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Featured Article

Standardized Patients Portraying Parents in Pediatric End-of-Life Simulation

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KEYWORDS

end of life;
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education

Abstract: Teaching nursing students how to support families during the death of their child is an important aspect of pediatric nursing. Faculty created a novel end-of-life simulation where standardized patients portrayed an infant's parents. The purpose of this article is to describe how the characters were created, how standardized patients were trained, and the importance of psychosocial care with standardized patients. Anecdotally, students and faculty have noted how standardized patients improved the fidelity of the simulation. Standardized patients allowed students to practice communication skills during simulations, which may augment the critical thinking and psychomotor skills often used in simulation.

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Standardized patients (SPs) have been incorporated into many settings to help participants engage in realistic simulations that often focus on developing communication and assessment skills. SPs are commonly defined as “a person who has been carefully coached to simulate an actual patient ... the body language, the physical findings, and the emotional and personality characteristics as well” (Lopreiato et al., 2016, p. 36). In the pediatric setting, there are essentially two patients that the nurse must care for: the child and the child's caregivers. Therefore, pediatric simulations should strive to include both the child and the caregivers. During curriculum planning, an effort was made to thread end-of-life (EOL) content throughout the entire nursing curriculum. As a result, pediatric nursing faculty members developed an interdisciplinary EOL

simulation as a part of a pediatric undergraduate nursing course in a baccalaureate program, and SPs portrayed the infant's parents. The purpose of this article is to describe the benefits of involving SPs in the simulation, how the characters were created, how SPs were trained, and how psychosocial needs were addressed. Issues about the fidelity of the simulation, the role of SP feedback during debriefing, and the importance of incorporating both psychomotor and communication skills into the simulation are also discussed.

Background

Nursing faculty members have stated that teaching nursing students about EOL care is essential (Jeffers, 2014). EOL simulations appear to be common in the adult health nursing setting (Fluharty et al., 2012; Smith-Stoner, 2009). A review of the literature found that EOL simulations were effective

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for knowledge acquisition, developing communication skills, and enhancing confidence; however, they were also costly to implement and required attention to the psychological safety of the participants (Gillan, Jeong, & Van der Riet, 2014).

Key points

- Standardized patients can effectively portray the parents of an infant at end of life.
- Standardized patients allow students to practice communication skills.
- Standardized patients may improve the fidelity of an end of life simulation.

Less information about pediatric EOL simulations has been described in the literature. Lindsay (2010) described carrying out a simulation involving an unexpected pediatric code and death as a part of a unit about pediatric resuscitation. Kenny, Cargil, Hamilton, and Sales (2016) developed a home-based pediatric palliative care simulation that was focused on communication methods using drama students as SPs to portray the patient.

Among practicing nurses, pediatric EOL simulations have been used to help health care teams improve communication with families (Youngblood, Zinkan, Tofil, & White, 2012).

Pediatric EOL simulations can fill a necessary gap in nursing curricula. It is well documented that many nursing programs struggle to find meaningful inpatient and outpatient pediatric experiences for students (Bultas, 2011; Kenny et al., 2016; Pauly-O'Neill, Prion, & Lambton, 2013). Although nursing students could encounter a pediatric EOL event during a clinical course, these events are fortunately uncommon. One study found that pediatric nursing students participated in critical events, such as respiratory or cardiac arrest, hypotension, allergic reaction, and seizures, significantly more often in the simulation setting than in the inpatient setting (Pauly-O'Neill et al., 2013). EOL simulations may help students be more prepared when they encounter these situations in their clinical practice.

Finally, it is well known that nursing students often find their pediatric clinical rotation stressful, and some students fear they will make mistakes with medication administration that could harm their pediatric patient (Oermann & Lukomski, 2001). Pediatric EOL situations are certainly stressful experiences, and a recent study suggested that high-fidelity simulations about pediatric assessment decreased students' anxiety levels (Megel et al., 2012). These findings from the literature generally supported the potential utility of a pediatric EOL simulation.

Overview of the Simulation

The simulation was developed primarily from the author's own experiences as a pediatric critical care nurse and was

formally validated with other pediatric nursing faculty, pediatric intensive care unit (PICU) physicians, chaplains, and the local organ donation nursing staff. Objectives were created to guide the students' preparation. During the simulation, senior-level nursing students cared for multiple patients: a two-month-old infant, who was depicted by a high-fidelity mannequin, and the infant's parents, portrayed by SPs.

Prior to coming to the simulation, students were assigned readings to prepare them for the experience and also completed several short-answer questions as their ticket to enter the simulation. The INACSL Standards of Best Practice: SimulationSM recommend that students be given materials to prepare for the simulation, so that they can achieve the objectives of the simulation (INACSL Standards Committee, 2016). The students were told that the baby in the simulation would not survive and that the primary objective of the simulation was to support the baby's family during EOL.

The scenario involved an infant who was left in the care of a nanny while the parents were at work. The nanny called emergency medical services and stated that the baby had slipped under the bathwater during a bath and stopped breathing. When emergency medical services arrived, the baby was apneic and pulseless. They resuscitated the baby, and the simulation began with the paramedic giving report to the emergency department team. While in the emergency department, the baby was hypothermic and bradycardic. The four-member team assessed the baby, performed cardiopulmonary resuscitation, started an IV line, administered one dose of epinephrine, and placed a Foley catheter. At this point, phase one of the simulation was complete and debriefing occurred. The team typically took 20 to 30 minutes to complete this first phase of the simulation, and debriefing lasted approximately 45 minutes.

The next phase of the simulation occurred 24 hours later in the PICU. In order to improve environmental fidelity, the room was set up to look like a PICU room with IV pumps, a ventilator, a headwall, invasive lines, and catheters. Cards from the family decorated the bed; stuffed animals and family pictures surrounded the baby. The off-going nursing report revealed to the students that the baby was actually a victim of shaken baby syndrome, that the nanny had been arrested, and that the baby had an initial brain death exam done already. The baby had severe cerebral edema, no spontaneous movement, fixed and dilated pupils, and no spontaneous respirations. She was intubated and received an epinephrine infusion for blood pressure and heart rate instability.

During this phase of the simulation, students interacted with two SPs who portrayed the baby's parents. A chaplain from the local hospital also participated in the simulation to be available to the SPs for spiritual and social support, a practice that has been demonstrated to improve students' knowledge about spiritual care (Fink, Linnard-Palmer, Ganley, Caolico, & Phillips, 2014). A brain death exam was repeated during the simulation. There was no change, and

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