

EMMANUEL COLLEGE

Morally Resilient Pediatric Nurses' and Nurse Practitioners' Experiences in Providing Curative to Comfort Care

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Preparing Practice-Ready Nurses for End-of-Life and Comfort-Focused Care

ELNEC Webinar November 4, 2026

Strategies and Tools Used by Pediatric Nurses and Nurse Practitioners in Guiding Families From Curative to Comfort Care

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Background/Introduction: The timeframe from delivery of critical care and the transition to comfort care for the dying child can occur over minutes, days, weeks, or months. During this transition from curative to comfort care, nurses can play an active role in the management of vulnerable dying children and their families.
Objectives/Aims: The aims of this study were (1) to explore the actions, communication techniques, and interventions utilized by morally resilient registered nurses (RNs) and nurse practitioners (NPs) as they guide families through the transition from curative to comfort care and (2) to understand how pediatric intensive care RNs and NPs utilize strategies such as self-awareness and self-regulation to remain morally resilient providers.
Methods: RNs and NPs from 4 neonatal/pediatric intensive care units completed the Rushton Moral Resiliency Scale (RMRS) to assess moral resiliency. Nurses with an RMRS ≥3 were invited to participate in a Zoom interview to discuss their strategies of caring for patients and families they helped transition from curative to comfort care and for remaining morally resilient.
Results: Twenty-one RNs and NPs completed the RMRS. Seven RNs and 13 NPs participated in interviews lasting between 22 minutes 56 seconds and 65 minutes 6 seconds. The 6 RN themes were curative to comfort care transition toolbox, communication facilitators and barriers, advocacy, model of care, patient- and parent-focused comfort care activities, and morally resilient facilitators and barriers. The 4 NP themes were curative to comfort care transition toolbox, role definition, cultivating resiliency, and organizational structures influence care delivery.
Discussion/Conclusions: Findings from this research may assist RNs and NPs in identifying strategies they can implement to facilitate the transition from curative to comfort care for the benefit of patients and families, while remaining morally resilient providers.

Keywords: Comfort care; Critical care; Intensive care; Moral resiliency; Neonatal; Nurse practitioners; Nurses; Pediatric

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Problem Formulation

An abundance of literature exists describing the experiences of providers (nurses, nurse practitioners [NPs], and physicians) who care for dying children (neonates, infants, and children).[1-3] Research on nurses' experiences reveals their role as one of advocacy, building relationships, establishing a caring environment, creating opportunities, establishing memories, and involving families in preparing for death.[4-7] Studies examining the experiences of providers also illuminate difficulties in this care, such as discomfort moving from curative to comfort care and moral distress.[2,8-10] Factors shown to influence how well a nurse performs in caring for a dying child

Understanding the Role of Pediatric Nurses and Nurse Practitioners as they Guide Families from Curative to Comfort Care

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Background/Introduction

- The timeframe from delivery of critical care and the transition to comfort care for the dying child can occur over minutes, days, weeks, or months
- During this transition from curative to comfort care, nurses can play an active role in the management of vulnerable dying children and their families

Objectives/Aims

1. Explore the actions, communication techniques, and interventions utilized by morally resilient registered nurses (RNs) and nurse practitioners (NPs) as they guide families through the transition from curative to comfort care
2. Understand how pediatric intensive care RNs and NPs utilize strategies such as self-awareness and self-regulation to remain morally resilient providers

Methods

- RNs and NPs from four neonatal/pediatric intensive care units completed the Rushton Moral Resiliency Scale™ (RMRS) to assess moral resiliency
- Nurses with an RMRS =/> 3, were invited to participate in a Zoom interview to discuss their strategies of caring for patients and families they helped transition from curative to comfort care and for remaining morally resilient

Results

- **7 RNs and 13 NPs were interviewed**
- **data saturation was reached**
- **The 6 RN themes were: Curative to Comfort Care Transition Toolbox, Communication Facilitators and Barriers, Advocacy, Model of Care, Patient and Parent Focused Comfort Care Activities, Morally Resilient Facilitators and Barriers**
- **The 4 NP themes were Curative to Comfort Care Transition Toolbox, Role Definition, Cultivating Resiliency, and Organizational Structures Influence Care Delivery**

