

Exploring the Usefulness and Effectiveness of Debriefing to Process Emotions or Feelings
Experienced by Undergraduate Nursing Students in a Palliative Simulation-Based Experience

By

Stephanie Nunes

A Thesis submitted to the Faculty of Graduate Studies of
The University of Manitoba
in partial fulfilment of the requirements of the degree of

MASTER OF NURSING

College of Nursing

Rady Faculty of Health Sciences

University of Manitoba

Winnipeg

Copyright © 2017 by Stephanie Nunes

Abstract

The need for quality palliative care begins with quality palliative nursing education, however that has proven difficult to provide. Research has proven that palliative simulation is a beneficial bridge between the palliative theory and palliative clinical gap. Often overlooked during a debrief session in a simulation laden in emotions, is ensuring that participants have the skills to process the feelings they experience while providing palliative care. The purpose of this mixed-method concurrent triangulation study was to add to the knowledge and understanding about the usefulness of debriefing in palliative simulation-based experience to process feelings and emotions. Valuable components of debriefing following palliative simulation included emotional preparedness and normalization of feelings. Recommendations for future practice include using a different debriefing model that focuses on participants' feelings and emotions for simulation based experiences that are particularly emotionally laden. The results of this study have implications for nursing practice, education and research.

Acknowledgments

With the completion of this thesis, I am given the opportunity to reflect and acknowledge the many individuals and organizations that have helped contribute to my success.

Firstly, I'd like to acknowledge and genuinely thank Dr. Nicole Harder, my academic advisor and thesis chair for her endless words of wisdom, answering my endless emails and providing reassurance and support when I felt challenged and helping me see my potential. I have admired your dedication to excellence in simulation and hope to emulate this one day. I would also like to acknowledge and thank Dr. Genevieve Thompson, for your guidance and expertise on qualitative research and palliative care. Your passion for both have been invaluable in my research and I thank you. I would also like to thank and acknowledge Dr. Robert Renaud for your expertise in quantitative research and thoughtful feedback throughout the past four years.

Thank you to the MCNHR specifically James Plohman and Diane Cepenac for your help in grant proposal writing and conducting the study.

I am grateful for the generous financial support of the Manitoba Center for Nursing and Health Research, Foundation of Registered Nurses of Manitoba and the Irene E. Nordwich Foundation scholarship.

I would like to thank St. Boniface Hospital for granting me time away from work as I completed this further education.

Finally, I would like to thank the 98 students who completed the quantitative surveys and the 11 students who participated in the qualitative interviews. Discussing sensitive topics such as caring for palliative patients can be emotional and I thank you for sharing with me.

Dedication

This thesis could not have been completed without the steadfast support of my parents, sister, Chris and friends.

To my dear parents, there are not enough words to express my gratitude for your unwavering support through this process. Early on in my life, you instilled in me that an education is something no one can ever take away from you therefore it's one of the most valuable things in life. Your work ethic, determination and stubbornness are values that I took with me throughout this trying and fulfilling thesis, I could not have gotten through these last few years without your unwavering support.

To my sister, Alli, you were a source of comical relief, a necessary distraction at times when I needed a break from writing, and most importantly a voice of reason when I felt like I could not finish. Thank you.

To Chris, thank you for the encouragement you provided to me throughout graduate school and this thesis. Many tears and moments of joy occurred throughout this process and you were there with me every step of the way, comforting me and celebrating with me when I needed it. This could not have been possible without you.

To my friends, your words of encouragement during the past few years meant more than you know.

Table of Contents

Abstract.....	ii
Acknowledgments	iii
Dedication	iv
List of Tables	vii
List of Appendices.....	viii
Chapter One: Background.....	1
Introduction	1
Theoretical Approach	4
Study Purpose.....	7
Research Question.....	8
Significance of the Study.....	8
Chapter Two: Literature Review	9
Search Strategies for Literature Review	9
Definition of Terms	10
Simulation	10
Palliative Simulation	11
Fidelity	11
Debreifing	12
Degrieifing	12
Emotions/Feelings.....	12
Emotional Preparedness	13
History of Simulation in Related Disciplines	13
Simulation in Health Professions Education.....	14
Modalities of Simulation	15
Palliative Simulation	18
Debriefing.....	19
Forms of Debriefing in Simulation	20
Facilitated Debriefing	20
Self-Debriefing.....	21
Written Debriefing	22
Debriefing and Patient Death.....	23
Chapter Summary	25
Chapter Three: Research Methods and Design	26
Study Design	26
Sample and Setting	28

Recruitment	28
Procedure	29
Simulation Scenarios.....	31
Research Instruments	32
DASH.....	32
Validity.....	34
Reliability.....	34
Debriefing Experience Scale.....	35
Data Preparation and Analysis	37
Qualitative Interview.....	37
Trustworthiness and Integrity	37
Quantitative Survey.....	39
Data Analysis	40
Ethical Considerations	41
Chapter Four: Results	44
Quantitative Data Analysis	44
Sample Demographics	45
Summary of Sample Characteristics	46
Debriefing Assessment for Simulation in Healthcare (DASH) Results	46
Modified Debriefing Experience Scale (DES) Results	47
Qualitative Data Analysis	48
Description of Participants.....	49
Characteristics of the Interview and Transcripts.....	49
Theme – Preparedness	49
Category 1- Preparedness Before Simulation	51
Category 2 –Preparedness During Simulation	55
Category 3- Preparedness After Simulation (Debriefing).....	59
Summary of Findings	64
Chapter Five: Discussion.....	67
Study Overview.....	67
Research Question.....	68
Perceived Value of the Debriefing Process.....	68
Limitations	72
Recommendations for practice.....	73
Future research.....	75
Conclusion	76
References.....	79
Appendices.....	94

List of Tables

Table 1: Demographic characteristics of the sample (n=98)	46
Table 2 :DASH Results.....	47
Table 3: DES Results	48

List of Appendices

Appendix A- University of Manitoba Education/Nursing Ethics Research Board Approval Certificate.....	94
Appendix B –Ethics Appendix B - Amendment Approval Certificate	95
Appendix C- Request for Access Approval from the College of Nursing through	98
Appendix D – College of Nursing Access Approval Certificate	98
Appendix E-Letter of Invitation for Potential Participants.....	99
Appendix F- Poster Advertising Study	101
Appendix G- Script for MCNHR Research Coordinator.....	102
Appendix H- Informed Consent	103
Appendix I-DASH Survey.....	107
Appendix J- Additional Quantitative Questions	109
Appendix K – Demographics	110
Appendix L- Interview Guide.....	111
Appendix M- TCPS 2: Core Certificate	112

Chapter One: Background

Introduction

Nursing programs across North America are increasingly beginning to implement simulation for instructing students in clinical skills. Human simulation is an educational process that can replicate clinical practices in a safe environment (Cant & Cooper, 2010). Simulation-based learning can be integrated across the curriculum, and can be used in conjunction with traditional clinical rotations to increase practice readiness (Hayden, Smiley, Alexander, Kardong-Edgren & Jeffries, 2014). A systematic review of the literature authored by Yuan, Williams and Fang (2012) concluded that there was evidence that implementing simulation in undergraduate nursing education enhanced scores in knowledge and skill competency.

Registered nurses in many practice areas provide palliative care and support to patients and their families. While it has been well documented in the simulation literature that debriefing following a stressful and emotional situation has positive outcomes (Andersen, 2016; Epp, 2012) additional evidence documents that debriefing following patient death is not current practice for many registered nurses (Gillan, Jeong, & Van Der Riet, 2014; Healy, S., & Tyrrell, 2013). When a patient dies, nurses find themselves in conflicting roles. Nurses are expected to remain strong and lend support to distraught families; meanwhile they are often very much moved by the loss of someone with whom they were intimately involved. Consequently, many nurses may adopt ineffective coping mechanisms such as evasion and compartmentalization of the experience to minimize emotional strain. These ineffective coping mechanisms may lead to burnout and other physical and emotional issues (Brunelli, 2005).

Nursing and other healthcare leaders have repeatedly recognized that nurses experience grief when their patients die, however many nurses receive little to no training concerning healthy coping mechanisms and effective debriefing (Wright & Hogan, 2008). The opportunity for health care professionals to manage personal and professional responses to a patient's death is important yet absent (McCoyd & Walter, 2007). Death is a reality in the health care profession and research has described its impact on nurses' and health care providers including emotional stress, distancing and burnout (Melo & Oliver, 2011; Peterson et al., 2010)

Furthermore research has demonstrated that supportive interventions such as opportunities to debrief and reflect on the experience have beneficial properties, such as reducing staff burnout and turnover (Epp, 2012). Despite these studies, nurses are frequently missing the necessary tools and education to care for themselves following patient death. Health care providers such as nurses and physicians regularly indicate that they feel underprepared to care for patients and their families who are actively dying, and desire more debriefing after the event to recognize the challenging nature of the experience with patient death (Birkholz, Clements, Cox & Gaume, 2004; Mooney, 2005).

Research has shown that it can be difficult for student nurses to cope with their own personal emotions and feelings when caring for patients who are dying (Dame & Hoebeke, 2016). Nursing students reported feeling anxious and unprepared to be with patients who are dying. Furthermore, students also experience feelings of helplessness and powerlessness when their patient dies and depending on the length of relationship they have had with their patient, feelings of deep sadness and anguish (Sadala & Silva, 2009). Student nurses report that they often feel unprepared to care for patients who are palliative. Additionally, they have stated that they often do not know how to deal with the emotional reactions that emerge when providing

care and support to the patient and his/her family, and expressed a need to acquire competencies that would facilitate the expression of emotion (Edo-Gual, Tomas-Sabado, Bardallo-Porras, & Monforte-Royo, 2014). Student nurses have reported that being able to talk about and share one's experience regarding a patient death was one of the things that they felt helped "normalize" the death and allowed them to process their own thoughts about that death (Edo-Gual et al., 2014). To process one's emotions and feelings is to learn to understand, make sense of and deal with emotions in healthy productive ways (Vries-Erich, Dornan, Boerboom, Jaarsma, & Helmich, 2016). Folkman (1997) suggested that it also important to consider the role played by positive psychological states in coping with highly stressful situations such as the ability to find positive meaning in a stressful event. Nursing students have stated that they were better able to cope with their own feelings regarding death when they saw it as a learning opportunity, in that the care they provided was of help to a patient (Edo-Gual et al., 2014).

For decades, researchers have suggested that student nurses' first experiences with patient death have a substantial influence on future practice, with attitudes towards death and dying firmly established by the time nurses gain licensure (Chen, Del Ben, Fortson, & Lewis, 2006). Debriefing after a patient death can assist students' in understanding their thoughts and feelings regarding death. Debriefing as a strategy, has multiples purposes and uses in nursing education. While not limited to the clinical setting, debriefing following clinical simulation is considered a fundamental element of the simulation experience (Cantrell, 2008). Further research suggests debriefing and degriefing are crucial aspects to simulation and can be argued as even more important in palliative simulation. Therefore, debriefing following simulation is in itself an important pedagogical aspect of the simulated clinical experience (Parker & Myrick, 2012).

Debriefing sessions also afford learners the opportunity to examine any previous palliative care experiences, both personal and professional in a supportive and non-threatening environment. According to Sanford (2010), debriefing fosters student critical thinking of the lived experience of the simulation and promotes reflection on practice. Endorsing a culture of self-reflection about death, mortality and practice is of utmost importance if students are to grow both professionally and personally (Johnson, Chang & O'Brien, 2009).

The inclusion of simulation learning in nursing education has grown as a pedagogy over the past decade, which utilizes debriefing as a learning method in conjunction with the simulation. Debriefing as an essential component of simulation is an effective learning method to consolidate nursing knowledge and skills for students (Cantrell, 2008). Debriefing enables self-reflective thinking through structured discussion and feedback following simulation experience, enhances decision making, and allows students to adjust undesirable nursing performance (Reed, Andrews, & Ravert, 2013). Effective debriefing facilitates maximized learning outcomes, whereas poor debriefing can be detrimental to the student (Chronister & Brown, 2012). Despite the recommendations through the literature that simulation must have a component of quality debriefing, there is minimal research regarding best practice in debriefing for palliative simulation.

Theoretical Approach

A theoretical framework connects the researcher to existing knowledge. Guided by a relevant theory, the researcher is given a basis for their hypotheses and choice of research methods (Kaakinen & Arwood, 2009). Given the nature of this study, two theoretical frameworks were chosen to guide the study. As the nature of simulation involves a cycle of learning, Kolb's experiential learning theory was chosen to guide the development of the

Simulation Based Experience (SBE) intervention. In addition to this, it became clear that the nature of the debriefing of a palliative SBE would require additional considerations that address the potentially sensitive nature of the type of SBE. A Trauma Informed Care framework was also chosen to specifically guide the debriefing component of this study. Both are described below.

Kolb's Experiential Learning Theory has been selected to provide a basis to guide debriefing and simulation research. Kolb (1984) viewed the process of transference of theoretical knowledge to practical application. Kolb (1984) cited that in 1938, Dewey identified that students must be able to apply abstract classroom concepts to practical situations in order to augment cognitive development, and focused on the thought that learning is a consequence of experience. The theory also provides a framework for the use of simulation and its connectivity to debriefing, in which learners are able to apply their nursing knowledge to the care of a simulated patient within a safe environment, leading to an improved attainment of knowledge.

Kolb's framework is a cyclical process that includes the concrete experience of learners, reflective observation, abstract conceptualization and active experimentation. The physical simulation process represents the concrete experience. Reflective observation takes place following the simulation debriefing. Abstract conceptualization occurs during and after the simulation during the debriefing phase (Poore, Cullen & Schaar, 2014). During debriefing, students are able to formulate a relationship between abstract concepts learned in their lecture and from textbooks and its practical application. Kolb's phase of abstract conceptualization occurs when students discuss new ideas, whether different decisions would have yielded different outcomes, either for the better or worse (Morse, 2012). During the active experimentation phase, students are able to practice learned knowledge during simulation in

future clinical practice and/or further simulation exercises (Morse, 2012). Kolb's theory was determined to be the best framework to guide research pertaining to the evaluation of theoretical knowledge translation into practical competence in simulation based learning in undergraduate nursing students.

Debriefing in simulation-based experiences is considered an essential component of learning (Fanning & Gaba, 2007). The purpose of debriefing in any SBE is to facilitate the participants' ability to relate the SBE to their clinical practice. The debriefing process actively engages participants in reflective critique and discussion regarding their participation and actions during the SBE (Dreifuerst, 2012). As the purpose of this study was to determine the effectiveness of a debriefing session to process feelings or emotions following a palliative care simulation-based experience, it was anticipated that students would have varying personal experiences with death and dying. These previous experiences may or may not be re-lived during the SBE.

It has been identified in social work that indirect exposure to stressful or traumatic events in clinical training can contribute to vicarious trauma in students and faculty (Bussey, 2008; Carello & Butler, 2014; Knight, 2015). Vicarious trauma is when exposure to information of victimization of others results in emotional, cognitive, and other symptoms that echo aspects of the victims' experience (Way, VanDeusen, Martin, Applegate, & Jandle, 2004). With nursing students participating in palliative SBE's, it has been observed that some students become much more emotional than others while engaged in the SBE (Kirkpatrick, Cantrell, & Smeltzer, 2017). While the SBE's in this study reflect a normal death, and do not include traumatic events, each student has a range of past experiences, including abilities to cope with these experiences. It is for this reason that Trauma Informed Care was chosen as the second guiding framework.

Trauma-Informed Care (TIC) is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of traumatic events that emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for provision of services that assists survivors in rebuilding a sense of control and empowerment (Harris & Falot, 2001). In 2009, Harris and Falot identified five fundamental principles to creating and sustaining trauma-informed settings. These principles are ensuring safety, establishing trustworthiness, maximizing choice, maximizing collaboration, and prioritizing empowerment. The framework involves supporting the individual through disclosure, giving them a sense of control, and allowing for informed decision-making (The Trauma Informed Care Project, 2014).

In the palliative SBE and debriefing that are part of this study, students are made aware of the types of scenarios to be experienced ahead of time, are provided with a safe-word that may be used at any time during the SBE that allows them to be removed from the SBE, are provided with the contact information of a psychologist assigned specifically to nursing students, and are participating in groups with debriefing discussion that attempt to normalize the emotional difficulty of the SBE. With this, we are supporting trauma-informed educational practices (Carello & Butler, 2015).

Study Purpose

The purpose of this mixed-method study was to add to the knowledge and understanding about the usefulness of debriefing in palliative simulation-based experiences. The specific aim of this study is to explore the usefulness and effectiveness of debriefing to process any emotions or feelings that students may experience during a palliative simulation-based experience.

Research Question

The target population included third year undergraduate nursing students participating in palliative simulation-based experiences (SBE). The specific research questions that were used to guide this study are:

1. What is the perceived value of the debriefing process in palliative SBE to process student emotions or feelings?
2. How does the quality of the debriefing affect students' emotions or feelings following a palliative SBE?

Significance of the Study

The positive impact that nursing has on improving end-of-life care has been well supported (Lewis, 2013). However, difficulties remain in ensuring that nurses have the skills to process the feelings they experience while providing palliative care. Nursing educators have a duty to prepare their students for this privilege by providing an opportunity to practice in an environment that permits each student to explore their responses to providing palliative care. There is a small but growing body of literature demonstrating the effectiveness of using simulation to educate nursing students in palliative care (Lippe & Becker, 2015; Smith-Stoner, 2009). Research also warrants the use of simulation to educate student nurses regarding healthy and effective debriefing techniques following providing palliative care. This study is significant, as contributions to this developing area of research will allow for the opportunity to evaluate effective palliative debriefing techniques.

Chapter Two: Literature Review

This chapter describes the search and strategies that were used in the literature review, and presents the findings of the review. The literature review was performed to appraise the current literature pertaining to palliative simulation debriefing. Four focused areas of literature will be discussed: simulation in the education of health professions, palliative simulation, debriefing and debriefing in simulated patient death.

Search Strategies for Literature Review

A search for relevant literature was undertaken to assemble the best available evidence relating to debriefing methods in palliative simulation. Using three electronic databases, CINAHL, MEDLINE, and EBSCOhost, as primary sources, a literature review was conducted. This literature review focused on previously conducted research articles that were published in English between the years 1992 to 2017. The keyword searches and phrases “debriefing, high fidelity simulation, debriefing clinical experience, debriefing simulations, end of life nursing, end of life simulation, emotional preparedness, palliative simulation preparation, palliative simulation, futility, palliative care, palliative nursing education, nursing education, and nursing simulation debriefing” were used in the electronic databases. The Boolean operators of “OR” and “AND” were utilized in narrowing down of search results. The abstracts of these articles were further examined and included a variety of topics related to the key concepts of this study: namely, undergraduate nurses, palliative care, and debriefing. Additionally specific criteria were used to ensure the selection of full-text articles that provided the most relevant evidence supporting this study. Articles were excluded if they focused on post-graduate nurses.

Definition of Terms

The Society for Simulation in Healthcare created a Healthcare Simulation Dictionary in order to create clarity and consistency for terms used in simulation (Lopreiato et al., 2016). Clear, concise and standardized terminology allows for effective communication and reflects shared principles in research and publications. Ensuring that information and ideas are communicated with consistent terminology furthers the advancement of the science of simulation. Furthermore standardized terminology enhances understanding and communication among planners, participants, and others involved in simulation-based experiences (Meakim et al, 2013). The following will be a definition of terms that will be utilized often throughout this thesis.

