End-of-Life Toolbox with Simulation Training

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Facilitating Communication

1. 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.

2. 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**

3. 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**

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

Barriers to Effective Communication

1. 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.

2. 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

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”

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.**

End-of-Life Toolbox Skill Set

➢ **Personal**
Reflect on prior end-of-life experiences to build self-awareness, resilience and readiness for emotionally complex care

➢ **Clinical**
Observe, model, and apply expert end-of-life communication and symptom-focused nursing practices

➢ **Situational**
Advocate for patient and family-centered goals, values, and informed end-of-life decision-making

➢ **Emotional/Spiritual**
Assess and respond to emotional, cultural, and spiritual needs through presence, support, and appropriate referrals

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.

1. 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**

2. 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**

3. 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**

Moral Resilience: Facilitators & Barriers

Common Challenges

- Loss of long-term of 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

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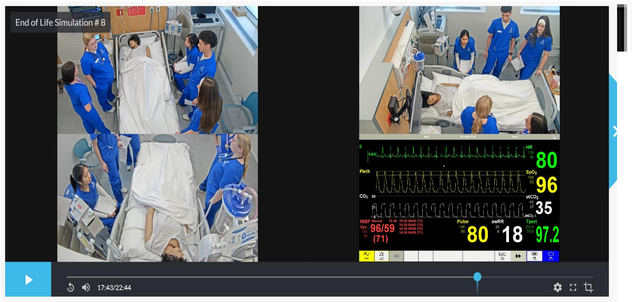

Simulation Scenario

- Stage IV metastatic breast cancer (BRCA mutation) without advance directives
- Junior BSN students assumed nurse and family roles
- Focus on goals-of-care discussions, emotional dynamics, and end-of-life decision-making

Learning Outcomes

- **Applied communication, advocacy, and ethical decision-making in end-of-life care**
- Strengthened clinical judgment in recognizing patient decline and prioritizing comfort
- Navigated complex family dynamics and anticipatory grief responses
- Reinforced patient- and family-centered care principles in a high-fidelity simulation setting

Debriefing Focus

- Clinical judgment and prioritization of comfort care
- Moral resilience in end-of-life decision-making
- Therapeutic communication in emotionally charged situations
- Reflection on the nurse’s role in advocacy, dignity, and holistic care

Simulation in End-of-Life Education

Within simulation-based end-of-life education, learners are guided to:

- **Recognize subtle clinical cues that prompt end-of-life conversations**
- **Develop confidence initiating goals-of-care discussions**
- **Integrate verbal and non-verbal communication techniques**
- **Respond effectively to emotional family dynamics**
- **Deliver culturally responsive and equitable communication**
- **Practice advocacy during emotionally charged decisions**
- **Communicate care transitions clearly and compassionately**
- **Coordinate interdisciplinary end-of-life resources**
- **Reinforce dignity-centered care at end-of-life**

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ENHANCING END-OF-LIFE COMMUNICATION COMPETENCY
THROUGH BACKWARD DESIGN AND INTENTIONAL LEARNING ACTIVITIES

Design with the end in mind to prepare compassionate, competent nurses for real-world end-of-life care.

BACKGROUND

- EOL care is a core nursing responsibility
- Students report discomfort with EOL communication
- Traditional approaches emphasize tasks over competency
- Clinical exposure to EOL conversations is inconsistent

PURPOSE

Apply backward design and competency-based education to align outcomes, assessment, and learning activities that prepare students for real-world end-of-life practice.

DESIGN BASIS

Align AACN Essentials and ELNEC CARES competencies to ensure intentional, competency-driven education.

BACKWARD CURRICULUM DESIGN FRAMEWORK

A 3-Stage Process That Drives the Curriculum

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

FOCUS: LEARNING ACTIVITIES THAT BUILD COMPETENCY

1. FOUNDATION	2. APPLY & ANALYZE	3. PRACTICE	4. DEBRIEF & REFLECT	5. DEMONSTRATE COMPETENCE
Expanded core EOL concepts (5 → 8)	Case-based discussions & role play	Simulation with standardized patients & families	Guided debrief using structured framework	Performance evaluation (OSCE / Mini-CEX)
Build knowledge and understanding	Analyze real-world scenarios	Practice communication, empathy, and decision-making	Promote insight, self-awareness, and growth	Demonstrate integrated competency

Student-centered | Competency-based | Emotionally responsive | Aligned to real-world practice

EVALUATION

Pre/post assessment using FATCOD-B

OUTCOMES

- ✓ FATCOD-B improved in 5/9 outcomes
- ✓ Increased student confidence
- ✓ Enhanced emotional preparedness
- ✓ Greater insight into family-centered care

IMPLICATIONS

- ✓ Supports deeper engagement with emotional EOL care
- ✓ Moves education from skills → competency
- ✓ Scalable and transferable model

Backward design transforms education from task-based learning by aligning outcomes, assessment, and learning activities with the realities of clinical nursing practice.

Begin with the end in mind

Align AACN Essentials & ELNEC CARES

Prepare students for real-world EOL practice

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AI-Supported Simulations in Hospice & Palliative Care Training

Enhancing Clinician Communication Skills for Hard Conversations with Older Adults

Angela Flemmer, DNP, AGNP, RN, CNE

Project Overview

An AI-driven simulation series built using School AI for the Older Adult course. Replicates emotionally complex scenarios to help learners practice empathy, active listening, and values-based dialogue. Each module uses the appropriate level of AACN Essentials to guide the conversation.

