication

Specialty Palliative Care
- Palliative Care Consult Service
- Advanced Practice Palliative Care Nurse

The 4C’s

<table>
<thead>
<tr>
<th>Role</th>
<th>Key Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convening</td>
<td>Make sure clinicians and families discuss prognosis, goals of care, and palliative care</td>
</tr>
<tr>
<td>Checking</td>
<td>• Identify family needs for information • Ensure that clinicians clearly convey information that families want • Ensure that clinicians understand family perspectives</td>
</tr>
<tr>
<td>Caring</td>
<td>Identify emotions and respond to feelings</td>
</tr>
<tr>
<td>Continuing</td>
<td>Follow up after discussions to clarify and reinforce information and provide support</td>
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</tbody>
</table>

Softening the Blow

“I liked the dynamic in the meeting when they finally gave us a prognosis. The doctor delivering the hard facts, ‘This is the prognosis. This is what will be needed.’ But then the nurses were there to interpret and soften the blow…. to break it down and explain it, [to] register the looks on some of my family members’ faces.”

-ICU family member

Anderson et al. / Pain Symptom Manage 2013
3 Conversations

Nurse-Family Conversation:
- Elicit family’s goals and needs
- Elicit understanding of prognosis
- Provide emotional support

Family Meeting:
- Ensure key topics are discussed
- Ensure family understands information
- Provide emotional support

Nurse-Physician Conversation:
- Elicit physician perspective on prognosis and goals
- Present family and nurse perspectives
- Develop plan to address family needs

A Communication Skills Toolbox

Workshop Focus
- Clear goals for communication
- Practice skills to achieve these goals
- Skills work across all conversations

What is Your Comfort Zone?

Telling vs. Asking
Talking vs. Listening
Giving information vs. Responding to emotion

Key Points
- Nurses have a key role in discussing prognosis, goals of care, & palliative care
- Effective communication is a skill; not a divine gift
- This is hard work! It requires practice
- Establishing competence is a process!
Introduction to Role Play

Why Role Play?

Effective behavior change methods:
- Learner-centered - *What you want to learn*
- Opportunity to observe + practice new skills – *You have to say the words*
- Supportive and safe environment – *Low risk to trying new skill*
- Focus on strengths – *So you know what to keep doing!*

Roles

Facilitator – moderates and directs session

Learner Roles:
- Lead role – Participant playing the nurse
- Supporting roles – Family/physician
- Observers –
  *Note specific communication behaviors and their effect and provide feedback*

Goal: *Everyone plays a role today*

Time Outs

- Called by learner in lead role or facilitator
- Allow discussion of a challenge in real time – this is how we all learn
- Create possibility of trying something new
- When you are in the lead role and feel stuck – call a time out!

Role Play Ground Rules

- Learner in the lead role debriefs first
- Facilitator directs observer feedback
- Useful feedback:
  - Specific and objective: Specific words? Effect?
  - Strengths: What went well?
  - Focused on learner’s objective
- Supporting roles (family/doctor):
  - Be in + learn from your roles (vs. feedback)
What is Palliative Care?

In 2011, the Center to Advance Palliative Care led public opinion research to determine what aspects of palliative care patients and families found most valuable, and how these could best be described to the public. They created the following definition:

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

When educated about this definition of palliative care, >90% of U.S. adults surveyed:

- Felt patients with serious illness and their families should be educated about palliative care
- Would likely consider palliative care for a loved one if they had a serious illness
- Felt palliative care services should be made available at all hospitals for patients with serious illness and their families

Primary vs. Specialty Palliative Care

Primary or generalist palliative care: Provided by patients’ primary or closest clinicians, e.g. the ICU clinicians

Specialty palliative care: Provided by a consultative team

To meet all of patients’ and families’ needs, all clinicians must learn to provide palliative care. Specialty consult teams are a valuable resource to support patient’s primary clinicians and provide guidance for the most complex cases.


OVERVIEW OF THE NURSES’ ROLE

The 4 Cs: Key Roles for Nurses in Communication about Prognosis, Goals of Care, and Palliative Care

Convening: Making sure multidisciplinary family-clinician communication occurs

Checking: • Identifying family needs for information
• Ensuring that families clearly receive desired information
• Ensuring that clinicians understand family perspectives

Caring: Naming emotions and responding to feelings

Continuing: Following up after discussions to clarify and reinforce information and provide support

After Krimshtein et al J Palliat Med 2011

3 Conversations: Implementing the 4 Cs in Practice

Nurse-Family Conversation:
• Elicit family’s goals and needs
• Elicit understanding of prognosis
• Provide emotional support

Family Meeting:
• Ensure key topics are discussed
• Ensure family understands information
• Provide emotional support

Nurse-Physician Conversation:
• Elicit physician perspective on prognosis and goals
• Present family and nurse perspectives
• Develop plan to address family needs
**CORE SKILLS: TOOLS FOR NAVIGATING FAMILY & PHYSICIAN CONVERSATIONS**

<table>
<thead>
<tr>
<th>Skill</th>
<th>Function</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Open-ended questions</strong></td>
<td>Eliciting another person’s perspective</td>
<td>“What do you understand about your husband’s illness?”</td>
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<td></td>
<td>“Doctor, what have your discussions been with Mrs. Jones about prognosis and goals of care?”</td>
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<tr>
<td><strong>Reflection statements</strong></td>
<td>Show that you want to understand another person’s perspective</td>
<td>“It sounds like this has been a really stressful week for you.”</td>
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<td></td>
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<td>“If I understand correctly, you’re re worried she may not regain the ability to care for herself.”</td>
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<tr>
<td><strong>Tell me more</strong></td>
<td>Learn more about another’s perspective</td>
<td>“Tell me more about what your mom liked to do with her time before she got sick.”</td>
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<td></td>
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<td>“Doctor, could you say more about the care she may need after discharge?”</td>
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<tr>
<td><strong>NURSE</strong></td>
<td>Empathy in response to expressions of emotion</td>
<td>Family: “It’s been a very hard week.”</td>
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<tr>
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<td></td>
<td>Name: “You sound frustrated.”</td>
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<td></td>
<td>Understand: “I can only imagine how hard it is.”</td>
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<td>Respect: “I really respect how much you have been here at your husband’s side.”</td>
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<td>Support: “I and the other staff are here to help you through this.”</td>
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<td>Explore: “What has been the hardest part?”</td>
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<tr>
<td><strong>Ask-Tell-Ask</strong></td>
<td>• Get permission to present information</td>
<td>Family: “What do you think – is she going to make it?”</td>
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<tr>
<td></td>
<td>• Present information clearly</td>
<td>Nurse (Ask): “That’s an important question. I’d be happy to discuss it. First, may I ask you what your sense of things is?”</td>
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<td>• Check understanding or agreement</td>
<td>Family: “She seems more peaceful today – maybe that’s a good thing?”</td>
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<td>Nurse (Tell): “I also see her being more sleepy - I’m worried its because we’ve had to increase the medications so she is more sedated.”</td>
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<td>Nurse (Ask): “I think it would be important for us to discuss your daughters’ status with her doctors. Would it be ok if I arranged a time later today?”</td>
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<td></td>
<td>Family: “Yes – that would be good I think.”</td>
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<tr>
<td><strong>Hope / worry statements</strong></td>
<td>Honestly present information while aligning with family/doctor</td>
<td>“We’re hoping that she gets stronger too. We’re also worried that her kidneys are showing signs of worsening.”</td>
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</table>
ROLE PLAY #1: ELICITING FAMILY PERSPECTIVES AND NEEDS

Conversation goals:
1. Elicit family’s understanding of prognosis
2. Elicit family’s goals for care
3. Elicit family needs for information
4. Provide emotional support

<table>
<thead>
<tr>
<th>Skills to Practice</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Open-ended questions** | Determine family’s understanding and perspectives on prognosis:  
  “What do you understand about your mom’s medical situation?”  
  “Have the doctors talked with you about what to expect?”  
  “Did they talk about the likelihood that she could survive? Would that information be helpful to you?”  
  “Do you have a sense of what the prognosis might be?”  
  Understand patient and/or family’s definition of quality of life and thus values and goals of treatment:  
  “What are you hoping for?”  
  “What worries you the most?”  
  “Could you tell me a little about what Jane is like?”  
  “What would be most important for her right now?”  
  “What would Joe think about the treatments he’s getting now?”  
  “What kind of things does Tony enjoy?”  
  THEN LISTEN! (using skills below) |
| **Tell me more** | Family: “I don’t understand why everyone keeps telling us she’s not responding - when I squeeze her hand she squeezes back.”  
  Nurse: “Tell me more about that.”  
| **Reflection** | “So, if I understand correctly, it seems like you and the doctors aren’t on the same page, is that right?”  
  “It sounds like you have a lot of questions for the doctors.”  
| **NURSE** | Family: “I’m afraid to even think that Stan might not recover.”  
  Nurse: Name: “It’s a scary thing to think about.”  
  Understand: “I can understand how that would be scary.”  
  Respect: “You have been so strong.”  
  Support: “We’re here to support you.”  
  Explore: “What are you afraid will happen?” |
ROLE PLAY #2: WORKING WITH PHYSICIANS TO ADDRESS FAMILY NEEDS

Conversation goals:
1. Elicit physician perspective on prognosis and goals of care
2. Present family and nurse perspective
3. Develop plan to address needs (e.g. family meeting, palliative care consult)

<table>
<thead>
<tr>
<th>Skills to Practice</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Hope / worry statements** | “I was talking with Mrs. Jones this morning, and I’m worried that we aren’t on the same page about Mr. Jones’ prognosis.”  
“I’m hoping to hear your perspective on his prognosis and goals of care – would you have a few minutes to talk with me about it today?”  
“I’m hoping you and I could sit down with Mrs. Jones to talk about Mr. Jones’ prognosis and discuss goals of care.” |
| **Open-ended questions** | “How would you estimate Mr. Jones’ prognosis?”  
“Could you tell me more about the discussions you have had with Mrs. Jones regarding prognosis and goals of care?”  
“What has been your experience with the palliative care consult team?” |
| **Ask-Tell-Ask** | Summarize your discussion with the family about prognosis and goals of care, emphasizing any discrepancies from physician’s understanding  
Nurse (Ask): “I talked with Mrs. Jones this morning – do you have a moment for me to tell you about our discussion?”  
Doctor: “Sure”  
Nurse (Tell): “She said she didn’t have a good understanding of his prognosis, but would like some information about it. I think she’s also hoping he’ll be off the ventilator soon, and based on what you said, I’m worried that won’t be the case.”  
Nurse (Ask): “I think it would help for us to sit down together and talk about his prognosis. Would you be willing to attend a meeting and give Mrs. Jones an update on Mr. Jones’ prognosis?” |
| **NURSE** | Name: “It sounds like her case has been especially challenging.”  
Understand: “These discussions are difficult.”  
Respect: “I appreciate you taking the time to discuss this with me.”  
Support: “I’d like to support you in making sure they understand the information you are presenting.”  
Explore: “Could you tell me more about your concerns about involving the palliative care team?”  
(THEN LISTEN!) |
**Family meeting goals:**
1. Review the patient’s situation / prognosis
2. Review overall goals of care
3. Ensure that treatment plan is consistent with the patient’s prognosis and goals of care