Simulation

Simulation in health care education can be described as a pedagogy, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion (Jeffries, 2007; Sittner et al, 2015).

Nursing is a practice profession in which beginning nursing students are required to acquire knowledge and psychomotor skills, develop self confidence in their abilities and subsequently transfer knowledge to the clinical setting where they have the opportunity to care for their patients (Childs & Sepples, 2006). Technology use in nursing education is rapidly evolving and has the ability to contribute to advancing educational opportunities. Simulation is at the forefront of this technological movement. With simulation, educators can imitate many patient situations and students are able to cultivate their nursing skills in a safe, non-threatening environment (Hayden, Smiley, Alexander, Kardong-Edgren & Jeffries, 2014). Simulation affords

students the opportunity to learn new information and problem-solve real-life situations in a safe and structured setting without the risk of harm to real patients (Childs & Sepples, 2006). Within the realm of simulation in nursing education, there are many degrees of simulation used today such as task trainers, high and low fidelity patient simulators, as well as computer-based programs, virtual reality simulators and standardized patients.

Palliative Simulation

Palliative simulation affords students a wide range of experiences related to pre- and post-mortem care. Simulations provide learners with vital opportunities to explore their own thoughts about mortality and caring for patients who are dying. Palliative simulations focus on the experience of caring for a simulated patient who is at the end of his/her disease process during the scenario and/or interacting with family members. Palliative simulation encourages students to critically think about the pronouncement of death and to focus on care for families in managing transitions before and after death (Lippe & Becker, 2015)

Fidelity

Simulation is categorized according to its degree of fidelity, or its realism (Jeffries, 2007). The word fidelity is often used in the simulation domain to describe the precision of the system being used. Simulation attempts to achieve a high enough fidelity to convince learners they are, in fact, using something that resembles what they would encounter in clinical practice. In simulation, fidelity can be organized into categories from low to high fidelity, however the categorizations are not concrete. Furthermore one simulation device can be used in both high and low fidelity capacities, depending on the way in which it is used and for what purpose (Seropian, Brown, Gavilanes & Driggers, 2004).

Debriefing

Debriefing has long been identified as an intentional and vital phase necessary for the consolidation and transference of learning (Baldwin, 2007; Gaba, Howard, Fish, Smith, & Sowb, 2001; Henneman, Cunningham, Roche, & Cumin, 2007; Rudolph, Simon, Rivard, Dufresne & Raemer, 2007). It allows individuals the opportunity to close the learning loop between the action and reflection phases of experiential learning (Brackenreg, 2004). Debriefing allows for opportunities to discuss and make sense of the events that occurred during a certain experience, and identify opportunities for improvement in a similar situation (Gardner, 2013).

Degriefing

Degriefing is a term that is usually reserved for palliative simulations. Degriefing is the process in which simulation facilitators and learners discuss and process sensitive issues such as palliative care. It is important for learners with emotional responses to discuss their concerns and learn healthy coping mechanisms to these types of simulations. Degriefing after a palliative or futility simulation allows learners the opportunity to voice and express their feelings related to fears they may have regarding death and dying of clinical patients. Furthermore, encouraging facilitators to acknowledge these feelings, fears and apprehensions regarding loss and grief can provide validation to learners (American Association of Colleges of Nursing, 2004).

Emotions/Feelings

A feeling denotes an emotionally tinged experience, coupled with its personal meaning. Emotions originate when an individual pays attention to a situation, assesses it as relevant for his or her needs, values, or goals, and reacts to that situation with a change in behavior and/or and physiology (Scherer, 2000; Seel, 2012). Emotions allow individuals to cope with objects and situations that are potentially dangerous or advantageous. In contrast, feelings are the by-product

of the brain perceiving and assigning meaning to an emotion and are influenced by personal experience, beliefs and memories (Damasio, 2001). Feelings are expressed as overt behaviors, a category that includes sensations such as guilt and pain, and affective states as being happy or sad (Barrett, 2006). Additionally, feelings are usually subconscious, and cannot be measured precisely (Damasio, 2001)

Emotional Preparedness

Preparedness has been defined as something carried out before a crisis to improve the response. It has also been described as a condition or activity to foresee potential problems and project possible solutions and builds abilities and capabilities (Henriksson et al., 2015). Preparedness for death has long been identified as an important factor in family caregiver outcomes and considerable research has established that death preparedness is multidimensional and can be furthered by focusing on cognitive/informational and emotional preparation. As research has indicated that family caregivers benefit from emotional preparedness for the grieving process, it stands to reason that formal caregivers such as health care providers who replace or complement family caregivers would stand to benefit from emotional preparedness as well (Boerner, Burack, Jopp & Mock, 2015). Venkatasalu, Kelleher, & Shao (2015) argued that students experience anxiety especially when faced with the notion of care of dying people and that we must afford students with opportunities to master the essential skill of emotional preparedness.

History of Simulation in Related Disciplines

Historically, simulation can be said to originate from the medieval times with the use of chess and jousting as simulation training (Harder, 2009). Merriam-Webster dictionary (n.d.) describes simulation as a noun and defines it as “something that is made to look, feel, or behave like something else especially so that it can be studied or used to train people”. The practice of

simulation, while customarily associated with military or aviation, has recently become more ubiquitous in nursing. Simulators have been used in training for centuries and vary from low-fidelity static models to high-fidelity simulators that highly reproduce reality (Kable, Levett-Jones & Reid-Searl, 2013). The military and aviation were documented as the first to use simulation, and research in the aviation industry has shown that high self-determined efficacy is related to the predictor of competency during flight (Prinzell, 2002). As in these disciplines, nursing requires quick decision-making and skilled task performance, and in turn simulation can be perceived as a valuable training tool to achieve these skills.

Simulation in Health Professions Education

Prior to the 1950's, health care education was taught didactically, through an instructor lecturing to pupils and physical skills were practiced on patients. Following that, simulation was conducted at a low level of fidelity in nursing education to assist in skill attainment with simulations such as practicing injections on fruit (Harder, 2009). This level of simulation did not afford students a very realistic experience of what patient injections would feel like.

During the 1950's technology became more widespread and development of higher fidelity simulation in nursing education has been noted. Asmund Laerdal developed Resusci-Anne®, a torso mannequin, and helped transform training healthcare professionals in cardiopulmonary resuscitation (Bradley, 2006). In 1960, Abrahamson and Denson created a full-body simulator, Sim One®, and used this reactive simulator to assist the development of psychomotor and decision making skills with anaesthesia residents (Hotchkiss & Mendoza, 2001). In the 1960s and 1970s, issues arose surrounding educators' acceptance of mannequins as an important aid in teaching clinical skills. Lack of research and an exorbitant cost of the mannequins caused deterrence in the acceptance of simulation in educational institutions.

Throughout the 1970's allocation of skills from medicine to nursing was becoming more common as was the emphasis being placed on technology in nursing education (Harder, 2009). During this time period, intrigue was expressed regarding simulation as a useful learning tool, however accessibility still provided challenges. Importance was placed on advanced skill acquisition, and the use of simulations and other technology was emerging as a useful learning tool to achieve this. While accessibility to educational institutions was still an issue, technical advances had been made, and now interest in new teaching and learning approaches was being expressed (Harder, 2009).

The 1980's to the present demonstrated a change in teaching methodology and an even higher increase in curiosity regarding simulation. Educators were beginning to recognize the benefits of simulation and its ability to meet different needs of students and other health care practitioners (Harder, 2009). Along with this, came an interest in researching the benefits and utility of simulation along with a curiosity regarding the potential of simulation in its many dimensions.

Currently simulation in health care and nursing education has a stable foundation. Health care education has now advanced to critically evaluate teaching and learning methods and is amalgamating this new knowledge base with innovative simulation techniques. Progressive teaching and learning approaches, along with research development will continue to advance simulation as a teaching pedagogy (Harder, 2009).

Modalities of Simulation

Simulation is a methodology that attempts to produce attributes of the real world. In healthcare, simulation may refer to a device representing a simulated patient or part of a patient, such as a chest that has audible respirations; these devices may or may not be able to respond to

the actions of the learners. Simulation can also be activities that mimic clinical practice and are designed to allow learners a safe environment to practice decision-making and critical thinking. In health care education, simulation may range from simple to highly technical, and is dependent on the learning objectives and needs of the learners (Durham & Alden, 2008). The different types of simulators are described below.

Task trainers are models that are static and typically represent full or part body models that range from low to high technological features. Learners have a variety of advantages with this type of simulation such as, acquiring technical, procedural and psychomotor skills. These simulation tools are relatively inexpensive, and generally allow for larger numbers of learners to practice simultaneously (Durham & Alden, 2008).

Standardized patients are trained actors that role-play. They can be used to simulate physical assessment skills, history taking, and communication techniques. Trained standardized patients can be trained to reproduce psychological, emotional and physical manifestations while being observed, interviewed or examined by learners (Hill, Davidson & Theodoros, 2010).

Human patient simulators are life-sized mannequins, which can be low or high technology. Low and high technology is used to describe the simulation products that are used, referring mainly to the degree of technology the mannequins possess (Kameg, Howard, Clochesy, Mitchell & Suresky, 2010). When discussing patient simulators low-technology refers to a full size mannequin that can be used to introduce and practice skills prior to performing them on real patients (Durham & Alden, 2008) However, these mannequins lack realism which is necessary for transfer of learning from lab to real-life situations to easily occur (Durham & Alden, 2008). High technology patient simulators are among the most recent technologic advances in instructional methodologies for medical and nursing education (Jeffries, 2007). These interactive mannequins

are capable of realistic physiologic responses, including respiration, pulses, heart sounds, breath sounds, urinary output, and pupil dilation/constriction. Additionally, more advanced models can communicate with the learner, responding to questions posed by the learner in real time during the simulation exercise. These mannequins can respond appropriately to the student's actions, having the ability to elicit observational responses to physical and pharmacological interventions (Jeffries, 2007).

Screen-based computer simulators are designed to model various aspects of human physiology or specific tasks or environments. Through a variety of computer programs, learners use information to make clinical decisions and observe the results in action and there is often feedback during and after the interaction (Durham & Alden, 2008).

Hybrid simulation is an emerging term. Generally, it is when two or more simulation modalities are used in the same simulation activity. In healthcare simulation, a common form of hybrid simulation is the combination of a task trainer or another low-fidelity modality that may be applied to a simulated patient or standardized patient. The purpose of creating a hybrid simulation is to provide a realistic experience for the learner (Lopreiato et al., 2016).

Simulation involves many aspects that educators must recognize and consider for it to be an effective teaching strategy (Seropian et al., 2004). Simulation can be a useful teaching and learning tool, so educators must keep in mind that the selection of the best simulation strategy depends on the learning objectives (Nagle, Mchale, Alexander & French, 2009). There is strong evidence of high learner satisfaction with the use of high fidelity simulation, which is significant as learner satisfaction may enhance student engagement and therefore facilitate learning (Lapkin, Levett-Jones, Bellchambers, & Fernandez, 2010). Selecting the most appropriate simulation method will help achieve desired outcomes for both educators and students.

Palliative Simulation

Of all health care professionals, it has been shown that nurses spend the most time with patients who are dying (Foley & Gelband, 2003). Research suggests that increased experience with death and dying situations has a positive effect on nursing students' attitudes towards patients experiencing this course in their illness and therefore promotes increased quality of care.

(Hamilton, 2010). Historically, palliative care has been taught in undergraduate nursing curricula through theory lectures, clinical case studies, tutorials, hospice visits and audio visual aids (Dickinson, Clark, & Seque, 2008; Kirkpatrick et al., 2017; Lloyd- Williams & Field, 2002).

Providing students with the opportunity to gain competencies in understanding the value of holistic care, therapeutic communication, the need for preserving patient dignity and learning how to incorporate patient's family members during a clinical rotation has proven to be difficult (Leighton & Dubas, 2009). In clinical situations, where a patient is dying, members of the health care team may have apprehensions about students saying the wrong thing to patients and families, or not knowing how to respond appropriately during this sensitive time (Gordon, Wilkerson, Shaffer & Armstrong, 2001). Affording students the opportunity to simulate these clinical scenarios allows students a chance to experience an interactive, hands-on experience in a safe, risk free environment through the use of a patient simulator (Hope, Garside & Prescott, 2011; Kurz & Hayes 2006; Leighton & Dubas, 2009).

Simulation facilitates active and experiential learning, and teaches creative thinking in conjunction with critical problem solving techniques (Bland, Topping & Wood, 2011). It has also been suggested that simulation supports peer interaction and assists in applying previously learned knowledge bridging the gap between theory and practice (Kopp & Hanson, 2012; Sperlazza & Cangelosi, 2009). Current literature supports the need to provide opportunities in palliative

nursing care in a clinical setting and suggests that experiential learning strategies such as simulation can provide student with the opportunity to explore their own ideas about death and what it means to care for patients who are dying, in a safe and supportive environment. Benefits of palliative simulation include the opportunity to learn pain management techniques, therapeutic communication, and the management of transitions before and after death. In addition, the reflection component afforded during debriefing provides students the opportunity to express their thoughts and feeling on the death and dying process (Dame & Hoebeke, 2016; Smith-Stoner, 2009; Venkatasalu et al., 2015). Current research relating to palliative simulation suggests the use of this method as an effective teaching strategy in undergraduate nursing education (Hamilton, 2010).

Debriefing

Several models of debriefing exist related to a healthcare context, and there is no one standard approach to debriefing, though key structural elements have been identified that include 1) the debriefer, 2) participants to be debriefed 3) an experience 4) the impact of the experience 5) recollection and reflection 6) report, and 7) time (Gardner, 2013).

Items 1-3 are fairly straightforward and will be explained briefly. Item one, the debriefer, is the individual who guides the debriefing session. Item two, the participants to be debriefed, are the individuals who have participated in the situation and will be led through a debriefing session. Item three, the experience, is the actual occurrence that requires debriefing. Item four, the impact of the experience refers to the emotional impact of the situation. These are the reactions that occur immediately after a simulation or clinical situation. This is when participants have congregated to discuss the recent situation and conversations tend to be emotionally charged and do not require facilitation from the debriefer. Item six may range from the students writing a formal report to

completing a survey and item seven refers to the amount of time that has passed between the end of the experience to the beginning of debriefing (Gardner, 2013). Debriefing is most successful if it occurs immediately after the scenario.

Consequently, the aim of debriefing is to create real time representations of interactions and to build on existing knowledge to form representations of clinical problems through pattern recognition and cognitive inference (Wotton, Davis, Button, & Kelton, 2010). Debriefing facilitates students' articulation of actions and rationales, knowledge and skills. Although debriefing is not a time to lecture or introduce new knowledge or ideas, it can be an opportunity to highlight the nursing knowledge, skills, and attitudes that were evident in the experience or simulation and explore issues that arose (Decker et al., 2013; Neill & Wotton, 2011).

Forms of Debriefing in Simulation

Despite the recommendations through the literature that simulation must have a component of quality debriefing, there is minimal research regarding the best format for debriefing for simulation to occur. The literature consistently speaks of three different types of debriefing; self-debriefing, written debriefing and facilitated debriefing. Below is a summary of all three formats.

Facilitated Debriefing

Traditionally, transfer of information from instructors to learners has been the main way of conveying and transferring information in most skill-based professions such as nursing. However, research shows that individuals learn far better as active participants responsible for their own learning process, rather than as passive recipients of wisdom imparted from instructors (Decker et al 2013; Shin, Sok, Hyun, & Kim, 2015). Furthermore, for learners to become true experts and to continue their professional growth beyond formal training, they must also develop critical thinking skills. Among these skills is the ability to critically analyze one's own performance

retrospectively, not just what went well and what went wrong, but *why* it went that way, which requires practitioners to critically re-examine the situation confronting them.

Rudolph, Simon, Dufresne and Raemer (2006) argue that the goal of the facilitator should be to lead the learners' to the issues he or she observed affecting performance during simulation. A large part of the job of the facilitator is to help learners' articulate and explore those processes, and to develop their critical thinking skills in this regard, so that they can readily explore the same issues arising in real patient care settings.

Unfortunately, facilitators are rarely explicitly trained in the art of facilitation and debriefing. Facilitators need both a structure and specific techniques to make facilitation effective. Among the techniques that facilitators should master are: the use of questions to elicit team participation, lead the team to topics, and to deepen discussion; the strategic and tactical uses of silence and active listening (e.g., nonverbal, echoing, reflecting, and expanding). Researchers encourage the healthcare community to expand the use of facilitated debriefings, especially following challenging simulations of individuals and teams, and to further develop explicit training for instructors so that this approach can be used to its greatest benefit in these important arenas. To have the maximum effect, these facilitated team debriefings should be performed after real patient care situations such as in post conference following clinical as well, not just during simulation exercise (Rudolph et al., 2006). Furthermore, when it comes to reflecting on complex decisions and behaviours of health care professionals there is no substitute for skilled humans facilitating an in-depth conversation with their peers.

Self-Debriefing

The existing debriefing literature for facilitators provides guidance on how to create an environment in which learners feel simultaneously challenged and psychologically safe (Rudolph

et al., 2006). A misworded statement from the facilitator during a debriefing can have serious implications for a learner such as; humiliation, decreased motivation, and a hesitancy to ask questions in the future (Rudolph et al., 2006). Furthermore, by definition, instructor-facilitated simulation requires the presence of an experienced facilitator for the duration of the simulation session. Instructor facilitated debriefing faces challenges such as acquiring sufficient funding for human resources and appropriate training to implementing a simulation curriculum (Rudolph et al., 2006). Self-guided debriefing may address this barrier and may potentially be more cost effective than facilitated debriefing.

Self-assessment encourages learners to identify their own strengths and opportunities. This skill is crucial to self-regulating professions such as nursing that pride themselves on lifelong learning and the maintenance of professional competence (Leach, 2002). Self-assessment can be conceptualized as being either summative or formative. Summative assessment (assessment of learning) typically refers to judgment and scoring of learning, while formative assessment (assessment for learning) aims to inform and guide learning using constructive feedback (Ward, Gruppen, Regehr, 2002). Self-debriefing has a role to play in simulation debriefing but it should be utilized as an adjunct to facilitated debriefing, and not applied independently.

Written Debriefing

Written debriefing is an experiential learning activity in which learners have the opportunity to express thoughts about their experiences and feelings through written word. Literature suggests that it should occur following oral debriefing and allows for some private time to examine behaviours, emotions and feelings (Petranek, 2000). Longer reflection is essential for learning, and it brings perspective to the whirlwind of activity such as simulation during critical events.

Extensive guidelines have evolved in the field for oral debriefing that also apply to written debriefing. Simulation has emphasised the importance of oral debriefing, so that the simulation activity is supported in theory (Cantrell, 2008). Petranek, Corey, and Black (1992) highlighted oral debriefing and proposed journal writing as another debriefing technique. Written debriefing compels learners to decipher the simulation experience on a personal basis. If one considers the theory of simulations, one realizes that participants learn by doing (Kolb, 1984). Written debriefing is the next step in the learning process because individuals are again learning by doing. A notable difference with written debriefing is that a learner has had time to reflect on his or her actions and emotions and hear about others' experiences. Most theorists of debriefing have stressed reflection, but in oral debriefing there is so little time (Cantrell, 2008).

A benefit of written debriefing is that it allows the facilitator a chance to access the learning for each individual participant without having to assume that everyone learned the main concept from the oral debriefing. As the facilitator reads the written assignment, they are able to judge the degree of learning that took place among the learners.