RN and NP Theme	Quotes
Curative to Comfort Care Transition Toolbox • Personal • Clinical • Situational • Emotional/Spiritual	RN Personal: "I feel like my experience, my personal experience, but also my professional experience has created a place for me to be pretty successful in these situations (015)." NP Personal: "But I think you learn through the years…you know you just learn through the years what works for you and your mechanisms that you can establish that you feel you can be there. You can provide the care, you're there for the nurses, you're willing to talk with the family and be there for them. You need to find a way for yourself that works, and that takes, that takes years really, I think, to establish you know a long time. It's not something you learn right away. A lot of years, a lot of family meetings, a lot of team meetings, a lot of learning about yourself…before you can really feel some degree of comfort with the moving through the process (006)."
RN Themes	
Communication Facilitators and Barriers	"I just remember every day coming in, and she just wasn't recovering, and [I] just started by trying to talk to them about like, where do you see this going."
Advocacy	"This meeting is your opportunity to say what you need to say, and if you can't say it, if you give me permission to say it for you, I'm more than happy to do that."
Model of Care	"We're there with them (patients) day in and day out rather than just splitting in for 20 min."
Patient and Parent Focused Comfort Care Activities	"Some parents really want to participate in the bath afterwards, and they really want to be able to like dress their baby. Where others absolutely don't want to participate in the bath."
Morally Resilient Facilitators and Barriers	"I can compartmentalize it and do what I need to do in that situation. For me like, exercise is a huge outlet and coping mechanism."
NP Themes	
Role Definition	"I feel like my role is more often to just function as a conduit between various consulting services that are involved and keeping them informed about what's going on, and that sort of thing, and I don't know, I don't feel my role is really that much, very much connected with the family, only because we are doing sort of these other things."
Cultivating Resiliency	"You know our biggest supports are colleagues… whether you have been an NP for a year or 30 years, we rely on each other, we run things by each other, we talk to each other about it whether it's a medical thing or a social thing. It's sort of like a little sacred group that we have, and that we can rely on each other."
Organizational Structures Influence Care Delivery	"The supports and the … the compassion and follow up, I think, are exemplary here. So, I think I've been able to grow in that because of my environment."

Discussion/Conclusions

- Findings may assist RNs and NPs in identifying strategies to facilitate the transition from curative to comfort care
- Key personal attributes and skill sets necessary for the provision of a good death are identified and can be used to guide the education of RNs

Acknowledgments

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References

Boston Children's Hospital Cardiovascular, Critical Care, and Perioperative Services

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End of Life Communication Tips

Words to say that are HELPFUL

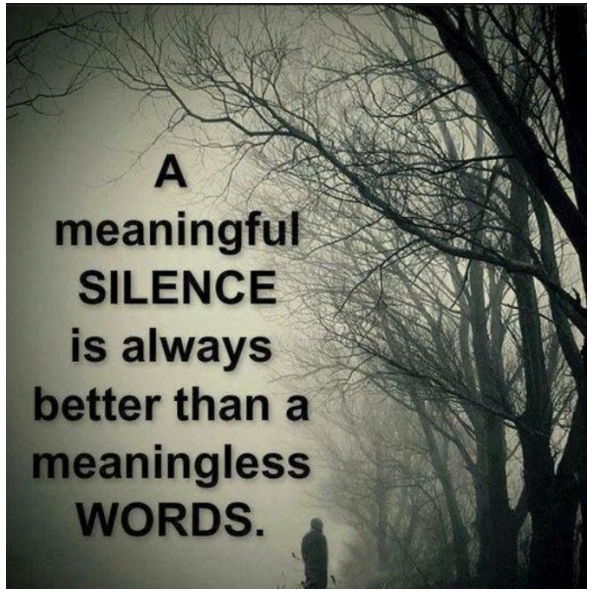
- “What is this like for you?”
- “Tell me about {use person’s name}” or “What I remember most about {use person’s name} is…”
- “I wish you didn’t have to go through this painful process.”
- “How are you coping?”
- “It's okay to grieve and feel many different emotions.”
- “Grieving takes time. Don't feel pushed to hurry through it.”

Words that are NOT HELPFUL

- **“I know/can imagine/understand how you feel.”**
- **“[Higher power] needed your loved one,” or “It was [Higher power’s] plan.”**
- **“You shouldn’t feel that way,” or “You’ll get over it.”**
- “You should be over it by now. It’s time you moved on.”
- “At least you have your other children.”
- “You had so many years together. You are so lucky.”
- “You’re young, you’ll meet someone else/you can have more children.”
- “At least your loved one’s suffering is over, and he/she/they are in a better place now.”
- “Your loved one lived a really long and full life.”

What do grieving families want?

- Care honoring the patient’s wishes
- Compassionate care for the patient
- Acknowledgement of the value of the patient’s life and their relationships
- To be included in decision-making
- Support, assistance, and practical help (e.g., someone to assist with household tasks)
- Honest conversation with accurate information
- To be listened to, including by healthcare professionals
- Education about coping, grief, and death
- Follow-up support



Facilitating Communication

Clinical Observation as an Entry Point

Learners are taught to initiate conversations by grounding discussions in objective patient assessment findings, including:

- Observable signs of decline (e.g., changes in skin color, increased pallor, mottling)
- Level of consciousness and responsiveness
- Pain indicators (verbal and nonverbal cues)
- Functional status and overall quality of life
- This approach supports a gradual, clinically anchored transition into goals-of-care discussions, reducing abrupt or distressing communication shifts for families.