Each module includes:

- Purpose
- Learning Objectives
- Scenario Setup
- AI Prompts
- Learner Task
- Assessment Focus
- Debrief Questions

Five Simulation Modules

1. **Goals of Care with an Older Adult with Advanced illness:** Build foundational skills for initiating and navigating goals-of-care conversations.
2. **Family Conflict** around Hospice enrollment: Navigating disagreements around hospice enrollment
3. **Cognitive Decline with limited insight:** Limited patient insight and decision capacity due to dementia diagnosis
4. **Cultural Values:** Honoring cultural context in decision-making
5. **Existential Suffering:** Emotional distress and meaning-making with a terminal cancer diagnosis

ELNEC poster submission Summer 2026.docx

student.schoolai.com/join?code=PZ9F-VP4N

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EAST TENNESSEE STATE UNIVERSITY

Outcomes

- Consistent case fidelity
- Scalable access
- Individualized feedback
- Reduced faculty burden
- Improved learner confidence
- Clarity in explaining hospice
- Comfort with emotional cues

Key Takeaways

- AI simulations offer a scalable, consistent, and emotionally safe environment for practicing difficult clinical conversations.
- Learners gain confidence without risk to real patients or families.
- Reduces reliance on standardized patients and faculty availability.
- Early evaluation metrics show measurable improvement in communication competency.

Palliative and End-of-Life Care Education in Undergraduate, Pre-Licensure Nursing Program Curriculums: The Lived Experience of Students

Whitney Hicks PhD, RN

UNC GREENSBORO
School *of* Nursing

Background

- Palliative and EOL care education is inconsistent
- Education can improve quality of care provided

Study Purpose

- Explore student experience with palliative and EOL education and if they feel it prepared them to provide care

Sample and Setting

- One private University in NC with BSN and ABSN program

Methods

- Qualitative
- Interviews, Observations in the Clinical Setting, and Journal Entries

Participants

- 12 senior-level nursing students enrolled in BSN or ABSN program

Results

- 5 themes
- 6 participants felt prepared to provide palliative and EOL care, 6 did not

Conclusions

- Consider placement of education in programs
- Seek more practice opportunities
- Develop programs and resources to support students following difficult events

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

A Simulation-Based Pedagogy for Advance Care Planning Communication Across Diverse Patient Populations

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San Francisco State University School of Nursing, Baccalaureate Program - End of Life Course

1 Background & Significance

Provider Orders for Life-Sustaining Treatment (POLST) form translates patient goals into actionable medical orders, yet new graduate nurses often report low confidence initiating these conversations.

Standardized curricula rarely pair POLST content with structured practice in culturally humble communication, leaving students to navigate differences in race, religion, language, and family decision-making structure without a rehearsed framework.

Cultural Humility is a lifelong process of self-reflection, redressing power imbalances, and honoring the patient as expert in their own life; is distinct from cultural competence and is well suited to simulation-based rehearsal.

2 Purpose & Aims

Design and evaluate a high-fidelity simulation to build baccalaureate students' knowledge, comfort, and cultural humility in facilitating POLST conversations with diverse standardized patients.

- Increase student knowledge of POLST scope, sections, and legal standing
- Improve self-reported comfort initiating goals-of-care conversations
- Strengthen cultural humility using a validated self-assessment measure
- Gather student reflections on bias, positionality, and communication gaps

3 Theoretical Framework

Grounded in Campinha-Bacote's Process of Cultural Competemility and Jeffries' Simulation Theory: experiential rehearsal plus guided reflection builds both technical skill and reflective stance simultaneously, rather than sequencing knowledge then attitude.

Curricular Alignment

Maps to AACN Essentials domains on person-centered care and diversity, equity, and inclusion, and satisfies gerontology course objectives on advance care planning and end-of-life communication. ELNEC curriculum.

4 Design & Methods

Design: Single-group, pre/post mixed-methods pilot embedded in a senior-level gerontology course.

Setting: University clinical simulation center; standardized patient (SP) program.

N = 64 senior BSN students, three cohorts.

Simulation Scenario Flow

1. **Prebrief**
   Cultural humility framing; psychological safety contract
2. **SP Encounter**
   Rotating cases: language interpreter use, family hierarchy conflict, religious objection to intubation
3. **POLST Completion**
   Student drafts orders in real time using teach-back
4. **Debrief**
   Facilitated reflection using the GRIID model plus a structured bias check-in

Measures: POLST Knowledge Quiz (12 items); Self-Efficacy in Goals-of-Care Conversations Scale (0–100); Cultural Humility Assessment Scale; open-ended debrief reflections (thematic analysis).

Fidelity & Resources

SPs trained through a 4-hour case-specific workshop with cultural consultants; scenarios piloted with faculty and revised for authenticity prior to data collection.

Limitations

Single-site, single-group pre/post design without a comparison group; self-report measures; results not yet linked to clinical practice behavior post-graduation.

5 Results

All three domains improved from pre- to post-simulation (paired t-tests, 01); largest gain observed in self-efficacy for initiating goals-of-care ersations.

Qualitative Themes

"I didn't know what I didn't know"

Students named prior blind spots around family decision-making norms

Interpreter use reframed as a relationship tool, not a delay

Slowing down to listen

Naming my own discomfort

Debrief surfaced anxiety about "getting it wrong" with unfamiliar traditions

6 Discussion

Findings suggest a brief, structured simulation can move both technical POLST skill and the reflective stance central to cultural humility in a single learning encounter. The scenario's built-in bias check-in appeared to normalize discomfort as data for growth rather than a deficit to hide.

7 Implications for Education

Embed culturally humble communication explicitly into advance-care-planning simulation objectives, not as an add-on

Use diverse SP casting deliberately, rotating cases each cohort to avoid a single stereotyped narrative

Pair every debrief with a structured bias-reflection prompt, not open reflection alone

Scale to interprofessional simulation with social work and chaplaincy learners

8 Conclusion

Simulation is a feasible, effective vehicle for teaching baccalaureate students to complete POLST forms while practicing the humility that culturally safe end-of-life conversations require.

Future Directions

multi-site randomized trial with a comparison group and a follow-up survey of graduates' clinical practice behaviors.