There are many different forms that written debriefing can take and the literature does not lend preference to any specific method. Written debriefing methods include journal writing, written concept technique, letters and written answers. Written debriefing is a vital step in the experiential learning process (Petranek, 2000).

Debriefing and Patient Death

Nursing is known to be a stressful profession, and one of the leading stressors is patient death (Wilson & Kirshbaum, 2011). Caring for a palliative patient and their family requires nurses to balance societal expectations, as well as potential moral and ethical dilemmas, all the while providing culturally safe and holistic care, along with family education and support. Furthermore,

nurses are also tasked with managing complex symptoms all the while attempting to provide the patient with the comfort and dignity they deserve (Mallory, 2003; Mitchell, Bennett, & Manfrin-Ledet, 2006). Nurses who identify experiences with death early in their careers as negative encounters can also experience feelings of inadequacy and helplessness, as well as employ ineffective coping mechanisms such as suppression, isolation, and avoidance (Cooper & Barnett, 2005; Kent & McDowell, 2004; Terry & Carroll, 2008).

Recent studies demonstrate the need for grieving health care professionals to be offered emotional support and opportunities to make meaning of the events that transpired leading up to death (Lee & Dupree, 2008). Papadatou (2000) proposed a model for how health care professionals grieve and has suggested a multifaceted approach to supporting health care professionals, including informational, clinical, and emotional support, as well as opportunities for meaning making. For example, John Hopkins Children's Center offers bereavement-debriefing sessions as just one intervention in part of a larger pediatric palliative care program focused on providing support to clinical staff. Other supportive interventions include palliative care educational forums for information support, patient care conferences for health care team member support, bereavement debriefing sessions for emotional support, and rituals of remembrance as opportunities for meaning-making (Rushton et al., 2006).

Parallels are seen in studies regarding nursing students and their need to be supported in order to develop their capacity to care for palliative patients (King-Okoye & Arber, 2013). Student nurses struggle to deal with death and dying and research has shown that they do not worry over the actual experience of caring for their patient but rather their greatest concern is of not having control of their own reactions (Parry, 2011; Sadala & Silva, 2009). It is vital that student nurses are given the opportunity to become aware of and reflect on potential feelings that may arise (Edo-

Gual et al, 2014). When students are not given support in caring for dying patients throughout their education, they tend to avoid forming relationships and tend to focus on providing strictly basic care (Mallory, 2003). Supportive interventions include providing students with the opportunity to practice reflective practice and continued support throughout their time spent caring for palliative patients (Ek et.al, 2014). Group or individual group debriefing sessions after a palliative experience are appropriate for providing support to students. Students will benefit from the support that a guided opportunity to discuss the experience will have. Additionally, having students work alongside a staff nurse in providing physical, emotional and spiritual care to a palliative patient can also strengthen the student experience. Ultimately, if nursing educators can increase student knowledge, understanding and acceptance of caring for palliative persons it will translate into increased student comfort and confidence, which will in turn become improved nursing care of individuals and their families (Allchin, 2006).

Chapter Summary

In this chapter, topic related literature was reviewed. Debriefing is indisputably the heart and soul of simulation. Other simulation debriefing authors agree and refer to debriefing as the pivotal point in simulation (Baldwin, 2007), but there is little evidence of data-based investigation in debriefing practices following palliative simulation. To ensure clear communication, key words were defined (simulation, palliative simulation, fidelity, debriefing and degriefing). A chronological history of simulation in nursing was examined, as were the various modalities of debriefing. Finally, debriefing and patient death was reviewed and yielded important information. This portion of the literature review informed us that, indeed debriefing following patient death is a necessity, however nurses feel that they lack the adequate skills, training and knowledge to do this effectively resulting in possible negative outcomes.

Chapter Three: Research Methods and Design

The purpose of this study was to add to the knowledge and understanding about the usefulness of debriefing to process emotions and feelings experienced following a palliative simulation with undergraduate nursing students. The sections in this chapter include the study design, sample selection and setting, procedures, as well as data preparation and analysis. In this chapter, ethical considerations are also discussed.

Study Design

For this study, a mixed methods approach was selected. Mixed methods research is an approach to inquiry that combines both qualitative and quantitative approaches. It utilizes both approaches in conjunction so that the overall strength of the study is greater than either individual quantitative or qualitative components (Creswell, 2009). The specific mixed method design that was used for this study is the concurrent triangulation approach.

The concurrent triangulation approach to a mixed methods research design allows the researcher to collect both quantitative and qualitative research concurrently and then compares the two databases to determine if there is a convergence, differences, or a combination (Creswell, 2009). This traditional mixed methods approach often yields in well-validated and substantial findings (Creswell, 2009).

A mixed methods approach to research has many features that makes it appropriate to investigate the usefulness of debriefing following a palliative simulation based experience to process feelings experienced newly registered nurses' perceptions. Specific to qualitative research, Munhall (2012) noted that researchers conducting basic qualitative research are primarily interested in "what happened to the person, what they feel like, and how they experienced the event" (p. 21, 2012). According to Munhall (2012), to understand qualitative research, it is

important to realize that “the source of knowledge comes from the knower and the people who are the knowers provide outcomes of qualitative research” (p. 21). Typically, data is collected through analysis of observations, and interviews. Analysis is then conducted by organizing the data according to themes or reoccurring patterns (Munhall, 2012). Creswell (2009) explained that qualitative research focuses on describing or understanding phenomena, and allows the researcher to become more intimate with and further their proficiency of the topic of interest. This study design benefitted the researcher by allowing the researcher to gain an awareness of the participants’ insights, attitudes, and experiences using flexible open-ended questions (Brink & Wood, 1998).

Specific to quantitative research, describing the data occurs first and secondly an attempt is made at inferring what the effect of a particular intervention is in the population from which our sample came from (Abrahms & Scragg, 1996). Research is gathered empirically, and generally phenomons are measured by attaching numeric values that express quantity (Polit & Beck, 2012). This research occurs systematically through a series of steps, and data is gathered according to an established plan. Wherein qualitative research, researchers are often interested in understanding *why* a particular person feels/thinks a certain way, quantitative research looks to understand what factors influence people generally (Polit & Beck, 2012). This study design benefitted the researcher by allowing the researcher to gain an awareness of the overall populations’ thoughts and feelings regarding the debriefing following their SBE.

A mixed methods design allowed the researcher to thoroughly investigate the usefulness of debriefing following a palliative simulation in undergraduate nursing students to process emotions and feelings experienced. Data from both stages of the study was incorporated to expand

the understanding of student's perspectives to provide the best possible data to answer the research question.

Sample and Setting

A convenience sample of baccalaureate students from the University of Manitoba's College of Nursing, meeting the inclusion criteria, were recruited. Convenience samples are particularly useful when researchers need potential participants to come forward and identify themselves (Polit & Beck, 2012). Inclusion criteria included third year nursing students who were currently in NURS 3540, a clinical course, and currently participating in palliative simulation. The students could be taking courses on either a full or part-time basis. Students must also have participated in simulation in their second year of nursing. Third-year nursing students who were registered in the College of Nursing in the winter term of 2017, and who had completed the required courses were invited to participate in the study.

As there are no fixed rules on sample size in mixed methods research, qualitative data was collected until data saturation occurred (Polit & Beck, 2012). Morse (2000) furthers this by indicating that the number of participants necessary to reach data saturation is dependent on a variety of factors. Those factors include the scope of the research question, quality of data from participants, and the sensitivity of the phenomenon being studied. This study continued accepting participants for interviews until data saturation occurred, that is, data was collected until no new themes or messages emerged.

Recruitment

Upon receiving ethics approval (Appendix A, Appendix B), an access approval from the College of Nursing through Manitoba Centre for Nursing and Health Research (MCNHR) was attained to access participants (Appendix C, Appendix D). Methods for recruitment were as

follows. A research coordinator from the MCNHR made an announcement in one of the students' classes, the study was introduced and students were invited to participate. Following that, an invitation (Appendix E) to learn more about the study was emailed to the students by the MCNHR in January 2017. Posters advertising the study were placed in two hallway bulletin boards to increase student awareness regarding the study, along with posters in the simulation lab (Appendix F). Potential participants had the opportunity to contact the MCNHR as indicated on the poster for further explanation of the study. The researcher was not directly involved in the recruitment process, however was available via the MCNHR to answer any questions that students may have.

To increase the response rate, incentive to participate in the qualitative interviews included being entered in a draw to win 1 of 10 gift-cards valued at \$25.00 to the University of Manitoba bookstore, which occurred on March 1st, 2017. The MCNHR conducted the draws and awarded the gift cards to the students. The MCNHR managed awarding the incentives, including keeping confidential the documentation of receipt of the incentive. All gift card recipients were notified by the MCNHR by their U of M email address.

Procedure

At the beginning of the day of simulation, an announcement was read by the MCNHR Research Coordinator asking students if they would like to participate (Appendix G). Those who were interested consented to participate via the consent form (Appendix H) attached to the front of the surveys following their simulation based experience. The surveys were based on the Debriefing Assessment for Simulation in Healthcare (DASH) model (Appendix I), along with seven quantitative questions that the researcher has adapted for this study from the Debriefing Experience Scale (Appendix J), and a demographics questionnaire (Appendix K). The surveys

were administered as a first step of the study in order to obtain quantifiable data on the overall effectiveness of the debriefing following a palliative simulation.

The participants were assigned to a simulation session within the course, NURS 3540, as usual. They then proceeded with their simulation and debriefing as they normally would. They were asked to complete the surveys as part of their coursework and had the option to consent to allow anonymous data to be used for this research study. Once the surveys and consent forms were completed, the attached consent forms were detached by the simulation facilitator prior to being given to the primary researcher. This was done so they could not be linked to each other. The simulation facilitator did not grade or evaluate the student in any course. There was a check box on the consent form asking if the students would like to consent to the interview portion of the study. If they decided that they would like to participate in the interview, the researcher contacted them to arrange a mutually agreeable time and location for the interview. The participants then had an opportunity to sign up for a one-on-one interview with the researcher to discuss the debriefing further. Using a concurrent triangulation mixed methods strategy, the researcher was able to obtain information regarding student's perceptions of effectiveness and usefulness of debriefing using two different data sources (Creswell, 2009). Furthermore, using a concurrent triangulation method afforded the researcher the ability to capture the multiple dimensions of nursing student experiences during a palliative simulation based experience. The interview was audio recorded for transcription purposes. A transcriptionist hired through the MCNHR transcribed the interviews. The transcriptionist signed pledges of confidentiality through the MCNHR. Once the interviews had been assigned an anonymous code as identifiers, the researcher's advisor was granted access to the data.

Simulation Scenarios

The simulation based experiences were conducted at the University of Manitoba's main campus. As part of the standard University of Manitoba, College of Nursing curriculum, students were assigned to participate in simulation based-experiences as part of their clinical course. In preparation for their clinical simulation days, students had pre-learning activities and pre-briefing sessions prior to starting their SBE. This was facilitated by a simulation facilitator. Over the course of two days, each student group participated in a series of six 50-60-minute scenarios, with debriefing taking place immediately after each SBE. Two of these simulation sessions were based on palliative care and one of the sessions was a part of this study. The SBE's that was a part of this study was titled: Communication Sim: Coping with Diagnosis. In this SBE, there were various concepts of palliative care, death and dying, and communication that were addressed.

The modality of simulation used for the SBE's was a hybrid simulation technique. More specifically, a Shadow Box technique, combined with role play was used. The Shadow Box technique is a series of videos created by experts that allow students to see the world through the eyes of the expert without having the expert present (Hintze, 2008). The purpose is to develop higher-level cognitive skills by watching videos with decision points ranked by experts. The SBE began with the pre-briefing, followed by an introductory video. From there, the students engaged in role play to determine their response to the situation. A second video depicting an expert response was shown, followed by a debriefing that included comparisons between novice and expert responses. On the day of the simulation session, the students received a 10-minute pre-briefing to orient students to their roles and activities. There were 10 students in this simulation. In this simulated palliative experience, the students watched a video of a young woman who had been recently diagnosed with cancer and underwent surgery. This woman asks the nurse how she

is going to speak to her young children about her terminal status and strategies she can use. The students then brainstormed among each other how to respond to this patient. The students then watched a second video where an expert nurse interacts with the same patient. The students then participated in a facilitated debrief discussing how and what to say as a group which lasted approximately 30 minutes. Following completion of the debriefing, students were asked to complete the surveys as part of their normal coursework and could consent to having their surveys used for data collection if they so choose to.

Research Instruments

DASH

The Debriefing Assessment for Simulation in Healthcare (DASH) was developed by the Center for Medical Simulation (Appendix I). The DASH is based on an extensive literature review as well as best debriefing practices derived from an expert panel. The students completed a DASH survey following the end of their simulation based experience. The DASH evaluates the strategies and techniques used to conduct debriefings by examining concrete behaviors. It is based on evidence and theory about how people learn and change in experiential contexts. The DASH has been developed to identify a set of generally accepted best practices for effective and ineffective debriefing, and in particular designed to assess debriefing quality in a variety of simulation environments across health care disciplines and educational objectives. There is a student and facilitator version of the DASH. Learners use the student version of the DASH to rate the quality of debriefing that they experienced with the faculty facilitator.

There are six elements in the DASH; **Element #1 –Sets the stage for an engaging learning environment.** This rating has to do with how well the debriefer introduces the simulation experience and the course. **Element #2 – Maintains an engaging context for**

learning. Throughout the debriefing, the instructor helps trainees be clear about what is expected of them, helps them, learn from a simulated clinical setting, feel that the environment is safe for sharing thoughts and feelings, e.g., that they won't be shamed or humiliated; and that the focus is on learning, not on "catching" people in a mistake. **Element #3 – Structures debriefing in an organized way.** An effective debriefing should have a start, middle and end; each phase has a purpose. In this instrument, the phases are collapsed into a starting reactions phase, a middle understanding phase (that includes both analysis and generalizing to other settings) and a summary phase. **Element #4 - Provokes interesting and engaging discussions and fosters reflective practice.** This rating is an assessment of how well the debriefer engages the participants in interesting discussions and helps them to be reflective practitioners. **Element #5 – Identifies performance gaps.** Debriefings should provide participants concrete feedback about performance. When performance is sub-optimal, the debriefer explores the basis for the performance gap including knowledge, skills, and attitudes. **Element #6 – Helps close performance gaps.** This rating refers to how effective the debriefer helps learners to close negative performance gaps or to repeat excellent performance.

Raters score each element using the dimension descriptions and example behaviours as guides. A DASH score is comprised of six element ratings. The scale for each element is based on a 7-point effectiveness rating. The rating scale is as follows; 7 - extremely effective / outstanding, 6 - consistently effective / very good, 5- mostly effective / good, 4-somewhat effective / average, 3- mostly ineffective / poor, 2-consistently ineffective / very poor, 1-extremely ineffective / abysmal (Simon, Raemor & Rudolph, 2010).

Validity

The DASH was reviewed for content and usability by eight simulation experts from the United States and Canada. These experts had at least 5 years of experience in simulation and debriefing. In the first round of feedback, experts reviewed the rater's handbook, discussed each element, and suggested edits and asked questions that were used to make the language easier to understand. After that initial review, the experts reviewed and completed the DASH for two demonstration videos and two debriefing videos and made further modifications. Finally, using a teleconference format, final suggestions for changes were made to the language of the elements and behaviors to reflect language familiar to clinician educators.

After refining the instrument, 114 international health-care educators participated in 4.5-hour interactive DASH rater training session to further provide validity. The participants included a broad range of health care providers and educators from community-based hospitals and academic medical centers. The means for each of the videos that were rated were compared using a one-way repeated-measures analysis of variance comparing three video types: poor, average, and superior. The differences for the ratings across the three standardized debriefing were statistically significant with overall means of 2.18, 4.77, and 5.35 for the poor, average, and superior videos, respectively. These ratings indicate that differentiation between the quality of debriefings is effective using the DASH (Brett-Fleegler et al., 2012)

Reliability

Interrater reliability was measured using the same 114 rater trainees' ratings at the element level and the overall mean of the six elements and intraclass correlation coefficients. The overall intraclass correlation coefficient overall coefficient was 0.74. The videos were rated as poor, average, or superior, and the Cronbach's coefficient alpha was calculated using the average video

data. The average video was the most difficult to rate as it did not represent an extreme of performance and hence was selected for estimating internal consistency. The resulting Cronbach coefficient alpha was reported as .89, which is a strong indicator of internal consistency which means that the DASH survey is reliable for the assessment of healthcare simulation debriefings.

Debriefing Experience Scale

The Debriefing Experience Scale (DES) was developed to evaluate the nursing student experience during debriefing following simulation and is comprised of 20 items that are divided into four subscales (Reed, 2009; Reed, 2012). The subscales of this tool are: Analyzing Thoughts and Feelings; Learning and Making Connections; Facilitator Skill in Conducting the Debriefing; and Appropriate Facilitator Guidance. These subscales utilized a Likert-type rating from 1 (*strongly disagree*) to 5 (*strongly agree*). For the purpose of this research, the two subscales: Analyzing Thoughts and Feelings and Learning and Making Connections were utilized.

The subscale, Analyzing Thoughts and Feelings questions students related to emotional, psychological, behavioral, and environmental aspects of debriefing. Debriefing is a time for learners to reflect on their experience and emotions and also a time to affirm those feelings felt (Cantrell, 2008; Jeffries, 2006). The second subscale, Learning and Making Connections focuses on the learning that takes place during debriefing. Debriefing literature argues that debriefing is a venue for learning and is a vital step in experiential learning (Kolb, 1984; Reed, 2009; Rudolph et al., 2007).

Validity

This instrument was developed following an extensive review of simulation literature, with an original scale consisting of 37 items. Three nationally recognized simulation experts reviewed it for content and wording, with two additional items were identified by the experts and added to

the tool (Reed, 2012). During instrument development, pilot testing was performed and the DES was administered to undergraduate nursing students in a baccalaureate nursing program. Students participated in three types of debriefing, oral discussion, journaling and blogging and rated their debriefing experience using the DES. For additional content validity, a comments sections was included for input from students concerning scale clarity, item wording, and scale format (Reed, 2012)

From the data collected, exploratory factor analysis and item analysis were performed, following factor analysis, 29 items were left in the overall scale and wording was changed based on student comments (Reed, 2012). The tool was then refined a second time, and testing was done with two groups of students who had participated in either video-assisted oral discussion debriefing or oral discussion without video. During the second factor analysis process, nine items were removed from the final version of the scale. Items in the four factor areas were then identified as subscales on the final version of the scale. A Likert-type rating, from 1 to 5, is present for all 20 items in both scale areas.

Reliability

The resulting Cronbach coefficient alpha was reported as .80 for Analyzing Thoughts and Feelings subscale and 0.89 for Learning and Making Connections subscale, which is a strong indicator of internal consistency (Reed, 2012).

The researcher adapted 7 questions from this tool for this study (Appendix J). The original tool had generic questions asking students about thoughts and feelings following simulation debriefing. I added the word “palliative” to questions 1,2,6 & 7 to ensure students understood that they were to discuss their thoughts and feelings in relation to the palliative simulation debrief they had just participated in. The subscales used to guide the additional questions used for this study

were Analyzing Thoughts and Feelings and Learning and Making Connections. Subsequent reliability and validity were not conducted for this adaptation.

