Collaborative Practice Model

Improving the delivery of bad news

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The delivery of bad news can be challenging for any member of the healthcare team for many reasons, ranging from personal beliefs to feelings of inadequacy or blame (Bumb, Keefe, Miller, & Overcash, 2017). The term bad news conjures negative thoughts and feelings, and bad news is often distressing for oncology practitioners who deliver it every day.

Some research indicates that the delivery of bad news should be a collaborative process (Baile, Buckman, Schapira, & Parker, 2006; Bumb et al., 2017). However, confounding factors (e.g., perceptions of staff availability, role expectations, experience, training) may prevent team coordination. When bad news is delivered without provision of the key elements for support and advocacy, the results can be devastating to the patient and family, as well as to the healthcare team (Brown, Parker, Furber, & Thomas, 2011).

This article describes the development and implementation of a collaborative practice model (CPM) to promote the optimal delivery of bad news on an inpatient medical oncology unit. The authors address staff perceptions of daily practice prior to the CPM intervention, barriers identified in the delivery of bad news, and steps involved in the development and adoption of the CPM intervention.

Literature Review

Bad news may be defined as any information that negatively affects an individual’s perception or expectation for the future (Barclay, Blackhall, & Tulsy, 2007). The delivery of bad news has been discussed since Buckman (1984) coined the phrase breaking bad news. The original five-year literature search, from 2006–2010, of the MEDLINE®, CINAHL®, and PsycINFO® databases produced 358 articles from these terms: delivery, breaking, receiving, giving, or communicating bad news. Three themes were identified from the literature:

- Patient and family perceptions of how bad news was presented and its impact on care decisions
- Roles of the healthcare team in the delivery of bad news and their perceptions of patient and family responses
- Healthcare training simulations for the delivery of bad news

Patient Preferences

Patients and families want honest and direct communication when bad news is delivered; all options should be discussed, including no treatment (Dougherty, 2010). Families perceive that less suffering and pain and an overall better end-of-life experience occur when bad news communications are good (Bumb et al., 2017; Parker, Aaron, & Baile, 2009). When a mismatch exists between patient/family expectations and healthcare team communications, distrust and negative care outcomes are the result (Dougherty, 2010).

Best Practices

Training healthcare teams in the delivery of bad news varies greatly, depending
mostly on mentor experiences (Brown et al., 2011). When scenarios or simulations are used for delivery of bad news training, team members report increased accountability to the patient and to one another (Back, Arnold, Tulsky, Baile, & Fryer-Edwards, 2003). The six-step SPIKES protocol emphasizes six components in the process of delivering BN: setting, perception, invitation, knowledge, emotion, and summary (Baile et al., 2000). Fundamental to the SPIKES protocol is the concept that bad news is best received when it is delivered as a planned event. This ensures that essential members of the healthcare team and of the patient’s family are present, and that privacy, comfort, cultural considerations, and assistance with young children are provided (Bumb et al., 2017).

Effective team member communication styles include openness, responsiveness, acceptance, empathy, and honesty; it is important that team members are unhurried and show concern.

Optimal delivery of bad news occurs when all team members are prepared (Bumb et al., 2017). A predelivery planning meeting provides opportunities for the care nurse and the advanced practice nurse to communicate relevant patient and family information regarding healthcare directives, cultural influences, and family dynamics. The meeting promotes the nurse’s role as a patient advocate regarding treatment and end-of-life decisions (Eid, Petty, Hutchins, & Thompson, 2009). Such planning efforts facilitate staff’s arranging of patient care coverage during and after the event to provide adequate patient and family support (Penson, Kyriakou, Zuckerman, Chabner, & Lynch, 2006). Checklists have been developed to help teams systematically review components integral to the delivery of bad news (Baile et al., 2000).

**Conflicting Demands**

Many barriers to optimally delivering bad news have been reported. Physicians note that conflicting demands and interruptions, lack of experience, and feelings of failing the patient contribute to their being unavailable or providing a less optimal bad news meeting (Ben Natan, Shahar, & Garfinkel, 2009). Through surveys, physicians and nurses have identified that nurses are excluded from planning and executing the delivery of bad news as often as 50% of the time (Ben Natan et al., 2009). Barriers that preclude nurse involvement during the delivery of bad news include perceiving a lack of responsibility, feeling overwhelmed, and not feeling adequately prepared.

**FIGURE 1.**

**COLLABORATIVE PRACTICE MODEL FLOW CHART**

1. **Bad news identified**
   - Discuss in physician late-morning rounds.
2. **Is charge nurse present?**
   - Yes
     - Convey to care RN.
   - No
     - Physician attending and charge nurses meet to address bad news issues.
3. **Is a time and location finalized and family notified?**
   - No
     - Physician and care nurse coordinate time and notify family.
   - Yes
     - Charge and care RN coordinate coverage of patient care during meeting and reassessment.
4. **Physician and care nurse notify team members (social worker, clinical nurse specialist, patient resource manager, chaplain) as needed.**
5. **Brief meeting about goals by physician, RN, and others as needed.**
6. **Bad news meeting with patient and family, physician, RN, and others as identified.**
7. **Summary after meeting and next steps with physician, RN, and others as identified.**
8. **Care RN revisits with patient and family for reassessment, understanding, and questions.**
9. **Notify identified resource teams or place consultations.**
10. **Complete documentation checklist.**
11. **Report any concerns back to physician or appropriate personnel.**
of time, facing competing patient demands, and having insufficient coverage. Nurses also report feeling inadequately prepared to handle family emotions when providing needed support (Barclay et al., 2007).