**Nurses’ goals for family meetings:**
1. Ensure key topics are discussed, based on your earlier discussions with family & physician
2. Ensure that family understand information that is given
3. Provide emotional support

<table>
<thead>
<tr>
<th>Skills to Practice</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Open-ended questions</strong></td>
<td>Ask physician to address a topic, based on a family need you identified: “Jane, before the meeting, you said it would be really helpful to discuss what type of care your husband might need if he were to make a recovery. Dr. Jones, would you mind sharing your opinion on that topic?”</td>
</tr>
</tbody>
</table>
| **Ask-Tell-Ash** | Ensure that the family understands information presented:  
Doctor: “She has renal failure, and we haven’t been able to stabilize her electrolytes. At this point, we’re looking at long-term renal replacement therapy.”  
Husband: “Ok.”  
Nurse (Ask): “Dr. Taylor, may I ask something? I just want to make sure we’re being clear. Mr. Davis, could you tell me what you’ve understood of the conversation so far?”  
Husband: “It’s kind of confusing actually.”  
Nurse (Tell): “If I understand correctly, Dr. Taylor is worried that your wife will need dialysis, perhaps permanently.”  
Nurse (Ask): “Does that make sense?”  
Husband: “Yes – but I’m not sure she’d want that.” |
| **NURSE** | Name: “You sound sad.”  
Understand: “This is a hard topic to discuss.”  
Respect: “I’m so impressed with the strength your dad has shown through all of this.”  
Support: “We’ll all be here for you and your dad.”  
Explore: “What’s the most difficult part of this for you?” |
| **Hope / worry statements** | “We’re also hoping that she can wake up to see her grandkids.”  
“If I understand Dr. Jones correctly, she is worried that your husband’s breathing is not improving, and that he isn’t waking up.” |
ROLE PLAY #1: ELICITING FAMILY PERSPECTIVES AND NEEDS

NURSE (LEAD) ROLE

Mr. Ames is a 78 year-old man with COPD who was admitted to ICU 4 days ago from the ER, where he presented with respiratory distress and was intubated. He was diagnosed with pneumonia in addition to a COPD flare. Despite treatment for both, he deteriorated into ARDS.

You are the bedside nurse caring for Mr. Ames for the first time this morning. Overnight, he became hypotensive; he received fluid boluses and vasopressors were initiated. This morning his urine output began falling. He has become increasingly confused and agitated. His night nurse was giving him frequent fentanyl boluses to keep him calm.

You hear that Mr. Ames’ wife has been at his bedside each day, and will be coming in this morning. You and the night nurse agree about the importance of beginning to address prognosis and goals of care. An hour after you start your shift, Mrs. Ames arrives and you invite her in to say hello to her husband and hold his hand. After a few minutes, Mrs. Ames steps outside of the room where you are charting to talk to you.

ROLE PLAY #1: ELICITING FAMILY PERSPECTIVES AND NEEDS

FAMILY (SUPPORTING) ROLE

Mr. Ames is your husband of 50 years. He is 78 years old and has been increasingly struggling with COPD for the past few years. He had severe difficulty breathing 4 days ago at home. You called an ambulance and the EMTs took him to the ER, where he was placed on a breathing machine. He has been in the ICU since then. The past 4 days have been very hard for you. You spend the days with him in the ICU, which is exhausting. At night, you go home but it is hard to sleep because he is not there and you worry about him.

It is now morning, and you have just arrived at the hospital. You hold your husband’s hand for a few minutes and then go outside the room to talk to his nurse.

Your understanding of your husband’s prognosis is: You have been given brief, bedside updates about your husband’s condition from his nurses and doctors. You have understood that his lungs aren’t working and that his condition is “critical.” When you called last night, you heard his blood pressure was low. You find this information concerning, but don’t understand what it means. You are hoping he will recover so that he can come home with you and resume his previous life.

If asked what he is like as a person or how he might feel about certain treatments: He is a fighter and you think he would want to “beat this thing.” He told you in the past he wouldn’t mind being on life support for a limited period of time. At the same time he is fiercely independent, and his passions are hunting, fishing, and going camping. He loves being home with family, and told you he would never want to be in a nursing home.
ROLE PLAY #2: WORKING WITH PHYSICIANS TO ADDRESS FAMILY NEEDS

NURSE (LEAD) ROLE

In your conversation with Mrs. Ames, you learned that though she is very worried about her husband, she doesn’t have a sense of what to expect regarding his recovery. She would like “honest information from the doctor” about her husband’s status and what the future might hold. Regarding his goals of care, she is clear that he is a “fighter” and told her he would be okay with being on life support. However, he is also fiercely independent and loves the outdoors. She is clear that he would never want to be in a nursing home.

You are worried about the prolonged recovery that Mr. Ames is likely to have, and feel it is important that Mrs. Ames receive realistic information about his risk of death as well as prolonged functional impairment. While you feel that continuing his current level of care is appropriate given Mrs. Ames’ description of his values, you want to make sure that Mrs. Ames, you, and his physician begin to discuss his prognosis and goals of care.

You also are concerned about his confusion and feel a need for better assessment and management of his agitation.

After your discussion with her, Mrs. Ames went to get a cup of coffee. Mr. Ames’ attending, Dr. Taylor, comes to check on him. Before he enters the room, he asks you “How are things going?”

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ROLE PLAY #2: WORKING WITH PHYSICIANS TO ADDRESS FAMILY NEEDS

PHYSICIAN (SUPPORTING) ROLE

You are Dr. Taylor, Mr. Ames’ attending physician, and have been caring for him since his ICU admission 4 days ago. You have been concerned about his severity of illness and prognosis. With ARDS and his underlying COPD, he has a high risk of in-hospital mortality. If he does survive, he will have a prolonged recovery and may never return to his previous functional status.

At admission, before Mr. Ames was intubated, your team verified that he desired treatment with a ventilator. Though there has been no formal family meeting, you have spoken with Mrs. Ames a number of times about her husband’s status. You feel you have been very clear about the severity of his illness and respiratory failure.

In rounds, you heard that Mr. Ames didn’t do that well overnight so you are coming back to check on him. When you arrive at the room, you first check in with his nurse, “How are things going?”
Dr. Taylor told you that he was very worried about Mr. Ames’ continued ventilator dependence and decreased urine output. He would not be surprised if Mr. Ames’ died during this hospitalization. If Mr. Ames does recover sufficiently to be discharged from the hospital, he is likely to have significant impairment in his activities of daily living. He might never recover to his previous functional status; if he were able to do so it would take a long time.

Dr. Taylor agreed to attend a family meeting with you to discuss this information with Mrs. Ames. When Mrs. Ames came back to the bedside after her coffee, you tell her that you would like to sit down with her and Dr. Taylor to talk about how her husband is doing. She said she would be grateful.

You arranged to meet together in a conference room near the ICU.

After talking with Mr. Ames’ nurse, you agreed to meet with her and Mrs. Ames and to give an update on her husband’s condition. You are happy to do this, though you feel you’ve already relayed the severity of his illness to her.

You will take the initial lead in this meeting, asking Mrs. Ames what she understands and then giving her information about her husband’s status. When you give information to Mrs. Ames, you use medical terms such as “respiratory failure”, “prolonged recovery”, and “high functional dependency.”

You will also ask Mrs. Ames about whether her husband would want to continue on the ventilator, though you will not frame this in his overall goals, or inquire about his idea of quality of life.

When you talked with Mr. Ames’ nurse, she asked you to attend a meeting to talk with her and Dr. Taylor, your husband’s attending physician, for an update.

Your understanding of your husband’s prognosis is: You are concerned that he is still on the ventilator. You have been given brief, bedside updates from Dr. Taylor, who was clear that he is very sick. He looks very sick to you, but you are hoping he can recover to his previous status.

* In the meeting, if you are given information about your husband’s status using only medical terms, you will not understand it. However, you won’t state that you don’t understand unless asked.

If asked how you think your husband would feel about certain treatments: Your husband told you in the past that he wouldn’t mind being on life support for a limited period of time. You’re not sure how long that would be, or how you could decide to take him off the ventilator if he would die.

If asked what your husband is like as a person: He is a “fighter” and would want to “beat this thing.” He also fiercely independent; his passions are hunting, fishing, and camping. He loves being at home with family, and told you once that he would never want to be in a nursing home.

Your emotions: You express worry about your husband. If told that he might die or not be able to walk, you become upset. If asked about taking him off the ventilator, you become overwhelmed.
Reference and Resource List

Journal Articles:


Books:

Websites and Popular Media:
Center to Advance Palliative Care (www.capc.org)
• I-PAL ICU: Tools for Improving Palliative Care in the ICU: http://www.capc.org/ipal-icu/
Oncotalk: Improving Oncologists’ Communication skills – includes videos showing use of skills covered in this workshop: http://depts.washington.edu/oncotalk/
Options / Ideas for Reflection Session Activities (can combine as you like)

Guidance:
* should be interactive / experiential – not didactic
* should demonstrate best practices to participants that they can take home with them

Activities we have used:

I. Offer tea

II. Mindful movement – brief guided yoga (5-10min) to stretch, get mind in body

III. Consider moving chairs in a circle in center of room, away from tables

IV. Discussion of stresses of work with seriously ill patients

V. Discussion of methods people use for coping

VI. Mindfulness practice – brief guided mindfulness practice (5-10 min)

VII. Can follow with The Metta practice:
   May I realize grace in the midst of suffering
   May I find the inner resources to truly be able to give
   May I remain in peace and let go of expectations
   May I see my limits compassionately, just as I view the suffering of others
   May I forgive myself for mistakes made and things left undone
   May I offer my care and presence unconditionally, even though it may be met with
grateful, indifference, anger, or anguish.

   Source document for this - "The Boundless Abodes for Caregiving, Dying, Grieving" by
   Joan Halifax Roshi

VIII. Writing Exercise – can focus on challenging communication / interpersonal experience, or
   positive experience (recommend ending on positive note). Possible prompts:
   * give participants notebooks to write in and take home to use for reflective practice

   “Remember a time that had a significant impact on you, when communication with a patient,
   family, or colleague did not go well.”
   Option 1: write about this experience for 5 minutes
   Option 2: write about this experience from the perspective of the other person involved (e.g.
   patient, family, colleague) for 5 minutes
“Remember a time when you made a difference to a patient or family.”