Data Preparation and Analysis

Qualitative Interview

To ensure that a specific set of topics was covered pertinent to the study purpose a semi-structured interview was conducted with students who agreed to participate. Polit and Beck (2012) note that “the role of the interviewer is to encourage participants to talk unreservedly about all topics on the guide and to tell stories in their own words” (p. 537). DiCicco-Bloom and Crabtree (2006), further this by adding that in-depth interviews should be personal and intimate encounters in which open, direct, verbal questions are used to elicit detailed narratives and stories. An interview guide was developed based on supporting literature including the Debriefing Assessment for Simulation in Healthcare (DASH) student version (Simon et al., 2010) and the International Nursing Association for Clinical Simulation and Learning: Standards of Best Practice: Simulation Standard VI: The Debriefing Process (Decker et al., 2013) (Appendix L). A checklist of points was discussed with the participant prior to commencing the interview including; format of the interview, approximate length of interview, purpose of digital recorder - asking permission to use it, explaining who will listen to the recording, assuring participant that he or she may seek clarification of questions, assuring participant that he or she can decline to answer a question and assuring participant that there would be opportunity during the interview to ask questions (Rose, 1994).

Trustworthiness and Integrity

High quality qualitative research is imperative to advance the science of nursing. Language is the medium in which health behaviours, policy and practice are created and understood yet in

many health science disciplines, nursing included, research analysing qualitative data comprises a tiny component of the research spectrum (Rolfe, 2006). A quality framework developed by Lincoln and Guba (1985) is most often used by qualitative researchers according to Polit and Beck (2012). This framework consists of four criteria; credibility, dependability, confirmability and transferability that establish trustworthiness of qualitative research (Polit & Beck, 2012).

Credibility speaks to the confidence in the truth of the data and interpretations of them (Polit & Beck, 2012). In order to ensure credibility, the researcher conducted peer debriefing to ensure credibility.

Peer debriefing is a process of revealing oneself to a peer by presenting an oral or written summary of the data for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the researcher's mind (Polit & Beck, 2012). Peer debriefing occurred, as all data was shared in a written summary with researcher's thesis committee chair.

Dependability is the second criterion in Lincoln and Guba's framework, which refers to the stability of the data collected over time and varying circumstances. Lincoln and Guba also stress the closeness between credibility and dependability, in that, without dependability, credibility cannot be attained (Polit & Beck, 2012). The researcher maintained an audit trail consisting of materials and documentation that would allow an independent auditor to come to independent conclusions regarding the data. To ensure dependability the researcher asked the thesis committee chair to review the study's methods along with several transcripts. Furthermore, discussion took place to discuss emerging themes between the thesis committee chair and the researcher to further confirm dependability.

Confirmability in qualitative research can be referred to as objectivity, in that, if two or more independent researchers were to conduct similar studies, a resemblance in data accuracy and

relevance would be noted (Polit & Beck, 2012). This criterion in Lincoln and Guba's framework is concerned with ensuring that the researcher's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher (Shenton, 2004). Detailed methodological description enables the reader to determine how far the data and concepts developing from it may be accepted. Essential to this process is the "audit trail", which allows any reader to track the course of the research step-by-step via the decisions made and procedures, described (Polit & Beck, 2012). An audit trail is provided as the researcher has provided a detailed description of the research methodology described above and data analysis and discussion of findings are discussed in subsequent chapters.

The fourth criteria in Lincoln and Guba's framework are transferability. Transferability is the ability to apply the results of the study in other settings or groups (Polit & Beck, 2012). The researcher could not facilitate the transferability of the findings, but interviewing study participants of different ages and at different points in their lives may aid in the transferability of the findings.

Conducting high quality qualitative research consists of not only credible methods and strategies but also ensuring trustworthiness and integrity. By describing how this research is credible, dependable, confirmable and transferable reinforces its trustworthiness and integrity.

Quantitative Survey

The DASH survey has questions evaluating the debriefing component of the palliative simulation based experience. The adapted DES survey had questions evaluating the effectiveness of the debriefing specifically related to its ability in assisting students in processing feelings and emotions experienced in palliative simulation. The surveys took approximately 10 minutes to

complete and was part of the normal coursework. However, only those students who had consented to participate in the study had their data included in the analysis.

Data Analysis

The researcher hired a transcriptionist and had complete verbatim transcription of the digitally audio-recorded interviews done.

The objectives of data analysis in qualitative research are to organize, provide structure to, and elicit meaning from data (Polit & Beck, 2012). Verbatim transcripts were read to classify and index data according to preliminary categories or themes. Transcripts were re-read in order to identify emerging or recurring themes. Once the categories had been identified, transcripts were reread and coded for correspondence to the categories. The excellence of the research rests in large part on the excellence of the coding (Polit & Beck, 2012). A code in qualitative inquiry is most often a word or short phrase that symbolically assigns an essence-capturing word for a portion of language-based data (Polit & Beck, 2012).

As indicated by qualitative research experts (Creswell, 1998) the process of coding involved aggregating the text, seeking evidence for the code in the interview transcripts, and then assigning a label to the code. Methods of data analysis for the interviews consisted of recommended techniques (Creswell, 1998) including line-by-line coding, focused coding, development of categories, field notes and theme development.

The student's DASH tool and additional quantitative questions utilized Likert-type questions and provided data to be analyzed. Statistical analysis was completed by using Statistical Package for Social Sciences (SPSS) V.24.0 (Kinnear & Gray, 2012). By completing a statistical analysis, the validity and reliability of the data has been assured (Plichta & Garson, 2009). Screening and cleaning of this data was completed. Cleaning the data is the process of making

certain that all variables have valid usable values (Plichta & Garson, 2009). The Likert-type question responses were numbered for quantitative analysis from 1-7. Descriptive statistics including frequency, percentage, mean and standard deviation have been performed to identify the effectiveness of debriefing following the simulation-based experience. Mean scores were calculated for each question, higher scores implied that the overall debriefing session was effective and lower scores implied ineffectiveness of the overall debriefing session.

These two sets of data have been analyzed, and are compared to one another. Findings have been interpreted and integrated which is described in the final discussion section.

Ethical Considerations

Polit and Beck (2012) assert that when humans are used as study participants, carefulness must be executed to ensure their rights are protected. After agreeing to participate in the proposed study, each participant was required to sign an informed consent form (Appendix H) that detailed the nature of the study. Every precaution was taken to protect subjects from any physical or mental harm. As there was a potential risk of emotional distress when interviewing undergraduate nurses about their experiences with palliative simulation, the researcher used empathy and active listening skills during the interviews and participants were provided with the contact information for the student counselling services at the university. Participants were reminded that they may end the study during any point without repercussion or penalty. The participants did not receive any monetary benefits, nor did they receive extra credit for their participation and there was also no cost to the participants for their participation in the study. The researcher's supervisor and the researcher were the only individuals privy to the data. To protect confidentiality of all study participants, and to reduce bias, an identification number was randomly assigned to each participant. Each identification number was kept in an encrypted file on the researcher's computer

and the researcher's supervisor had access as necessary. Research data will be kept for seven years and then erased permanently. Participants wishing to receive results of the study indicated this on the consent forms and the researcher will mail a summary to any participants requesting feedback.

As with all SBE's, psychological safety must be ensured. Psychological safety has been demonstrated to be a necessary component for learning-oriented behaviors such as asking questions, sharing one's thoughts, and asking for assistance. Psychological safety helps diminish defensive behaviors triggered by feelings of personal threat such as withdrawing; and ego defenses such as mocking or denigrating the simulation activity (Rudolph, Raemer, & Simon, 2014). Prior to beginning the SBE, the simulation facilitator informed the students about the safe word for that particular day, and if the student felt the need to stop their participation in the simulation for any reason, they were able to say the safe word and be removed from the situation without question. The students at the University of Manitoba also have access to free counselling through the University's Student Affairs department.

The researcher does hold a teaching position at the University of Manitoba's College of Nursing and did teach those students in another course. The researcher taught the students early in the term, and had no contact with the students beginning three weeks prior to data collection. The researcher was not involved in any means of assessment or evaluation of the students. The researcher was familiar to the students, but as a previous instructor, not a current or future one. The researcher ensured that it was made clear that they are not in position of evaluation or influence over any academic grading.

The researcher also successfully completed the online tutorial, TCPS 2: CORE (Course on Research Ethics) consisting of eight modules (Appendix M). This tutorial is an introduction to the 2nd edition of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans

(TCPS 2). The tutorial provides ethical research education and is applicable to all research regardless of discipline or methodology.

Conclusion

This mixed-method design study has addressed the following question: Is debriefing useful and effective to process thoughts or feelings that undergraduate nursing students may experience during a palliative simulation-based experience? Data was collected using the quantitative DASH tool (Appendix I), along with 7 quantitative questions that the researcher has adapted for this study from the Debriefing Experience Scale (Appendix J), and a demographics questionnaire (Appendix K) along with qualitative semi-structured interviews. Data analysis followed using SPSS 24.0 for the descriptive statistics of the results from the DASH tool, and thematic analysis of the qualitative data occurred concurrently. Recruitment and ethical considerations have also been discussed. The next chapter will focus on the results from the study.

Chapter Four: Results

In this chapter, the results of the study are reported. Demographics of the sample population are first described, followed by quantitative and qualitative results related to testing of the research question.

The purpose of this study was to address the following research questions:

1. What is the perceived value of the debriefing process in palliative SBE to process student emotions or feelings?
2. How does the quality of the debriefing affect students' emotions or feelings following a palliative SBE?

Quantitative data was collected on February 8th and 10th, 2017 and qualitative data was collected from February 22-March 10th, 2017. The total potential sample population of N=120 were divided into simulation groups over the two-day period. A total of 98 students agreed to participate in the quantitative portion of the study and 11 of those 98 students agreed to participate in the qualitative portion of the study for response rates of 82% and 9% respectively.

Quantitative data was entered by a hired member of MCNHR into IBM Statistical package for the Social Sciences (SPSS) version 24.0. The statistical analysis was then further verified by a statistician. Qualitative data was transcribed by a hired member of MCNHR.

Quantitative Data Analysis

Descriptive analysis (frequencies, percentages, means and standard deviations) were performed with the demographics data, DASH tool, and modified DES survey. Quantitative results contributed to answering primarily the perceived value of the debriefing process in a palliative SBE to process student emotions or feelings.

Sample Demographics

Characteristics of the demographic survey are discussed below and include gender, age, highest level of education completed and previous experience with death and dying (personal/professional). The final sample consisted of 98 participants.

Of the 98 participants, 84.7% identified as female and 15.3% identified as male, no one self-identified as other. Ages ranged from 19-35 with 86.7% of respondents in the 19-25 year category and the remainder of respondents in the 25-35 year old category. Participants were asked regarding their highest level of education completed and a total of 81 participants (82.7%) selected high school or equivalent. 13 participants (13.3%) selected bachelor's degree, one participant selected master's degree and three (3.1%) participants selected other certificate/diploma. Participants were also asked if they had previous experience with death and dying, and if so, was the experience in personal setting, professional setting, or in both settings. 68 participants (69.4%) stated that they had experience with death and dying. This question had a 100% response rate. Of the 68 participants that answered YES to previous experience with death and dying, 46 participants stated that their past experience with death and dying was personal, 6 participants stated that it was professional, and 3 participants stated that it was both personal and professional. 13 participants who answered YES to having prior experience with death and dying did not answer the follow up question. Table 1 provides a summary of the demographics characteristics of the sample.

Table 1: Demographic characteristics of the sample (N=98)

Characteristics	Frequency	Percent
Gender		
Female	83	84.7
Male	15	15.3
Age		
19-25	85	86.7
25-35	13	13.3
35<	0	0
Level of education		
High school or equivalent	81	82.7
Bachelor's Degree	13	13.3
Master's Degree	1	1.0
Other certificate/Diploma	3	3.1
Experience with death/dying		
Yes	68	69.4
No	30	30.6
If yes to death/dying		
Personal	46	46.9
Professional	6	6.1
Personal & Professional	3	3.1

Summary of Sample Characteristics

In summary, the sample consisted mainly of female students aged 19-25 whose highest level of education was high school or equivalent. More than half of the participants (69.4%) had had previous experience with death and dying. Of those who had had previous experience with death dying, that experience was mostly in a personal facet (46.9%).

Debriefing Assessment for Simulation in Healthcare (DASH) Results

The DASH consists of six items that are rated using a 7-point Likert scale. The DASH was administered immediately following debriefing of the simulation described earlier. Participant responses were analyzed through descriptive statistics. The raw scores for questions 2-6 ranged from 4-7 with question one having raw scores of 1-7, and one participant rating question one as a one, and one participant rating question one as a score of two. The mean scores for the questions

ranged from 6.04- 6.56 with question 5: The instructor identified what I did well or poorly-and why having the lowest mean of 6.04 (SD=0.865) and question 2: The instructor maintained an engaging context for learning having the highest mean of 6.56 (SD= 0.704). Table 2 summaries this data.

Table 2 :DASH Results

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
DASH 1: The instructor set the stage for an engaging learning experience.	98	1	7	6.27	1.011
DASH 2: The instructor maintained an engaging context for learning.	98	4	7	6.56	.704
DASH 3: The instructor structured the debriefing in an organized way.	98	4	7	6.53	.661
DASH 4: The instructor provoked in-depth discussions that led me to reflect on my performance.	98	5	7	6.51	.677
DASH 5: The instructor identified what I did well or poorly - and why.	97	4	7	6.04	.865
DASH 6: The instructor helped me see how to improve or how to sustain good performance.	98	4	7	6.43	.746

Modified Debriefing Experience Scale (DES) Results

The modified DES was administered with the demographics questionnaire and DASH survey immediately following debriefing. Participant responses were analyzed through descriptive statistics. These subscales utilized a Likert-type rating from 1 (*strongly disagree*) to 5 (*strongly agree*). Questions 1-3 were derived from the subscale Analyzing thoughts and feelings and questions 4-7 were derived from the subscale Learning and making connections. The raw scores for questions 1-7 ranged from 1-5 with 97% of questions having a score of 3-5. The mean scores for the questions ranged from 4.41-4.73 with question 6: Debriefing was effective in helping me to

cope with the feelings experienced in a palliative simulation having the lowest mean of 4.41 (SD=0.835) and question 7: Debriefing was beneficial to my learning in a palliative simulation based experience having the highest mean of 4.73 (SD= 0.566). Table 3 summaries this data.

Table 3: DES Results

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
DES 1: Debriefing helped me to analyze my thoughts about the palliative simulation.	98	1	5	4.68	.585
DES 2: Uncomfortable feelings experienced in the palliative simulation based experience were addressed by debriefing.	95	1	5	4.52	.650
DES 3: Debriefing assisted me in identifying my feelings and emotions experienced during the simulation based experience.	97	1	5	4.61	.622
DES 4: Debriefing assisted me in reflecting on my feelings and emotions experienced during the SBE.	98	1	5	4.61	.636
DES 5: Debriefing assisted me in processing my feelings and emotions experienced during the SBE.	97	1	5	4.55	.736
DES 6: Debriefing was effective in helping me to cope with the feelings experienced in a palliative simulation.	98	1	5	4.41	.835
DES 7: Debriefing was beneficial to my learning in a palliative simulation based experience.	98	1	5	4.73	.566

Qualitative Data Analysis

The purpose of this study was to explore the usefulness and effectiveness of debriefing to process emotions or feelings experienced by undergraduate nursing students in a palliative simulation based experience. During the semi-structured interviews, students discussed their feelings before, during and after the palliative SBE. While the focus was on the debriefing, interview questions also explored the importance of acknowledging their feelings before the

debriefing stage to allow for a better understanding of the perceived usefulness of debriefing to process feelings or emotions during a palliative SBE.

As the interviews progressed, one overarching theme along with three categories, and three subcategories emerged from the data as useful and effective components to process emotions or feelings experienced. The theme of Feeling Prepared, along with how this was different at various time points during the SBE were identified. This was further elaborated when discussing the debriefing aspect of the SBE. Findings of the qualitative portion of the study and sample characteristics are described in this chapter.

Description of Participants

Eleven third-year College of Nursing students from the University of Manitoba who met inclusion criteria participated in the interviews. When participants consented to participating in the quantitative portion of the study, they had the opportunity to consent to being contacted regarding participating in the qualitative portion of the study. Nineteen students consented to being contacted by the researcher and eleven returned the researcher's request to participate. Data was collected over a 16-day period from February 22nd, 2017 to March 10th, 2017. Of the eleven students that participated, nine were female and two were male.

Characteristics of the Interview and Transcripts

Overall interviews ranged from 9-22 minutes with interviews ranging in depth of responses. Data saturation was achieved and noted in the eighth interview when redundancy and repetition in respondent answers was observed.

Theme – Preparedness

One overarching theme emerged during the qualitative analysis with three categories that supported this theme. The theme that emerged was preparedness, specifically emotional preparedness. Henriksson et al. (2015) defined preparedness as something carried out before a crisis to improve the response. It has also been described as a condition or activity to foresee potential problems and project possible solutions and builds abilities and capabilities. As participants were discussing participating in a palliative SBE prior to caring for a palliative patient, they described their emotional preparedness to care for a palliative patient and how the simulation affected their emotional preparedness. During the interviews, students frequently commented on feelings of preparedness to deal with patients who were palliative.

I feel like it's hard to prepare for something like that. Like you can [--] say all you want about what you're going to be watching or what you're going to be doing, but when you're actually watching and you're doing it like, it's a little different so [...]. I think as well as I could have been prepared, but like you can't really prepare for something like that. Just like when someone comes to you with like a problem that you're having and if it has something to do with end-of-life, or like, whatever kind-of-thing, it's like a tough thing to talk about like you can't really prepare exactly. Like you can have general idea, but you can't really completely prepare yourself for that. (Student 3)

With regards to preparedness for participating in a palliative SBE, participants were asked if they felt prepared and what may or may not have contributed to this feeling. Overwhelmingly, the participants indicated that the debriefing component of the SBE assisted them in processing their feelings and emotions.

But I also think as much as it was emotional I think that you could take away [--] you could learn different things from other people and [--] how they would deal with that situation, and how you would deal with that situation. So, [--]I think coming together, debriefing is important (Student 1)

Participants were also asked if they would like to see anything different that may have assisted them in processing feelings and emotions. Several students indicated that they saw value in the palliative SBE and would like additional resources and supports that they could bring with them into the practice setting.

So [--] I don't know. I think that would be nice, because I want to go into Cancer Care too, so it would be nice to know some coping methods, and I'm definitely the type of person that like [--] I'm so emotional and I take everything on, so it would be nice to know how to separate that from like work and home. (Student 8)

Overall, throughout all aspects of the discussion, the theme of preparedness, specifically emotional preparedness emerged. In asking participants about their thoughts and feelings during the palliative SBE, regardless of whether it was before, during, or after the active phase of the SBE, this feeling was prevalent.

Category 1- Preparedness Before Simulation

The first category to support the theme of preparedness that emerged from the interviews was that students felt that they were aware that it was a palliative SBE, but described varying

degrees of preparedness. Some did not feel prepared at all for the emotional aspects of the SBE and overall a minority felt prepared.