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Development and Evaluation of a Theory-Based End-of-Life Simulation to Enhance Palliative Care Competence and Knowledge Among Prelicensure Baccalaureate Nursing Students

BINGHAMTON UNIVERSITY | DECKER COLLEGE OF NURSING AND HEALTH SCIENCES

Elizabeth Lesko, MSN, RN, CHPN, PhD Student

Background

- Increasing demand for PEOL care services (aging population, increasing chronic/serious illness)
- Limited opportunities for students to engage in experiential PEOL educational opportunities
- Simulation provides a safe learning environment
- Evaluate and strengthen a current EOL undergraduate simulation (initiated 2023)
- Address and incorporate recent NYS legislation regarding MAiD

Significance: Improving palliative care education
- Enhancing student competence and confidence
- Improve communication with patients/families
- Promote delivery of compassionate, patient-centered EOL care
- Address expectations for AACN's spheres of care

Purpose

To develop and evaluate a theory-based EOL educational simulation to enhance palliative care knowledge and perceived competence among prelicensure baccalaureate nursing students

Framework

1. Imogene King's Dynamic Interacting Systems Framework & Theory of Goal Attainment
- Perception
- Communication
- Interaction
- Transaction/Mutual Goal Attainment

2. NLN Jeffries Simulation Theory
- Structured framework for designing, implementing, and evaluating simulations.
- Promotes learner engagement, reflection, and experiential learning.
- Emphasizes clear objectives, fidelity, and active debriefing for knowledge integration.
- Encourages evaluation of outcomes across cognitive, psychomotor, and affective domains.
- Supports safe, evidence-based practice through repeated skill application.
- Aligns well with theories of adult learning and clinical reasoning.

3. Integrating the theories
- King's focus on communication, perception, and mutual goal setting aligns with Jeffries' learner–faculty interaction model.
- Both emphasize collaboration—King in nurse–patient transactions, Jeffries in facilitator–learner engagement.
- Integration provides both theoretical (King) and methodological (Jeffries) rigor for simulation design.
- King guides relational and ethical aspects of end-of-life dialogue; Jeffries ensures structured, evidence-based learning.
- Together, they foster reflective practice, empathy, and competence in serious illness communication.

4. Adherence to INASCL best practice simulation guidelines

Methods

Research Questions: Does participation in an EOL simulation improve palliative care knowledge? Does participation in an EOL simulation improve perceived competence in providing EOL care?

Design: Quasi-experimental pretest-posttest study

Setting: Undergraduate nursing program at a public university in New York State

Participants: Traditional prelicensure baccalaureate senior year nursing students ~ 115

Intervention: Assigned ELNEC Modules 1-6 prior to prebrief; structured pre briefing; high-fidelity EOL simulation with standardized family member interaction; debriefing & reflection

Measures: Demographic information; Undergraduate Nursing Palliative Care Knowledge Survey (UNPCKS 2.0); CARES Perceived Competence Measure 2.0; Collected demographic info

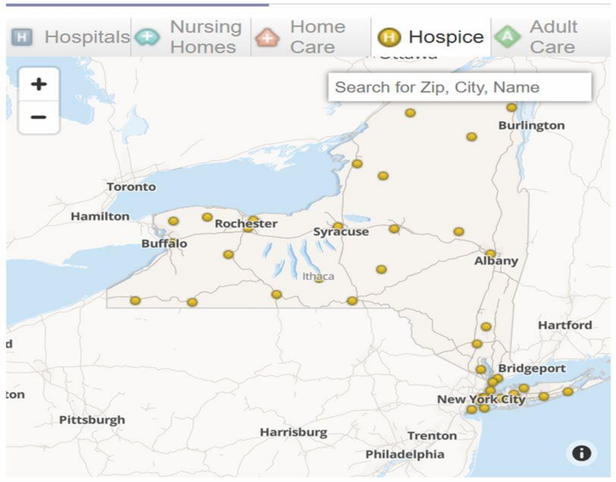
Expected Outcomes

Students will demonstrate:
- Increased palliative care knowledge
- Improved confidence and competence in caring for dying patients
- Enhanced communication skills with patients/families
- Greater preparedness for professional nursing practice

Significance

Implications for Nursing Education:
- Provides an evidence-based model for EOL simulation instruction
- Supports integration of palliative care education in undergraduate curricula
- Potential expansion of study to other nursing student cohorts (accelerated students, RN to BSN on-line curriculum, masters and DNP programs)
- Aligns with AACN Essentials (2021) and NCP (2018) palliative care competencies
- Includes assigned ELNEC modules
- Preparing future nurses to deliver improved EOL care

New York State Specific Issues:
- Historically low hospice utilization: increased education may help mitigate this issue and lead to earlier PEOL discussions
- Recent passage of MAiD (effective August 5, 2026): nursing students need education on current legislation



Location of the 39 hospices in NYS – note rural vs urban
(currently only 2 for-profits)

References

Poster Abbreviations

SCAN ME

Poster References

SCAN ME

Evaluating Nursing Student Responses to Hospice Simulation Across Contrasting Care Environments

Brooke Maleszewski, AGPCNP-c, DNP, MSN, RN & Sara Fairclough MSN, RN
Undergraduate Department of Nursing

Purpose:

Primary: Evaluate hospice simulation effectiveness using SET-M Survey

Secondary: Compare responses across two campuses with different simulation environments.

"It made me feel more comfortable in caring for a patient who is ready to try a different way of care."

Background:

-End of life care is limited in clinical setting; students have increased anxiety/fear; Sim is a safe space

-Assessed via SET-M a validated learning outcomes instrument

-Meets AACN Hospice/Palliative/ Supportive Care Sphere; Promotes competency-based learning

Results in Progress: Set-M data being reviewed. Findings will identify strengths/opportunities

References upon request

Methods:

Design: -Seniors completed 3 sims: routine visit, death visit, homecare; complete pre work, pre brief, post brief; complete voluntary survey

-Retrospective review of SET-M data from Fall 2024, Spring/Fall 2025, and Spring 2026

N = approx. 300 survey results

"I feel this simulation gave me good practice for therapeutic communication with patients and their families."

WASHINGTON STATE UNIVERSITY
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Building Confidence in Palliative and End-of-Life Care Through Early ELNEC Integration in Undergraduate Nursing Education

Bonnie Sarkinen, MN, ARNP, FNP-C, CNE

PURPOSE

- To evaluate early ELNEC integration on first-semester BSN students' confidence providing palliative and end-of-life (EOL) care.

