Teaching Metacognitive Skills: Instructional design, video production & pedagogy

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End-of-Life Essentials eLearning

- Modules & quality resources on end-of-life care for doctors, nurses and allied health professionals who work in acute hospitals

- Developed from Australian Commission on Safety and Quality in Health Care - *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*

5 IMPORTANT ELEMENTS
IN YOUR
END-OF-LIFE CARE SKILLS

COMMUNICATION

RECOGNISING DYING

NEGOTIATING GOALS OF CARE

ACT IF THINGS AREN'T GOING WELL

EFFECTIVE TEAMWORK

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Outline of presentation

- Background to the pedagogy
- Underlying assumptions to learning
    - Cognitive task analysis methods
    - Metacognitive skills
- Instructional design – critical self-reflection, knowledge translation & collection of impressions for growth and learning
- Making thinking skills explicit – eLearning, scriptwriting and video production

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Background to pedagogy

Underlying assumption

- Our targeted learners were already integrating end-of-life care into practice

  ➢ Build on knowledge

- End-of-life care / communication at the end of life is complex, difficult to practice, and often emotionally taxing for health care teams.

Background to pedagogy

<u>Key to learning</u> - giving patients agency

<u>Limits of project</u> – scope, pitch

<u>Importance of language</u> – palliative care, <u>end-of-life care</u>, dying – keep to the terminology of the Commission

<u>Dying in acute settings</u>

- Hours, days, or weeks

- 12 months

| End-of-life care[4] | Includes physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff. It also includes support of families and carers, and care of the patient's body after their death.

People are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and co-existing conditions that mean that they are expected to die within 12 months
- existing conditions, if they are at risk of dying from a sudden acute crisis in their condition
- life-threatening acute conditions caused by sudden catastrophic events. |

4. General Medical Council. *Treatment and care towards the end of life: good practice in decision making*.

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Background to the pedagogy

Knowing the range of various learners and abilities in health professional learners

- Advocates

- Specialists and interventionalists

- Powerless or institutionalised

- Isolated and overwhelmed

- Disengaged and disenfranchised

- Rogues

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Who are our target learners?

Advocates
- Doctors, Nurses, MET's, Allied Health providers and Palliative Care specialists advocating for and talking about dying and End of Life care
- Actively engaged in E-O-L activities & education
- Happy to champion cause and influence others

Specialists & Interventionists
- Senior Doctors, MET's
- Extremely time poor
- Limited end of life training
- Powerful and connected within own specialty but does not take holistic perspective to patient diagnosis
- Experts at fixing ill health & saving lives
- Not programmed to deal with dying (not core business).
- Just keep treating patients to prolong life

Powerless or Institutionalised
- Senior nurses, Unit Managers & Experienced Allied Health staff
- Witnessed chaos in system
- Time Poor & not always well connected to medical colleagues
- Limited E-O-L education
- Advocating for patient & families but feels powerless to affect patient treatment
- Challenged by doctors & system
- Can feel isolated and disempowered from recognising dying or getting access to decision makers
- Often experience moral distress because they cannot influence care or death

Isolated & Overwhelmed
- Early Career Doctors, junior nurses and allied health practitioners
- Time Poor & still learning on job
- Limited experience in E-O-L education
- Working long hours on coal face without support in dealing with dying patients but often called to do so
- Frightened of failure
- Little guidance after hours & often unsure of what to do
- Reluctant or fearful to call senior doctors or decision makers
- Follows rules & protocols and will call in MET when in doubt.

Disengaged or Disenfranchised
- Senior Doctors, Nurses and Allied Health practitioners
- Limited E-O-L education
- Feel reluctant to act due to past mistakes or experiences
- Time poor so focus on saving lives not dying
- Easier to continue treatment than talk about dying
- Can operate in silo's, within own specialty and not engaged with multidisciplinary teams
- Attitude is to provide health care not end-of-life care.

Rogues
- Senior Doctors, Nurses & MET
- Limited experience or no interest in E-O-L education & training
- "My way or no way" attitude to diagnosis & treatment
- Well connected and powerful in their specialist role
- Time poor but highly engaged in area of specialty through conferences, papers etc
- Only focus is to fix ill health or issues related to their specialty
- Failure is not an option
- Avoids families and refuses to have conversations about dying (not their job).

Cognitive task analysis methods[1] - the pitch

- The concepts of 'novice' and 'able' (or expert) were used in various ways to promote learner reflection on their own thinking

- Concurrent reporting – reflections and answers

- Critical decision methods – experts identify a way in which they solve problems

1. Clark RC, Mayer RE. *e-Learning and the Science of Instruction*, Wiley, 2011.

ABLE

VERSUS

NOVICE

which one are you?