I think just [--] knowing what palliative was, we learned that in the course [--] what constitutes as being palliative [--] just the emotions attached to it. I mean, how do you prepare someone for.. I think that people deal with things differently [...] I found that simulation [--] all the more challenging [--] I think honestly that one was probably the most challenging. (Student 1)

Umm, the only thing is I wish I had been more emotionally prepared. I think everybody feel the same too. 'cause they didn't expect it. [--] Honestly, they didn't expect it. So, if they are to know that somebody is going to die then they better prepare how to say to the family member, and what to say before the death. Like, prepare the family to umm to let them know that this patient is going through the end-of-life and uh not providing [--] we generally don't provide false hope 'cause it's the idea, but um, if we could tell them that the patient is dying soon then we could have [--] could have done it earlier if we know (Student 2)

Students described their life stage as having an impact on their emotional preparedness in discussing death and dying with a potential patient.

First I [--] it's a simulation and I know that, but I think it could have helped to be emotionally prepared, I guess...just 'cause [--] We are all kind of young. We don't really face the subject of mortality very often...This is hard (Student 4)

Umm, like, if I [--] I personally haven't lost anyone recently, but like if I did I would know what's coming and kind of prepare myself to talk about end-of-life, and that kind of thing. (Student 7)

Students indicated that it is difficult to emotionally prepare for palliative SBE, as it's not as straight-forward as reviewing diseases, medications, or psychomotor skills. Students discussed that though they learn various communication techniques in class, without having ever practiced it, they found it difficult to apply to a practical situation.

For all the other ones I was kind of like [--] 'oh you know I'm going to study my Med Surg'.. I think this is just something [--] I mean you can't [--]. We're taking the palliative course.. and yeah, we're learning stuff about it, but until you're actually [...] immersed into it ... what constitutes as being palliative [...]just the emotions attached to it. I mean, how do you prepare someone for? (Student 1)

yeah, for all the other ones I was kind of like [--] 'oh you know I'm going to study my Med Surg' ... you can study it, go home and study it but when you actually have that conversation with someone [...] and that communication [...] that therapeutic

communication is definitely a skill that will take time to [--] uh and I think that's what's obviously so important for the palliative [...] (Student 1)

I think it's just important to like have that opportunity to like, to experience those feelings that you might be having if you [--] if it were a real situation. Just to like kind of see an expert like do it kind like it's really helpful to get that kind of experience. 'Cause then you don't go into like a real situation and like feel uncertain and floundered and not know what to say and say something like totally stupid or whatever, like, it gives you that kind of understanding like how it can be done. And like, you can read about it all you want in like your text book, but it's not the same as like seeing it happen (Student 3)

Students appreciated being made aware that it was going to be a palliative simulation but felt that the emotional aspect that they may experience wasn't emphasized enough. Students also stated that having prior experience in simulation and communication based simulations contributed to a sense of preparedness for this SBE.

Um, I don't know I guess if [--] I would have liked more heads up, like "this is more emotionally based" versus [--] like, I mean, it's a huge part of nursing, but I guess we are all expecting the physical aspect of it and like, you know, how to nurse for someone who's in palliative versus, "this is how you should talk to someone in palliative care," and you know, emotionally connect with them.. I think [--] yeah, telling students that it's going to a little bit more emotionally, [--] more emotional, as well as [--] ...I think stress that more,

because I think a lot of students didn't, and so I think people who actually reviewed got more out of it (Student 9)

I think just the importance of having like the simulations build up to that kind of; like, if we had just been thrown in there that day it may have been heavier, but having like [--] ...I think we did communication before too, so having that knowledge built in like I think prepared us for that sim (Student 11)

Umm, yeah; 'cause it was the third week of our simulations, so I think those two leading up to it were really good; and I think that just based on the palliative class we've been taking and stuff it's helped. In clinical we haven't really [--] ...So, in that sense maybe like, real-life you wouldn't be prepared necessarily, but for what we saw I think like we were pretty prepared.(Student 11)

Category 2 –Preparedness During Simulation

Another question posed to students was to discuss which emotions or feelings were the strongest in simulation. Many students discussed the emotions and feelings experience during the active phase of participating in the simulation, which included feelings of sadness, empathy, compassion anxiety and fear.

*[...] probably emotions would have been [...] I would guess sadness for the situation. [...].
Umm, I don't know if anxiety is the right word, but just not knowing what is the right thing*

to say to someone. Umm [...] to find that balance between showing your compassion, your emotion, but not losing it yourself. (Student 1)

Yeah, sadness and umm [--] I know it's not supposed to be empathy, but it was also sympathy for the family, like, I'm in the right context I guess sympathy is okay. (Student 4)

[...] I would say, probably sadness, for sure, just because that particular simulation it was like a really hard case, with a young person. Umm, not- [--] I did feel bad for he [--] but it was because she seemed very distressed. (Student 5)

Umm, I think when Deepa was talking about [--] she was saying like, "I don't know how they're going to remember me." I think that was really sad, 'cause [--] 'cause then I related it to my life and was like, you know, it's [--] it's sad. (Student 8)

Although students experienced feelings of sadness, empathy, fear and anxiety, they described the role modeling of expert nurses as beneficial as it allowed to them to see textbook materials applied in a real situation which in turn increased feelings of preparedness.

Just the way that she [expert nurse] spoke to Deepa in the simulation [...]...she just put her at ease, and the tone of her voice [--] Yeah, just like all the [...] therapeutic communication techniques that we hear about in class and stuff. It's just like seeing that used in a certain context was very [--]very helpful to understand in that type of communication; 'cause like, giving examples like "open ended questions..." and like blah blah blah, "okay I can do

that”, but someone comes to you with a comment like that or a problem that they’re having, it’s like “ok, but what do I actually say to you?”. (Student 3)

Just to like kind of see an expert like do it kind like it’s really helpful to get that kind of experience. ‘Cause then you don’t go into like a real situation and like feel uncertain and floundered and not know what to say and say something like totally stupid or whatever, like, it gives you that kind of understanding like how it can be done. And like, you can read about it all you want in like your text book, but it’s not the same as like seeing it happen (Student 3)

What stood out in my mind is just how she [expert nurse] talked to her and gave her resources to be able to talk to her kids, and ideas. It was helpful, because it’s hard to know what to say to people in those situations. So, just learning what to say. (Student 10)

Students appreciated the type or modality of simulation. They felt that role play was not real enough, but working with a standardized patient was too psychologically stressful. The Shadow Box technique of videos and decision points of experts engaging in clinical practice was an appropriate introduction into emotionally laden simulation.

Umm but when it’s actual, like a real situation like watching it either on the video or umm [--]. I think that just these simulations become more real so it’s just [--] It’s a lot easier to apply, and when it’s us kind of posing the questions to each other, I think that it can sometimes be a little bit fake. Does that make sense? (Student 1)

Students discussed their need for support from their peers during simulation to feel comfortable with their feelings of sadness and uncertainty. They appreciated the normalization of feelings that occurred throughout debriefing conversations with peers. Students also stated that having their peers express feelings resonated with them and allowed them to explore their own feelings.

I feel like it'd be helpful if we all share what we feel, and to [--] I feel like a lot of people would feel the same that I do and each of them would have different feelings, but generally we all have the same feelings so if we know that it's common and everybody feels the same then we feel less overwhelmed. (Student 2)

I kind of like just having the group, because if you do hear someone that's going through the same emotion as you then you can kind of connect with them... So, I guess it's just, umm, you're not alone in the sense where it's like you're not fighting something [--]. Um, there's other students that are going through the same thing. (Student 6)

Umm the group was nice, 'cause you could hear other people's, like, opinions – what they thought of it. I think if someone was really upset about something then one-on-one might be better so you can delve a little bit deeper into what's bothering them or coping mechanisms they could take (Student 10)

I think that if I felt [--] like I saw in the one before she took a few people out because I think they were having a harder time with it. So, I think ... a one-on-one would be better; but just in a group conversation, like having a small group, I think people feel more comfortable to [--] or at least I do [--] to like say things – like opinions [...] versus one-on-one where you can't necessarily [--] like I think it's helpful to have other students kind of bring things up also, 'cause then maybe it resonates with you too... they bring things up that you don't even think of, and then you're like, "oh, yeah I do feel that watching that" kind of, and then it brings up a lot more things that you can say, kind of [--] (Student 11)

Category 3- Preparedness After Simulation (Debriefing)

The third category that supported the theme of preparedness emerged through analysis of the qualitative interviews was the post simulation based experience component. The data in this category further created three sub-categories consisting of sub-category 1: Qualities of the debriefer, sub-category 2: Fellow participants in the debriefing room and sub-category 3-Value of debriefing.

Sub-Category 1: Qualities of the debriefer.

Students shared that the debriefer normalized feelings, along with guiding discussion and allowed participants to speak when they felt comfortable. Students made it clear that the debriefer and the qualities of the debriefer were a key component to ensuring a positive SBE. Students appreciated the fact that the debriefer had experience not only in simulation but in palliative care as well, they felt that this added value to the SBE.

I think that um [the debriefer] is great. She's just so excellent, ...because, she just like so friendly and like kind and like the kind [--] like the kind of palliative nurse I would want

to have if I were to have one. Like, she's great. So like she really helped, umm, guide everyone through and like, was very understanding of like what we had experienced throughout the day and like how we had felt about it. Kind of like empathized with that so, she didn't really push us too much to say anything if we didn't want to... leaving the space to like to talk about it if we needed to talk about it... she guided us through...she asked us questions and stuff, but like, wasn't aggressive, which I think it wasn't like [--] it was like.. like certain situations it's appropriate to be like, more pushy, but especially with something kind of sensitive it's like you don't want to push somebody if they don't want to be pushed to talk about it.. (Student 3)

She was a very good instructor for that. Umm, and I think it is from like her experience in palliative...Like, I think that's very important is like having someone that maybe has had to do that already in their career. I think that would be very important to keep with that activity. (Student 5)

Probably just the instructor just saying how it's okay to feel what you're feeling. .. 'cause it's a new experience for some people and if you're upset and stuff it's okay, this is why we do the simulations, so you can have a feel for it before you actually get it in real life. (Student 10)

She [debriefer] was really good at like, umm allowing us like to just kind of say how we felt and then like yeah, like she asked questions at the end too, just in case anyone did want to like debrief about it I guess (Student 11)

Sub-Category 2: Other participants in the debriefing room.

Throughout the interviews, students consistently discussed the other participants in the room and the benefits to having group debriefing. As established earlier, students felt that sharing feelings with their peers was important and it helped to normalize the feelings they were experiencing. Students also commented on group size, stating that groups of 8-10 participants was appropriate, in that it was enough to hear other people's perspectives but not too many that it would deter individuals from sharing their own feelings.

I think just having the opportunity to [--] for everyone to just say what they want to say, like if they want to say something about it like, I think we all have had our own like experiences with loss, and with like situations of [--] well, not exactly like that, but of different things and it helps to just talk about it and just say what you're [--] just say what you're feeling and like that kind of helps other people tune into their own feelings as well. Like someone else is thinking, "Oh, yeah that's kind of how I feel", and just couldn't really articulate it, kind-of-thing. So, I think it helps to hear other people like talk about how they're feeling. (Student 3)

but, I guess it really comes back to like the discussion aspect, and like everyone sharing their feelings on it kind of just helped like understand [--] like sharing the things that they liked about it or like the type of communication techniques that they liked for example, like help to solidify a lot of what we did see. (Student 3).

Okay, so personally for me, I don't think I had issues with being in a room full other people. It was good to kind of like bounce ideas off each other and see how, [--] different people have different perspectives right? So, I also wanted to see how it impacted other people so that was helpful and that was okay, and it also helped to know that I wasn't the only person feeling some kind of way. So, if someone was else was saying "oh, this is how it affected me" then like well, that's relatable 'cause that's the exact same way I felt. However, like, with some other people [--] I think I saw couple of people crying – so, I don't know if for them it would have been better to have like individual or something, but personally I think it was good having it in a group (student 4)

[..] I think one of the strategies was [--] like, 'cause we were in a team of four – so, I guess instead of [--] if you had something in your mind, like if there was something bugging you, you wouldn't just keep it to yourself. You would actually communicate with your team... I kind of like just having the group, because if you do hear someone that's going through the same emotion as you then you can kind of connect with them. (Student 5)

Yeah, possibly even smaller groups, 'cause there were probably around eight of us or so... Um, that was probably the least helpful – having so many people, and like people you don't really know that well [--] so, you don't want to share as much; or like you wouldn't feel as comfortable sharing. (Student 7)

For sure; yeah, I think [--] I feel like we all have things to say and questions to ask but we weren't really comfortable with each other, so we kind of just stayed quiet. (Student 8)

Umm the group was nice, 'cause you could hear other people's, like, opinions – what they thought of it. I think if someone was really upset about something then one-on-one might be better so you can delve a little bit deeper into what's bothering them or coping mechanisms they could take (student 10)

So, I think in that sense if I was really like uh, affected by it, maybe a one-on-one would be better; but just in a group conversation, like having a small group, I think people feel more comfortable to [--] or at least I do [--] to like say things – like opinions and then [...] Versus one-on-one where you can't necessarily [--] like I think it's helpful to have other students kind of bring things up also, 'cause then maybe it resonates with you too (Student 11)

Sub-Category 3: Value of debriefing.

Students commented on the value of debriefing in relation to clinical practice. Some students believed that debriefing should be part of their clinical education as well, especially when emotionally stressful situations arise. Two students described wanting a simulation and debriefing session structured around coping as a nurse, specifically as it relates to compassion fatigue.

I think, to be honest, I think debriefing is very important even if it's not palliative, it just, you know [--] let's just say you deal with a code and I think that it's important because it's a way for everyone to lean. And, umm [...]. I don't have a problem with opening up with

my emotions, I think that some people probably would have would ha-had more of a difficult time with it (Student 1)

Just because it was [--] I think I'm remembering, it was just us talking about how we were feeling so, that was good [--] that's always good so you don't have your feelings left to yourself and then you have to sort through them by yourself. It was helpful to have that (Student 4)

Yeah, we actually didn't discuss like the nurse's feelings...It was more like communicating and like focusing on the patient ...So, I would have liked to see more stuff – like about [--] we talk about compassion fatigue [--] I think that's what it's called – but we just kind of mentioned it and defined it, but it would have been nice to have talked about that and have some coping methods too. (Student 8)

Summary of Findings

The purpose of this study was to explore the usefulness and effectiveness of debriefing to process emotions or feelings experienced by undergraduate nursing students in a palliative simulation based experience

This chapter described the demographics of the study participants. The majority of the participants were female aged 19-25 with a highest education of high school or equivalent. More than half of the participants had previous experience with death and dying, and the majority of those individuals' experience was categorized as a personal experience.

Ninety-eight participants completed the DASH survey which consisted of six questions that were rated on a 7-point Likert scale. Participant responses were analyzed through descriptive statistics and overall students rated their debriefing experience highly with mean scores for the questions ranging from 6.04-6.56. Participants also completed the modified DES survey which consisted of seven questions that were rated on a 5-point Likert scale. The mean scores ranged from 4.41-4.73.

Eleven participants participated in semi-structured one-on-one interviews to discuss their emotions and feelings on debriefing following a palliative simulation based experience. As the interviews progressed one theme emerged having three categories to support this theme, along with three subcategories of the last category to allow for greater understanding of the specific aspects of debriefing that contributed to student's perception of overall usefulness and effectiveness to process emotions and feelings experienced the simulation. The theme that emerged was preparedness specifically emotional preparedness, and the three categories were: *Before the Simulation, During the Simulation, and After the Simulation*. The three sub-categories that emerged fell under the category of After the Simulation Based Experience and were: *Qualities of the debriefer, Other participants in the room and Value of debriefing*.

Students were open in discussing aspects of debriefing that they felt contributed to a positive debriefing experience and data saturation was obtained by the eighth interview. A reemerging theme of emotional preparedness was noted during interviews and students discussed similar aspects of debriefing that they felt were beneficial to processing their emotions and feelings in a palliative simulation based experience. Though the purpose of this study was not to determine what emotions and feelings were experienced during the palliative simulation based

experience, all eleven participants shared their feelings and as similar feelings were noted throughout the progression of the interviews, it was important to share it in this findings chapter. The following chapter will explore the findings in relation to current literature and the implications of these findings for future research.

Chapter Five: Discussion

This chapter will discuss the results based on the findings of the previous chapter. The limitations of this study will be examined, followed by recommendations for practice and future research related to nursing education.

Study Overview

The purpose of this mixed-method study was to add to the knowledge and understanding about the usefulness of debriefing in palliative simulation-based experiences. In the literature, it has been well established that nursing students find it difficult to cope with their own personal emotions and feelings when caring for patients who are dying (Sadala & Silva, 2009). However, nursing students have stated that they were better able to cope with their own feelings once they were given an opportunity to share their experience regarding patient death. Having an open conversation was one of the things that they felt helped “normalize” the death and allowed them to process their own thoughts about that death (Edo-Gual et al., 2014). It has been well documented that debriefing is an essential component of simulation and is an effective learning method to consolidate nursing knowledge and skills for students (Cantrell, 2008). Despite the recommendations through the literature that simulation must have a component of quality debriefing, there is minimal research regarding best practice in debriefing for palliative simulation. The specific aim of this study was to explore the usefulness and effectiveness of debriefing to process any emotions or feelings that students may experience during a palliative simulation-based experience.

There were two parts to the study. Students who agreed to participate were asked to choose to do one of two things. After attending a palliative simulation-based experience, students could choose to 1) complete a survey of the debriefing process using the DASH tool provided along with

7 additional questions and a demographics survey or 2) complete the survey in item 1 AND participate in a one-on-one interview with the principal investigator to further discuss their thoughts on the usefulness of debriefing to process emotions evoked during their palliative simulation based experience.

This study was guided by two theoretical frameworks. As the characteristics of simulation involve a cycle of learning, Kolb's experiential learning theory was chosen to guide the development of the SBE intervention. In addition to this, it became clear that the nature of the debriefing of a palliative SBE would require additional considerations that address the potentially sensitive nature of the type of SBE. A Trauma Informed Care framework was also chosen to guide specifically the debriefing component of this study.

Research Question

The target population was third year undergraduate nursing students participating in palliative simulation-based experiences (SBE). The specific research questions that were used to guide this study were:

1. What is the perceived value of the debriefing process in palliative SBE to process student emotions or feelings?
2. How does the quality of the debriefing affect students' emotions or feelings following a palliative SBE?

Perceived Value of the Debriefing Process

The first question of this study was: What is the perceived value of the debriefing process in palliative SBE to process student emotions or feelings? The overarching theme noted in the qualitative interviews and supported through quantitative analysis of the surveys indicated that the value of debriefing contributes to overall preparedness. Valuable components of the debriefing

following the palliative SBE included normalization of feelings, and feeling better prepared to deal with feelings that may be experienced during a palliative SBE or in the clinical setting.

Normalization of feelings was a common subcategory noted throughout the qualitative interviews. Students indicated that they appreciated hearing about feelings and emotions that were experienced by their peers during the debriefing. Hearing that they were experiencing similar feelings helped students both identify and normalize the feelings experienced in the palliative SBE. The adapted DES survey asked participants to rate the following statement on a Likert scale of 1(Strongly Disagree)-5 (Strongly Agree) “Debriefing assisted me in identifying my feelings and emotions experienced during the simulation based experience” which yielded a value of 4.61. The score on that item clearly agreed with qualitative interview results. A study by Edo-Gual et al (2014) mirrors the finding that students have an increased sense of security talking about their emotions and feelings after they hear other students’ experiences. This research also indicated that students who reflect on palliative care in small groups have been shown to have an increased awareness of their own emotions, a deeper appreciation of the normality of their reactions and healthier coping strategies. Additionally, research conducted by Yang et al. (2011) on pediatric medical residents echoed this sentiment and found that the most helpful educational tool in end of life care decision making was discussion amongst peers and colleagues. The evidence in this study and supporting literature indicates that students perceive a value of debriefing as the normalization of feelings experienced.