BACKGROUND & RATIONALE

- A Fall 2025 needs assessment identified limited and inconsistent palliative and end-of-life (EOL) content across the WSU PL-BSN curriculum.
- No simulation-based palliative or EOL learning experiences were identified.
- AACN Essentials identify hospice, palliative, and supportive care as a key sphere of nursing practice.
- Early ELNEC integration addresses this curriculum gap and supports development of compassionate, patient-centered, practice-ready nurses.

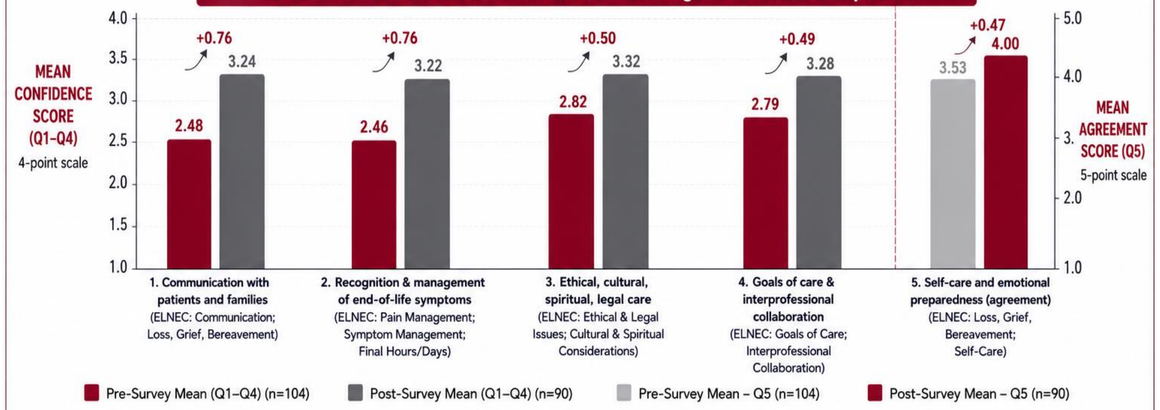
METHODS

- Students in N316 Intro to Nursing Theory course completed ELNEC Undergraduate/New Graduate Modules 1, 3, 4, 5, and 6, addressing introduction to palliative care, pain management, symptom management, loss/grief/bereavement, and final hours of life. Module 2 was excluded as therapeutic communication was already incorporated elsewhere in the course.
- ELNEC content was reinforced through a palliative care graphic narrative reflection, small-group and class discussions, a functional and palliative assessment case study using the KATZ Index and Palliative Performance Scale (PPS), and a hospice guest speaker presentation.
- A Qualtrics pre/post survey measured student confidence in five domains: communication, symptom recognition and management, ethical/cultural/spiritual care, interprofessional collaboration, and self-care.
- An open-ended post-survey question explored areas in which students felt more confident after completing the ELNEC modules.

STUDENT SELF-REPORTED CONFIDENCE BEFORE AND AFTER ELNEC MODULES

Q1–Q4 measured on a 4-point confidence scale (1 = Not confident at all; 4 = Confident with support available).
Q5 measured on a 5-point Likert agreement scale (1 = Strongly disagree; 5 = Strongly agree).

Confidence increased across all five domains following ELNEC module completion.



QUALITATIVE POST-SURVEY FINDINGS

Students were asked: "Identify one area of end-of-life care in which you feel more confident after completing the ELNEC modules." (N = 90 responses)

Top Themes

- **Communication with patients and families** (n=34, 38%) *"Therapeutic communication," "Having hard converstations"*
- **Recognition and management of end-of-life symptoms** (n=30, 33%) *"Recognizing signs and symptoms," "Managing pain and dyspnea"*
- **Supporting families through grief and bereavement** (n=16, 18%) *"Supporting families," "Understanding the grieving process"*

Additional responses included: ethical decision-making, cultural/spiritual considerations, and self-care strategies.

KEY TAKEAWAY

Students reported higher confidence across all competencies after completing ELNEC modules.

The greatest improvements were in **communication** (+0.76) and **end-of-life symptom management** (+0.76).

Agreement with **self-care and emotional preparedness** also improved (+0.47 on the 5-point scale).

NOTES

- Q1–Q4 measured using a 4-point confidence scale (1 = Not confident at all; 4 = Confident with support available).
- Q5 measured using a 5-point Likert agreement scale (1 = Strongly disagree; 5 = Strongly agree).
- Lower standard deviations post-survey across all domains indicate greater consistency in student responses.
- Pre-survey n = 104; Post-survey n = 90.

OUTCOME & IMPLICATIONS

- Early integration of ELNEC modules improved first-semester nursing students' confidence in foundational palliative and EOL care competencies.
- Students reported greater readiness to communicate with patients and families, recognize EOL symptoms, and provide compassionate, patient-centered care.
- Findings support introducing palliative and EOL care education early in nursing curricula and reinforcing learning through experiential activities.

NEXT STEPS

- Incorporate all 6 ELNEC Undergraduate/New Graduate modules into N316 beginning Fall 2026.
- Expand ELNEC integration throughout the PL- BSN curriculum.
- Develop simulation-based learning experiences (single-event and unfolding simulations) focused on palliative and EOL care.
- Evaluate future cohorts using validated measures of palliative care confidence, knowledge, and competency.
- Add objective competency assessment through simulation rubrics, case-based evaluation, or OSCE-style activities.

REFERENCES

- Scan QR code for reference list and supplemental materials

Bringing End-Of-Life Care to Every Student

NUR 305 – Healthy Aging and Chronic Care Management

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Teaching Chronic Care in Northeastern Wisconsin

NUR 305 covers chronic illness in our concept-based curriculum and is the core of our universities end-of-life care curriculum. In the first week of the semester, the cohort is divided into groups of four students, with each group assigned a patient with a chronic illness such as chronic renal failure, congestive heart failure or bipolar II disorder. These groups will follow the patient as an unfolding case study throughout the semester, building a case-management style care plan with eight sections including ***Resources, Safety, Medications, Cardiovascular/Respiratory, Nutrition, GI/GU, Musculoskeletal/Integumentary and Psychosocial/Spiritual***.

