Education

Question
I am a chaplain who attended the Resolve Through Sharing training a year ago (which was wonderful!). We are interested in more universally educating our nursing staff on Resolve Through Sharing and, also, on our own policies, and thinking that we will do so through one of your DVDs. What do you recommend for a good foundation for our staff? Unfortunately, we will have approximately one hour to cover what we need to for the mandated training.

Answer
We created the DVD *Resolve Through Sharing Perinatal Bereavement Overview: Principles and Practice* (RTS item #9114) for that purpose.

The Perinatal Bereavement Overview is a narrated PowerPoint intended for staff who have not had the opportunity to attend RTS Bereavement Training: Perinatal Death; for those for whom you would like to provide a brief update; and as annual mandatory education. The speaker, Jill Wilke, emphasizes interprofessional care, creating memories, and honoring the parent/child relationship. After watching the DVD, staff will understand the principles and practice of the RTS model of perinatal bereavement care and have beginning competencies in delivering care. Go to this link to order: https://glbereavement.dcopy.net/category/dvd-library.

Some coordinators also purchase webinars to provide training to a group of people on the same subject. Our webinars are listed on our website at bereavementservices.org.

Question
I teach 3rd semester OB/Peds nursing students. Which DVDs do you think would be appropriate?

Answer
I would suggest either the Guided Participation DVD or the Supporting Angry Families DVD, both available for purchase on the RTS website (www.gundersenhealth.org/resolve-through-sharing). Guided Participation shows a nurse using this communication style that guides the family in deciding how they will address people who ask about their baby who has died. Two scenarios are played out to illustrate the impact of using guided participation. The Supporting Angry Families DVD talks about how anger is an emotion that can come from grief and how a nurse or member of the interdisciplinary team can support families in a variety of settings while they are angry. It explains the reasoning behind the anger and how to help diffuse the situation so that the family feels supported and cared for. I hope this helps. Let me know if you have any other questions.

Question
I was fortunate to attend one of your workshops in Denver several years ago. I have a question and wondered if you might be able to help. In your section of nonverbal communication (Chapter 2.82) you spoke about a study that showed that families did not remember a Chaplain visit unless the Chaplain sat and spoke to them at eye level. The Chaplains that remained standing during their pastoral visit were not remembered by the families. Do you have the information about that study by chance? Thank you so much for the wonderful work that you do!

Answer
Thank you for writing to us. We will add these citations to the next edition of the manual. I reached out to the two chaplains who are part of our RTS national faculty, Mark Hart and Darryl Owens, who knew these studies. First of all, they were done using physicians, but the results are similar to your summary. Here are the articles and their abstracts.

Effect of sitting vs. standing on perception of provider time at bedside: A pilot study
Kelli J. Swayden a, Karen K. Anderson b, Lynne M. Connelly c, Jennifer S. Moran d, Joan K. McMahona, Paul M. Arnold b,*

a. Department of Nursing, University of Kansas Hospital, Kansas City, USA
b. Department of Neurosurgery, University of Kansas Medical Center, Kansas City, USA
c. Department of Nursing, Benedictine College, Atchison, USA
d. Department of Nursing, University of Kansas Medical Center, Kansas City, USA
Patient Education and Counseling 86 (2012) 166–171

Keywords:
Provider–patient communication, physician behavior, patient satisfaction, patient care outcomes, quality improvement

Abstract
Objective: Patients commonly perceive that a provider has spent more time at their bedside when the provider sits rather than stands. This study provides empirical evidence for this perception.
Methods: We conducted a prospective, randomized, controlled study with 120 adult post-operative inpatients admitted for elective spine surgery. The actual lengths of the interactions were compared to patients' estimations of the time of those interactions.
Results: Patients perceived the provider as present at their bedside longer when he sat, even though the actual time the physician spent at the bedside did not change significantly whether he sat or stood. Patients with whom the physician sat reported a more positive interaction and a better understanding of their condition.

Conclusion: Simply sitting instead of standing at a patient's bedside can have a significant impact on patient satisfaction, patient compliance, and provider–patient rapport, all of which are known factors in decreased litigation, decreased lengths of stay, decreased costs, and improved clinical outcomes.
Practice implications: Any healthcare provider may have a positive effect on doctor–patient interaction by sitting as opposed to standing during a hospital follow-up visit.