Preparedness and feelings of unpreparedness were identified by students prior to the palliative SBE. Preparedness as defined earlier was described as a process that is routinely practiced before a crisis to improve a response (Henriksson et al., 2015). Interestingly, 69.4% of participants stated on their demographics questionnaire that they had past experience with death

and dying, be it personal or professional. While the participants knew that they would be participating in a palliative SBE, many indicated that initially felt unprepared to deal with any emotions that they were anticipating experiencing. Upon participating in the palliative SBE and debriefing, students expressed relief and indicated that the debriefing helped prepare them for upcoming SBE's or experiences in the clinical setting. In being able to go through the experience with a supportive debriefer, students feel better prepared and less anxious about being asked to care for a palliative patient. The strength of palliative simulation based experiences has laid in its debriefing component, specifically having skilled and trained debriefers. Researchers have echoed this sentiment and have found that the use of simulation in end of life education has increased nursing student's confidence in caring for patients in a clinical setting and that the debriefing component augments students' personal feelings of emotional preparedness (Hope et al., 2011, Kurz & Hayes, 2006; Venkatasalu et al., 2015). A recent study by Dame and Hoebeke (2016) yielded similar results concluding that student anxiety levels decrease following participation in an end of life simulation with a supportive debriefer.

Quality of the Debriefing

The second question of this study was: How does the quality of the debriefing affect students' emotions or feelings following a palliative SBE? In discussing the quality of the debriefing, students indicated that the quality of the debriefer was directly linked to the quality of the debriefing, and was evidenced by having a structured debriefing that engaged students to participate in the in-depth discussions regarding feelings and emotions.

In discussing the quality of the debriefing to affect students' emotions or feelings following a palliative SBE, students indicated that it was the debriefer that played a significant role in determining the quality of the debriefing. The debriefer was skilled in debriefing and a

content expert in palliative care. In reviewing the results from the surveys, creating an engaging learning environment and provoking in-depth discussions positively affected the quality of the debriefing. This is supported by the literature and the INACSL: Standards of Best Practice: Simulation Standard VI: The Debriefing Process (Decker et al., 2013). The INACSL: Standards of Best Practice recognize the debriefer as the first criterion necessary in having a successful debrief. In order to ensure a quality debrief, the debriefer must be competent in best practices in debriefing with regard to structuring the format of the debriefing and facilitating reflective discussion. This is further supported in the literature as Fanning and Gaba (2007) have described the imperativeness of a knowledgeable and consistent debriefer to ensure a participant's simulation experience is useful and transferable into their clinical practice. Additionally, a literature review conducted by Neill and Wotton (2011) established that the demeanor of the debriefer has a significant influence on student participation, learning and perceived psychological safety. A study by Hjelmfors, Strömberg, Karlsson, Olsson, and Jaarsma, (2016) indicated how imperative it was that nursing students need to have post simulation debriefing conducted by not only an expert in debriefing but an expert in palliative care to ensure that students are supported psychosocially while reflecting on feelings, thoughts and responses following a palliative simulation based experience.

The final and perhaps most compelling result regarding the perceived value and the quality of debriefing the palliative SBE to process emotions and feelings was when students indicated that they would like similar debriefing to take place in the clinical setting. It is common practice in most North American and Australian nursing schools for students to reflect on their experience in clinical with each other and their instructor, they share information, analyze situations that occurred during their day and reflect on their actions (Andersen, 2016). This debrief or post conference that occurs following clinical education tends to focus on describing clinical

situations/patient cases that are often complex and difficult to solve, and conversation revolves around thinking of solutions to these issues (Andersen, 2016). Research specifically regarding clinical in a palliative care setting (Allchin, 2006) has encouraged the use of group or individual debriefing sessions to provide support to students who have been exposed to the emotional challenges of caring for individuals who are dying and their families. Allchin (2006) further stated that it is important to have an instructor constructively guide this debriefing session to allow for students to make sense of the thoughts and feelings they are experiencing as well as to be available to discuss personal feelings of loss and grief.

Limitations

This study had several limitations. Limitations of this study include the use of a convenience sample from a single institution with a fairly homogenous sample for females aged 18-25 years of age, which can limit generalizability of the results. Additionally, convenience sampling is highly vulnerable to selection bias as participants choose whether or not they would like to participate (Polit & Beck, 2012). Students who chose to discuss their experience with the researcher in a one-on-one interview may have had reasons to do so, they may have had strong opinions, and wanted to further discuss the positives or negatives associated with their debriefing session which as mentioned earlier, can attribute to selection bias and bias in the results.

The interviews conducted generated thoughtful and insightful information regarding debriefing following palliative based simulation, however, results may have been induced by extraneous variables such as previous experience (personal or professional) with death and dying, student course load and other life stressors (Brown & Chronister, 2009; Kirkman, 2011). Information relayed in the interviews may have been influenced by these variables and it would

Be necessary to identify extraneous variables when designing this experiment again to limit misinterpretation.

Limitations of mixed-methods research design must also be discussed. Creswell (2009) states mixed-methods research, specifically, concurrent triangulation method requires diligence and a strong knowledge base to utilize two separate methods, and adds that challenges can arise when analyzing and comparing data of two different forms. As a novice researcher, this limitation provides true and difficulties were noted when attempting to analyze quantitative and qualitative data, along with attempting to provide meaningful links between them.

Recommendations for practice

Current debriefing models used in nursing education are based on learning models. For SBE's that may be emotionally stressful, a different debriefing model that focuses on participants' feelings and emotions should be employed. Participants in the SBE valued the opportunity to share feelings and emotions during the debrief with colleagues which in turn helped them to gain a sense of normalization of those feelings and emotions. However, unfortunately strategies were not discussed with participants regarding healthy coping mechanisms of emotionally charged simulations. Emotionally charged simulations, such as simulations involving palliative care patients should have a component during the debrief where participants are allowed to share their emotions and feelings with one another, and then followed up with being able to strategize and discuss ways in which they will deal with these feelings experienced in a healthy way.

Research has demonstrated that there is a practice gap between theory and clinical, specifically regarding the care of palliative patients where nursing students have identified that they are nervous and anxious when asked to care for a palliative patient. Through this research, a recommendation for future practice is to include a palliative simulation as a bridge between theory

and clinical for nursing students. The palliative simulation should be more than just role play, as students have indicated that that was not enough, but less intensive than having a standardized patient. Shadow-box simulation was an effective medium for an emotionally stressful simulation and is recommended for future practice.

The debriefer needs to have expertise in facilitating emotionally stressful situations. It has been established that the most important component of simulation is debriefing and participants attributed the quality of the debrief directly to the quality of the debriefer. INACSL: Standards of Best Practice recognize the debriefing must be facilitated by a person competent in the process of debriefing (Decker et al., 2013). Based on the results of this study, recommendations for practice are in accordance with the INACSL guidelines regarding debriefers. Debriefers should have training in debriefing, either with formal coursework, a workshop conducted by an expert or working with an experienced mentor. When debriefers are involved in emotionally stressful situations, additional training should be afforded to the debriefers to ensure they have the necessary skills and resources to discuss such sensitive matters with participants, and are prepared for the variety of emotions that may be invoked during such a simulation. Caswell (2010) discusses strategies to invoke when discussing sensitive topics such as death with students. Strategies discussed included: having a plan beforehand if someone became visibly upset, asking questions that did not require personal responses from students, not pressuring students who did not speak up, being present for students who wished to discuss matters following simulation and referring students to counselling if necessary.

The final recommendation for practice is to include a component in the post clinical debrief that discusses emotions that students felt during their day and ways to cope with those feelings. Emotionally charged situations occur in clinical daily, not just in palliative care settings

and therefore students need to have an outlet to express those feelings and be guided by an expert on how to deal with those feelings. A focus on healthy coping mechanisms should be included during this debrief and students should not feel as though they need to keep these emotions and feelings to themselves. Students need to be reminded that compartmentalizing the feelings they experience in clinical is not healthy and that by hearing that other students feel the same way, we can help bring a sense of normalcy of these feelings to nursing students in the clinical setting.

Future research

This study has noted that there is a gap in debriefing following an emotionally stressful simulation and that often debriefing regarding emotions and feelings experienced is not common practice. Kirkpatrick et al., (2017) echo this sentiment following a literature review on end of life simulations and have concluded that there is a lack of theoretical frameworks for palliative care nursing which may be due to minimal theory development in palliative care nursing. Future research should include a debriefing model that focuses on participants' feelings and emotions. This future research may help to provide further development in debriefing to assist students in learning healthy ways to cope with stressful situations in simulation which can then be translated to clinical and then their own professional nursing practice.

Future research using students from a different educational institution with a different palliative based simulation would also help to strengthen the results of this study and perhaps provide different information regarding best practices to debriefing an emotionally stressful simulation.

This study noted that the debriefer was one of the most significant factors contributing to a "good" debrief. As indicated earlier in recommendations for practice section, the debriefer needs to have expertise in facilitating emotionally stressful situations. This study was conducted with a

debriefing that had no formal education in debriefing, however was an expert in palliative care nursing. Future research should be conducted in a similar setting with a formally educated debriefer to determine if/or there is a difference in participant responses.

Conclusion

The need for quality palliative care begins with quality palliative nursing education, however that has proven difficult to provide. Research has proven that palliative simulation is a beneficial bridge between the palliative theory and palliative clinical gap. Often overlooked during a debrief session in simulation laden in emotions, is ensuring that participants have the skills to process the feelings they experience while providing palliative care. The specific research questions that were used to guide this study were:

1. What is the perceived value of the debriefing process in palliative SBE to process student emotions or feelings?
2. How does the quality of the debriefing affect students' emotions or feelings following a palliative SBE?

Overall the debriefing process in the palliative SBE to process emotions or feelings was positively received by participants. Valuable components of the debriefing following the palliative SBE included normalization of feelings, and feeling better prepared to deal with feelings that may be experienced during a palliative SBE or in the clinical setting. In discussing the quality of the debriefing to affect students' emotions or feelings following a palliative SBE, students indicated that it was the debriefer that played a significant role in determining the quality of the debriefing. The debriefer was skilled in debriefing and a content expert in palliative care. In reviewing the results from the surveys, creating an engaging learning environment and provoking in-depth discussions positively affected the quality of the debriefing.

Recommendations for future practice include using a different debriefing model that focuses on participants' feelings and emotions for SBE's that are particularly emotionally laden. Future practice should continue to use palliative SBE's as a bridge between theory and practice and the SBE's should be more realistic than roleplay and less than using standardized patients. Shadow box has proven to be a useful simulation mode for palliative SBE's. Future practice should also include debriefers who have training in simulation debriefing to ensure competent and knowledgeable debriefing. Lastly, future practice should include a component in the post clinical debrief that discusses emotions that students felt during their day and ways to cope with those feelings.

Recommendations for future research include studying students' perceptions of their debrief session utilizing a debriefing model that focuses on participants feelings and emotions and utilizing debriefer formally trained in debriefing.

As a debriefer in simulation myself, I have learned that students want to discuss emotions and feelings that they are experiencing, that they are nervous and anxious, and often that piece of being a new nurse is not discussed in formal education and students are left to deal with these feelings on their own. Being a new student in a profession that is known to have a high level of stress and emotions and coupled with being in an environment such as palliative care, many students feel overwhelmed with their own emotions, and the emotions of their patients and their families. This study has provided first hand insight as to the best way to help debrief the feelings and emotions students experience during palliative simulation. Students have spoken to the best physical learning environment for sensitive topic debrief, the amount of peers they want to share these feelings with and the benefits their peers bring to them. They have spoken to the characteristics and traits they need from a debriefer to help allow them to open up about such a

vulnerable topic and they have discussed the want for emotional debriefing following clinical in health care facilities. It is my hope that by disseminating the results of the study, we as educators will better prepare future health care providers to discuss openly emotions and feelings experienced as regular practice, and encourage and facilitate healthy coping mechanisms.

References

- Abrams, K., & Scragg, A. (1996). Quantitative methods in nursing research. *Journal of Advanced Nursing*, 23(5), 1008-1015.
- Allchin, L. (2006). Caring for the dying: Nursing student perspectives. *Journal of Hospice and Palliative Nursing*, 8(2), 112-117.
- American Association of Colleges of Nursing (AACN). (2004). *Peaceful death: Recommended competencies and curricular guidelines for end-of-life nursing care*. Retrieved October 5, 2015, from <http://www.aacn.nche.edu/Publications/deathfin.htm>
- Andersen, E. (2016). Enhancing the clinical reflective capacities of nursing students. *Nurse Education in Practice*, 19, 31– 35.
- Baldwin, K. (2007). Friday night in the pediatric emergency department: A simulated exercise to promote clinical reasoning in the classroom. *Nurse Educator*, 32(1), 24-29.
- Barrett, L. F. (2006). Solving the emotion paradox: Categorization and the experience of emotion. *Personality and Social Psychology Review*, 10(1), 20-46.
- Birkholz, G., Clements, P., Cox, R., & Gaume, A. (2004). Students' self-identified learning needs: A case study of baccalaureate students designing their own death and dying course curriculum. *The Journal of Nursing Education*, 43(1), 36-9.
- Bland, A. J., Topping, A., & Wood, B. (2011). A concept analysis of simulation as a learning strategy in the education of undergraduate nursing students. *Nurse Education Today*, 31(7), 664-670.

- Boerner K., Burack, O., Jopp, D., & Mock, S. (2015). Grief after patient death: Direct care staff in nursing homes and homecare. *Journal of Pain and Symptom Management, 49*(2), 214-222.
- Brackenreg, J. (2004). Issues in reflection and debriefing: How nurse educators structure experiential activities. *Nurse Education in Practice, 4*(4), 264-270.
- Bradley, P. (2006). The history of simulation in medical education and possible future directions. *Medical Education, 40*(3), 254-262.
- Brett-Fleegler, M., Rudolph, J., Eppich, W., Monuteaux, M., Fleegler, E., Cheng, A., & Simon, R. (2012). Debriefing assessment for simulation in healthcare: Development and psychometric properties. *Simulation in Healthcare: Journal of the Society for Simulation in Healthcare, 7*(5), 288-94.
- Brink, P., & Wood, M. J. (1998). *Advanced design in nursing research* (2nd ed.). Thousand Oaks, Calif.: Sage Publications.
- Brown, D., & Chronister, C. (2009). The effect of simulation learning on critical thinking and self-confidence when incorporated into an electrocardiogram nursing course. *Clinical Simulation in Nursing, 5*(1), e45- e52
- Brunelli, T. (2005). A concept analysis: The grieving process for nurses. *Nursing Forum, 14*(4), 123–128.
- Bussey, M. C. (2008). Trauma response and recovery certificate program: Preparing students for effective practice. *Journal of Teaching in Social Work, 28, 117*(2), 117-144.
- Cantrell, M. A. (2008). The importance of debriefing in clinical simulations. *Clinical Simulation in Nursing, 4*(2), e19-e23.

- Cant, R., & Cooper, S. (2010). Simulation-based learning in nurse education: Systematic review. *Journal of Advanced Nursing*, 66(1), 3-15.
- Carello, J., & Butler, L. (2014). Potentially perilous pedagogies: Teaching trauma is not the same as trauma-informed teaching. *Journal of Trauma & Dissociation*, 15(2), 153-168.
- Carello, J., & Butler, L. D. (2015). Practicing what we teach: Trauma-informed educational practice. *Journal of Teaching in Social Work*, 35(3), 262-278.
- Caswell, G. (2010). Teaching death studies: reflections from the classroom, *Enhancing Learning in the Social Sciences*, 2(3), 1-11.
- Chen, Y. C., Del Ben, K. S., Fortson, B. L., & Lewis, J. (2006). Differential dimensions of death anxiety in nursing students with and without nursing experience. *Death Studies*, 30(10), 919-929.
- Childs, J., & Sepples, S. (2006). Clinical teaching by simulation lessons learned from a complex patient care scenario. *Nursing Education Perspectives*, 27(3), 154.
- Chronister, C., & Brown, D., (2012). Comparison of simulation debriefing methods. *Clinical Simulation in Nursing*, 8(7), E281-E288.
- Cooper, J., & Barnett, M. (2005). Aspects of caring for dying patients which cause anxiety to first year student nurses. *International Journal of Palliative Nursing*, 11(8), 423-30.
- Creswell, J. (1998). *Qualitative inquiry and research design : Choosing among five traditions*. Thousand Oaks, Calif.: Sage Publications.
- Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: SAGE Publications
- Damasio, A. (2001). Fundamental feelings. *Nature*, 413(6858), 781.

- Dame, L., & Hoebeke, R. (2016). Effects of a simulation exercise on nursing students' end-of-life care attitudes. *The Journal of Nursing Education, 55*(12), 701-705.
- Decker, S., Fey, M., Sideras, S., Caballero, S., Boese, T., Franklin, A. E., ... & Borum, J. C. (2013). Standards of best practice: Simulation standard VI: The debriefing process. *Clinical Simulation in Nursing, 9*(6), S26-S29.
- Dickinson, G. E., Clark, D., & Seque, M.,(2008). Palliative care and end of life issues in UK pre-registration, undergraduate nursing programmes. *Nurse Education Today, 28*(2), 163-170.
- DiCicco-Bloom, B., Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*(4), 314-321.
- Dreifuerst, K. (2012). Using debriefing for meaningful learning to foster development of clinical reasoning in simulation. *Journal of Nursing Education, 51*(6), 326-333.
- Durham, C. F., Alden, K. R. (2008). Enhancing patient safety in nursing education through Patient simulation. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville: Agency for Healthcare Research and Quality, 51*. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK2628/>
- Edo-Gual, M., Tomas-Sabado, J., Bardallo-Porras, D., & Monforte-Royo, C. (2014). The impact of death and dying on nursing students: An explanatory model. *Journal of Clinical Nursing, 23*(23-24), 3501-3512.
- Epp, K. (2012). Burnout in critical care nurses: A literature review. *Dynamics: The Official Journal of the Canadian Association of Nurses, 23*(4), 25-31.
- Ek, K., Westin, L., Prahl, C., Österlind, J., Strang, S., Bergh, I., & Hammarlund, K. (2014). Death and caring for dying patients: Exploring first-year nursing students' descriptive experiences. *International Journal of Palliative Nursing, 20*(10), 509-515.