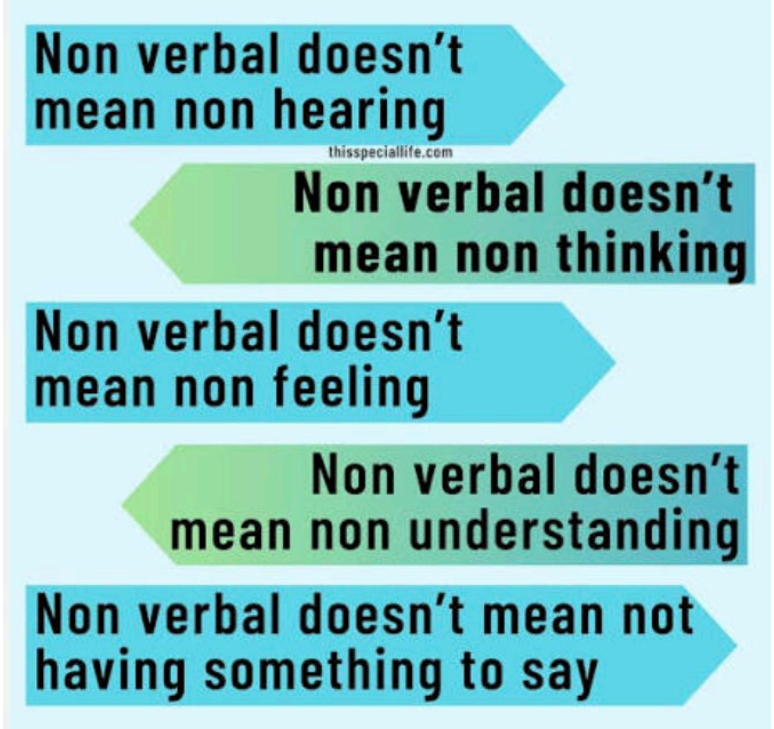


Facilitating Communication in End-of-Life Care

Use of Verbal Communication Skills

Clear and compassionate language is essential when discussing prognosis, goals of care, and comfort-focused treatment. Effective strategies include:

- Using simple, non-technical language
- Avoiding medical jargon and euphemisms
- Pausing frequently to allow processing time
- Checking for understanding using teach-back techniques
- Acknowledging emotion before providing additional information



Intentional Non-Verbal Communication

Non-verbal behaviors often communicate more than spoken words in EOL situations. Key strategies include:

- Therapeutic presence and sitting at eye level with family members
- Sustained eye contact to demonstrate attentiveness and empathy
- Open body posture and calm tone of voice
- Use of silence to allow reflection and emotional expression

Barriers to Effective Communication in End-of-Life Care

Emotional Burden and Family Readiness

Families often process grief in real time, which may affect comprehension and decision-making. Educators emphasize that:

- Families may experience denial, anger, or guilt
- Understanding may be impaired during high-stress moments
- Decisions made in these conversations often have long-term emotional impact
- Simulation scenarios help learners practice responding to strong emotional reactions while maintaining therapeutic presence.

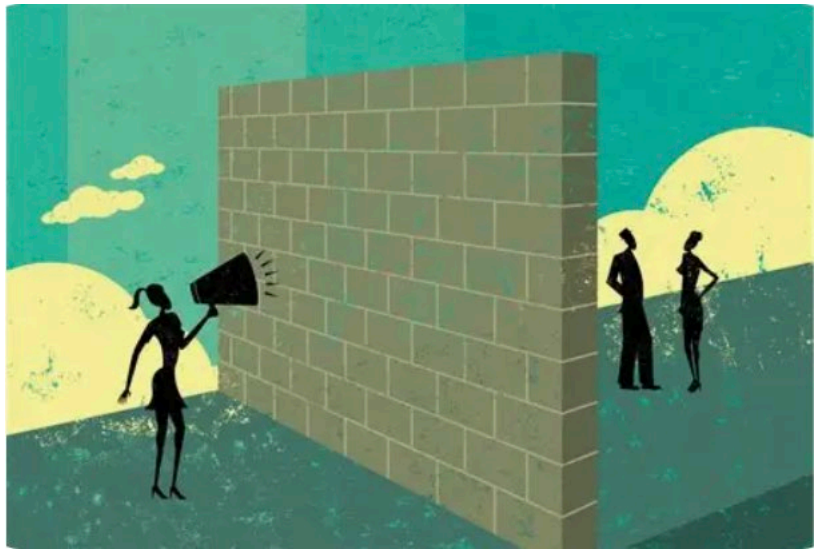
Best practices include:

- **Use of professional medical interpreters**
- **Avoiding reliance on family members as translators**
- **Asking culturally sensitive, open-ended questions about values and preferences**
- **Respecting diverse definitions of "quality of life"**

Cultural and Language Differences

Cultural values significantly influence perceptions of illness, death, and decision-making. Communication barriers may include:

- Differing expectations regarding disclosure of prognosis
- Varied beliefs about life-sustaining treatment
- Language differences affecting comprehension and consent



Advocacy in End-of-Life Care

Advocacy in end-of-life care focuses on protecting patient dignity, honoring expressed wishes, and supporting families through complex decision-making. Nurses serve as consistent advocates during the transition from curative to comfort-focused care.