Impact of Physician Sitting Versus Standing During Inpatient Oncology Consultations: Patients' Preference and Perception of Compassion and Duration. A Randomized Controlled Trial
Florian Strasser, MD, J. Lynn Palmer, PhD, Jie Willey, MSN, Loren Shen, BSN, Ki Shin, MD, Debra Sivesind, MSN, Estela Beale, MD, and Eduardo Bruera, MD, Department of Palliative Care and Rehabilitation Medicine (F.S., J.L.P., J.W., L.S., K.S., D.S, E.Br.) and Department of Neuro-Oncology (E.Be.), The University of Texas M. D. Anderson Cancer Center, Houston, Texas, USA

Key Words: Communication style, patient's preference, perception of physician's compassion

Abstract
The purpose of this study was to determine the impact of physician sitting versus standing on the patient's preference of physician communication style, and perception of compassion and consult duration. Sixty-nine patients were randomized to watch one of two videos in which the physician was standing and then sitting (video A) or sitting and then standing (video B) during an inpatient consultation. Both video sequences lasted 9.5 minutes. Thirty-five patients (51%) blindly preferred the sitting physician, 16 (23%) preferred the standing, and 18 (26%) had no preference. Patients perceived that their preferred physician was more compassionate and spent more time with the patient when compared with the other physician. There was a strong period effect favoring the second sequence within the video. The patients blinded choice of preference (P _ 0.003), perception of compassion (P _ 0.0016), and other attributes favored the second sequence seen in the video. The significant period effect suggests that patients prefer the second option presented, notwithstanding a stated preference for a sitting posture (55/68, 81%). Physicians should ask patients for their preference regarding physician sitting or standing as a way to enhance communication.
J Pain Symptom Manage 2005;29:489–497.

Question
A small hospital in our system wants information for their nurses to read or view when they are not busy, specifically information on how to better support families with early loss. What would you suggest they buy?

Answer
There are books on miscarriage, but I would recommend having several copies of two brochures from the RTS catalog available to the nurses: "Miscarriage" [RTS 4113-E] and "Learning you will miscarry" [RTS 4129E]. They could peruse these during their down time and increase their competence in knowing what to say and things to offer when the loss is early in pregnancy.

You may want to provide a copy of the following article and the continuing education section that follows it for additional resources. Limbo, R., Glasser, J. K, & Sundaram, M. E. (2014). Being sure: Women's experience with inevitable miscarriage. MCN, The American Journal of Maternal/Child Nursing, 39(3), 165-174. [CE: 175-176]. This research on dimensions of a woman's experience with inevitable miscarriage recently won the "Best Research Poster Award" at the 2014 annual AWHONN Convention. Conference participants were particularly interested in the clinical implications, which were taken from the article.

Encourage them to create "early loss bereavement packets" that include the early loss checklist (in the manual), Miscarriage, Caring for yourself after loss, and a baby ring. They could also include the Remembrance of Blessing. The frontispiece of Meaningful Moments: Ritual and Reflection When a Child Dies (by Rana Limbo and Kathie Kobler, 2013) features a powerful photo of what the parents called an "altar" in memory of the baby they miscarried. It's really a piece of art and a very special idea for families.

Question
I am a social worker and we just started a perinatal palliative care program. My role is actually the program director and I am looking for a training program to attend for myself and possibly team (i.e.

educator and RN specialist) as we can hopefully then return to the hospital and train more staff. I would appreciate any advice. I have heard numerous wonderful things about the trainings in La Crosse.

Answer
Thank you for contacting us! Here are a few steps that will serve you well in your planning.

First of all, I encourage you to purchase our perinatal palliative care toolkit that provides a foundational structure for a program.

Second, on our website is a PPC position paper that will provide a handout to your planners. Have you been in touch with Amy Kuebelbeck at perinatalhospice.org? Go to the website and join the listserve. The group is almost 300 strong, Amy does not bombard the members with too-frequent emails, and the resources on the site are tremendous.

There are two types of education that I hope you will consider: one of our core courses, RTS Bereavement Training: Perinatal Death which is offered in various locations throughout the year.

Kathie Kobler and I wrote an article for JPNN a few years ago on how to implement PPC services within an existing bereavement program. That, too, may provide some helpful ideas to you in your planning. See our publications.

I encourage you to find a family who has had a great experience with PPC who can advise, inspire and serve as a parent representative in your planning.

Should you wish to have a consultant for a day or so (or do a Web Ex consultation), our staff are available to walk you through various aspects of implementation (e.g., using the EHR). If you are interested in that service, please let us know at berservs@gundersenhealth.org or (800) 362-9567, ext. 54747. In addition, The Joint Commission offers an accreditation. However, if you use the resources I've described above; read the literature cited on perinatalhospice.org and in our position paper; implement the elements of the toolkit; and get connected with some of our RTS folks who are quite experienced in PPC (we can make some connections for you), I think you'll be ready to go. If you're interested, we also have a whitepaper on implementing RTS (any facet of the program).