- Fanning, R., & Gaba, D. (2007). The role of debriefing in simulation-based learning. *Simulation in Healthcare: Journal of the Society for Simulation in Healthcare*, 2(2), 115-25.
- Foley, K. M., Gelband, H. (2003). Improving palliative care, a report end-of-life care in nursing homes. *Issues in Law and Medicine*, 19, 1-2
- Folkman, S. (1997). Positive psychological states and coping with severe stress. *Social Science & Medicine*, 45(8), 1207-1221.
- Gaba, D., Howard, S., Fish, K., Smith, B., & Sowb, Y. (2001). Simulation-based training in anesthesia crisis resource management (ACRM): A decade of experience. *Simulation & Gaming*, 32(2), 175-193.
- Gardner, R. (2013). Introduction to debriefing. *Seminars in perinatology* , 37(3), 166-174).
- Gillan, P. C., Jeong, S., & Van Der Riet, P. J. (2014). End of life care simulation: A review of the literature. *Nurse Education Today*, 34(5), 766-774.
- Gordon, J., Wilkerson, W., Shaffer, D., & Armstrong, E. (2001). "Practicing" medicine without risk: Students' and educators' responses to high-fidelity patient simulation. *Academic Medicine: Journal of the Association of American Medical Colleges*, 76(5), 469-72.
- Hamilton, C. A. (2010). The simulation imperative of end-of-life education. *Clinical Simulation in Nursing*, 6(4), e131-e138.
- Harder, B. (2009). Evolution of simulation use in health care education. *Clinical Simulation in Nursing*, 5(5), E169-E172.
- Harris, M., & Fallot, R. (2001). Trauma-informed inpatient services. *New Directions for Mental Health Services*, 89, 33-46.

Hayden, J. K., Smiley, R. A., Alexander, M., Kardong-Edgren, S., & Jeffries, P.R. (2014).

Supplement: The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in prelicensure nursing education. *Journal of Nursing Regulation, 5*(2).

Healy, S., & Tyrrell, M. (2013). Importance of debriefing following critical incidents. *Emergency Nurse, 20*(10), 32-37.

Henneman, E., Cunningham, H., Roche, J., & Cumin, M. (2007). Human patient simulation: Teaching students to provide safe care. *Nurse Educator, 32*(5), 212-217.

Henriksson, A., Hudson, P., Öhlen, J., Thomas, K., Holm, M., Carlander, I., . . . Årestedt, K. (2015). Use of the preparedness for caregiving scale in palliative care: A rasch evaluation study. *Journal of Pain and Symptom Management, 50*(4), 533-541.

Hill, A., Davidson, B., & Theodoros, D. (2010). A review of standardized patients in clinical education: Implications for speech-language pathology programs. *International Journal of Speech-Language Pathology, 12*(3), 259-270.

Hintze, N. R. (2008). First responder problem solving and decision making in today's asymmetrical environment. Unpublished master's thesis, Naval Postgraduate School, Monterey, California.

Hjelmfors, L., Strömberg, A., Karlsson, K., Olsson, L., & Jaarsma, T. (2016). Simulation to teach nursing students about end-of-life care. *Journal of Hospice & Palliative Nursing, 18*(6), 512-518.

Hope, A., Garside, J., & Prescott, S. (2011). Rethinking theory and practice: Pre-registration student nurses' experiences of simulation teaching and learning in the acquisition of clinical skills in preparation for practice. *Nurse Education Today, 31*(7), 711-715.

- Hotchkiss, M., & Mendoza, S. (2001). Update for nurse anesthetists. Part 6. Full-body patient simulation technology: Gaining experience using a malignant hyperthermia model. *AANA Journal*, 69(1), 59-65.
- Kable, A. K., Arthur, C., Levett-Jones, T., & Reid-Searl, K. (2013). Student evaluation of simulation in undergraduate nursing programs in australia using quality indicators. *Nursing & Health Sciences*, 15(2), 235-243. doi:10.1111/nhs.12025
- Kameg, K., Howard, V., Clochesy, J., Mitchell, A., & Suresky, J. (2010). The impact of high fidelity human simulation on self-efficacy of communication. *Issues in Mental Health Nursing*, 31(5), 315-323.
- Kaakinen, J., & Arwood, E. (2009). Systematic review of nursing simulation literature for use of learning theory. *International Journal of Nursing Education Scholarship*, 16 (6).
- Kent, H., & McDowell, J. (2004). Sudden bereavement in acute care settings. *Nursing Standard*, 19(6), 38.
- King-Okoye, M., & Arber, A. (2014). 'It stays with me': The experiences of second- and third-year student nurses when caring for patients with cancer. *Eur Journal of Cancer Care (Engl)* 23(4), 441-9. doi: 10.1111/ecc.12139. Epub 2013
- Kinney, P.R., & Gray, C.D. (2012). IBM SPSS Statistics Made Simple. *International Statistical Review*, 80, 333.
- Kirkman, T. R. (2011). The effectiveness of human patient simulation on baccalaureate nursing students' transfer of learning (Doctoral dissertation, The University of Alabama). Retrieved from http://acumen.lib.ua.edu/content/u0015/0000001/0000746/u0015_0000001_0000746.pdf

- Kirkpatrick, A. J., Cantrell, M.A., & Smeltzer, S.C. (2017). Palliative care simulations in undergraduate nursing education: An integrative review. *Clinical Simulation in Nursing, 13*(9), 414-431.
- Knight, C. (2015). Trauma-informed social work practice: Practice considerations and challenges. *Clinical Social Work Journal, 43*(1), 25-37.
- Kolb, D. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs: Prentice Hall.
- Kopp, W., & Hanson, M. A.,(2012). High-fidelity and gaming simulations enhance nursing education in end-of-life care. *Clinical Simulation in Nursing, 8*(3), E97-E102.
- Kurz, J. M., & Hayes, E. R. (2006). End of life issues action: Impact of education. *International Journal of Nursing Education Scholarship, 3*(1). doi:10.2202/1548-923X.1189
- Jeffries, P. (2006). Designing simulations for nursing education. *Annual Review of Nursing Education, 4*, 161-165.
- Jeffries, P., & National League for Nursing. (2007). *Simulation in nursing education : From conceptualization to evaluation*. New York, NY: National League for Nursing.
- Johnson, A., Chang, E., & O'Brien, L. (2009). Nursing the dying: A descriptive survey of Australian undergraduate nursing curricula. *International Journal of Nursing Practice, 15*(5), 417-425.
- Lapkin, S., Levett-Jones, T., Bellchambers, H., & Fernandez, R. (2010). Effectiveness of patient simulation mannequins in teaching clinical reasoning skills to undergraduate nursing students: A systematic review. *Clinical Simulation in Nursing, 6*(6), E207-E222.
- Leach, D. (2002). Competence is a habit. *Journal of American Medical Association, 287*, 243–244.

- Lee, K. J., & Dupree, C. Y. (2008). Staff experiences with end-of-life care in the pediatric intensive care unit. *Journal of Palliative Medicine, 11*(7), 986-990.
- Lewis, K. (2013). How nurses can help ease patients transitions to end of life care. *Nursing Older People, 25*(8), 22.
- Leighton, K., & Dubas, J. (2009). Simulated death: An innovative approach to teaching end-of-life care. *Clinical Simulation in Nursing, 5*(6), E223-E230.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Lippe, M., & Becker, H. (2015). Improving attitudes and perceived competence in caring for dying patients: An end-of-life simulation. *Nursing Education Perspectives, 36*(6), 372-8.
- Lloyd-Williams, M., & Field, D. (2002). Are undergraduate nurses taught palliative care during their training? *Nurse Education Today, 22*(7), 589-92.
- Lopreiato, J. O., Downing, D., Gammon, W., Lioce, L., Sittner, B., Slot, V., Spain, A. E. & The Terminology & Concepts Working Group. (2016). Healthcare simulation dictionary. Retrieved from <http://www.ssih.org/dictionary>.
- Mallory, J. L. (2003). The impact of a palliative care educational component on attitudes toward care of the dying in undergraduate nursing students. *Journal of Professional Nursing, 19*(5), 305-312.
- Meakim, C., Boese, T., Decker, S., Franklin, A. E., Gloe, D., Lioce, L.,... Borum, J. C. (2013). Standards of best practice: Simulation standard I: Terminology. *Clinical Simulation in Nursing, 9*(6S), S3-S11. <http://dx.doi.org/10.1016/j.ecns.2013.04.001>.
- Melo, C. G., & Oliver, D. (2011). Can addressing death anxiety reduce health care workers' burnout and improve patient care? *Journal of Palliative Care, 27*(4), 287-295.

- McCoyd, J. L., & Walter, C. (2007). A different kind of holding environment: A case study of group work with pediatric staff. *Journal of Social Work in End-of-Life & Palliative Care*, 3(3), 5-22.
- Mitchell, D. L., Bennett, M. J., & Manfrin-Ledet, L. (2006). Spiritual development of nursing students: Developing competence to provide spiritual care to patients at the end of life. *The Journal of Nursing Education*, 45(9), 365-370.
- Mooney, D. C. (2005). Tactical reframing to reduce death anxiety in undergraduate nursing students. *American Journal of Hospice and Palliative Medicine*, 22(6), 427-432.
- Morse, J. (2000). Determining Sample Size. *Qualitative Health Research*, 10(1), 3-5.
- Morse, C. J. (2012). Debriefing after simulated patient experiences. *Human Simulation for Nursing and Health Professions*, 1, 58-68.
- Munhall, P. (2012). *Nursing research: A qualitative perspective (5th ed.)*. Mississauga: Jones & Barlett
- Nagle, B., Mchale, J., Alexander, G., & French, B. (2009). Incorporating scenario-based simulation into a hospital nursing education program. *Journal of Continuing Education in Nursing*, 40(1), 18-25.
- Neill, & Wotton. (2011). High-fidelity simulation debriefing in nursing education: A literature review. *Clinical Simulation in Nursing*, 7(5), E161-E168.
- Papadatou, D. (2000). A proposed model of health professionals' grieving process. *OMEGA-Journal of Death and Dying*, 41(1), 59-77.
- Parker, B.C., & Myrick, F. (2012). The pedagogical ebb and flow of human patient simulation: Empowering through a process of fading support. *Journal of Nursing Education*, 51(7), 365.

- Parry M. (2011). Student nurses' experience of their first death in clinical practice. *International Journal of Palliative Nursing*, 17(9), 446- 51.
- Peterson, J. L., Johnson, M. A., Halvorsen, B., Apmann, L., Chang, P., Kershek, S., . . . Pincon, D. (2010). What is it so stressful about caring for a dying patient? A qualitative study of nurses' experiences. *International Journal of Palliative Nursing*, 16(4), 181-187.
- Petranek, C. (2000). Written debriefing: The next vital step in learning with simulations. *Simulation & Gaming*, 31(1), 108-18.
- Petranek, C. F., Corey, S., & Black, R. (1992). Three levels of learning in simulations: Participating, debriefing and journal writing. *Simulation & Gaming: An International Journal*, 23, 174-185.
- Plichta, S.B., & Garson, L.S. (2009). *Statistics for nursing and allied health*. Lippincott Williams & Wilkins: Philadelphia, PA.
- Polit, D., & Beck, C. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.
- Poore, J.A., Cullen, D.L., & Schaar, G. L. (2014). Simulation-based interprofessional education guided by Kolb's experiential learning theory. *Clinical Simulation in Nursing*, 10(5), E241-E247.
- Prinzell, L. J. (2002). *The relationship of self-efficacy and complacency in pilot- automation interaction*. Hampton, VA: National Aeronautics and Space Administration. Retrieved 02/04/16:http://ntrs.nasa.gov/archive/nasa/casi.ntrs.nasa.gov/20020076395_2002125619.pdf
- Reed, S. (2009). Comparison of debriefing methods following simulation: Development of pilot instrument. Doctoral thesis, Case Western Reserve University, Cleveland, OH

- Reed, S. (2012). Debriefing Experience Scale: Development of a Tool to Evaluate the Student Learning Experience in Debriefing. *Clinical Simulation in Nursing*, 8(6), E211-E217.
- Reed, S. J., Andrews, C. M., & Ravert, P. (2013). Debriefing simulations: Comparison of debriefing with video and debriefing Alone. *Clinical Simulation in Nursing*, 9(12), E585-E591.
- Rolfe, G. (2006). Validity, trustworthiness, and rigour: Quality and the idea of qualitative research. *Methodological Issues in Nursing Research*, 53(3), 304-310.
- Rose, K.,(1994). Unstructured and semi-structured interviewing. *Nurse Researcher*, 1(3), 23-32.
- Rudolph, J., Raemer, D., & Simon, R. (2014). Establishing a safe container for learning in simulation: The role of the presimulation briefing. *Simulation in Healthcare: Journal of the Society for Simulation in Healthcare*, 9(6), 339-349.
- Rudolph, J., Simon, R., Dufresne, R., & Raemer, D. (2006). There's no such thing as "nonjudgmental" debriefing: A theory and method for debriefing with good judgment. *Simulation in Healthcare*, 1(1), 49-55.
- Rudolph, J., Simon, R., Rivard, P., Dufresne, R., & Raemer, D. (2007). Debriefing with good judgment: Combining rigorous feedback with genuine inquiry. *Anesthesiology Clinics*, 25(2), 361-376.
- Rushton, C. H., Reder, E., Hall, B., Comello, K., Sellers, D. E., & Hutton, N. (2006). Interdisciplinary interventions to improve pediatric palliative care and reduce health care professional suffering. *Journal of palliative medicine*, 9(4), 922-933.
- Sadala, M. L. A., & Silva, F. M. D. (2009). Taking care of terminal patients: nursing student's perspective. *Revista da Escola de Enfermagem da USP*, 43(2), 287-294.

- Sanford, P. G. (2010). Simulation in nursing education: A review of the research. *The Qualitative Report, 15*(4), 1006-1011.
- Scherer, K. R. (2000). Psychological models of emotion. In J. C. Borod (Ed.), *The neuropsychology of emotion* (pp. 137–162). New York, NY: Oxford University Press.
- Seel, N. (2012). *Encyclopedia of the Sciences of Learning*. Boston, MA: Springer US.
- Seropian, M., Brown, K., Gavilanes, J., & Driggers, B. (2004). Simulation: Not just a mannequin. *The Journal of Nursing Education, 43*(4), 164-9.
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*(2), 63-75.
- Simon, R., Raemer, D.B., & Rudolph, J.W. (2010). Debriefing assessment for simulation in healthcare (DASH)[®] – Student version, long form. Center for Medical Simulation, Boston, Massachusetts. https://harvardmedsim.org/_media/DASH.SV.Long.2010.Final.pdf. 2010. English, French, Japanese.
- Simulation. (n.d.). Retrieved from Merriam-Webster website: Simulation. (n.d.). Retrieved October 5, 2014, from https://www.merriam-webster.com/dictionary/simulation?utm_campaign=sd&utm_medium=serp&utm_source=jsonld
- Sittner, B., Aebersold, M., Paige, J., Graham, L., Schram, A., Decker, S., & Lioce, L. (2015). INACSL standards of best practice for simulation: Past, present, and future. *Nursing Education Perspectives, 36*(5), 294.
- Shin, H., Sok, S., Hyun, K., & Kim, M. (2015). Competency and an active learning program in undergraduate nursing education. *Journal of Advanced Nursing, 71*(3), 591-598.
- Smith-Stoner, M. (2009). Using high-fidelity simulation to educate nursing students about end-of-life care. *Nursing Education Perspectives, 30*(2), 115-20.

- Sperlazza, E. R., & Cangelosi, P. (2009). The power of pretend: Using simulation to teach end-of-life care. *Nurse Educator*, 34(6), 276-280
- Terry, L. M., & Carroll, J. (2008). Dealing with death: first encounters for first-year nursing students. *British Journal of Nursing*, 17(12), 760-765.
- The Trauma Informed Care Project. (2014). *Home page*. Retrieved from <http://www.traumainformedcareproject.org/index.php>
- Vries-Erich, J., Dornan, T., Boerboom, T., Jaarsma, A., & Helmich, E. (2016). Dealing with emotions: Medical undergraduates' preferences in sharing their experiences. *Medical Education*, 50(8), 817-828.
- Ward, M., Gruppen, L., Regehr, G. (2002). Measuring self-assessment: Current state of the art. *Advanced Health Sciences Education Theory*; 7, 63– 80
- Way, I., VanDeusen, K., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma. *Journal of Interpersonal Violence*, 19(1), 49-71.
- Wilson, J., & Kirshbaum, M. (2011). Effects of patient death on nursing staff: A literature review. *British Journal of Nursing (Mark Allen Publishing)*, 20(9), 559-63.
- Wotton, K., Davis, J., Button, D., & Kelton, M. (2010). Third-year undergraduate nursing students' perceptions of high-fidelity simulation. *The Journal of Nursing Education*, 49(11), 632-9.
- Wright, P. M., & Hogan, N.S. (2008). Grief theories and models: applications to hospice nursing practice. *Journal of Hospice and Palliative Nursing*, 10, 350–358.
- Venkatasalu, M.R., Kelleher, M., & Shao, C.H. (2015). Reported clinical outcomes of high-fidelity simulation versus classroom-based end-of-life care education. *International Journal of Palliative Nursing*, 21(4), 179-186.

Yang, C., Leung, J., Hunt, E., Serwint, J., Norvell, M., Keene, E., & Romer, L. (2011). Pediatric residents do not feel prepared for the most unsettling situations they face in the pediatric intensive care unit. *Journal of Palliative Medicine, 14*(1), 25-30.

Yuan, H., Williams, B., & Fang, J. (2012). The contribution of high-fidelity simulation to nursing students' confidence and competence: A systematic review. *International Nursing Review, 59*(1), 26-33.

Appendices

Appendix A- University of Manitoba Education/Nursing Ethics Research Board Approval

Certificate



Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Email: humanethics@umanitoba.ca

APPROVAL CERTIFICATE

TO: **Stephanie Nunes** (Advisor: **Nicole Harder**)
Principal Investigator

FROM: **Zana Lutfiyya, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2016:127 (HS20243)**
“Exploring the Usefulness and Effectiveness of Debriefing to Process Emotions or Feelings Experienced by Undergraduate Nursing Students in a Palliative Simulation-Based Experience”

Effective: November 30, 2016

Expiry: November 30, 2017

Education/Nursing Research Ethics Board (ENREB) has reviewed and approved the above research. ENREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

This Certification is subject to the following conditions:

1. Approval is granted only for the research and purposes described in the application.
2. Any modification to the research must be submitted to ENREB for approval before implementation.
3. Any deviations to the research or adverse events must be submitted to ENREB as soon as possible.
4. This approval is valid for one year only and a Renewal Request must be submitted and approved by the above expiry date.
5. A Study Closure form must be submitted to ENREB when the research is complete or terminated.
6. The University of Manitoba may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

Funded Protocols:

- Please mail/e-mail a copy of this Approval, identifying the related UM Project Number, to the Research Grants Officer in ORS.

Appendix B –Ethics Amendment Approval Certificate



Human Ethics
 208-194 Dafoe Road
 Winnipeg, MB
 Canada R3T 2N2
 Phone +204-474-7122
 Email: humanethics@umanitoba.ca

AMENDMENT APPROVAL

January 13, 2017

TO: **Stephanie Nunes** (Advisor: **Nicole Harder**)
 Principal Investigator

FROM: **Zana Lutfiyya, Chair** [REDACTED]
 Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2016:127 (HS20243)**
“Exploring the Usefulness and Effectiveness of Debriefing to Process Emotions or Feelings Experienced by Undergraduate Nursing Students in a Palliative Simulation-Based Experience”

Education/Nursing Research Ethics Board (ENREB) has reviewed and approved your Amendment Request dated **January 11, 2017** to the above-noted protocol. ENREB is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*.

This approval is subject to the following conditions:

1. Approval is given for this amendment only. Any further changes to the protocol must be reported to the Human Ethics Coordinator in advance of implementation.
2. Any deviations to the research or adverse events must be submitted to ENREB as soon as possible.
3. Amendment Approvals do not change the protocol expiry date. Please refer to the original Protocol Approval or subsequent Renewal Approvals for the protocol expiry date.