Nurse as Advocate

- Defends patient and family wishes in care planning
- Supports transition from curative treatment to comfort care
- Identifies misalignment between treatment plans and goals of care



Facilitating the Transition to Comfort Care

- Reinforces goals focused on comfort, dignity, and symptom relief
- Supports family understanding of prognosis and care options
- Helps reframe “cure” to quality of life and peaceful dying

Voice of the Patient and Family

- Clarifies complex medical
- Coordinates palliative, hospice, and support services
- Promotes comfort, dignity, privacy, and family presence
- Ensures symptom management remains a priority

Patient & Family Focused Comfort Care

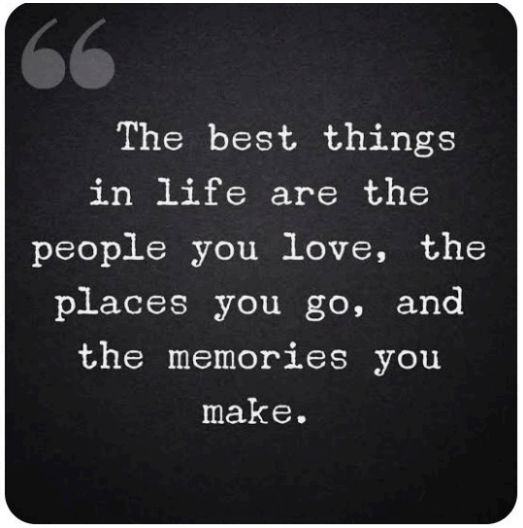
Facilitate discussions focused on quality of life, values, and goals of care

- Support expression of emotions, conflict, grief, and suffering
- Integrate meaningful experiences

  (e.g., outdoor/garden time, pet visits)
- Engage hospice and supportive services early in care planning
- Collaborate with interdisciplinary teams to honor patient and family wishes
- Memory making







Model of Care: Primary Nursing Approach

Nurses serve as a consistent presence at the bedside throughout the end-of-life trajectory, providing continuity, trust, and coordinated support for patients and families

Primary Nursing Model

- Ensures continuity of care through consistent nurse–patient relationships
- Builds trust and supports open communication during vulnerable end-of-life transitions
- Promotes holistic, patient- and family-centered decision-making
- Facilitates coordination of care across disciplines
- Supports timely recognition and communication of changes in patient condition
- Guides families through goals-of-care discussions
- This model reinforces the nurse's role as a constant advocate, communicator, and stabilizing presence during end-of-life care.

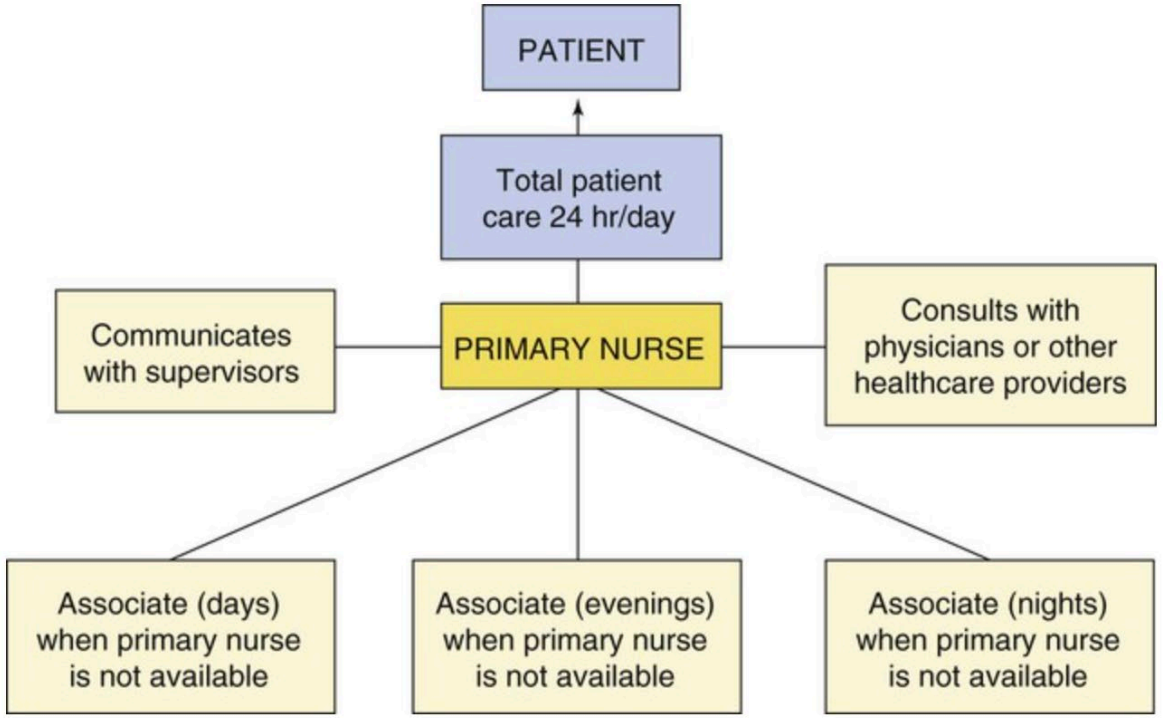


FIGURE 13-5 Primary nursing.