In the first weeks, each group is responsible for building a short slide show presentation on the disease process, treatment regimens, patient's current situation and eventual prognosis. These slide shows are then presented to the class throughout the semester, tying into the appropriate concepts as they come in the course schedule. As UWGB is a rural-access school, each of these patients are given a home in a small rural community, usually without easily accessible healthcare, transportation or other resources.

Interdisciplinary Guest Speakers

In the first weeks, the students meet an **RN Educator** from the **ADRC** (Aging and Disability Resource Center) presenting on the basics of Medicare and Medicaid, including parts **A, B, C and D** and how each works and how they work together.

During the concept of **Safety, *Falls Free Wisconsin*** provides several virtual speakers including a Community Health Educator, Pharmacist, Geriatric Nurse Practitioner, Physical Therapist and DME Vendor. The following class session is shared by ***Green Bay Metro Fire*** discussing home safety and ***Community Paramedics*** and an **APS** (Adult Protective Services) ***Social Work Investigator***, discussing abuse situations and steps Wisconsin nurses should take when they see possible cases.

In the final weeks of the class, we welcome a ***Hospice Chaplain*** to the classroom to discuss End-of-Life Care, communication, and what it means to simply be present. It is at this time that the students are provided an update on their case studies; their patients' conditions have declined, and all have now been admitted to a hospice program.

The last day of the semester, a different type of guest(s) attends the class. This is either a chronic disease patient or a surviving family member(s) of a patient. This gives the students a connection to chronic care and end-of-life care and is always received as the most important interaction of the year.

The Hospice and Palliative Concepts

On that last day of classes and after the discussion with the family, the students find out that there assigned patients have died. The students simulate pronouncing the death of their patient within our HER and the assignment to be completed as a "Ticket From Class" is the completion of the Wisconsin **Notice of Removal of a Corpse** Form. Comments regarding this assignment include:

"Caring for Virginia over the past semester has made her passing feel deeply personal, and pronouncing her death is an experience I won't forget. I became so invested in her and cared so deeply for her after having her as my patient for the past three months."
"Although Stephen's death was expected, as he was recently put on hospice care, it is still odd to not be able to care for him at the bedside anymore."
"Now, after Lois' passing, I cannot help but wonder whether we could have done more, or whether we did too much."
"I feel sad, but not helpless. The goal was never to avoid death; the goal was to reduce suffering and honor her choices."
"I have spent the whole semester getting to know my patient not just medically, but with a social relationship. After this initial sock of my patient being pronounced dead, my next thoughts are if my patient passed the way that she wanted to pass on to another life."

In Class Activities

Just after students are assigned to their teams for the semester, these teams are split with two members going to opposite sides of the lecture hall. Two of the students are given a bag of Lego-style building pieces, the other two students have the instructions. The only means of communication available is Post-It Notes. This builds communication skills, both sending and interpreting messages, very similar to nurses writing dressing change instructions for others to follow.

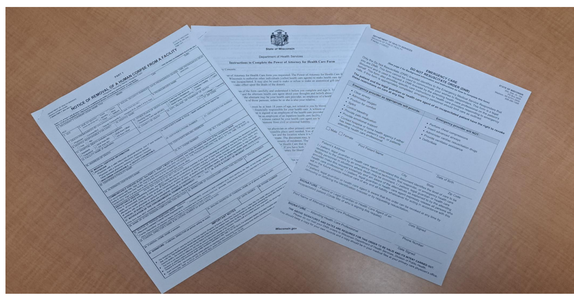
When studying about dementias, students participate in an interdisciplinary activity with each station limiting sensory capabilities and many offering physical disabilities. Sensory impairments include "drunk driving" glasses, earplugs, housekeeping gloves with cotton balls in fingertips and loud polka music in the room. ***Nursing*** stations include and ADL station with dressing and brushing teeth, filling a medication planner and folding fitted sheets. ***Social Work*** students assist in counting cash, writing checks and balancing a checkbook and building origami swans. Our ***Exercise Science*** students use bariatric and geriatric suits with our students on stair climbers and ambulation.

There is also a lower GI ***Escape Room***, using ammunition boxes with color-coded zip ties for triage, organizing skills (following completion of their ***Advanced Skills*** course), SBAR and discharge education. With each puzzle piece completed, the corresponding tie is cut. When all four are cut, students receive their prize – a "*Free Ticket to Class*".

The patient has acute toxic megacolon. This spring, three of my clinical students on the oncology floor provided acute care for such a patient, with the patient avoiding surgical interventions. The surgeon was very impressed with the students' knowledge of the condition.

Working Within a Concept-Based Nursing Education Program

Cooperation is the most important aspect of how a faculty needs to operate. We are fortunate, as a newer traditional program, that we have a high level of interaction with our instructors. Balancing the concepts between health alterations, pharmacology, pathophysiology and other didactic courses such as this one can be difficult but is necessary. ***Healthy Aging and Chronic Care Management*** takes the lead on concepts such as the many type of ***dementias***, on ***cancers and cancer treatments*** and on ***End-of-Life Nursing Care*** while reinforcing the learning happening in the other courses.



Continuation into NUR 380

The next semester, our students' clinical practicum is NUR 380, Alterations in Health and Illness II. Within the first month of class, students have a post conference provided by the Palliative Departments of their host hospital; utilizing a ***CHPN, APNP, Social Worker and Chaplains*** to review the Wisconsin Durable Power of Attorney for Healthcare standard form. As an assignment due the following week, each student completes their own DPOA-HC (*Note: the document does not need to be signed/witnessed, but this service is available through the chaplaincy programs at each of our three hospital systems on the following week.*). We believe that this greatly aids our students' understanding of and ability to interpret POA forms.

Project HEALS: Helping Educate and Advocate Life with Support

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Pediatric Acute Care Nurse Practitioner Program

University of CINCINNATI

Background/Purpose

What are we trying to accomplish?

