Feature Article

Using Qualitative Feedback to Adapt a Communication Simulation for Nursing Students and Novice Nurses

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Nurses and nursing students must be competent to provide quality care in a population with increasing serious illness needs. A significant gap exists in nursing education and professional development, in palliative care communication, and in its role in serious illness. Simulation-based education provides a dynamic, interactive platform to practice communication strategies in a safe setting. This paper describes how an established, standardized palliative communication simulation was adapted to fill curriculum gaps in prelicensure and nurse residency programs. The original simulation was adjusted to prelicensure students in an unfolding scenario in their third and fourth year of a 4-year prelicensure nursing program. Students practiced conversations about symptom management, advance directives, and advance care planning in their third year. In the students' fourth year, they use communication tools to discuss goals of care with the same patient they met the previous year. Key modifications from the original simulation included guided discussions based on a foundational article about palliative care concepts, as well as pre- and post-reflections on students' feelings about engaging in these conversations. The nurse residency program incorporated all phase 1 adaptations used in the prelicensure version. Data was gathered through a simple open-ended question, and results from students and nurse residents showed that they had less fear and anxiety about conversations and learned approaches to talking with patients. Implementing more palliative care training, including simulations, provides greater exposure to effective communication.

KEY WORDS
nursing education, simulation, palliative care, communication skills, advance care planning, nurse residency

Palliative care addresses the physical, psychological, social, and spiritual challenges of patients with serious illnesses. The aim of palliative care is to improve quality of life, making it an essential component of healthcare for these patients.[1] As the global burden of chronic diseases continues to rise, the need for effective palliative care services has become increasingly urgent. However, despite its recognized benefits, palliative care remains underutilized and inadequately integrated into healthcare systems worldwide.[2] In prelicensure nursing education and professional development, there is a lack of training on providing palliative care, specifically in initiating discussions on advance care planning and utilizing opportunities to discuss patients' and their families' goals of care.[2]

One promising approach to enhancing palliative care education and practice is the use of simulation-based education (SBE). SBE offers a dynamic and interactive platform for students and clinicians to develop vital skills in palliative care, including compassionate communication, empathetic listening, and initiating difficult conversations. This educational strategy creates realistic clinical scenarios that allow participants to engage in experiential learning, fostering both technical proficiency and emotional resilience.[3] SBE has been shown to enhance clinicians' abilities to conduct difficult conversations about end-of-life (EOL) care, manage complex symptomatology, and navigate ethical dilemmas in palliative settings. Moreover, the adaptability of SBE makes it a valuable resource across diverse environments, such as nursing schools and settings for professional development in health systems.[3] Given the growing recognition of the importance of palliative care and the demonstrated benefits of SBE, educators may want to incorporate palliative care scenarios into their

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instruction for their intended learners. This paper describes how an established palliative care communication simulation for practicing registered nurses (RNs) was altered for the audiences of prelicensure nursing students and nurse residents to fill curricula gaps in their respective programs.

BACKGROUND

Effective communication is at the heart of palliative care, where the primary goals include alleviating suffering and improving the quality of life for patients. Nurses, as frontline providers, are frequently tasked with engaging in difficult conversations. Communicating effectively in these emotionally charged situations requires not only clinical knowledge but also highly developed interpersonal skills. To address this need, SBE has been increasingly employed in nursing programs to enhance communication competencies in palliative care.

Research consistently demonstrates that SBE significantly enhances communication skills in palliative care settings. According to Gillan et al., SBEs enable nursing students to practice and refine their communication skills in discussing topics such as documenting patient preferences and setting goals.[4] Similarly, another study highlighted the effectiveness of SBE in improving not only verbal communication but also nonverbal cues, such as body language and active listening, which are crucial in conveying empathy and support in palliative care.[5] This study found that students who underwent simulation training were better equipped to handle the emotional complexities of patient interactions, resulting in more compassionate and patient-centered care. SBE has also been shown to positively impact the emotional preparedness of nursing students by allowing students to practice empathy. This is a core component of effective communication in palliative care but can be challenging to teach through traditional didactic methods. For instance, Kirkpatrick et al[6] reported that nursing students who participated in communication SBE involving EOL scenarios exhibited increased empathy toward patients and families. The immersive nature of SBE allows students to engage more deeply with the emotional and psychological challenges of palliative care, fostering a greater understanding of the patient's experience.