Moral Resilience Facilitators & Barriers

Common Challenges

- Loss of long-term patients
- Maintaining therapeutic patient relationships
- Family conflict or disagreement in goals of care
- Rapid or unexpected patient decline
- Moral Distress
- Moral Residue



Support Strategies

- **Maintain professional boundaries while preserving empathy**
- **Engage in self-care and healthy emotional processing**
- **Utilize peer support and structure debriefing after end-of-life events**

End-of-Life Toolbox with Simulation Training

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Communication: Facilitators & Barriers

Ease into difficult conversations by:

Observing patient condition (pain, color, alertness, quality of life)

Use both:

Verbal communication
(clear, compassionate explanations)
Non-verbal communication
(presence, eye contact, body language)

Recognize:

Families will live with these decisions long-term

Address:

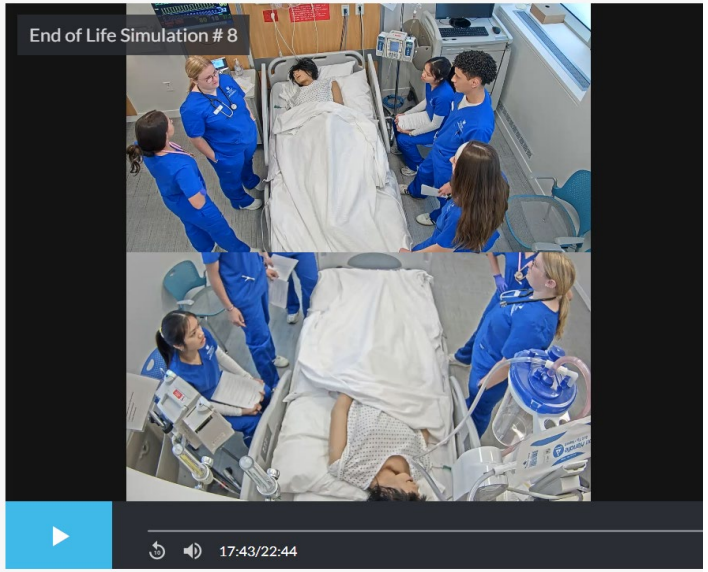
Language and cultural barriers to ensure understanding

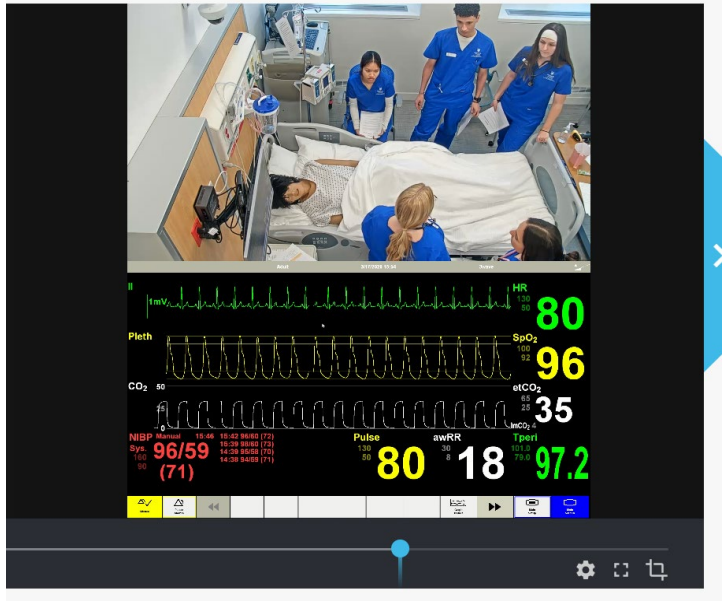
Advocacy

Act as a **defender** for both patient and family
Support transition from **curative to comfort care**

Serve as the **voice** of the patient and family by:

- Clarifying medical information
- Coordinating consult services
- Promoting comfort, dignity, and privacy





Patient & Family-Focused Comfort Care

Encourage conversations about:

- Quality of life
- Feelings, conflicts, and suffering
- Coordinate meaningful activities such as:
  - Outdoor/garden visits
  - Pet visits
  - Day passes
- Hospice involvement
- Collaborate with interdisciplinary teams to meet family wishes

Moral Resilience: Facilitators & Barriers Challenges

- Loss of long-term patients
- Family disagreements
- Sudden patient decline

Support Strategies:

- Maintain professional boundaries
- Practice self-care and emotional compartmentalization
- Seek peer support and debriefing opportunities

Model of Care

- Nurses are a constant presence at the bedside
- **Primary Nursing Model**:
  - Builds trust and continuity
  - Helps guide and support care transitions

PREPARING PRACTICE-READY NURSES: TRANSFORMING END-OF-LIFE EDUCATION THROUGH COMPETENCY-BASED LEARNING

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UAB The University of Alabama at Birmingham

School of Nursing

OBJECTIVES



DESCRIBE
the importance of
end-of-life education in
undergraduate nursing.