The Neonatal Intensive Care Unit (NICU) provides end-of-life (EOL) care involving complex clinical, ethical, and emotional considerations (World Health Organization, n.d.; American Academy of Pediatrics, 2019). NICU nurses play a central role in support through comfort-focused care, communication, and bereavement support (American Nurses Association, n.d.; National Association of Neonatal Nurses, 2015). Despite this, NICU nurses often report limited formal education and variable confidence related to neonatal palliative and EOL care, which may contribute to inconsistencies in practice (Abuhammad et al., 2023; Beckstrand et al., 2010; Cavinder, 2014).

The World Health Organization defines palliative care as an approach that improves quality of life for patients and families facing life-threatening illness through the prevention and relief of suffering (World Health Organization, n.d.). Professional organizations emphasize the importance of integrating palliative care principles within a family-centered approach across the neonatal care continuum (American Nurses Association, n.d.; National Association of Neonatal Nurses, 2015).

State the Question

In NICU nurses (P), does participation in an asynchronous neonatal palliative and end-of-life care education module (I), compared with no formal EOL education (C), improve palliative care knowledge, attitudes, and self-efficacy (O) over an eight-week implementation period (T)? By addressing this practice gap, Project HEALS seeks to promote consistent, compassionate, and evidence-based neonatal EOL care while reinforcing nurses' roles during some of the most vulnerable moments for families.

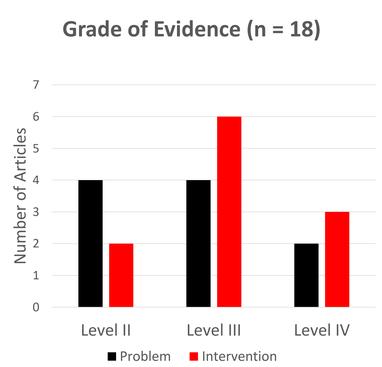
Available Knowledge

What can we change that will result in an improvement?

A literature search was completed using CINAHL, PubMed, and Scopus, focusing on peer-reviewed articles published within the last 10 years related to neonatal palliative and EOL care. Thirty-one articles were identified, with 18 articles meeting inclusion criteria based on relevance to nursing practice. All included studies were appraised using the Johns Hopkins Evidence-Based Practice Leveling and Grading Tool (Dang et al., 2022).

Ten studies focused on the clinical problem, describing NICU nurses' experiences, knowledge gaps, moral distress, and preparedness related to neonatal EOL care (Abuhammad et al., 2023; Beckstrand et al., 2010; Cavinder, 2014; Curcio, 2017; Cortezzo et al., 2015; Gibson et al., 2018; Bloomer et al., 2016). The studies identified limited education and variable confidence as contributing factors to inconsistent care practices. The remaining 8 studies evaluated educational interventions assessing the impact of palliative and EOL education on nurses' knowledge, attitudes, communication skills, and self-efficacy (DeSanto-Madeya et al., 2020; Chen et al., 2024; Yildirim & Koş, 2024; Abuhammad et al., 2023). Overall, the evidence was graded as moderate to high quality, including two Level II studies, twelve Level III studies, and four Level IV studies demonstrating high relevance to the practice problem and proposed intervention.

Figure 1:
Evidence Grading



Across intervention studies, structured asynchronous education emerged as a feasible and effective strategy for improving NICU nurses' preparedness for neonatal palliative and EOL care, particularly within high-acuity NICU environments (Kimura et al., 2023; Zsifkovits et al., 2025).

Model

Project HEALS is guided by the Institute for Healthcare Improvement (IHI) Model for Improvement, (Institute for Healthcare Improvement, 2020) a widely used quality improvement framework designed to support systematic, measurable practice change. The IHI Model was selected for its applicability to clinical quality improvement initiatives and its structured approach to evaluating changes within healthcare systems.

The IHI Model is organized through three questions:
(1) *What are we trying to accomplish?*
(2) *What changes can we make that will result in improvement?*
(3) *How will we know that a change is an improvement?*

These questions guided: identification of the practice gap in neonatal palliative and EOL care education, selection of a structured asynchronous educational intervention, and evaluation of outcomes. The IHI Model provides a replicable framework to support sustainability and future dissemination of Project HEALS within the NICU setting.

Figure 2:
IHI Model for Improvement Framework

Methods

Design

Quality improvement (QI) pre- and post-intervention design guided by the Plan-Do-Study-Act (PDSA) cycle. The PDSA cycle operationalized this QI initiative: **Plan:** identified the practice gap and developed the asynchronous modules; **Do:** implemented the 8-week educational program; **Study:** analyzed pre–post survey outcomes; **Act:** identified opportunities for sustainability and spread (Institute for Healthcare Improvement, 2020).

Setting and Participants

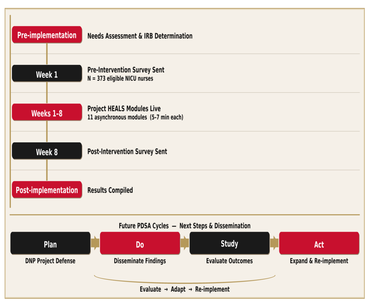
This project was conducted in a Level IV Neonatal Intensive Care Unit at a pediatric academic medical center. Approximately **N = 373** bedside NICU registered nurses were eligible to participate.

Intervention

Project HEALS is a nurse-designed, asynchronous educational program developed by a NICU nurse for NICU nurses. The program consisted of 11 brief modules (5–7 minutes each) that were available for self-paced completion via an online learning platform over an 8-week implementation period. Pre-intervention surveys were completed prior to module access. Post-intervention surveys were completed at the conclusion of the 8-week intervention period, consistent with a pre–post quality improvement cycle (Kimura et al., 2023; Zsifkovits et al., 2025).

Module content included:
Foundations of neonatal palliative and end-of-life care
Nurse-led communication and family support
Neonatal comfort and symptom management
Cultural and ethical considerations
Memory-making and after-death care
Nurse resilience and self-care

Figure 3:
Project Timeline



Measure/Evaluation Tools

- Pre- and post-intervention surveys included:
- Self-Efficacy in Palliative Care Scale (SEPC) (Mason & Ellershaw, 2004).
- Palliative Care Quiz for Nursing (PCQN) (Ross et al., 1996).
- Neonatal Intensive Care Unit Palliative Care Attitude Scale (NiPCAS) (Kain et al., 2009).