For practicing RNs, a study by Beck et al[7] found that nurses felt more prepared to handle the emotional demands of palliative care, including dealing with grief, supporting families, and managing their emotional responses after completing palliative care scenarios. SBE also provided a platform for practicing ethical decision-making, such as balancing patient autonomy with family wishes or managing conflicts about care goals.

Despite the apparent benefits, the implementation of palliative care communication SBE in nursing education is not without challenges. Standardized, evidence-based simulation design and assessment tools are needed to ensure that SBE effectively targets the specific communication skills required in palliative care. The lack of standardized protocols can lead to variability in the quality and outcomes of SBE across different nursing programs.[8] Additionally, integrating SBE throughout the nursing curriculum, rather than in isolated learning experiences, can reinforce communication skills and ensure that students are adequately prepared for the challenges of palliative care. This integration, however, requires careful planning and coordination among faculty members. Furthermore, the resources required for SBE, such as simulation equipment and trained facilitators, can be a barrier for some institutions. Despite these challenges, the benefits of SBE in palliative care education are substantial, and with the proper support and resources, these challenges can be effectively addressed.[9] The following section describes how researchers and faculty members modified an existing simulation to cater to 2 separate learner audiences.

ALTERATION OF EXISTING SIMULATION

A previous publication describes the original simulation.[10] This simulation was modified for 2 sets of learners, located in different settings, including novice nurses enrolled in a nurse residency program (first year as a practicing RN) at a hospital system and prelicensure nursing students in their third and fourth years at a large university.

Original Simulation

The simulation, "Conversation Had at Trying Times" (CHATT), was developed based on a theoretical framework that combines the National League of Nursing Jeffries Simulation theory[11] and Albert Bandura's Self-Efficacy theory.[12] The goal of the simulation was to assess practicing RNs palliative care knowledge, attitudes, and comfort related to advance care planning conversations, and their approach to discussing these topics with patients and families. Researchers created simulation components that strictly adhered to the International Nursing Association of Clinical Simulation and Learning standards[13] with outcome measures that evaluated changes in knowledge, attitudes, and self-efficacy. Feasibility and acceptability of the simulation, along with content validity and reliability, were tested along with outcome measurements. The simulation was then pilot-tested among RNs with varied specialties and experience levels. The pre- and post-survey results revealed an overall significant change, with an increase in knowledge, a positive shift in attitudes, and improved self-efficacy scores for participants. The most significant finding was that younger, inexperienced nurses achieved these 3 positive outcomes related to knowledge, attitude shifts, and self-efficacy, but not to the same extent as older, experienced practicing nurses.[10] This pilot study yielded initial outcomes that align with findings in the literature, suggesting that nurses with limited experience or practice in palliative care possess lower levels of palliative care knowledge and lack confidence and comfort in communicating with patients with

serious illnesses.[7] However, after the nurses completed the CHATT simulation, their knowledge and comfort increased significantly. The pilot study also revealed that the CHATT simulation was feasible and acceptable, with valid and reliable content.

The researchers next sought learner groups that could benefit from this simulation, specifically those that may not have exposure or experience working with palliative care patients. Two groups that were invited for collaboration included prelicensure students at a university's school of nursing and nurse residents at a local health system. Through multiple meetings, researchers and educators identified a gap in communication skills, with anecdotal evidence of students and residents expressing discomfort talking to patients with serious illness or at the EOL. The researchers and coordinators at both sites then determined how best to incorporate this simulation into their respective curricula. Overall, for both programs, educators would use the purpose and objectives of the original CHATT simulation with the expectation of similar outcomes. However, the educators did not want to use the survey instruments of the original simulation, which were intended to capture outcomes for palliative care knowledge, changes in attitudes, and self-efficacy. The educators decided to take an informal approach instead and have participants reflect on their thoughts and feelings about their comfort with conversations before and after the simulation, thus providing qualitative data in the form of quotes.