OBJECTIVES



EXPLAIN
the integration of competency-based learning across semesters.

OBJECTIVES



IDENTIFY
strategies to promote competency development in end-of-life care.

OBJECTIVES

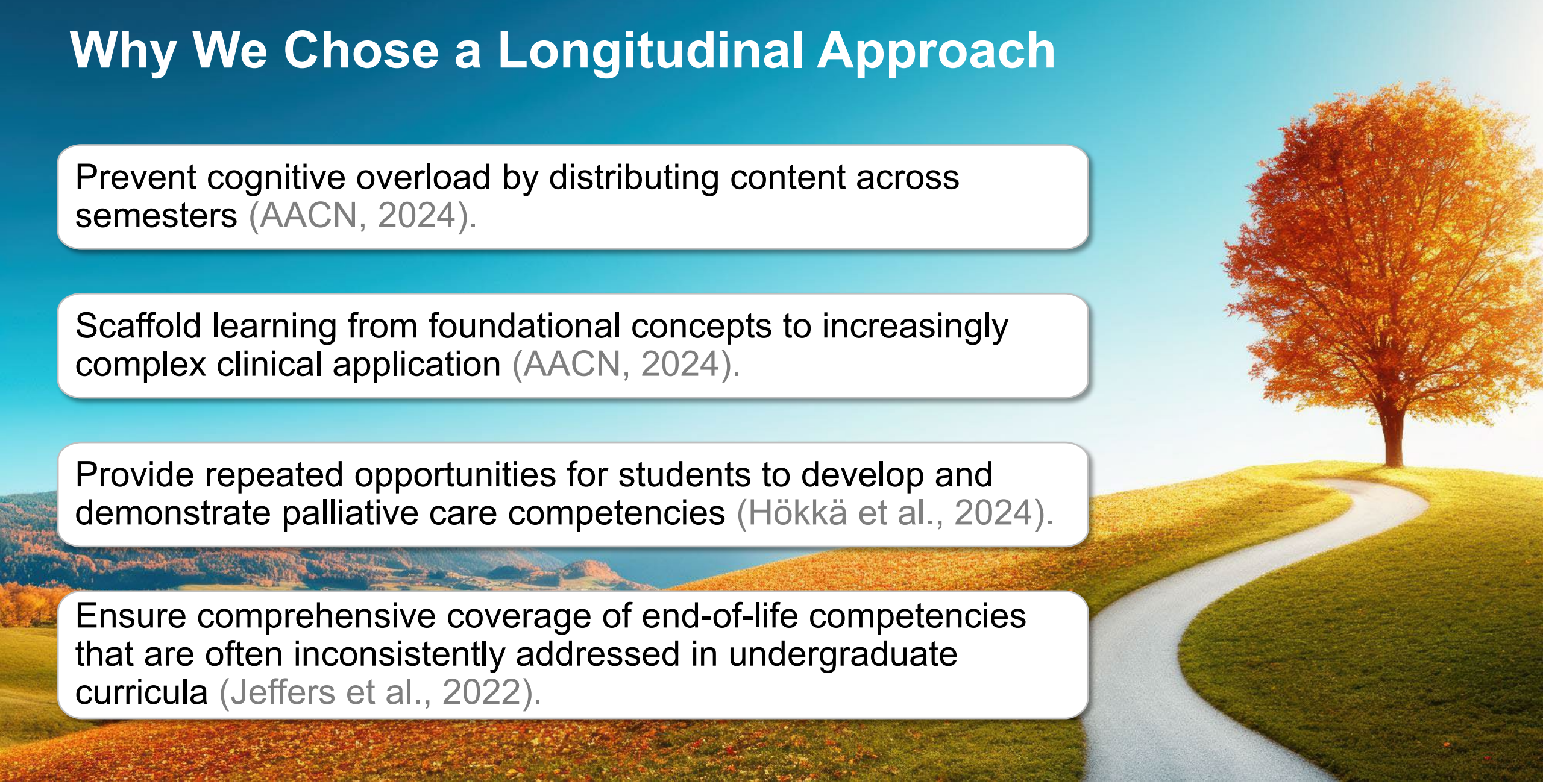


DISCUSS
approaches to evaluating student competency.

Why This Matters

- **A critical gap in nursing education:** End-of-life care is often underrepresented in BSN curricula (Jeffers et al., 2022).
- **A common part of nursing practice:** Nurses across specialties care for patients and families experiencing serious illness, dying, and loss (American Association of Colleges of Nursing [AACN], n.d.).
- **Preparation builds confidence:** Students need opportunities to develop the knowledge, skills, and communication needed to provide compassionate end-of-life care (Cross et al., 2024).
- **Competency takes practice:** Longitudinal learning helps students build and apply these competencies throughout the nursing program (Cross et al., 2024).
- **Better preparation, better care:** Equipping future nurses to support patients and families promotes compassionate, person-centered care (AACN, n.d.).

Why We Chose a Longitudinal Approach



Prevent cognitive overload by distributing content across semesters (AACN, 2024).

Scaffold learning from foundational concepts to increasingly complex clinical application (AACN, 2024).