Development of the Collaborative Practice Model Intervention

On the current authors’ 31-bed medical oncology unit, healthcare team members provide oncology treatment and symptom management for adults with solid tumor cancers, and they deliver bad news daily. Nursing work culture surveys have indicated poor nurse–physician communication. Subsequent staff meetings have identified that a lack of communication occurred during distressing bad news events. Consequently, the authors pursued optimization of bad news delivery by exploring staff perceptions, daily routines, and best practices. Sixty-two team members responsible for providing immediate care and support for unit patients participated in the surveys and in implementation of the CPM intervention. Institutional review board approval was obtained.

Intervention

A baseline interdisciplinary survey focusing on daily patterns of practice and perceived barriers to optimal delivery of bad news was performed (60 team members responded). In addition, a 12-member interdisciplinary work group was created; this consisted of key stakeholders (medical/nursing leadership, midlevel provider and clinical nurse specialist, staff nurses, chaplain, social worker, case manager). During a one-day retreat, members of the work group discussed best practices, reviewed baseline survey responses to address barriers and define bad news events, and identified workflow routines to develop the CPM intervention. The following barriers were identified:

- Failure of nurse participation
- Failure of provider to include the nurse
- Inadequate planning for bad news delivery time
- Inadequate coverage for participation of the nurse
- Failure to provide staff follow-up when unplanned bad news decisions occur

The work group defined bad news events for the unit as involving a patient receiving news of a new cancer diagnosis or a recurrence of cancer, or that no treatment options were available, that no response to treatment had been observed, or that hospice was being initiated. Integral to CPM development were discussions of daily roles and responsibilities; efforts were made to identify opportunities within the normal daily workflow to collaboratively deliver bad news. The authors provided a bad news scenario to illustrate the daily workflow of the healthcare team and describe how collaboration could occur when bad news was delivered. In addition, the work group addressed unit-based barriers by developing appropriate strategies. As the workflow diagram took shape (see Figure 1), members of the work group became energized and were champions for the CPM process, advocating for practice change.

Prior to CPM implementation, all healthcare team members received staff training on best practices for bad news delivery, key communication strategies for follow-up conversations with patients, and unit expectations in using the CPM; the model’s use was supported by medical and nursing leadership. Additional training was provided through role playing using the SPIKES protocol and empathetic communication strategies.

Implementation

During the first six months of implementation, members of the work group spoke directly with healthcare team members to discuss concerns or issues related to bad news delivery. These conversations, along with audits by charge nurses, showed that the CPM was used 85% of the time. Six-month
postimplementation surveys, distributed to healthcare team members working on the unit prior to implementation, indicated significant improvements (p < 0.001). Improvements were noted in the following areas for nurses and allied health professionals: participation in planning for bad news, receipt of staff support for patient care coverage, increased confidence in their communication skills to provide support to patients and families following bad news events, and inclusion in bad news events (see Figure 2). In addition, medical team improvements were observed in including the nurse in delivering bad news (p = 0.09) and in notifying the nurse about upcoming bad news events (p = 0.06) (see Figure 3). All healthcare staff indicated that they understood how to incorporate the delivery of bad news CPM into daily practice and used the model successfully (p < 0.05).

Structured interviews with staff suggested two themes: inclusion and support. Nurses were being sought out more for bad news events, feeling informed afterward if they were not present, and feeling valued within the team because more collaborative conversations were occurring throughout their daily practice. The medical team had a new awareness that nurses wanted to be included. The CPM intervention improved communication and teamwork, increased everyone’s ability to provide essential support for patients and families, and promoted feelings of being prepared for the delivery of bad news.

**Implications for Practice and Conclusion**

Implementation of new practices requires dedicated efforts, and the work group provided the energy and momentum needed to motivate staff toward successful unit adoption. Stakeholder involvement was essential because they thoughtfully considered implementation pros and cons while developing the model. Advanced practice nurses played key roles from formation of the work group, auditing, and role-modeling CPM use. For example, advanced practice nurses provided reminders of what constituted bad news events during care rounds and notified the charge or care nurse to initiate bad news planning.

An unanticipated barrier was learning that nurses felt unprepared to adequately support patients going through the crises that bad news events can evoke. Consistent with other reports, nurses often feel uncomfortable and unprepared and as though they lack the skills to effectively communicate with patients about bad news (Abbaszadeh et al., 2014). Because optimal delivery of bad news involves being aware of body language, portraying openness and inclusion, providing a therapeutic relationship, and being accountable (Barclay et al., 2007), the educational rollout included bad news simulations for staff to practice therapeutic communications in the delivery and aftermath of bad news.

The CPM is the product of interdisciplinary teamwork that affects patient-centered care via the optimal delivery of bad news. This study provides a unique contribution to the literature by describing the development and implementation of a model to improve the delivery of bad news using evidence-based practices. The CPM, now the standard of care, continues to be used in all clinical situations for the delivery of bad news. Delivery of bad news is discussed during new intern orientations, and all new staff undergo bad news scenarios to build communication skills during the onboarding period. Advanced practice nurses are key to the CPM’s sustainability. The CPM has been discussed across the health system and can be easily adapted to meet the unique needs of other clinical units for successful implementation.

**REFERENCES**


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