Prelicensure Program Integration

Researchers and university educators collaborated to integrate the simulation into prelicensure classes, including Fundamentals of Nursing (students' third year) and Capstone Leadership and Practicum (students' fourth year). The purpose of integrating the simulation was to increase students' exposure to difficult conversations in 2 consecutive years of nursing school. Educators at the university modified the CHATT simulation to address learners in the 2 different classes, and as a result, the simulation became an unfolding scenario spanning 2 years where students practiced advanced care planning and goals of care conversations. In phase 1(third year), students completed the objectives encompassing a discussion with an elderly patient and family member on options for treatment and goals of care. The patient, who had been hospitalized multiple times for progressive chronic obstructive pulmonary disease, had an anxious daughter at her bedside. Aside from initiating the goals of care conversation, students had to educate the patient and the family member on the effects of morphine and define the role of palliative care in the medical plan of care. Phase 2 (fourth year) of the unfolding simulation included further discussion on treatment options and hospice eligibility. In both phases, the simulation's objectives aligned with key didactic and clinical objectives of therapeutic communication, interprofessional collaboration, and the professional identity of nursing.

To mitigate the students' lack of knowledge on palliative care, an article by Whitehead reviewing the concepts of palliative care and advance care planning was added as a presimulation assignment.[14] The facilitator clarified and discussed concepts in the prebrief, including advance care planning, code status, advanced directives, and medications used in palliative care. After this discussion, students wrote a short reflection in response to the question, "Would you be comfortable having an advance care planning conversation with a patient?" Two students from each group were encouraged to volunteer or were selected to participate as active learners in the SBE, while the remaining students observed the SBE as passive learners. Each group contained approximately 6–8 students. After the debrief, the students completed another reflection with the same question prompt. The scenario script, outline, or debrief process remained unchanged from the original CHATT. During the debrief, the facilitator prompted discussions about the connection between advanced care planning and patient-centered care.

Nurse Residency Program

Educators in the health system also adapted the CHATT simulation for nurse residents in a hospital system in Connecticut. This program has a longstanding history of supporting new graduates by partnering with the Vizient/ANCC Nurse Residency Program, which focuses on curriculum development, continuous improvement, and evidence-based practices. The goal for Vizient is to align nurse residency programs with current healthcare standards and expectations, particularly in high-stakes areas such as EOL care. Vizient has extensively studied nurse residents over the years, revealing that new graduates often struggle with the complexities of EOL care and face significant difficulties delivering compassionate and competent care during this critical phase of life.[15]

Like the prelicensure program, the CHATT simulation adaptation for nurse residents incorporated the Whitehead article as prework, and nurses completed pre- and post-reflections about advance care planning conversations.[14] Two participants volunteered as active learners, and the remaining nurse residents observed the SBE. Additionally, the nurses only completed phase 1 of the simulation due to the 1-year duration of the residency. Table 1 presents the CHATT original simulation and its adaptations for prelicensure students and nurse residents.

DATA COLLECTION

For the prelicensure students, typed pre- and post-simulation reflections from phase 1 were collected from the students and, with their consent, de-identified and transcribed into a password-protected Excel spreadsheet. The researchers and educators extracted significant quotes from reflections before the simulation and those completed after the debrief. The goal of gathering quotes from the reflections

TABLE 1 Details of Simulation Adaptations to BSN Students and Nurse Residents

	Original Simulation	Adaptation to BSN Students	Adaptation to Nurse Residents
No. of participants	36	153 (phase 1), 131 (phase 2)	28
Types of participants	Registered nurses of one health system	3rd and 4th year BSN prelicensure students	Nurse residents (in 1st year of nursing)
Location	Simulation lab in small community hospital in CT	University simulation lab	Simulation lab in small community hospital in CT
Modifications	N/A	Phase 1: Added article & discussion questions as prework to introduce concepts of palliative care. Pre-and post-simulation reflections Phase 2: Introduce communication tools for serious illness in prework. Pre-and post-simulation reflections.	Added article & discussion questions as prework to introduce concepts of palliative care. Pre-and post-simulation reflections.