- Have participants write for 5 minutes
- Then have them write 3 words that describe how the experience made them feel
- Optional: can place a basket in the center of the room, and have people put the 3 words on a slip of paper in the basket. Others then select a paper from the basket to read aloud.
**Assessing Symptoms in ICU Patients**

- Perform a symptom assessment at least once per shift.
- Assessment method guided by sedation level and mental status:

<table>
<thead>
<tr>
<th>Patient Status</th>
<th>Appropriate Assessment Methods</th>
</tr>
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</table>
| RASS = -1, 0, or +1 | • Verbal descriptor scale (None/Mild/Moderate/Severe)  
• Numeric rating scale: 0-10 (0=none, 10=worst) |
| Patient unable to rate e.g. RASS <-1 or >+1, +CAM-ICU | • "Yes/No"  
• Observation tool, e.g. Critical Care Pain Observation Tool  
• Treat symptom presumptively, e.g. pain during procedures |

**Evaluation & Treatment of Common Symptoms in ICU Patients**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Treatments / Work-Up</th>
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| Pain          | Non-opioid and opioid analgesics  
Nonpharmacological, e.g. Guided relaxation, massage, music |
| Tired         | Assess and address sleep hygiene                 |
| Thirsty       | Frequent mouth care  
Consider thirst bundle³                  |
| Anxious       | Nonpharmacological, e.g. Guided relaxation, music, massage, aromatherapy  
Consider medication, e.g. Benzodiazepines |
| Restless      | Assess & treat delirium  
Nonpharmacological: e.g. Physical therapy, massage |
| Hungry        | Assess and adjust feeding method                 |
| Short of Breath | Consider change in breathing support  
Nonpharmacological, e.g. Guided relaxation, music  
Consider medication, e.g. Opioids, benzodiazepines |
| Sad           | Assess & treat depression  
Nonpharmacological, e.g. Frequent reassurance, music |
| Scared        | Assess & treat delirium  
Nonpharmacological, e.g. Frequent reassurance, massage |
| Confused      | Assess & treat delirium  
Nonpharmacological, e.g. Frequent orientation, family visits |
| Nauseated     | Nonpharmacological, e.g. Aromatherapy, limit smells  
Antiemetic medications |
| Constipated   | Bowel regimen                                     |

*Puntillo et al Critical Care Med. 2010;38:1-6
**ICU Communication Quality Bundle**

**by ICU Day 1**
- Identify & document surrogate decision-maker
- Determine & document advance directive status
- Establish & document resuscitation status

**by ICU Day 2**
- Offer social work & spiritual support to family
- Multidisciplinary family meeting

**by ICU Day 5**
- Multidisciplinary family meeting

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**Key Roles for Bedside Nurses in Communication about Prognosis, Goals of Care, and Palliative Care**

**The 3 Conversations**

- **Nurse-Family Conversation:**
  - Elicit family's goals and needs
  - Elicit understanding of prognosis
  - Provide emotional support

- **Family Meeting:**
  - Ensure key topics are discussed
  - Ensure family understands information
  - Provide emotional support

- **Nurse-Physician Conversation:**
  - Elicit physician perspective on prognosis and goals
  - Present family and nurse perspectives
  - Develop plan to address family needs

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**The 4C’s**

- **Convening:** Making sure multidisciplinary family-clinician communication occurs
- **Checking:**
  - Identifying family needs for information
  - Ensuring that families clearly receive desired information
  - Ensuring that clinicians understand family perspectives
- **Caring:** Naming emotions and responding to feelings
- **Continuing:** Following up after discussions to clarify and reinforce information and provide support

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**Core Communication Skills: Tools for Navigating Discussions with Families & Other Clinicians**

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<tr>
<th>Skill</th>
<th>Function</th>
<th>Example</th>
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<tbody>
<tr>
<td>Open-ended questions</td>
<td>Elicit another person's perspective</td>
<td><em>What do you understand about your husband's illness?</em></td>
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<tr>
<td>Reflection statements</td>
<td>Show you want to understand another person's perspective</td>
<td><em>It sounds like this has been a really stressful week for you.</em></td>
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</table>
| NURSE | Demonstrate empathy in response to expressions of emotion | Name: “You sound frustrated.”
Understand: “This must be so difficult.”
Respect: “I respect how you haven’t left your daughter’s side.”
Support: “I am here to help you through this.”
Explore: “What is the hardest part?” |
| Tell me more | Learn more about another’s perspective | *Tell me more about what your mom liked to do before she got sick.* |
| Ask-Tell-Ask | Start with family/physician understanding | Family: “How is my daughter doing?”
Nurse: “That’s an important question. I’d be happy to discuss it. First, may I hear your sense of things?” |
| | Get permission to give information | |
| | Present information clearly | |
| | Check understanding or agreement | |
| Hope / worry statements | Honestly present information while aligning with family/physician | *We’re hoping that she gets stronger too. We’re also worried that her lungs are showing signs of worsening.* |

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**Krimshien et al. J Palliat Med. 2011;14:1325-1332**

Pre-Workshop Evaluation

Thank you for completing this evaluation – your responses will be kept anonymous and confidential. Your evaluations are very helpful for us in planning continued support of ICU bedside nurses and future workshops and efforts.

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Communicating about Prognosis, Goals of Care, and Palliative Care: A Workshop for Critical Care Nurses

Post-Workshop Evaluation

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III. Please help us plan for future trainings by answering the following questions:

In answering the questions below, please be frank. The program will benefit from all feedback you can provide, even if it is critical. Your responses are confidential and anonymous.

1. To what degree did this workshop increase your awareness of your role and responsibilities in communication about prognosis, goals of care, and palliative care? (please circle one)

   1-Greatly increased  2-Increased  3-No change  4-Less aware of this now

Please share some of your thoughts about the above question:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

2. What other clinical situations and/or communication skills would you liked to have worked on during this workshop (or work on in future workshops)?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

3. The most useful aspects of the workshop were:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

4. Aspects of the workshop that could be improved were:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

5. Please share any other thoughts:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Thank you for completing this evaluation
Follow-up Evaluation

This evaluation is to be completed 3-4 months after you completed the workshop. Its goal is to determine whether the workshop has had a sustained impact on your communication about prognosis, goals of care, and palliative care. We also hope to learn about your experiences in implementing the role and skills we discussed in the workshop, and assess any barriers you have perceived in taking a lead role in discussions of prognosis, goals of care, and palliative care. Your responses will be kept anonymous and confidential. We greatly appreciate your feedback – it is very helpful for us in planning continued support of ICU bedside nurses.

V. Please rate your current level of confidence to perform each of the following activities by placing an “X” in the corresponding box:

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<th>Excellent</th>
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<tbody>
<tr>
<td>31. Elicit a family’s understanding of a patient’s prognosis.</td>
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<tr>
<td>32. Elicit a family’s understanding of a patient’s goals of care.</td>
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<tr>
<td>33. Identify a family’s need for information about a patient’s illness and treatments.</td>
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<tr>
<td>34. Identify and respond to a family member’s expressions of emotional distress.</td>
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<tr>
<td>35. Elicit a physician’s perspectives on a patient’s prognosis.</td>
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<tr>
<td>36. Elicit a physician’s understanding of a patient’s goals of care.</td>
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<tr>
<td>37. Convey a family’s communication needs to a physician.</td>
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<tr>
<td>38. Communicate the need for a family meeting to a physician.</td>
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<tr>
<td>39. Provide families with emotional support during family meetings.</td>
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<tr>
<td>40. Ensure that a family’s needs for information are addressed during a family meeting.</td>
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<tr>
<td>41. Ensure that a family member understands information that is presented during a family meeting.</td>
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<tr>
<td>42. Define palliative care.</td>
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<tr>
<td>43. Communicate the value of a palliative care consultation to a physician.</td>
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<tr>
<td>44. Describe palliative care and how it can be useful to a patient’s family member.</td>
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<tr>
<td>45. Use self-care practices to prevent burnout and compassion fatigue.</td>
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</tbody>
</table>

Please continue on next page
VII. Please tell us a little about your involvement and experience discussing prognosis, goals of care, and palliative care since you completed the workshop 3-4 months ago.

1. Since completing the workshop, have you discussed prognosis, goals of care, and/or palliative care with families?
   - [ ] Yes
   - [ ] No

2. Since completing the workshop, have you discussed prognosis, goals of care, and/or palliative care with physicians?
   - [ ] Yes
   - [ ] No

3. Since completing the workshop, have you attended family meetings?
   - [ ] Yes - If yes did you participate in the discussion? →  [ ] Yes  [ ] No
   - [ ] No

4. Have you been more involved in discussions about prognosis, goals of care, and palliative care since attending the workshop?
   - [ ] Yes
   - [ ] No

5. Have you found the skills that were presented in the workshop to be helpful in discussing prognosis, goals of care, and palliative care with families and other clinicians?
   - [ ] Yes
   - [ ] No
   - [ ] Not applicable – I have not used the skills

6. What skills or aspects of the workshop have you found most helpful?
   __________________________________________________________
   __________________________________________________________

7. How could the workshop have been more useful to you?
   __________________________________________________________
   __________________________________________________________

8. Please add any comments about the impact of the workshop on your practice:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Please continue on next page
VIII. Next, please tell us about barriers you have perceived to discussing prognosis, goals of care, and palliative care.

1. Which of the following have limited your involvement in discussions of prognosis, goals of care, and palliative care? (please put an “X” next to all that apply)

<table>
<thead>
<tr>
<th>Barriers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>It’s not my role to discuss prognosis, goals of care, and palliative care</td>
<td></td>
</tr>
<tr>
<td>I need more training in how to discuss prognosis, goals of care, and palliative care</td>
<td></td>
</tr>
<tr>
<td>I don’t feel that physicians support my involvement in these discussions</td>
<td></td>
</tr>
<tr>
<td>My managers don’t adequately support my involvement in these discussions</td>
<td></td>
</tr>
<tr>
<td>I don’t have time for these discussions</td>
<td></td>
</tr>
<tr>
<td>It is hard to get coverage for my patients so I can attend family meetings</td>
<td></td>
</tr>
<tr>
<td>I don’t know when or where family meetings are occurring</td>
<td></td>
</tr>
<tr>
<td>Engaging in these discussions is emotionally draining</td>
<td></td>
</tr>
<tr>
<td>Families have negative reactions to palliative care</td>
<td></td>
</tr>
<tr>
<td>Physicians have negative reactions to palliative care</td>
<td></td>
</tr>
</tbody>
</table>

2. Please list any other factors that limit your involvement in discussions about prognosis, goals of care, and palliative care:

____________________________________________________________________________

____________________________________________________________________________

IX. Finally, please tell us about how we can best support you.

1. As part of the IMPACT-ICU project, an advance practice nurse has been rounding in your unit to support your work in palliative care and communication.