Empowers patients to direct own care	**Mainly focuses on health professional decision making**
Recognises when patients could be approaching end of life	**Tendency to see all ill health as a fixable biomedical problem**
Sees end-of-life care as urgent	**Doesn't always see signs or patterns of end-of-life care**
Able to have courageous conversations about dying	**Still learning about end-of-life conversations**

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Stepwise approach to instruction

Because of the varied baseline knowledge and skills of learners - **what is not known**

- Quizzes

- Self-reflective questions

- Targeted learning based on adult learning principles

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Metacognitive questions behind the design

Learner to reflect on:

➢ Their current practice

➢ Is this getting them anywhere?

➢ Why that approach?

➢ What other approaches could be considered?

➢ Recognising when to use different approaches

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Teaching metacognition skills – making expert thinking explicit

- Understand **what is not known**

- Displayed expert thinking

  - ➢ On screen through text

  - ➢ Consideration of alternative responses

  - ➢ Giving a rationale for responses

  - ➢ Responses to avoid

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Teaching metacognition skills – making expert thinking explicit

- Evaluation of a professional task

- Concurrently or retrospectively asking learners to record their thoughts at the same time they are responding/solving a problem

- Structured expert interview

- Making the education as interactive as possible

What will happen to me - Nurse
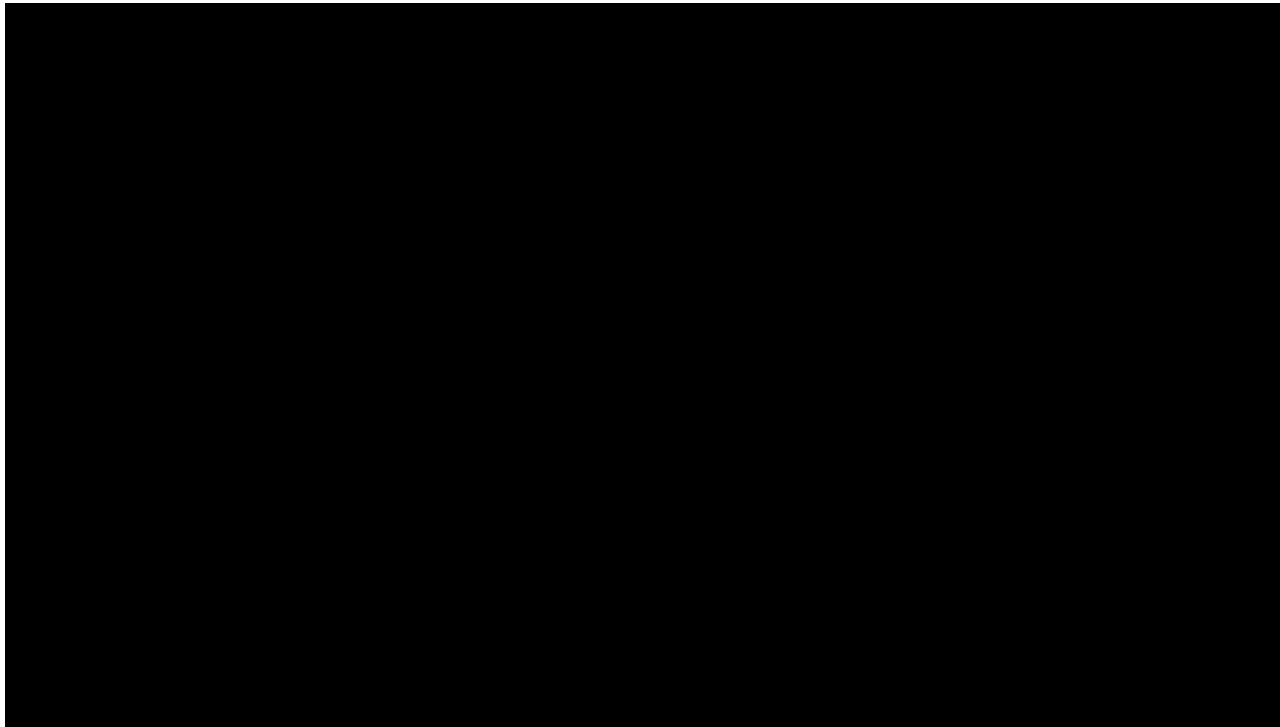
Making expert thinking explicit

- Scriptwriting – incorporating novice and expert responses

- Actor (expert) speaking to the learner, making known their inner thoughts

- Rewind, reframe and consider how the the response could be improved

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Feedback from our learners

- *"I feel since completing the eLearning I am more confident in approaching end of life subjects with patients and their families."*

- *"The eLearning has given me some valuable tools that I will reflect on and utilise."*

- *"The knowledge that I gained from doing the eLearning course for end of life will assist me when looking after patients at end of life."*

- *"I already recognised those patients approaching end of life, for me communication strategies that the modules taught were more valuable."*

- *"I am now more confident when researching information around end of life."*

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www.caresearch.com.au/EndofLifeEssentials

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