Provide repeated opportunities for students to develop and demonstrate palliative care competencies (Hökkä et al., 2024).

Ensure comprehensive coverage of end-of-life competencies that are often inconsistently addressed in undergraduate curricula (Jeffers et al., 2022).

Backward Curriculum Design Framework

1 STAGE 1: DESIRED RESULTS

What should students be able to do?



END-OF-LIFE COMPETENCIES

- Compassionate communication
- Goal-concordant care
- Ethical decision-making
- Family-centered care
- Nurse self-awareness

2 STAGE 2: EVIDENCE OF LEARNING

How will we know students can do it?



AUTHENTIC EVIDENCE

- Mini-CEX (clinical evaluation)
- OSCE / Simulation performance
- Reflective writing
- FATCOD-B (attitudes)
- Rubrics aligned to competencies

3 STAGE 3: LEARNING EXPERIENCES & INSTRUCTION

What learning experiences will prepare students?



INTENTIONAL LEARNING ACTIVITIES

- Case-based discussion
- Expanded EOL concepts (5 → 8)
- Simulation with family dynamics
- Structured debrief
- Self-reflection & nurse self-care
- Scaffolded across the semester

CONTINUOUS FEEDBACK & CURRICULUM REFINEMENT
Data-informed improvement

Semester Overview



- Foundations of Palliative Care and Communication
- Grief and Loss

- Ethical Decision Making
- Advanced Directives

- Person-Centered Care During End-of-Life

- End-of-Life Decision-Making
- System Navigation
- Postmortem Simulation

- Primary Palliative Integration & Quality Improvement

Competency Alignment across the Curriculum

All 15 CARES competencies are introduced, reinforced, applied, and assessed across five semesters through a longitudinal competency-based approach.

Semester	CARES Competencies (AACN, 2024)	AACN Essentials (AACN, 2021)	
1 **Introduce**	1, 3, 4, 5, 14, 15	**Domain 2:** Person-Centered Care **Domain 9:** Professionalism	**Domain 10:** Personal, Professional & Leadership Development
2 **Practice**	6, 7, 8	**Domain 2**: Person-Centered Care **Domain 6:** Interprofessional Partnerships	**Domain 9:** Professionalism
3 **Apply**	6, 7, 8, 10-12	**Domain 2:** Person-Centered Care **Domain 6:** Interprofessional Partnerships	**Domain 8:** Informatics & Healthcare Technologies **Domain 9:** Professionalism
4 **Integrate**	7, 8, 9, 13, 14, 15	**Domain 2:** Person-Centered Care **Domain 6:** Interprofessional Partnerships **Domain 8:** Informatics & Healthcare Technologies	**Domain 9:** Professionalism **Domain 10:** Professional Development
5 **Transition to Practice**	2, 5, 6, 7, 8, 14, 15	**Domain 3:** Population Health **Domain 7:** Systems-Based Practice **Domain 8:** Informatics & Healthcare Technologies	**Domain 9:** Professionalism **Domain 10:** Professional Development

First Semester

Topics

- Foundations of Palliative Care and Communication
- Grief and Loss

Focus (given in lecture format)

- Types of grief
- Responses to an individual experiencing grief and loss
- Individual response to grief and loss
- Nurse caring for self, clients, families experiencing grief and loss
- Hospice and palliative care



Activities

- Need for palliative care at diagnosis and Offering Hope case studies
- Defining Hope video vignettes promoting discussion afterwards
  (American Nurses Foundation, n.d.)

Second Semester

Topics

- Ethical Decision Making
- Advanced Directives

Focus (given in lecture format)

- Ethical Principles
- Goals of care
- Interprofessional collaboration
- Legal forms
- Policy basics

Activities

- Ethical principles case study
- Discussion questions about code status and withdrawal of care embedded in lecture
- Students practice goals of care discussion in a role play scenario
- OSCE at end of class where students practice identifying ethical principles, clarifying goals of care, communicating with patient family, giving an SBAR report, and documenting a goals-of-care note

Third Semester

Topics

- Person-Centered Care During End-of-Life

Focus (given in lecture format)

- Pharmacology at EOL
- Management of comfort & symptoms
- Prioritization
- Escalation/consult triggers
- Family engagement in planning

Activities

- ELNEC videos with patient in pain and family translator and interpreter
- Compare and contrast the differences
- Case studies with groups with classroom debrief
- Practice therapeutic communication with family members and patients
- Utilize an SBAR to escalate care

Fourth Semester

Topics

- End-of-Life Decision-Making
- System Navigation
- Postmortem Simulation

Focus (split between lecture format and simulation):

- Types of grief
- Responses to an individual experiencing grief and loss
- Individual response to grief and loss
- Nurse caring for self, clients, families experiencing grief and loss
- Hospice and palliative care

Activities

- Interactive Sherpath course assignments
- Palliative care, hospice, and organ donation knowledge evaluation via course exam
- Simulation with postmortem care skill, integrating therapeutic communication with family. Debrief to allow students to decompress the emotions involved with activity