   Do you recall talking with this nurse about palliative care or communication?
   - ☐ Yes - If yes, have you found it helpful? → ☐ Yes ☐ No
   - ☐ No

2. How could we further support you in taking a lead role in discussing prognosis, goals of care, and palliative care?

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Thank you for completing this evaluation
**Patient-Nurse Rounding Record**

<table>
<thead>
<tr>
<th>Site:</th>
<th>Unit:</th>
<th>Bed:</th>
<th>Bedside RN:</th>
<th>Date:</th>
<th>Completed by:</th>
</tr>
</thead>
</table>

**Patient Information** Place patient sticker below

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Hospital Admission Date: <em><strong>/</strong></em>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRN:</td>
<td>ICU Admission Date: <em><strong>/</strong></em>/____</td>
</tr>
<tr>
<td>Age:</td>
<td>Is palliative care already consulting on patient?</td>
</tr>
<tr>
<td>Sex:</td>
<td>☐ No ☐ Yes - CNS only ☐ Yes - full team</td>
</tr>
</tbody>
</table>

**Primary Service:**
- Critical Care
- Head and Neck Surgery
- General Surgery
- Cardiology
- Hospital Medicine
- Neurosurgery
- Orthopedic Surgery
- General Internal Medicine
- Family Medicine
- Neurology
- Surgical Oncology
- Geriatrics
- Pediatric Critical Care
- Neuro Critical Care
- Urology
- Medical Oncology
- Transplant
- Trauma Surgery
- Vascular Surgery
- Other: __________

**STEP 1: Identify Patients to Screen for Palliative Care Needs**

**“Does your patient have a serious illness?”**
- Pre-existing the ICU admission, e.g. cancer, advanced organ disease, dementia
- Prompting the hospital admission, e.g. intracranial hemorrhage, severe trauma
- Developed during the hospital stay, e.g., multiple organ system failure
- High risk for death or long-term functional impairment, e.g. s/p cardiac arrest, chronic critical illness

Please check one to indicate the disease category for patient’s primary serious illness:
- Cancer
- Gastrointestinal
- Pulmonary
- Hepatic
- Cardiovascular
- Neurologic/stroke/neurodegenerative
- Renal
- Infectious/immunological/HIV
- Complex chronic conditions/failure to thrive
- Multiple organ system failure
- Trauma
- Other: __________

**STEP 2: Screen for and Develop Plan to Address Palliative Care Needs**

Bedside Nurse’s Primary Palliative Care Assessment:

1. **“Does your patient have any uncontrolled symptoms?”** Check all that apply
   - Pain
   - Restless
   - Anxious
   - Tired
   - Hungry
   - Nauseated
   - Other:
   - Short of breath
   - Confused
   - Scared
   - Sad
   - Thirsty
   - Constipated

2. **“Is the patient’s family emotionally distressed or struggling to cope?”**
   - Yes ☐ No / family not present

3. **“Do you have concerns about the quality of family-clinician communication about prognosis and goals of care?”**
   - Yes ☐ No

**Plan for addressing identified needs:** Please check at least one if bedside nurse identified a need above
- Primary palliative care plan developed with bedside nurse to meet patient and family need(s)
- Palliative care CNS consult recommended (or already involved)
- Full team palliative care consult recommended (or already involved)
**STEP 3: Bedside Nurse’s Involvement in Communication**

1. “Have you, as the bedside nurse, discussed the patient’s prognosis and goals of care with the family?”
   - No  Yes

2. “Have you, as the bedside nurse, discussed the patient’s prognosis and goals of care with physicians?”
   - No  Yes

3. “Has there been a family meeting for this patient?”
   - No  Not sure  Yes → “Did you attend?”  No  Yes → “Did you participate?”

4. “What factors have challenged your involvement in the above discussions for this patient?”
   Please check at least one if the bedside nurse answered “no” to questions 1-3.
   - Lack of skill/training  Family not available  MD not available  Unfamiliar with patient
   - Lack of time  Difficulty with family  Difficulty with MD  Other: ________________
   - No coverage  Language barrier - family  Not invited to meeting

**STEP 4: Support and Education Provided to Bedside Nurse**

Please check all boxes that describe the education and support you provided to the bedside nurse.

<table>
<thead>
<tr>
<th>Palliative Care</th>
<th>Communication</th>
<th>Pain &amp; Symptoms</th>
<th>Support of Nurse</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defining/describing palliative care</td>
<td>Family support &amp; communication</td>
<td>Assessing symptoms</td>
<td>Supported nurse</td>
<td>IMPACT-ICU workshop</td>
</tr>
<tr>
<td>Primary palliative care assessment</td>
<td>Physician communication</td>
<td>Managing symptoms</td>
<td>Reinforced positive behaviors</td>
<td>Palliative care CNS / consult</td>
</tr>
<tr>
<td>Nurse’s role in palliative care</td>
<td>Family meetings - arranging</td>
<td>Nurse-directed interventions</td>
<td>Self-care strategies</td>
<td>Spiritual care service</td>
</tr>
<tr>
<td></td>
<td>Family meetings – participating</td>
<td></td>
<td>Navigating medical record</td>
<td>Ethics consultation</td>
</tr>
</tbody>
</table>

- Other: ________________________________

**STEP 5: Surrogate Contact Information**

For follow-up survey, please complete from all available sources, e.g. room white board, nurses notes, medical record

<table>
<thead>
<tr>
<th>1st Surrogate Name:</th>
<th>Relation to patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary phone #:</td>
<td>Secondary phone #:</td>
</tr>
<tr>
<td>Cell  Home  Work</td>
<td>Cell  Home  Work</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd Surrogate Name:</th>
<th>Relation to patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary phone #:</td>
<td>Secondary phone #:</td>
</tr>
<tr>
<td>Cell  Home  Work</td>
<td>Cell  Home  Work</td>
</tr>
</tbody>
</table>

**STEP 6: Patient Outcome Data** Complete with medical record after patient discharge or death

1. Date of discharge or death: ______/_____/______  2. Was Palliative Care consulted during the hospitalization?
   - No  Yes - CNS only  Yes - full team

3. Patient disposition:
   - Died  Skilled nursing facility  Acute care hospital (transferred)  Acute Rehab
   - Home  Hospice  Long term acute care  Other: ________________

Notes
## Rounding Time Log

### Month/Year:

### Site:

### Target Unit*:

*Please keep a separate log for each month for each of your target units.

<table>
<thead>
<tr>
<th>Rounding Date</th>
<th>Time Spent Rounding (Minutes)</th>
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</thead>
<tbody>
<tr>
<td>1. ___ / ____ / _____</td>
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<td>2. ___ / ____ / _____</td>
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<td>15. ___ / ____ / _____</td>
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<td>16. ___ / ____ / _____</td>
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</table>

**Number of rounds this month (this unit): _____  Total rounding time (minutes): _______**
Integrating Palliative Care into the ICUs across UC Health
April 2013 Nurse Trainer Workshop
Stakeholder Interview Guide

*PLEASE COMPLETE BEFORE THE APRIL TRAINING SESSION*

Site: _____________________________
Completed by: _____________________________

1. Identify 2 ICUs at your medical center in which you will target the intervention, including the communication workshop, semimonthly rounding, and systems support. Please briefly provide some information about the units, including the types of patients they care for, the number of beds, the current involvement of nurses in communication with families and clinicians, the current involvement of palliative care, and the attitudes of clinicians in the ICUs towards nurses’ involvement in communication and palliative care.

2. Identify key stakeholders whose support you will need to implement the project in your target ICUs. These could include medical center or ICU leadership, as well as clinical providers such as doctors, advance practice nurses, social workers, and spiritual care providers, who are involved in family-provider communication about prognosis, goals of care, and palliative care. Discuss the project with a few of these stakeholders, and elicit their perspectives on it. Ask them to identify barriers and facilitators to bedside nurses taking a lead role in communication about prognosis and goals of care, and to palliative care consultation for patients in the target ICUs. Ask them to recommend other stakeholders who you should talk with about the project. Please list all key stakeholders you identify and their position below, and summarize what you learn in the discussions:

3. Discuss the project with a few bedside nurses in each of your target units. Ask them about the following: 1) their current role in communication about prognosis, goals of care, and palliative care for their patients; 2) the barriers and facilitators to their involvement in this communication; and 3) the barriers and facilitators to the involvement of palliative care with their patients and families. Please summarize what you learn below:

Please email completed worksheet to Wendy.Anderson@ucsf.edu by April 8, 2013.
Integrating Palliative Care in the ICU: Trainer Workshop
April 8-11, 2013
Pre-Training Teaching Reflection Exercise

We are delighted that you will be participating in the upcoming trainer development workshop. In order to help maximize your experience in the training, please take 15-20 minutes to complete this reflection exercise. It is designed to help you reflect on your experience in teaching and learning communication skills, and to prepare you for discussions and practice in the training.

Please select the Option (#1 or #2) below that fits best with your previous experience.

This exercise should be completed in advance of the training. It is for your purposes only and will not be collected or turned in.
Option #1: Please reflect on a specific situation in which you were helping someone else to learn to communicate about prognosis, goals of care, and palliative care or another challenging topic.

1. How engaged was/were the learner(s) in the session? What seemed to make them more engaged? When did they seem less engaged, or when was it hard to tell whether they were engaged?

2. What was/were the learner(s) main struggles? What helped them to describe where they felt stuck or challenged?

3. How did you help the learner(s) to plan an approach that might address a challenge? What made it easier or harder to engage the learner in making a plan to address their challenge?

4. Was it hard for the learner(s) to try a new skill or approach? What made it easier for them to try a new skill or approach? What made it harder for them to try a new skill or approach?

5. Did the learner(s) get any feedback on skills they used? How did this feedback impact them? What feedback seemed to be most helpful? What feedback was less helpful or even harmful?

6. What did the learner(s) take home at the end of the session? When was it clear what they were taking home? When was it hard to tell what they had learned or whether they had learned?

7. What would you like to get out of this training?
Option #2: Please reflect on a specific time when you were learning to communicate with patients, families, and providers about prognosis, goals of care, and palliative care or another challenging topic.

1. How engaged were you in this learning? What made you feel more engaged? What made you feel less engaged?

2. What were the main things you struggled with? What made it easier to articulate what you were struggling with?

3. How did you come up with a different approach or skill that you could use to address the challenge you were facing? What made you want to plan a different approach? What made it hard to think about doing something differently?

4. Was it hard to try a new skill or approach? What made it easier to try a new skill or approach? What made it harder?

5. Did you get any feedback on skills you used? How did this feedback – or lack of feedback – impact you as a learner? What feedback was or would have been most helpful? What feedback was or might have been less helpful or even harmful?

6. What did you take home from this experience? What influenced what you took home from the experience? How has the experience influenced your practice?

7. What would you like to get out of this training?
Dear Colleagues,

We are very excited about your upcoming visit to UCSF on April 8-11. As you know, the focus of the workshop will be to prepare you to implement communication skills training workshops for ICU bedside nurses, and to facilitate their involvement in discussions about prognosis, goals of care, and palliative care with family members and other ICU providers.

Each of you brings a wealth of training and experience to this project. So that we can best leverage that, and also so that we can best tailor the April training session to meet your needs, we ask that you complete a brief on-line survey. The survey asks about your past and current experience and training, and it asks you to rate your skill to accomplish key aspects of the workshop. We will share your experience and training with the group, but will keep your self-ratings of your skills confidential - they are only for the training team to understand where we most need to focus the training. Your unique survey link is at the end of this email.

The survey will take 15 min to complete. To help us prepare for the workshop, please fill out this survey as soon as possible, and at the latest, by March 27th.

As the session nears, we will be sending some reading materials about the communication skills training method you will be practicing at the workshop, and a brief reflection exercise about teaching and communication.

Thank you in advance - we really look forward to working with you in the April training,

Wendy Anderson and the UCSF Project Team

**Integrating Palliative Care into the ICUs across UC Health**

**April Nurse Trainer Workshop – Pre-survey**

The first few items may be shared with other nurses participating in the project; the purpose of these items is to understand and leverage the wealth of training and experience in our group over the course of the project.