Abbreviation: BSN, Bachelors of Science in Nursing; CT, Connecticut.

was to allow students to write down their thoughts and feelings before the simulation and then again immediately after completing it. Both the researcher and faculty instructors sought to assess the impact of a communication simulation on these students and the comfort they may have gained from practicing a conversation. For the nurse residents, the same process took place. Researchers and educators kept these 2 sets of quotes separate so that differences could be noted in responses.

Prelicensure Students

At the university, 153 prelicensure students completed the first phase of the simulation, and 131 completed phase 2 of the unfolding simulation. Many prelicensure students felt that they were unprepared, fearful, or overwhelmed with having a conversation with a patient about advance care planning (ACP). One participant indicated, "Right now, being a nursing student, I don't think I would feel 100% comfortable or ready to have these conversations with patients". Another student stated, "As I write this, I'm realizing that I do not know any of information [on ACP], therefore further proving my point of not feeling comfortable talking about this". One student expressed fear that patients "would not accept my thoughts or suggestions…" The words used to describe the possibility of having these conversations included daunting, uncomfortable, difficult, and hesitant. These students also indicated that much of the fear of having ACP conversations stemmed from a lack of knowledge about ACP and anxiety about the patient's reaction to this topic.

After the simulation, many students' perceptions of ACP conversations underwent a change. One student noted, "I think this was good practice because I feel better equipped to have conversations on this topic. The resources discussed would definitely be helpful as well". Another student stated, "This simulation was helpful in learning how to approach the family in a calm manner and addressing their questions." A student liked it when "the student nurses in the simulation asked the patient's family member/daughter to sit down and reinforced that their role was to answer questions and be supportive." Finally, another student remarked, "While I still feel not fully comfortable with having this convo, I do think learning more in class and doing the same helped, but because not every patient and situation is the same, I think more exposure and time is necessary to be more comfortable."

The facilitators had to clarify aspects of the simulation. Many students focused on patients choosing code status rather than starting a conversation about options. They related advanced care planning to completing advanced directives rather than discussing goals of care and making decisions about continuing, changing, or stopping treatment. Lengthy debrief discussions led by the facilitator helped clarify these differences. Most of these nursing students felt that their perceptions had changed after completing the simulation. Some students stated that they felt comfortable, could at least initiate a conversation, or knew they should prepare before having these conversations.

Nurse Residents

Twenty-eight nurse residents completed the ACP simulation, equivalent to 14 residents per class over a 2-year period. Although there were fewer participants than in the prelicensure program, the residents gained valuable insights from the simulation. The nurse residents had similar prereflection responses; however, it was apparent that they had more exposure to ACP conversations and understood the various barriers to these conversations in their short time as nurses. One resident stated, "After working in the hospital for only a few months now, it is clear that many people do not have their [advance directives]

setup." Another resident noted that "institutional barriers can include a lack of time to discuss ACP with a patient, which I find to be very true. We sometimes take care of patients for only 1 night before they are discharged back home." A resident said, "being a young nurse with no [advance directives] myself, I am not sure as to everything that is included, let alone how to bring up the conversation with my patients." The nurse residents noted that they felt unprepared and intimidated, but they also mentioned institutional barriers, provider barriers, and a lack of promotion for advanced directive completion.

After completing the simulation, residents stated, "I am more aware of the delicate manner with which these decisions have to be made…it allowed me to consider ways with which I can make hard-to-have conversations more comfortable for both myself and the patient/families". Another resident wrote, "I learned how important it is to start by creating an environment for the conversation to occur that is calming with no distractions. I also learned to ensure that the patient understands their disease(s) and prognosis and the treatment they are receiving". One resident found it interesting that "we discussed that sometimes patient's goals don't align with the goals we as nurses feel is right for them. I think at times I struggle with this concept". Other statements by residents indicated that "it is important to have consults and for staffing to have more training and information on how to handle these conversations as these different forms of care can be misconstrued," and "I feel that I learned more from a nursing perspective about how to have these conversations with patients and loved ones."

IMPLICATIONS TO NURSING PRACTICE

The more nurses and nursing students learn the fundamentals of palliative care and communication, the more equipped they are to initiate ACP conversations, advocate for patients, and identify those in need of palliative care support. Therefore, an increase in focus on communication in palliative care is needed in the nursing curriculum and in professional development in clinical settings.