Fifth Semester

Topics

- Transition to Practice: Primary Palliative Integration & Quality Improvement

Focus

- Population health & equity in EOL access
- Cost/utilization
- Informatics & documentation quality
- Bereavement follow-up

Activities

- Group project with population health and equity topics related to end-of-life care in which students will:
- Develop a care plan
- Outline how they would promote therapeutic communication with the patient and family
- Document end-of-life care in the patient's chart
- Undergraduate Nursing Palliative Care Knowledge Survey (UNPCKS 2.0) (Davis et al., 2020) to test student knowledge of palliative care after implementation across the curriculum

Evaluating Student Competency



Knowledge

- Course examinations
- UNPCKS 2.0 assessment



Skills Integration

- Case study analysis
- Ethical decision-making activities



Communication

- Goals-of-care role play
- OSCE performance



Clinical Judgement

- End-of-life and postmortem care simulation



Documentation

- Goals-of-care note
- End-of-life charting assignment

Program Evaluation and Outcomes Assessment

Current Evaluation

- Frommelt Attitude Toward Care of the Dying, Form B (FATCOD-B) to assess student attitudes toward caring for patients at end of life (Molinengo et al., 2022).

Planned Evaluation Strategies

- Administer the Undergraduate Nursing Palliative Care Knowledge Survey (UNPCKS 2.0) to measure knowledge acquisition.
- Evaluate communication and clinical decision-making through OSCE performance.
- Assess competency demonstration during simulation and debriefing activities.
- Evaluate quality of goals-of-care documentation and care planning assignments.
- Explore longitudinal tracking of competency development across semesters.

Future Goal

- Develop a comprehensive evaluation framework that measures the longitudinal development of knowledge, skills, attitudes, and competency across the curriculum.

QUESTIONS?

Contact us!

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PREPARING PRACTICE-READY NURSES: TRANSFORMING END-OF-LIFE EDUCATION THROUGH COMPETENCY-BASED LEARNING

Elizabeth Byrd, PhD, RN; Ashley McMath, DNP, RN, CNE,
Cassandra Cobb, DNP, CRNP, FNP-C

Scan for **REFERENCES**

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SIMULATION -BASED PEDAGOGY · ADVANCE CARE PLANNING

Using Simulation to Teach Culturally Humble POLST Completion in Baccalaureate Nursing Students

Preparing practice-ready nurses to guide POLST completion and end-of-life conversations with confidence and cultural humility

Carole Kulik, DNP, RN, ACNP, HCIC
San Francisco State University School of Nursing

The preparation gap

Clinical need

POLST translates patient goals into actionable medical orders, yet new graduates report low confidence initiating these conversations.

Curricular gap

POLST content is rarely paired with structured practice in culturally humble communication across race, religion, language and family decision - making.

Cultural humility

A lifelong process of self - reflection, redressing power imbalances and honoring the patient as expert in their own life.

Aim: build knowledge, comfort and cultural humility in facilitating POLST conversations with diverse standardized patients.

Simulation design

1 · PREBRIEF

Cultural humility framing and a psychological safety contract

2 · SP ENCOUNTER

Rotating cases: interpreter use, family hierarchy conflict, religious objection to intubation

3 · POLST COMPLETION

Students draft orders in real time using teach-back

4 · DEBRIEF

GRIID model plus a structured bias check-in

Single-group pre/post mixed-methods pilot · N = 64 senior BSN students across three cohorts · grounded in Campinha-Bacote's Process of Cultural Competemility and Jeffries' Simulation Theory

Results: all three domains improved

Mean score (0 –100)	Pre	Post	Change
POLST knowledge	58	89	+31
Self-efficacy in goals-of-care conversations	51	84	+33
Cultural humility	62	80	+18

Paired t-tests, $p < .01$. Largest gain: self-efficacy for initiating goals-of-care conversations.

What students told us

“ I didn’ t know what I didn’ t know”

Blind spots about family decision - making norms

Naming my own discomfort

Anxiety about “getting it wrong” with unfamiliar traditions

Slowing down to listen

Interpreter use reframed as a relationship tool, not a delay

The bias check-in normalized discomfort as data for growth rather than a deficit to hide.

Implications and next steps

For nursing education

- Build cultural humility into ACP simulation objectives from the start
- Rotate diverse SP cases each cohort
- Pair every debrief with a structured bias-reflection prompt

Limits and future work

- Single site, no comparison group, self-report measures
- Multi-site randomized trial with graduate follow-up
- Interprofessional simulation with social work and chaplaincy

Validating

How do you keep standardized patient cases from becoming stereotypes?

- Cultural consultants shaped each case and trained SPs in a 4-hour workshop
- Faculty piloted and revised scenarios for authenticity
- Cases rotate each cohort, so no single narrative dominates

What would a validated measure of cultural humility add?

- Stronger evidence than our self-report scores alone
- A credible outcome for a multi-site randomized trial
- A clearer link to practice behaviors after graduation

A brief, structured simulation can build POLST skill and the reflective stance that culturally safe end-of-life conversations require.

Questions and discussion

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