1. Name:
2. Degrees and Certifications (e.g. RN/NP/CNS; palliative/critical care certifications):
3. Institution:
4. Position and/or Title:
5. Service or Department (e.g. palliative care, nursing education, medical center, etc):
6. Key areas of expertise (e.g. education, palliative care, critical care, self care, etc.):
7. Other areas of interest:
8. Experience and current role(s) in caring for ICU patients:
9. Experience and current role(s) in nurse education:
10. Previous training and experience in communication (e.g. Educating Nurses about End of Life Care (ELNEC), work on a palliative care service, etc.):
11. Previous training and experience in education, including teaching communication skills:

Your responses to the following questions are to help us tailor the workshop and evaluate its effectiveness. Only the core project team at UCSF will see your responses.
First, please rate your current level of skill for each of the following tasks, relating to YOUR COMMUNICATION with clinicians and families of ICU patients about prognosis, goals of care, and palliative care:

12. Assess a family’s understanding of a patient’s prognosis and goals of care:
   1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

13. Identify the needs of a family for information about a patient’s prognosis and treatments:
   1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

14. Identify and respond to a family’s expressions of emotional distress:
   1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

15. Elicit a physician’s understanding of a patient’s prognosis and goals of care:
   1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

16. Discuss a family’s communication needs with a physician:
   1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

17. Communicate the value of, and need for, a family meeting to a physician:
   1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

18. Be an active, contributing participant in a family meeting where prognosis and goals of care are discussed:
   1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

19. Describe what palliative care is, and what it can offer, to physicians, other nurses, and families:
   1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

20. Communicate the value of, and need for, a palliative care consultation to a patient’s physician:
    1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

21. Communicate the value of, and need for, a palliative care consultation to a patient’s family:
    1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor

22. Use self-care practices to prevent burnout and compassion fatigue:
    1-Excellent  2-Very Good  3-Good   4-Fair   5-Poor
Next, please rate your current level of skill for each of the following tasks, relating to TEACHING OTHER NURSES to communicate with ICU family members and other clinicians about prognosis, goals of care, and palliative care:

23. Describe the role for the ICU bedside nurse in communication with families and clinicians about prognosis, goals of care, and palliative care:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

24. List specific communication skills that nurses can use to take an active role in communication with families and clinicians about prognosis, goals of care, and palliative care:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

25. Engage a small group in a communication skills practice session and elicit their goals for the session:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

26. Facilitate a role-play session for ICU nurses to practice skills for communicating with families and clinicians about prognosis, goals of care, and palliative care:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

27. During a role-play session, help a participant to define a specific goal for practice and select skills to achieve their goal:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

28. During a role-play session, help a participant to identify their "learning edge", where he or she can feel challenged yet safely practice without feeling overwhelmed:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

29. During a role-play session, help a participant to try a new strategy so that he or she can succeed in a place where they would usually get "stuck" in an encounter:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

30. During a role-play session, leverage a group’s and your own observations to provide specific, objective, and learner-centered feedback on a participant’s performance:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

31. At the end of a role-play session, help participants consolidate what they have learned and make a commitment for future practice:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

32. Lead a reflection session for ICU bedside nurses focused on self-care practices for preventing burnout and compassion fatigue:

1-Excellent   2-Very Good   3-Good   4-Fair   5-Poor

33. As you think of leading a workshop for ICU nurses at your medical center, what would you most like to get out of this training session? ____________________________
CHQIQERM Project: Integrating Palliative Care into the ICUs across UC Health
Trainer development session
April 8-11, 2013

Goals for the Trainees:
1. Meet and develop relationships with nurse leaders from the 5 campuses and UCSF project staff
2. Observe methods for communication skills training during a communication workshop for UCSF ICU bedside nurses
3. Practice methods for communication skills training including small group facilitation
4. Begin to plan the workshop you will conduct at your institution

Schedule

Monday April 8th

Focus Introductions and Orientation

Location Parnassus Campus Library, 530 Parnassus Ave, Rooms CL-213 & 214*
   *located 1 floor below entry level of the library (2nd floor)

2:00pm-2:30pm Greeting, Informal Networking, and Afternoon Refreshments
2:30pm-3:00pm Introductions and goal setting
3:00pm-4:00pm Presentation and Discussion: UCSF Workshop Development and the CHQIQERM Project
4:00pm-4:15pm Break
4:15pm-5:15pm Discussion of communication skills training methods, including how to observe the UCSF workshop
5:15pm-5:30pm Walk to dinner together
5:30pm-7:30pm Dinner together
**Tuesday April 9**

**Focus**  
Observe Workshop for UCSF ICU Bedside Nurses

**Location**  
Parnassus Campus Library, 530 Parnassus Ave, Rooms CL 221 & 222*  
*located 1 floor below entry level of the library (2nd floor)

8:45am-9:00am  
Arrive and settle in

9:00am-5:00pm  
Observe UCSF workshop “Communication with Families and Providers about Prognosis and Goals of Care”  
*You will have lunch with the Program Faculty

5:00pm-6:00pm  
De-brief then walk to dinner together

6:00pm-8:00pm  
Dinner together
**Wednesday April 10th**

**Focus**
Faculty development in communication skills training methods

**Location**
UCSF Faculty Alumni House, 745 Parnassus Avenue

**9:00am-10:00am**
Overview and discussion of communication skills training methods, including observations from UCSF workshop

**10:00am-noon**
Practice facilitating small group role-plays:
“Communicating with Families about Prognosis and Goals of Care”

**Noon-1:00pm**
Lunch with program faculty and UCSF ICU beside nurses

**1:00pm-2:00pm**
Practice facilitating small group role-plays:
“Communicating the Need for a Family Meeting to Physicians”

**2:00pm-2:10pm**
Break

**2:10pm-3:20pm**
Practice facilitating small group role-plays:
“Advocating for Family Informational & Emotional Needs in the Family Meeting”

**3:20pm-3:30pm**
Break

**3:30pm-4:30pm**
Caring for ourselves: Self-care best practices and reflection session

**4:30pm-5:00pm**
Questions and open discussion

**5:00pm**
Adjourn for the day - Dinner on your own
Please see list of restaurant options, save receipts for reimbursement
Thursday April 11th

Focus Implementing the workshop at your center: Logistics

Location **Parnassus Campus Library**, 530 Parnassus Ave, Rooms CL-213 & 214*
*located 1 floor below entry level of the library (2nd floor)

9:00am-10:00am Implementing a reflection session to promote self-care best practices for ICU bedside nurses

10:00am-10:10am Break

10:10am-11:20am Pairs from each campus work together to plan workshop: Objectives, Cases, Materials, To-do list and Timeline

11:20am-11:30am Break

11:30am-12:45pm Lunch with CHQIQERM Program Leadership
  - Introductions
  - Brief presentations from CHQIQERM Leadership
  - Pairs from each campus present workshop plan
  - Group discussion

12:45pm-1:00pm Complete training evaluations and adjourn
Faculty schedule for April 10th, Development in communication skills training methods

**Overview of Roles**

**UCSF Trainers:** Develop the skills of facilitators-in-training  
Kathleen Puntillo – leads a group of 4 trainers from other UC campuses  
Wendy Anderson – leads a group of 4 trainers from other UC campuses  
Michelle Milic – rotating between groups

**Facilitators-in-Training (FIT): Practice facilitating role-play sessions**  
All facilitators in training will facilitate a role-play session for 30 minutes in the morning and 30 minutes in the afternoon  
They can also rotate through the following roles: observer of other facilitators-in-training, and if not enough ICU beside nurse volunteers: Mrs. Ames, physician, observer of the learner

**ICU Bedside Nurses: The session participants**  
An ICU bedside nurse will always play the learner  
They can also play roles of observer of the learner, Mrs. Ames, and the physician
Morning Practice Session

Total time: 10:00am-noon

Session focus: “Communicating with Families about Prognosis and Goals of Care”

Groups:

<table>
<thead>
<tr>
<th>Morning - Group 1 – In Living Room</th>
<th>Facilitator</th>
<th>Facilitators-in-Training</th>
<th>ICU Bedside Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathleen Puntillo</td>
<td>Jan Noort - UCD</td>
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<td>XXXXXX</td>
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<td></td>
<td>Diana Pearson - UCD</td>
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<td>Jeannie Meyer -UCLA</td>
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<td></td>
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<thead>
<tr>
<th>Morning - Group 2 – in Dining Room</th>
<th>Facilitator</th>
<th>Facilitators-in-Training</th>
<th>ICU Bedside Nurses</th>
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</thead>
<tbody>
<tr>
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<td>Michelle Grywalski-UCI</td>
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<td>Heather Herman -UCSD</td>
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<td>Julia Cain -UCSD</td>
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</table>

Schedule Breakdown:

10:00-10:30am FIT #1 facilitates role play with learner, Mrs. Ames, observer
10:30-11:00am FIT #2 facilitates role play with learner, Mrs. Ames, observer
11:00-11:30am FIT #3 facilitates role play with learner, Mrs. Ames, observer
11:30-12:00pm FIT #4 facilitates role play with learner, Mrs. Ames, observer
Afternoon Practice Session

Total time: 1:00pm-3:20pm

Session focuses: “Communicating the Need for a Family Meeting to Physicians”
“Advocating for Family Informational & Emotional Needs in the Family Meeting”

Groups:

<table>
<thead>
<tr>
<th>Afternoon - Group 1 – In Living Room</th>
<th>Facilitator</th>
<th>Facilitators in Training</th>
<th>ICU Bedside Nurses</th>
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<tbody>
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<table>
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<th>Morning - Group 2 – In Dining Room</th>
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<th>Facilitators in Training</th>
<th>ICU Bedside Nurses</th>
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<td></td>
<td>Julia Cain -UCSD</td>
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</tbody>
</table>

Schedule Breakdown:

1:00pm-2:00pm Practice facilitating small group role-plays:
“Communicating the Need for a Family Meeting to Physicians”

1:00pm-1:30pm FIT #1 facilitates role-play with learner, physician, observer

1:30pm-2:00pm FIT #2 facilitates role-play with learner, physician, observer

2:00pm-2:10pm Break

2:10pm-3:20pm Practice facilitating small group role-plays:
“Advocating for Family Informational & Emotional Needs in the Family Meeting”

2:10pm-2:40pm FIT #3 facilitates role play with learner, physician, Mrs. Ames, observer

2:40pm-3:10pm FIT #4 facilitates role play with learner, physician, Mrs. Ames, observer

3:10pm-3:20pm Debrief in groups about practice facilitation – key take home points
Key Steps within each 30 minute FIT session

[in a 30 minute session, we might cycle through the below 1-3 times]

Planning at the beginning = what is the FIT’s objective, how will they achieve it?
“What would you like to work on in particular during this session?”
“How will you accomplish that?”
“Looking at the facilitator quick guide, what area would you like to focus on?”
“Ok - we’ll have the observers watch for how you identify the participant’s learning edge.”
“When you’re ready, go ahead and get started.”

5 min (approx) – role-play – if FIT has not called time-out, pause role-play to check in

Time out discussion
a. Check-in
   “How is it going?”

b. Identify / name learner edge
   “So it sounds like you didn’t know whether or not to time her out when she just kept going, but you weren’t sure she was using the skills she had planned.”

c. FIT’s ideas re: what is going well
   “Ok, we’ll come back and talk about that [learning edge]. But first I want to talk about what you are doing well. I noticed a number of things. What did you feel you did well?”

d. Group ideas re: what is going well
   “Great – I agree you did a good job of identifying the learner’s goal and making a plan for practice. Could we get some feedback from the group about what you’re doing well?”

e. Learner ideas re: how to address edge
   “Ok, now I want to brainstorm about what you could do when the learner just kept going, even though she wasn’t using the skill she planned to.”

f. Group ideas re: how to address edge
   “You could time her out and just check in – to see how the learner feels things are going. Could we get some ideas from the group of other approaches?”

g. Learner plan for going back into session
   “So you’ve got three suggestions – letting the learner go until she times out, timing her out and asking her how things are going, or timing her out and asking her about a particular thing that Mrs. Ames said. Which would you like to try?”