Paired t-tests were used to compare pre- and post-intervention mean scores for the SEPC and PCQN. Descriptive analyses were conducted for NiPCAS responses.

IRB Determination

This project received dual non-human subjects research determinations. The University of Cincinnati College of Nursing determined this project to be non-human subjects research (MP-CON-2025-0804; August 9, 2025). The Cincinnati Children's Hospital IRB issued a Not Human Research Determination (IRB ID: 2025-0638; September 10, 2025). IRB review and approval was not required by either institution.

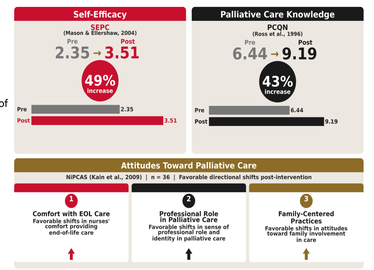
Results / Outcomes

Participation

Pre-intervention surveys:**49 NICU nurses (13.1%)**
Post-intervention surveys: **36 NICU nurses (9.7%)**.
Matched pre–post survey responses (**n = 36**).

Key Findings

Figure 4:
Key Findings



Self-Efficacy in Palliative Care (Mason & Ellershaw, 2004): Scored on a 1–5 scale (1 = no confidence; 5 = very confident; midpoint = 3.0). Mean self-efficacy scores increased from **2.35/5.00** (47% of maximum; below midpoint, indicating low confidence) to **3.51/5.00** (70% of maximum; above midpoint, indicating moderate confidence), representing a **49% increase**. While clinically meaningful, a post-score of 3.51 reflects that 1.49 points remain to the scale maximum, identifying continued opportunity for growth.

Palliative Care Knowledge (Ross et al., 1996):
Scored 0–10 (one point per correct answer; 10 = perfect score).

Mean knowledge scores increased from **6.44/10** (64% correct) to **9.19/10** (92% correct), representing a **43% increase**. Post-intervention scores approached the scale maximum, with participants scoring only 0.81 points from a perfect score indicating near-mastery of core palliative care knowledge following the intervention.

Attitudes Toward Palliative Care (Kain et al., 2009):
Scored 1–5 (1 = strongly disagree; 5 = strongly agree). Favorable directional shifts were observed across all three domains (n = 36):

- **Comfort with EOL Care:** 2.88 → 4.05/5.00 **(+41%)** the largest domain shift, driven by notable gains in comfort discussing palliative care with families 2.72 → 4.06 **(+49%)**, and confidence providing emotional support after infant loss 2.78 → 4.19 **(+51%).**
- **Professional Role in Palliative Care:** 4.00 → 4.33/5.00 **(+8%)** attitudes were already strongly favorable at baseline and were further reinforced post-intervention.
- **Family-Centered Practices:** 3.55 → 4.08/5.00 **(+15%)** meaningful gains in perceived team communication and clarity of NICU palliative care guidelines.

Discussion

Project HEALS demonstrated meaningful improvements in NICU nurses' self-efficacy, palliative care knowledge, and attitudes following a nurse-designed, asynchronous educational intervention consistent with evidence supporting structured education in neonatal palliative and EOL care (DeSanto-Madeya et al., 2020; Chen et al., 2024; Yildirim & Koş, 2024; Abuhammad et al., 2023). Notably, PCQN scores approached near-mastery (9.19/10) and SEPC scores crossed the scale midpoint, reflecting a shift from low to moderate confidence. NiPCAS results indicated the greatest attitudinal growth in comfort with EOL care (+41%), where nurses began below the scale midpoint and ended well above it.

Limitations: Voluntary participation and a single-unit QI design limit generalizability. Response rates were modest (pre: 13.1%; post: 9.7%; matched n = 36). Absence of a control group and reliance on self-report measures are additional limitations.

Conclusions

Project HEALS demonstrated measurable improvements in self-efficacy (2.35 → 3.51/5.00), palliative care knowledge (6.44 → 9.19/10), and attitudes toward EOL care among NICU nurses, supporting structured, asynchronous nurse-led education as a feasible and effective strategy for addressing this practice gap (Kimura et al., 2023; Zsifkovits et al., 2025).

Usefulness of the Work: Project HEALS offers a replicable, low-burden model adaptable across NICU settings to support consistent, compassionate, and evidence-based palliative care (American Academy of Pediatrics, 2019; American Nurses Association, n.d.; National Association of Neonatal Nurses, 2015).

Sustainability: Modules can be maintained within existing online platforms and updated as evidence evolves. Integration into NICU onboarding or annual competency education may further support sustainability and peer engagement.

Next Steps: Future directions include evaluating long-term sustainability, expanding to additional NICU or pediatric settings, and exploring the intervention's impact on family-centered outcomes. Findings will be disseminated at the TNEC Symposium and submitted for manuscript publication.

Scan for full reference list and project appendices.
Scan QR code for full references and project materials. Electronic versions link directly to these resources.

From Knowledge to Action: A Palliative Care Nurse Champion Mentorship Program to Increase Primary Palliative Care

Hui Qing (Sandy) Su, MS, AGACNP-BC | DNP Candidate, NYU Rory Meyers College of Nursing

INTRODUCTION

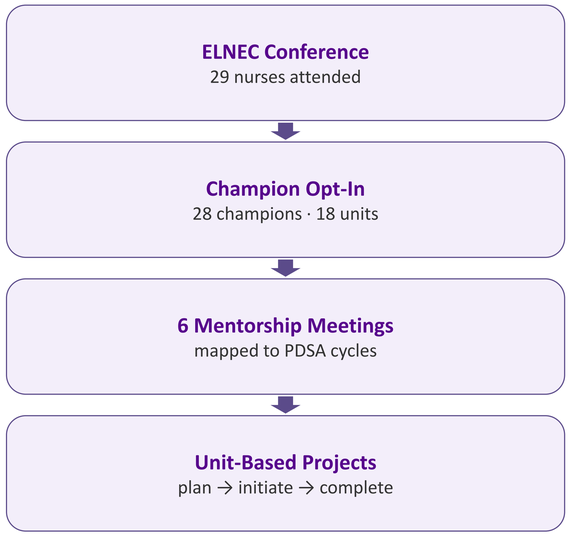
- Demand for palliative care is rising as the population ages with chronic illness, but a shortage of clinicians trained in palliative care limits access.
- Nurses are well positioned to deliver primary palliative care, yet need education, support, and collaboration to change practice.
- At a large academic medical center, the existing champion program had shifted to remote-only sessions with low engagement, no structured follow-up, and no documented practice change.