Currently, studies have shown that nursing students lack the knowledge and skills in EOL symptom management and therapeutic communication, and have negative experiences when caring for dying patients.[16] A systematic review found that nursing students' negative views about death and dying were due to the unknown concept of death. However, their perceptions improved significantly after palliative care training, which dispelled their fears about the process of dying.[17] A communication simulation is a viable addition to the curriculum that teaches students how to overcome barriers to EOL conversations in a safe space. Researchers also reported that nurse residents had the same discomfort and fear when talking to patients. Often, the response is to have another clinician, such as a provider or social worker, discuss ACP with patients. Repeated exposure to palliative care concepts and conversations can prepare nurse residents to recognize their anxiety or apprehension that are barriers to providing quality care. Early and ongoing exposure to difficult conversations is essential.[18]

A simulation in ACP is also necessary to develop a nurse's overall communication skills. Effective communication in nursing is crucial to improving patient education and outcomes, reducing errors, and fostering a positive rapport with patients. Nurse educators have recognized a deficiency in competent communication among nursing students, which can directly impact the safety and well-being patients.[19] Literature from the past 15 years has shown that undergraduate students struggle with ineffective communication patterns, including acting unprofessionally, providing disjointed and incomplete information, and showing nonempathetic communication.[20] Development of these skills is a challenge, and students face barriers such as anxiety and stress, limiting their ability to focus. Many clinical rotations are devoted to safe practice, including medication administration, practical skills, and assessments, without focusing much on communication. However, effective communication is an essential skill that nurses need to support patients and their families.[20] Therefore, other modalities need to be in place to develop effective communication strategies, provide constructive feedback, and allow students to make mistakes in a safe and supportive environment.

Adapting an established palliative care communication simulation is an effective method for meeting the American Association of Colleges of Nursing competencies.[21] The nursing curriculum is already tightly packed, and educators must be strategic when adding it. Adding a simulation or integrating parts of the simulation scenario can complement and align with the didactic portions of courses, providing students with a hands-on approach to palliative care.[22] For example, if a complete SBE is not practical, role-playing scenarios using the scripts in the SBE can elicit valuable discussions. Additionally, this simulation does not require advanced technologies, as standardized patients (actors) are used to play roles in the scenario. Educators can assess the curriculum's needs, identify gaps, and then consider the resources, infrastructure, and support required to conduct the simulation. Next, educators can map the curriculum to match learning objectives to course content and the program's overarching goals. Finally, a small pilot test can confirm whether students meet the objectives, providing the opportunity to modify the scenario before extending it to a larger class.[23]

The EOL Nursing Consortium offers a comprehensive, easily accessible, and widely available program for nursing students and practicing nurses in palliative care. Educators can integrate the information from this program into existing courses and thread throughout the nursing programs' curriculum.[24] A complementary pedagogical component can include simulation to provide a hands-on approach to applying learned communication skills in palliative care. Simulations in palliative care are established and available for use. Utilizing

existing resources to enhance palliative care training at the university level and in professional development is necessary to meet the American Association of Colleges of Nursing competencies and address the growing need for nurses to provide competent, quality care for individuals with serious illness.

CONCLUSION

Adapting an existing communication simulation for different populations has numerous advantages. This paper describes how 1 simulation was adjusted for 2 different populations in 2 settings—academically among nursing students and clinically with novice nurses. Adopting a rigorous and validated simulation is essential, and the process is not complicated. The simulation's learning objectives should align with the curriculum's goals, and facilitators should conduct a small-scale pilot test.

Nurses are poised to have difficult conversations with patients, and the more exposure they have to these conversations, the more comfortable they will be in recognizing, initiating, and following up with patients and families. Like the medical school course topic, "Breaking Bad News," palliative care and communication courses should be introduced into the nursing school curriculum and RN training early, receiving high importance.[21] In this example, the adaptation of a simulation spanned the third and fourth years of a prelicensure nursing program and nurses in their first year of practice. The aim is for students and novice nurses to have repeated exposure and opportunities to engage in conversations, allowing them to gain efficiency and hone their palliative care skills for practice. This will ensure a foundation of comfort and skill in caring for patients under palliative care, providing them with quality of care that focuses on the patient.

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