5 min (approx) – role play – goal is to let FIT try the new skill they planned – we want to make sure they do this, then pause the role-play to make sure that they note the success

2 min –discussion – with FIT – how did new approach feel, what will they take away?

a. Check-in
   “So you had planned to time out the learner and point out an emotional expression by Mrs. Ames – how did you feel that went?”

b. Identify learner take home lesson
   “So it sounds like the learner responded well to that, but still struggled with using a NURSE statement – what might you try next time?”
   “So what will you take home from this?”
WORKSHOP FACILITATOR CARD

Structure for Each 60-70 Min Role Play Session

A. Goals/challenges - group (5 min)
   • “What challenges do you encounter in talking with (families/physicians/in family meetings) about prognosis, goals of care, and palliative care?”

B. Review conversation goals & skills (5-10 min)
   • Walk through purple sheet
   • Review specific goals for the conversation
   • Review skills to be practiced, getting examples from the group

C. Model role play (5-10 min)
   • Faculty who will play nurse reads “nurse” case handout to group
   • Faculty just model skills - don’t need to goal set/debrief faculty for model role play
   • Direct participants to observe for skills and then report what they observed after

D. Skills practice (40 min)
   • Give case handouts to nurse, +/- patient/physician volunteers to read to themselves
   • Follow process on diagram on reverse for each learner

E. Take-home points - group (5 min)
   • “What are you taking home from this session for the discussions you have in practice?”

Diagram of Skills Practice Process for Each Learner

1a. Welcome Learner
   a. Thank you for volunteering
   b. Review conversation goals

1b. Learner Goal
   a. Specific learner goal
   b. Select skill to reach goal
   c. Direct observers to goal/skills

2. Role Play
   Time out when:
   • Learner has met goal
   • Learner struggling

3. Check-in with Learner
   * If learner identifies edge / stuck, reflect it & table for later

4a. Positive Feedback
   a. Brief general (+) feedback from facilitator “You did a lot well.”
   b. Specific (+) feedback from observers, other faculty, facilitator

4b. Brainstorm Edge
   a. Learner ideas
   b. Ideas from observers, other faculty, facilitator

5. Close Learner’s Practice
   a. Thank you
   b. Take home points?
Integrating Palliative Care in the ICU: Train-the-Trainer Program
Workshop Observation Guide

Use this guide while you are observing the workshop and your co-facilitators.

1. Learner engagement:
   • How engaged were the learners in the session and role-play?
   • What did the facilitator do to engage the learners?
   • What things made the learners seem less engaged, or made it hard to tell whether they were engaged?

2. Learner’s goals:
   • Were the learners’ goals clear?
   • What did the facilitator do to elicit the learners’ goals?
   • What was the consequence when the learners’ goals were or were not clear?

3. Learner trying new or recommended skills:
   • Did the learner(s) try new or recommended skills?
   • What did the facilitator do that encouraged the learner to try a new or recommended skill?
   • What seemed to discourage the learner from trying a new or recommended skill?

4. Learning edge:
   • Where was the participants’ learning edge – where they were challenged but still comfortable?
   • Did the facilitator help to clarify the learning edge for the learner? If so, how?

5. Feedback:
   • What kind of feedback did the learner get from the other participants? The facilitator?
   • How did the facilitator modulate feedback from the observers?
   • What kind of feedback seemed most helpful and why?
   • What effect did the feedback have on the learner’s performance?

6. Take home points:
   • Was it clear what the learner was going to take home from the session?
   • What did the facilitator do to encourage learners to state their take home points?
   • What effect did stating these take home points seem to have on the learner and session?
**IMPACT-ICU: Post-Workshop Reflection Exercise**

*Please reflect on your experience conducting your first workshop using the following questions.*

7. How engaged were the participants in the session? What seemed to make them more engaged? When did they seem less engaged, or when was it hard to tell whether they were engaged?

8. What were the participants’ main struggles? What helped them to describe where they felt stuck or challenged?

9. How did you help the participants to plan an approach that might address a challenge? What made it easier or harder to engage the participants in making a plan to address their challenge?

10. Was it hard for the participants to try a new skill or approach? What made it easier for them to try a new skill or approach? What made it harder for them to try a new skill or approach?

11. Did the participants get feedback on skills they used? How did this feedback impact them? What feedback seemed to be most helpful? What feedback was less helpful or even harmful?

12. What did the participants take home at the end of the session? When was it clear what they were taking home? When was it hard to tell what they had learned or whether they had learned?

13. Please list 3 main goals you have for your facilitation of future workshops including communication skills practice in the role play sessions:
   1.
   2.
   3.
Background: Why & How was IMPACT-ICU Developed?

- When integrated into the ICU, palliative care can improve outcomes in all domains of the triple aim: patient and family health, experience of care, and resource utilization (Figure). Sustained integration of palliative care into the ICU requires involvement of nurses, patients’ closest bedside provider.
- IMPACT-ICU is a quality improvement program designed to integrate palliative care into the ICU by training and supporting bedside nurses.
- IMPACT-ICU was developed by an interdisciplinary and multi-specialty team at the University of California, San Francisco (UCSF) Medical Center in 2011, in response to requests from critical care nurses for training in communication and increased specialty palliative care support in the ICU. It was refined at UCSF between 2011-2013.
- Between March 2013-August 2015, the University of California Office of the President’s Center for Health Quality and Innovation Quality Enterprise Risk Management program, a joint venture of the University of California Center for Health Quality and Innovation and Office of Risk Services, funded the dissemination of the IMPACT-ICU program across the 5 University of California Medical Centers: Davis, Irvine, Los Angeles, San Diego, and San Francisco.

Methods: What are the IMPACT-ICU Project Components?

I. Palliative Communication Workshop for ICU Nurses
   - 8-hour learner-centered workshop trains nurses to facilitate communication about prognosis, goals of care and palliative care among families and physicians.
   - Taught by a multidisciplinary team of experts in palliative care, critical care, and communication.
   - In role-plays, nurses practice conversations with families, physicians, and in family meetings (Figure).
   - A reflection session teaches self-care practices to address nurses’ distress & burnout.

II. Proactive Specialty Palliative Nursing Support
   - IMPACT-ICU positions bedside nurses to coordinate primary palliative care, including symptom management, family support, and communication about prognosis & goals of care.
   - Palliative care advanced practice nurses and nurse educators support bedside nurses, and provide specialty palliative nursing expertise. They round regularly at the bedside to coach bedside nurses through the process of screening for and developing a plan to address palliative care needs; they are available for consultation at other times.
   - Specialty palliative care consult service assists the ICU care team for complicated cases.

A. Needs Assessment Survey

- System-wide anonymous survey of ICU bedside nurses at the 5 University of California medical centers, to assess palliative care communication training needs; n=598 responded.
- A minority of respondents reported often discussing palliative care consultations with physicians (31%) or families (33%); 45% reported rarely or never participating in family meetings. The Table above shows most frequently reported barriers, which informed our program implementation.

<table>
<thead>
<tr>
<th>Barrier</th>
<th>% Endorsing (n=598)</th>
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<tbody>
<tr>
<td>Need for more training</td>
<td>66%</td>
</tr>
<tr>
<td>Physicians don’t ask for nurses’ perspectives</td>
<td>60%</td>
</tr>
<tr>
<td>Emotional toll of discussions</td>
<td>43%</td>
</tr>
<tr>
<td>Nurses’ role in palliative care discussions is unclear</td>
<td>42%</td>
</tr>
</tbody>
</table>

B. Design & Effectiveness of the IMPACT-ICU Train-the-Trainer Program

- We created teams at each University of California Medical Center to lead program implementation. Each team included 2 nurse experts in palliative and critical care, including nurse educators and advanced practice nurses, and one physician.
- We created a 2-year train-the-trainer program for the nurse experts, to provide training and mentoring in small group facilitation and using role play for communication skills training. Core elements of the train-the-trainer program were: 1) a 3-day in-person training focused on facilitating role play in small groups, 2) site visits by project leaders with feedback on leaders’ small-group facilitation, 3) regular phone calls, 4) yearly all-site meetings.
- A total of 8 nurse leaders, 2 at each center, completed the train-the-trainer program between 2013-2015. As shown in the following Figure, the nurse leaders’ ratings of their skills to conduct small group communication skills training sessions for bedside nurses increased over the course of the train-the-trainer program.

Train-the-Trainer Program Participant Evaluations 2013-2015. Participants rated their skill to conduct communication training for bedside nurses. Response options were: “Excellent”, “Very Good”, “Good”, “Fair”, “Poor”; the chart shows the percentage of nurse leaders rating their skill as “Excellent” or “Very Good”.

C. Feasibility & Effectiveness of Palliative Care Communication Workshops for ICU Bedside Nurses

- The leaders who competed the train-the-trainer program implemented the IMPACT-ICU program at their centers between 2013-2015. As of January 2015, each of the 5 University of California Medical Centers had completed at least seven 8-hour long palliative care communication workshops for bedside nurses across a range of ICU types; 43 workshops had been conducted across the 5 centers, with 527 nurses trained. Communication trainings for bedside nurses are ongoing at each center.
- Evaluations show that after the workshop, nurses feel that they have a higher level of skill to engage in discussions with clinicians and families about prognosis, goals of care, and palliative care, compared to before completing the workshop, as shown in the Figure on the following page.

“The communication tools from IMPACT-ICU have helped nurses to navigate crucial conversations with patients, families and teams to assure that the patient’s goals of care are met.”
- UC Davis Project Leader
ICU Bedside Nurse Communication Workshop Evaluations 2013-2014. Participants rated their skill to engage in palliative care communication tasks before and after the workshop. Response options were: “Excellent”, “Very Good”, “Good”, “Fair”, “Poor”; the chart shows the percentage of nurses rating their skill as “Excellent” or “Very Good”.

D. Importance of Proactive Specialty Palliative Nursing Support

- Nurse leaders at each center provided specialty palliative nursing support proactively and by serving as an expert upon whom nurses could call when they encountered challenges.
- Across the centers, rounds occurred 2-4 times per month, for a total of 4-10 hours per month. During these rounds, bedside nurses identified palliative needs in 74% of patients: uncontrolled symptoms (51%), family distress (43%), and inadequate communication about prognosis & goals of care (31%).
- During rounds, nurse leaders coached bedside nurses in addressing palliative care needs and provided education and support on a range of topics including: describing palliative care, family support and communication, assessing and managing symptoms including nurse-directed interventions, nurses’ role in providing palliative care, and organizing and participating in family meetings.

E. Sustainability & Dissemination: Ongoing Efforts Across University of California Health and Beyond

- The IMPACT-ICU project has become well-integrated into target ICUs, palliative care teams, and continuing nursing education at each campus. Leaders in these programs are dedicated to continuing palliative care education and quality improvement efforts at each center.
- Ongoing efforts across the University of California centers include designing and implementing programs that train interdisciplinary teams of clinicians in palliative care communication and teamwork. Additionally, palliative nursing education is being disseminated outside the adult ICU, to include pediatric ICU nurses and adult acute care nurses.
- University of California IMPACT-ICU program leaders have served as advisors and mentors for teams from other hospitals who are in the process of implementing the IMPACT-ICU program at their centers.