OBJECTIVES

- **Global aim:** Improve the delivery of primary palliative care by redesigning the Palliative Care Nurse Champion Program.
- **Specific aim:** Increase the number of nurse champions completing unit-based palliative care projects through the redesigned program.

MATERIALS & METHODS

- **Design:** Quality improvement with six PDSA cycles, guided by the Iowa Model and Rogers' Diffusion of Innovations; SQUIRE 2.0 reporting.
- **Intervention:** One-day ELNEC-based conference covering five palliative care domains; voluntary champion opt-in; unit-level gap analysis; six structured mentorship meetings (group via Zoom + 1:1 follow-up) mapped to PDSA cycles; project plan, initiation, and completion checklists; Unit Practice Council (UPC) chair and palliative care liaison engagement.
- **Primary measures:** Champions identified, project plan completion, project initiation, project completion.
- **Secondary measures:** Attendance, gap analyses, modified PCKT and PCSES (pre/post-conference); descriptive and thematic analysis.



RESULTS

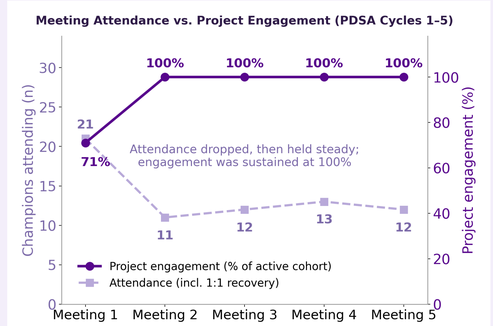
The Conference

- **29 nurses attended**; **7 nursing continuing education units (CEUs)** were provided.
- **Five ELNEC domains:** Introduction to Palliative Care, Communication, Symptom Management, Pain Management, and End-of-Life Care.
- **Knowledge (PCKT): mean 9.10 → 9.48 out of 10.**
- **Self-efficacy (PCSES): mean 2.93 → 3.50 on a 4-point scale.**
- **28 nurses opted in as champions** across 18 clinical units.

Table 1. Critical Gaps (N = 30 gap assessments)

Critical gap identified	% gap
Patients/families understand illness and choices	83%
Comfortable with tough conversations	77%
Grief support offered to families	77%
Speak up when referrals are missed or delayed	77%

Strengths: pain assessment (93%); routine symptom management (90%).



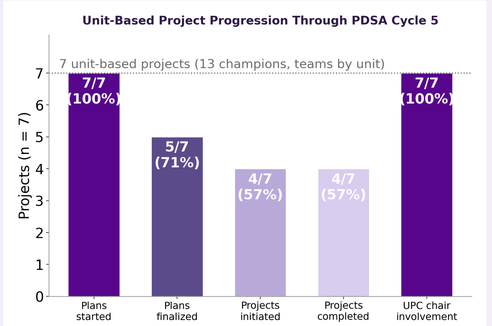


Table 2. PDSA Cycles 1–5

Cycle	Key results (Study → Act)
1	16/28 attended Meeting 1; 5 recovered via 1:1 → 21 engaged; 15 gaps identified; 12 knew their UPC chair. Fixed reminder-email typo.
2	11 engaged champions; 6/6 team plans started, all with UPC involvement. Shifted from universal follow-up to targeted support.
3	2 champions joined (n = 13); 12 attended; 7/7 plans started, 5/7 finalized (71.4%); 1:1 support for incomplete plans.
4	13/13 attended; 4/7 projects initiated (57.1%), the first concrete evidence of practice change; admin day planned.
5	12/13 attended; 4/7 projects completed; 2 scheduled within cycle; 7/7 UPC involvement; support for remaining launches.

Table 3. Champion-Led Projects by Unit

Unit	Project(s)
Oncology	Palliative care patient identification tool; unit infographic on tool use; palliative care referral tracking
Cardiac Stepdown	Grand rounds nursing education: ways nurses can empower themselves in palliative care
Cardiology	Regular palliative care in-services; palliative care information in weekly newsletter; Comfort Care Closet
Emergency Dept.	Palliative care patient identification tool and referral pathway for nurses
Burn Unit	Palliative care patient identification tool and referral pathway for nurses
Bariatric & Colorectal	Planned for 2027: palliative care education with assessment of nurse knowledge and confidence
Float Pool	Grand rounds on palliative care

CONCLUSIONS

- Structured mentorship with PDSA cycles translated ELNEC education into measurable practice change: 7 champion-led projects across diverse units, 4 completed by Cycle 5.
- A smaller, highly engaged cohort with targeted support outperformed universal follow-up: attendance dropped early, then held steady while engagement was sustained at 100%.
- Formalized champion roles, UPC partnership, and palliative care liaisons are key to sustaining nurse-driven palliative care change.

CONTEXTUAL FINDINGS

- **Individualized support:** champions who requested 1:1 follow-up progressed faster; an ED champion reached initiation, referral tracking, and their own PDSA cycle by Cycle 4.
- **Self-determined projects** (Oncology, ED, Cardiology, Float Pool) progressed independently from planning to initiation, outpacing the pre-assigned model.
- **UPC strength:** units with strong Unit Practice Council support initiated by Cycle 4 without needing 1:1 follow-up.
- **Microsystem:** high acuity, rotating staff, and referral processes that were not nurse-driven slowed engagement.
- **Mesosystem:** palliative care liaisons created a formalized nurse-to-provider referral pathway that had not previously existed.
- **Macrosystem:** administrative time and competing clinical priorities shaped attendance and project timelines.

28 champions opted in

18 clinical units

7 unit-based projects

100% UPC chair involvement

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