“Our ICU palliative care nursing rounds help nurses to problem-solve their patients’ and families’ concerns, and better communicate these concerns to other members of the ICU team.”
- UCSF Project Leader

UNIVERSITY OF CALIFORNIA HEALTH IMPACT-ICU TEAM

Principal Investigator & Contact: Wendy Anderson, MD MS | Wendy.Anderson@ucsf.edu

- Wendy Anderson, MD MS; Kathleen Puntillito RN PhD FAAN, FCCM; Susan Barbour RN WOCN ACHPN; Janica Cimino BA; Denah Joseph MFT; Ann Leemhuis RN; Michelle Milic MD; Tawnya Napoli RN; Kathleen Turner RN CHPN CCRN-CMC; Steven Pantilat MD, FAHAHPM, SFHM
- Janice Noort RN NP MS ACHPN; Nathan Fairman MD MPH; John MacMillan MD; Diana Pearson RN MS CCRN; Eric Moore RN MBA NEA-BC
- Deborah Boyle RN MSN FAAN AOCNS; Michelle Grywalski RN BSN; Lisa Moores RN, MSN CCRN; Maurice Espinoza RN MSN CCRN; Sherry Carter RN BSN; Karolina Soriano MSW ACSW; Adelina Linares RN; Jamie Capasso MD; Solomon Liao MD
- Jeannette Meyer RN MSN CCRN CCNS PCCN ACHPN; Diana Ramirez BA; Edith O’Neill-Page RN MSN AOCNS; Christopher Pietras MD; Delia Cortez LCSW; Lori Koutouratsas MDiv; Mary Lawanson-Nichols CNS; Bruce Ferrell MD
- Julia Cain RN MSN ANP; Heather Herman RN MS ANP; Kyle Edmonds MD; Kathryn Thornberry LCSW; William Mitchell MD

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Project Guide
Page 90
The IMPACT-ICU Project

Evaluation Plan

March 2013 – September 2015

Evaluation focus: To evaluate the effectiveness of Integrating Multidisciplinary Palliative Care into the ICU (The IMPACT-ICU) Project, a quality improvement initiative that integrates palliative care into the ICU by educating and supporting bedside nurses.

Intended use and users:

• Project team, who has implemented the program at the 5 UC medical centers and is deciding whether to continue elements of it after the end of grant funding. These teams include palliative care team leaders and palliative and critical care and nursing leaders

• Funder: UC Office of the President, Center for Health Quality and Innovation, Quality Enterprise Risk Management Program

• Leadership at the 5 UC medical centers, including chief medical and nursing officers and directors of nursing education

• Leadership and clinicians working in ICUs at the 5 UC medical centers, both those who have implemented the project in their unit, and those who might implement it in the future

• Leadership and clinicians working at other hospitals in California (and nationally) who might want to implement this program in their hospitals

• Audience of a peer-reviewed journal/target publication
Program Description

**Background:** One fifth of American deaths occur shortly after a stay in an Intensive Care Unit (ICU). In ICUs, seriously ill patients are at risk for receiving painful interventions that are not consistent with their wishes. Patients’ families experience significant distress, and the costs of ICU care near the end of life burden our health system. When integrated into ICUs, palliative care improves management of patients’ symptoms, decreases family distress, and increases satisfaction. By aligning patients’ care with their preferences, palliative care decreases ICU length of stay and costs. A key to the success of quality improvement efforts in the ICU is the involvement of nurses, as patients’ closest bedside provider. Yet nurses lack the training and support to take an active role in providing palliative care to their patients.

**Purpose:** The purpose of Integrating Multidisciplinary Palliative Care into the ICU (The IMPACT-ICU) Project is to integrate palliative care into the ICU by training and supporting bedside nurses to address 3 key patient and family needs: pain and symptom management, family support, and communication about prognosis and goals of care.

**Objective and Aims:** The objective of this 2-year project is to increase the integration of palliative care in the ICUs at the 5 University of California medical centers: Davis, Irvine, Los Angeles, San Diego, and San Francisco. The aims are to
1. Expand a training program to increase the involvement of ICU bedside nurses in communication about prognosis, goals of care and palliative care,
2. Support nurses at the bedside at they integrate the skills they learned in the workshop into practice.

**Project Activities:** The IMPACT-ICU project focuses on systematic integration of palliative care into ICUs. Our team consists of critical and palliative care nurse leaders and physicians from the 5 centers. The project involves bedside training bedside nurses in palliative care assessments and coordinating treatments by the multidisciplinary ICU team. The project has 3 components, to help nurses undertake this role:

1. An 8-hour communication workshop for ICU nurses to provide nurses with skills to discuss prognosis, goals of care, and palliative care with families and clinicians.
2. Rounding by advance practice palliative care nurses and nurse educators in the target units to support nurses in integrating the skills they learn in the workshop into practice.
3. Detailing and liaising with other clinicians in the target ICUs (e.g. physicians, leadership, social workers) to educate them about the program and incorporate the nurses’ assessments into practice.

**Stage of development:** The IMPACT-ICU Project was created at UCSF at the request of ICU bedside nurses who perceived a need for improved palliative care for their patients. In 2010, a multidisciplinary and multispecialty team created the communication workshop, which was piloted at UCSF medical center between 2011-2013. This team included ICU bedside nurses, palliative and critical care physicians, an expert on palliative care nursing in the ICU, and a palliative care chaplain. In 2013, the UC Center for Health Quality and Innovation Quality Enterprise Risk Management Program funded the dissemination and expansion of this program. This funding allowed us to add to the communication workshop support for ICU bedside nurses at the bedside, provided by palliative care and critical care advanced practice nurses and educators, to help nurses implement the skills they gained in the workshop as they care for patients at the bedside. The UCSF team trained project teams at UC Davis, Irvine, Los Angeles, and San Diego to implement the workshop and bedside support at their centers. They began this implementation in June of 2013. The end of the 5-center project evaluation is December 31, 2014.

**Environmental context:** The program is being implemented in 2 target ICUs at each of the UC medical centers: Davis, Irvine, Los Angeles, San Diego, and San Francisco. These centers all serve as tertiary and quaternary referral centers for patients throughout California, and also local hospitals for patients living near them, including providing safety net care. The target ICU in which the program is being implemented include medical, surgical, trauma, cardiac, and neurological ICUs.
PRECEDE/PROCEED Model Applied to the IMPACT-ICU Project

The goal of our project was to empower bedside nurses to lead palliative care assessments and development of treatment plans to address identified needs for their patients. This included performing daily assessments for their patients in 3 domains: 1) whether the patient had any uncontrolled physical symptoms, 2) whether the family was experiencing emotional distress, and 3) whether the prognosis and goals of care had not been clearly communicated among the family and clinicians. This required training of nurses to perform these assessments, and then to work with the ICU interdisciplinary team, including physicians, social workers, and spiritual care providers, to develop and implement a plan to address these needs. For example if a nurse identified family emotional distress, the spiritual care team or social worker might be called to support the family. Or if the patient was experiencing pain, the nurse would work with the physician to change the medications.

Because assessing family distress and communication about prognosis and goals of care involves addressing sensitive topics which nurses felt they were not adequately trained to do, communication skills training in palliative care communication was a large portion of our project activities. We also focused on providing support in the unit from advanced practice nurses and detailing with physicians to support nurses’ role in leading palliative care assessment and treatment. Nurses were also trained to describe and advocate for palliative care consultation when the efforts of the frontline providers had not met the identified patient and family needs.

We used PRECEDE/PROCEED, informed by our preliminary work at UCSF, as a foundation for our logic model, to assist us in identifying the behavioral antecedents and the relationship of these variables to nurses taking on this expanded scope of practice. The table on the following page outlines the Predisposing, Enabling, and Reinforcing factors that we identified and incorporated into the design of our 5-center dissemination and project expansion.
<table>
<thead>
<tr>
<th>TARGET BEHAVIOR</th>
<th>Daily palliative care assessments &amp; plans to address patient/family needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>TARGET AUDIENCE</td>
<td>ICU bedside nurses</td>
</tr>
<tr>
<td>OTHER KEY INDIVIDUALS</td>
<td>ICU physicians, family members of patients, advanced practice nurses, palliative care teams</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREDISPOSING</th>
<th>ENABLING</th>
<th>REINFORCING</th>
</tr>
</thead>
<tbody>
<tr>
<td>KNOW</td>
<td>BE ABLE TO (skills)</td>
<td>REMINDED</td>
</tr>
<tr>
<td>What is palliative care?</td>
<td>Assess patient symptoms</td>
<td>Nurse contributes palliative care assessment to team as part of daily rounds</td>
</tr>
<tr>
<td>What are the key domains in a palliative care assessment?</td>
<td>Assess family understanding of prognosis &amp; goals of care</td>
<td>Advanced practice nurses round on unit regularly to remind nurses to perform assessments</td>
</tr>
<tr>
<td>How to assess patient symptoms, family support, communication about prognosis &amp; goals of care</td>
<td>Collaborate with physicians to develop a plan to address palliative care needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Address family information &amp; emotional needs in family meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Describe palliative care and the benefits of a consult to a physician and a family member</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cope with stresses of working in the ICU</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BELIEVE / VALUE</th>
<th>ACCESS TO</th>
<th>POSITIVE REINFORCEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility: It is my job to assess palliative care needs &amp; work with the ICU team to address them</td>
<td>Effective, learner-centered communication skills training to practice palliative care communication</td>
<td>Positive connection with families &amp; physicians</td>
</tr>
<tr>
<td>Positive outcomes: It is rewarding to connect with families &amp; physicians about what really matters</td>
<td>Physicians present in unit and willing to have discussions</td>
<td>Feel you are making a difference to patients and families</td>
</tr>
<tr>
<td>Negative outcomes: Physicians get upset if I bring concerns to them</td>
<td>Support at the bedside from advanced practice nurses to navigate difficult situations and barriers</td>
<td>Feel care you are provided is what patients really want, and know patients/family understand prognosis</td>
</tr>
<tr>
<td>Efficacy: I can identify needs &amp; bring together a plan to address them</td>
<td>Palliative care consultations for complicated patients</td>
<td>Had the opportunity to voice concerns to family and physician</td>
</tr>
<tr>
<td>Others expect me to play this role: hospital/unit leadership, MDs</td>
<td></td>
<td>Praise from physicians, managers, advance practice nurses, palliative care teams, peers</td>
</tr>
<tr>
<td>Social norm: Senior and charge nurses, peers play this role</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTENTION</th>
<th>ACCESS REMOVED</th>
<th>NEGATIVE REINFORCEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>To assess patient symptoms on a daily basis &amp; report to ICU team</td>
<td>Even if physician not agreeable to palliative care consult, unit resource nurses and advance practice nurses can be called to navigate difficult situations and barriers</td>
<td>Physicians disregard/do not respond to nurses’ concerns</td>
</tr>
<tr>
<td>To start discussions with families about prognosis and goals of care</td>
<td>Coverage from colleagues to facilitate discussions with family members and attending family meetings</td>
<td></td>
</tr>
<tr>
<td>To initiate discussions with physicians about prognosis and goals of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To attend family meetings and actively participate in discussions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage of Precontemplation &amp; Contemplation</td>
<td>Stage of Preparation &amp; Action</td>
<td>Stage of Maintenance</td>
</tr>
</tbody>
</table>
Logic Model of IMPACT-ICU Project Implementation at 5 UC Medical Centers

**Goal:** Train and support bedside nurses in 2 target ICUs at each of the 5 UC Medical Centers to identify palliative care needs for their patients, and work with the ICU team to develop and implement plans to address needs

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seriously ill ICU patients and families have unaddressed palliative care needs: symptom management, emotional support, clear communication re: prognosis &amp; goals of care</td>
<td>Grant funding for team development</td>
<td>5-site meeting to agree on patient population and workflow of rounding in ICUs</td>
<td>Participation of UC teams in 5-campus meeting</td>
<td>Nurse leader confidence to train bedside nurses in communication</td>
<td>Nurse &amp; provider satisfaction</td>
</tr>
<tr>
<td>The active involvement of bedside nurses is essential to effective integration of palliative care into the ICU</td>
<td>Support + mentorship from medical center and ICU leadership at UC medical centers</td>
<td>3-day training session at UCSF to train nurse leaders to conduct communication workshop for ICU nurses</td>
<td>Participation of nurse leaders in training session at UCSF</td>
<td>Confidence and perceived skill of bedside nurses who complete the workshop to communicate with families &amp; physicians about prognosis, goals of care, and palliative care</td>
<td>Patient symptom management</td>
</tr>
<tr>
<td>Bedside nurses need support and education to lead palliative care in ICUs by activating the ICU team and recommending palliative care consults</td>
<td>Mentorship team from UCSF to train 4 other centers</td>
<td>Mentors at UCSF attend 1st workshop at each site to give support and feedback</td>
<td>Number of workshops conducted at each center</td>
<td>Involvement of bedside nurses in communication about prognosis &amp; goals of care for their patients</td>
<td>Family emotional distress</td>
</tr>
<tr>
<td></td>
<td>Peer mentorship across all centers for barriers to implementation</td>
<td>Monthly calls with UCSF and each site to help sites navigate barriers</td>
<td>Number of nurses trained at each center</td>
<td>Palliative care needs identified and addressed by bedside nurses in rounds with nurse leaders</td>
<td>Family satisfaction</td>
</tr>
<tr>
<td></td>
<td>Palliative care program director effort at each UC center to liaise with MDs</td>
<td>8 communication workshops at each center over 2 years including 15 bedside nurses per workshop</td>
<td>Number of patients about which nurse leaders council nurses on the unit</td>
<td>Type of support provided to bedside nurses by advance practice nurses</td>
<td>ICU length of &amp; costs for seriously ill patients</td>
</tr>
<tr>
<td></td>
<td>2 critical care nurse educators or advanced practice palliative care nurses at each site to conduct workshops and round in ICUs</td>
<td>Nurse leaders round in target ICUs twice per month to support nurses at bedside in identifying and addressing patient palliative care needs</td>
<td>Number of hours nurse leaders spend rounding in target ICUs</td>
<td>Palliative care consult frequency on target ICUs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Program coordinator to track data, support centers</td>
<td>Nurse leaders available to nurses “on-call” to navigate difficult situations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© The IMPACT-ICU Project, 2015  Project Guide  Page 95
Evaluation Scope:

Initial outcomes expected as a result of the project are:

Increases of:
- Bedside nurse knowledge of palliative care and confidence and skill to engage in discussions of prognosis and goals of care
- Screening of patients for palliative care needs: uncontrolled symptoms, family emotional distress, misunderstandings among the family and medical team of prognosis and goals of care
- Involvement of bedside nurses in prognosis & goals of care discussions – with families, physicians, and in family meetings
- Access of bedside nurses to specialized palliative care nurses to navigate barriers to addressing palliative care needs
- Palliative care consults for patients with unaddressed palliative care needs

The logic model above will guide the evaluation of the IMPACT-ICU palliative nursing education program. Evaluation questions derive from the logic model. The RE-AIM framework is used to organize the outcome evaluation.

Process Evaluation Plan Methods (Inputs → Activities → Outputs):

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Indicator/Performance Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>What inputs have been used to disseminate the IMPACT-ICU palliative nursing education project?</td>
<td>Description of recruitment of site physician and nurse leaders, garnering of support from ICU and campus leadership at each site</td>
<td>Program records, interviews with project leaders</td>
</tr>
<tr>
<td>What activities have gone into disseminating the project?</td>
<td>Description of collaborative and train the trainer activities: 5-campus meetings of project leaders, train the trainer program, mentoring: peer, from UCSF, from campus leadership at each center</td>
<td>Program records, interviews with project leaders</td>
</tr>
<tr>
<td></td>
<td>Description of activities at each site: communication workshop, rounding of nurses leaders in target units, liaising with MDs and incorporating nurse assessment into workflow in ICUs</td>
<td></td>
</tr>
</tbody>
</table>

Outcome Evaluation Plan Methods (using RE-AIM framework):

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Indicator/Performance Measure</th>
<th>Data Source(s)</th>
</tr>
</thead>
</table>
| What is the reach of the train the trainer program and collaborative efforts and the activities at each site? | #/% of site PIs and nurse leaders who participated in 5-campus meetings  
# of Participation of nurse leaders who completed train the trainer session at UCSF  
Number of workshops conducted at each center  
Number of nurses trained at each center and Percent of nurses in target ICUs at each medical center who completed communication workshop  | Study records  
Monthly conference calls with each site  
Workshop participation logs at each site  
Rounding logs at each site |
<table>
<thead>
<tr>
<th>Question</th>
<th>Method</th>
</tr>
</thead>
</table>
| What is the **efficacy** of the train the trainer program and the activities to educate and support bedside nurses at each center? | Nurse leader confidence to train bedside nurses in communication  
Confidence and perceived skill of bedside nurses who complete the workshop to communicate with families & physicians about prognosis, goals of care, and palliative care  
Palliative care needs identified and addressed by bedside nurses in rounds with nurse leaders  
Type of support provided to bedside nurses by advance practice nurses  
Surveys of nurse leaders before and after train the trainer program  
Surveys of bedside nurses before and after the workshop  
Rounding logs                                                                 |
| To what extent do nurses working in target units **adopt** the skills and role taught in the workshop | Involvement of bedside nurses in communication about prognosis & goals of care for their patients  
Rounding logs                                                                 |
| To what extent are the communication workshops and rounding **implemented** at each center? | Fidelity of communication workshop at each site  
Fidelity of rounding procedures at each site  
Effect of intervention on unit culture and nurse involvement in communication and palliative care  
Site visit observation of workshops at each site  
Did workshops at each site increase nurses skill and confidence?  
Completeness with which rounding logs are completed  
Monthly conference calls to discuss workshop and rounding procedures  
Exit interviews with nurse and site leaders |
| Do bedside nurses who participate in workshops **maintain** their increased confidence and skill? | 3-months post workshop - Confidence and perceived skill of bedside nurses to communicate with families & physicians about prognosis, goals of care, and palliative care  
Surveys of nurses who completed workshop |
| Do the centers **maintain** the workshops and rounding after the project period? | Intent of centers to continue workshops and rounding and scheduled workshops in the future  
1-year post end of funding assessment – are workshops continuing? Rounds continuing?  
Exit interviews with nurse and site leaders |
Data gathering and collection tools

Project data sources will include program documentation (grant, training materials), records of program meetings and conference calls, palliative care service records at each site, surveys of site-leaders and trainers at each site, surveys of nurses who participate in the communication skills training workshop, and administrative data.

**Surveys of site directors and nurse educators:** Directors and nurse educators from each of the 5-sites will be surveyed throughout the proposal to evaluate which systems are in place or being implemented to integrate palliative care in the ICU. In addition, nurse educators will be surveyed multiple times to assess their self-perceived competence and confidence in communication skills training methods and implementing the workshop. At the end of the project, the PI will perform in depth exit interviews with nurse and service director leaders at each site to get their detailed feedback about the implementation of the program, and how it will be maintained at their center. Questions for that interview include:

I. Tell me about how the IMPACT-ICU program has been received at your center?
   - What challenges have you experienced in implementing it? How have you navigated them?
   - What have been the contributions of the workshop?
   - What has been the impact of the rounding?
   - What do you see as the major successes of implementing the IMPACT-ICU program at your center?

II. What have been the impacts of the IMPACT-ICU program at your center?
   - Has program contributed to identification and addressing of palliative care needs for patients in target ICUs? How so? How has program achieved this aim?
   - Has program contributed to generalist / primary specialty palliative care – that provided by the ICU clinicians?
   - Has program contributed to patients being referred to specialty palliative care (consult service) when needs cannot be addressed by frontline providers? How has is done this?
   - What have been unanticipated impacts (positive or negative) of the IMPACT-ICU program?

III. IMPACT-ICU and program and medical center strategic goals:
   - Do you feel the IMPACT-ICU program has helped you to achieve the goals of your palliative care program at your institution? How so or how not?
   - Do you feel the IMPACT-ICU program has helped you to achieve the strategic goals of your medical center? How so or how now?

IV. Plans for sustainability
   - What aspects of the project do you plan to continue after UCOP funding? Workshops? Rounding?
   - What will be different / stay the same?
   - How will you fund / support these continued efforts this?
   - Other ideas for future things?

V. Are there any other things that we haven’t discussed that you’d like to be included in our program report?

**Surveys of ICU bedside nurses who participate in the communication workshops:** Nurses who complete the workshop will complete surveys before, immediately after, and 3-months after the workshop to assess their self-perceived competence and confidence in communicating with families and other providers about prognosis, goals of care, and palliative care. In addition, the 3-month follow-up survey asks about involvement in communication and initiation of palliative care referrals. These surveys were developed based on past nurse communication training interventions in the ICU, and have been used at UCSF to evaluate the workshops for the past 2 years.
Palliative care service data: All of the palliative care services keep logs of the patients seen on their service, including information about the patient’s location at the time of the consult. Palliative care service data will be used to track the number of palliative care consults in the target ICUs. Palliative care consult rates in other ICUs will be followed as a comparison.

Audit/feedback and support rounds by nurse trainers: The two nurse trainers will round in each of the two target ICUs at each of the hospitals on two weekdays out of every month. The purpose of these rounds will be dual: 1) to provide real time support and feedback to nurses at the bedside about communication and documentation about palliative care, and 2) to collect data that will be used in audit and feedback. The two days of each month on which the nurse trainers round will be randomly selected, so that these rounds reflect changes that occur in census and patient mix during each week. We anticipate that this frequency of rounding and unit size would yield approximately 20-30 patients per hospital per month on which the audit and feedback would be based. In these rounds, the trainers will identify all target patients (above), and collect the patient’s bedside nurse and medical record, including the following:

- ICU admission and life-limiting diagnoses
- Whether the bedside nurse caring for the patient participated in the communication workshop
- Whether a discussion about code status and advance directive was documented on Day 1 of the ICU stay
- If the patient has been in the ICU for at least 5 days, whether an interdisciplinary family meeting is documented
- Whether the patient has had a palliative care consult
- The patient’s name and medical record number (for linkage with palliative care service and administrative data)
Dissemination plan

Based on the above evaluation plan, I will prepare the following documents:

1. Detailed program evaluation report 6-10 pages for project team, site leaders

2. 2-page summary for:
   - Leadership at the 5 UC medical centers, including chief medical and nursing officers and directors of nursing education
   - Leadership and clinicians working in ICUs at the 5 UC medical centers, both those who have implemented the project in their unit, and those who might implement it in the future
   - Leadership and clinicians working at other hospitals in California (and nationally) who might want to implement this program in their hospitals

3. Structure narrative report for funder

4. Journal article for peer reviewed journal