Rady Faculty of
Health Sciences

College of Nursing

Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452

Appendix C- Request for Access Approval from the College of Nursing through MCNHR

To whom it may concern,

My name is Stephanie Nunes and as you already are aware I'm working on completing my Master's of Nursing. For thesis research project I would like to access third year nursing students in the College of Nursing at the University of Manitoba. This letter is to request your permission to access them.

The following letter describes the research and what potential involvement participant will be asked of. If you would like further details regarding anything in this letter, or more information, please do not hesitate to contact myself.

Research Project Title: Exploring the usefulness and effectiveness of debriefing to process undergraduate nursing students' emotions during a palliative simulation-based experience

Principal Investigator and contact information:

Stephanie Nunes
Email: Stephanie.nunes@umanitoba.ca
Phone: 2044788266

Research Supervisor and contact information:

Dr. Nicole Harder, Helen Glass Centre for Nursing, University of Manitoba
Email: Nicole.Harder@umanitoba.ca Phone: 2044746714

This research that I am studying explores the usefulness of debriefing following a palliative simulation based experience to process emotions. There are two parts to the study. If students agree to participate, they will be asked to do one or both of the following. 1) Complete their survey of the debriefing process as they normally would in their palliative simulation-based experience. This normally takes 5-7 minutes to complete, and would be the end of their participation. OR 2) Complete the survey in item 1 AND participate in a one-on-one interview with the principal investigator, to further discuss their thoughts on the usefulness of debriefing to process emotions or feelings evoked during the palliative simulation based experience. The

interview will take approximately 20-30 minutes. The results of the study will add to the body of simulation research on the use of debriefing following a palliative simulation based experience, and help to develop best practice guidelines for effective debriefing techniques.

The participants will be assigned to a simulation session within the course, NURS 3540, as usual. They will then proceed with their simulation and debriefing as they normally would. They will be asked to complete the survey as part of their coursework and have the option to consent to allowing anonymous data to be used for this research study. Once the DASH tools and consent forms are completed, the attached consent forms will be detached by the simulation facilitator prior to being given to the primary researcher. This will be done so they cannot be linked to each other. There will be a check box on the consent form asking if they would like to consent to the interview portion of the study. If they decide that they would like to participate in the interview, the researcher will be contact them to arrange a mutually agreeable time and location for the interview. The interview will be audio recorded for transcription purposes.

Student participation is completely voluntary. They may choose to leave the study at any time, except after data aggregation/calculation. There are no known risks to participate in the study. All surveys will be collected by the simulation facilitator and will have had the consent forms detached and given separately to the researcher. DASH tools will not be accessible to the researcher's advisor until the data has been inputted into SPSS for analyzing and is non identifiable. The interviews will also be assigned a code. The audio recordings will be stored in a locked office, and the data and transcripts will be entered and stored in a password-protected file on my computer. Once the interviews have been assigned an anonymous code as identifiers, the researcher's advisor will be granted access to this data.

Data will be reported in aggregate and will not contain any individual identifiers. Quotations from interviews may be reported but will contain no individual identifiers.

Also of note, I will be guest lecturing in another course that these students will be in. I will have no access to the student's grades, tests or any evaluation method. I will not have access to their online course information. I am also not listed on the syllabus as a course instructor.

The researcher's advisor, Dr. Nicole Harder does not evaluate or grade this population group.

Thank you for your time, and considering access to the third year nursing students.

Sincerely,

Stephanie Nunes RNBN
Graduate Nursing Student

University of Manitoba

Stephanie.nunes@umanitoba.ca

2044788266

Appendix D – College of Nursing Access Approval Certificate

Rady Faculty of
Health Sciences



UNIVERSITY
OF MANITOBA

College of Nursing
Helen Glass Centre for Nursing
89 Curry Place
Winnipeg, Manitoba
Canada R3T 2N2
Telephone (204) 474-7452
Fax (204) 474-7682

College of Nursing Research/Quality Assurance Project – Student, Faculty and Staff Access Approval Certificate

January 16, 2017

To: Stephanie Nunes, RN
Graduate Student
College of Nursing
Faculty of Health Sciences

From: Beverly O'Connell, BN, MSc, PhD
Dean
College of Nursing

Beverley Temple, BN, PhD
Associate Dean, Research
College of Nursing

Re: Exploring the Usefulness and Effectiveness of Debriefing to Process Emotions or Feelings Experienced by Undergraduate Nursing Students in a Palliative Simulation-Based Experience

Please be advised that your above-referenced protocol has received College of Nursing Research/Quality Assurance Access Approval by the College of Nursing Leadership Team. You may include College of Nursing students, faculty, and/or staff in your project as outlined in your submitted proposal.

Any changes to the protocol and/or informed consent form must be reported to the College of Nursing Leadership Team in advance of implementation of such changes.

Regards,

████████████████████
Dr. Beverly O'Connell
Dean
College of Nursing

████████████████████
Dr. Beverley Temple
Associate Dean, Research
College of Nursing



Rady Faculty of Health Sciences

College of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452
Fax 204-474-7682

Appendix E-Letter of Invitation for Potential Participants

Research Project Title: Exploring the usefulness and effectiveness of debriefing to process undergraduate nursing students' emotions during a palliative simulation-based experience

Principal Investigator and contact information:

Stephanie Nunes
Email: Stephanie.nunes@umanitoba.ca
Phone: 2044788266

Research Supervisor and contact information:

Dr. Nicole Harder, Helen Glass Centre for Nursing, University of Manitoba
Email: Nicole.Harder@umanitoba.ca Phone: 2044746714

The following letter describes the research and what your potential involvement as a participant will include. If you would like further details regarding anything in this letter, or more information, please do not hesitate to contact the principal investigator. Please take the time to read this carefully.

Dear Student:

My name is Stephanie Nunes and I am completing my Master's of nursing degree at the University of Manitoba under the supervision of Dr. Nicole Harder. I would like to invite you to participate in a research studying which explores the usefulness of debriefing following a palliative simulation based experience to process emotions. There are two parts to the study. If you agree to participate, you will be asked to do one or both of the following. 1) Complete your survey of the debriefing process using the DASH tool provided along with 7 additional questions and a demographics survey as you normally would in your palliative simulation-based experience. This normally takes 5-7 minutes to complete, and would be the end of your participation. OR 2) Complete the survey in item 1 AND participate in a one-on-one interview with the principal investigator, to further discuss your thoughts on the usefulness of debriefing to process emotions evoked during your palliative simulation based experience. The interview will take approximately

20-30 minutes. Individuals who participate in the interview will be entered in a draw for 1 of 10 giftcards valued at \$25.00 to the University of Manitoba bookstore. The draw for the gift cards will be completed by the Manitoba Centre for Health Research. The results of the study will add to the body of simulation research on the use of debriefing following a palliative simulation based experience, and help to develop best practice guidelines for effective debriefing techniques.

You will be assigned to a simulation session within your course, NURS 3540, as usual. You will then proceed with your simulation and debriefing as you normally would. You will be asked to complete the survey as part of your coursework and have the option to consent to allowing your anonymous data to be used for this research study. The DASH tools will be detached from the consent forms by the simulation facilitator, prior to being given to the primary researcher, and will be kept separately so they cannot be linked to each other. There will be a check box on the consent form asking if you would like to consent to the interview portion of the study. If you decide that you would like to participate in the interview, the researcher will be contact you to arrange a mutually agreeable time and location for the interview. The interview will be audio recorded for transcription purposes.

Your participation is completely voluntary. You may choose to leave the study at any time, except after data aggregation/calculation. There are no known risks to participate in the study. All surveys will be collected by the simulation facilitator and consent forms will be detached from the surveys prior to being given to the primary investigator so that they are not linked in any way. The DASH tools will not be accessible to the researcher's advisor until the data has been inputted into SPSS for analyzing and is non identifiable. The interviews will also be assigned a code. The audio recordings will be stored in a locked office, and the data and transcripts will be entered and stored in a password-protected file on my computer. Once the interviews have been assigned an anonymous code as identifiers, the researcher's advisor will be granted access to this data..

The researcher's advisor, Dr. Nicole Harder, does not evaluate or grade this population group. If you have any concerns or complaints about this study, you may contact any of the above-named persons or the Human Ethics Secretariat at 2044747122, or email humanethics@umanitoba.ca

Thank you for your time, and considering this study.

Sincerely,

Stephanie Nunes RNBN

Graduate Nursing Student

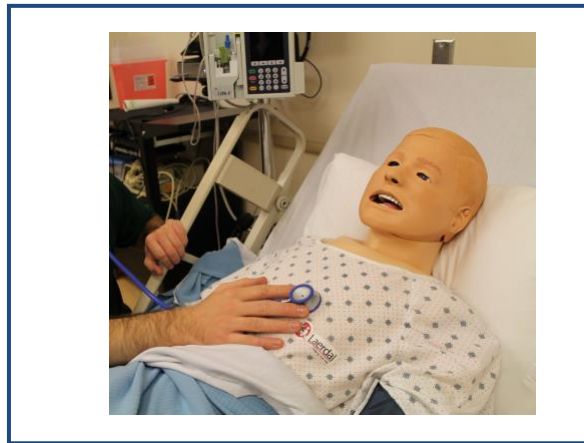
University of Manitoba

Stephanie.nunes@umanitoba.ca

Appendix F- Poster Advertising Study

PARTICIPANTS NEEDED!

ARE YOU A THIRD YEAR NURSING STUDENT?
IF SO, YOU MAY QUALIFY FOR THIS STUDY!



Study Purpose: Exploring the usefulness of debriefing following a palliative simulation based experience to process emotions or feelings.

Who/Where/When: 3rd year nursing students who will be participating in a palliative simulation based experience in February 2017 at the University of Manitoba

OPTION 1) Participants will participate in simulation as usual, and complete a survey as part of normal coursework. Participants will have the option to consent to allowing anonymous data to be used for this research study. There will be a check box on the consent form asking if they would like to consent to the interview

OR

OPTION 2) Complete the survey in item 1 AND participate in a one-on-one interview with the principal investigator, to further discuss their thoughts on the usefulness of debriefing to process emotions evoked during the palliative simulation based experience. The interview will take approximately 20-30 minutes.

Participants who participate in the interviews will be offered 1 of 10 \$25 gift card to the University of Manitoba bookstore

For more information please contact [REDACTED]



College of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452
Fax 204-474-7682

Appendix G- Script for MCNHR Research Coordinator

To be read prior to the Simulation Facilitator handing out the consent form/DASH surveys to students

On behalf of Stephanie Nunes, graduate student at the College of Nursing, I am reading the following to you.

I am a graduate nursing student at the University of Manitoba and am doing my research in palliative simulation debriefing.

I am interested in understanding the usefulness of debriefing following a palliative simulation based experience to process emotions. The results of the study will add to the body of simulation research on the use of debriefing following a palliative simulation based experience, and help to develop best practice guidelines for effective debriefing techniques. If you are interested in the study, please take the time to read the consent form. If you wish to participate in the study, please sign the form and your simulation facilitator will collect them with the DASH surveys, 7 additional questions and demographics survey.

If you have any questions, please feel free to ask me or you may contact Stephanie directly at 2044788266.



UNIVERSITY
OF MANITOBA

Rady Faculty of
Health Sciences

College of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452
Fax 204-474-7682

Appendix H- Informed Consent

LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Student Participants

**Title of Research Study: Exploring the Usefulness and Effectiveness of Debriefing to
Process Emotions or Feelings Experienced by Undergraduate Nursing Students in a
Palliative Simulation-Based Experience**

Researcher:

Stephanie Nunes RN BN
485 Helen Glass Centre for Nursing
University of Manitoba
Winnipeg, Manitoba
R3T 2N2
2044788266
Email: Stephanie.nunes@umanitoba.ca

Funding Source:

Manitoba Centre for Nursing and Health Research

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

THE STUDY

The purpose of this study is to add to the knowledge and understanding about the usefulness of debriefing in palliative simulation-based experiences. The specific aim of this study is to explore the usefulness and effectiveness of debriefing to process any emotions or feelings that students may experience during a palliative simulation-based experience.

There are two parts to the study. If you agree to participate, you will be asked to do one or both of the following. 1) Complete your survey of the debriefing process using the DASH tool provided along with 7 additional questions and a demographics survey as you normally would in your palliative simulation-based experience. This normally takes 5-7 minutes to complete, and would be the end of your participation. OR 2) Complete the survey in item 1 AND participate in a one-on-one interview with the principal investigator, to further discuss your thoughts on the usefulness of debriefing to process emotions evoked during your palliative simulation based experience. The interview will take approximately 20-30 minutes. Individuals who participate in the interview will be entered in a draw for 1 of 10 giftcards valued at \$25.00 to the University of Manitoba bookstore and the draw will be done by the MCNHR.

If you agree to participate, you will be asked to do one or both of the following:

OPTION 1

- Read and sign a consent form.
- Participate in a palliative based simulation experience.
- Complete the DASH survey, demographics survey and 7 additional questions as part of the regular course work
- This would end your participation in the study

OPTION 2

- Complete all the items in Option 1 AND;
- Supply your contact information so that the researcher may contact you to participate in a 20-30 minute interview

RISKS / BENEFITS

There are no significant risks to take part in this study beyond what would be encountered in everyday life. Participants of the study will be instructed to maintain confidentiality of the other students' participation, however I cannot guarantee that participants will not divulge information to other people. Participation or withdrawal from the study will not affect your grades at the University.

CONFIDENTIALTY

All information will be kept private. Once the DASH tools and consent forms are completed, the attached consent forms will be detached by the simulation facilitator prior to being given to the primary researcher. This will be done so they cannot be linked to each other. The DASH tools will not be accessible to the researcher's advisor, Dr. Nicole Harder until the data has been inputted into SPSS for analyzing and is non identifiable. The interviews will also be assigned a code. The audio recordings will be stored in a locked office, and the data and transcripts will be entered and stored in a password-protected file on my computer. Once the interviews have been assigned an anonymous code as identifiers, the researcher's advisor will be granted access to this data. The researcher, researcher's supervisor, MCNHR Research Coordinator and simulation facilitator will

know you have participated, however all will keep that information confidential. Once the survey data has been inputted, that data will be in electronic format and will be held on a password-protected computer in the researchers' office in the Helen Glass Centre for Nursing.

DASH tools and identifiable consent forms will be kept as hard copies in the researcher's locked office in a locked file cabinet. Once the DASH data has been inputted into a statistical analyzing program, it is non identifiable and it will be kept in a password encrypted file on the researcher's computer in the researcher's locked office, room 485 Helen Glass, University of Manitoba. The qualitative interviews will be assigned an anonymous code immediately and will never have identifiable information. The digital audio recordings, and digital transcripts will be also kept on the researcher's computer in the researcher's locked office. The hard copy DASH tools and consent forms will be put in confidential shredding locked bin in the College of Nursing, University of Manitoba in December 2023. The digital files will be deleted permanently from the researcher's computer and computer trash bin in December 2023.

Data will be reported in aggregate and will not contain any individual identifiers. Quotations from interviews may be reported but will contain no individual identifiers

Your participation in the study is voluntary. You can drop out of the study at any time without giving us a reason by informing the researcher. This includes up to the moment when you hand in your DASH tool. Your grades will not be affected and your instructors will not know whether or not you participated. The data you provide on the tool will not be linked with your name so it will not be possible to remove your data from the study after you have submitted the completed survey to the researchers. Only the researcher, Manitoba Centre for Nursing and Health Research, and simulation facilitator will know that you have participated.

If you would like a written summary of the results, you will need to provide your email address at the end of the consent form to receive these. The results will be available approximately December 2017.

GUEST LECTURING

I will be guest lecturing in NURS 3512, another course that you are in. I do not have access to the student's grades, tests or any evaluation method. I do not have access to your online course information.

COMPENSATION

There is no payment for taking part in this study, however if you participate in the interview, you will be entered into a draw for a chance to win one of ten \$25 gift cards to the University of Manitoba Bookstore. To enter this draw you will have to provide your email address at the bottom of the form. This draw will be conducted approximately the week of March 1st. Giftcards will be awarded by the Manitoba Centre for Nursing and Health Research (MCNHR).

If you have any questions about the study, contact the researcher, Stephanie Nunes, at Stephanie.nunes@umanitoba.ca

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain

from answering any questions you prefer to omit, without prejudice or consequence by informing the researcher. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Education and Nursing Research Ethics Board of the University of Manitoba. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 2044747122, or email humanethics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

By checking off this box, I consent to have my *DASH tool* information, demographic survey and 7 additional questions to be used in this research

Participant signature _____ Date _____

By checking off this box, I consent to being contacted by the researcher (Stephanie Nunes) to *participate in an interview* about my experience in the palliative based simulation

Contact Name _____

Contact email/phone number _____

Participant signature _____ Date _____

By checking off this box, and providing my email address below to receive research results in approximately December 2017:

The email address you may provide below, will be used to contact you in the event that you are randomly selected as a winner of one of the ten \$25 gift cards. The draw will be conducted by Manitoba Centre for Nursing and Health Research. They will contact you via email should you be chosen.

Your Email:



Rady Faculty of Health Sciences

College of Nursing
 Helen Glass Centre for Nursing
 Winnipeg, Manitoba
 Canada R3T 2N2
 Telephone 204-474-7452
 Fax 204-474-7682

Appendix I-DASH Survey



Debriefing Assessment for Simulation in Healthcare (DASH) Student Version®

Directions: Please summarize your impression of the introduction and debriefing in this simulation-based exercise. Use the following scale to rate each of six “Elements.” Each Element comprises specific instructor behaviors, described below. If a listed behavior is impossible to assess (e.g., how the instructor(s) handled upset people if no one got upset), don’t let that influence your evaluation. The instructor(s) may do some things well and some things not so well within each Element. Do your best to rate the **overall effectiveness for the whole Element** guided by your observation of the individual behaviors that define it.

Rating Scale

Rating!	1!	2!	3!	4!	5!	6!	7!
Descriptor!	Extremely Ineffective / Detrimental!	Consistently Ineffective / Very Poor!	Mostly Ineffective / Poor !	Somewhat Effective / Average!	Mostly Effective / Good!	Consistently Effective / Very Good!	Extremely Effective / Outstanding!

Element 1 assesses the introduction at the beginning of a simulation based exercise.!!

Skip this element if you did not participate in the introduction. If there was no introduction and you felt one was needed to orient you, your rating should reflect this.

Element 1 The instructor set the stage for an engaging learning experience.	Overall Rating Element 1 _____
--	--

- The instructor introduced him/herself, described the simulation environment, what would be expected during the activity, and introduced the learning objectives.
- The instructor explained the strengths and weaknesses of the simulation and what I could do to get the most out of simulated clinical experiences.
- The instructor attended to logistical details as necessary such as toilet location, food availability, schedule.
- The instructor made me feel stimulated to share my thoughts and questions about the upcoming simulation and debriefing and reassured me that I wouldn’t be shamed or humiliated in the process.

Elements 2 through 6 assess the debriefing.!!

Element 2 The instructor maintained an engaging context for learning.	Overall Rating Element 2 _____
--	--

- The instructor clarified the purpose of the debriefing, what was expected of me, and the instructor’s role in the debriefing.
- The instructor acknowledged concerns about realism and helped me learn even though the case(s) were simulated.
- I felt that the instructor respected participants.
- The focus was on learning and not on making people feel bad about making mistakes.
- Participants could share thoughts and emotions without fear of being shamed or humiliated.

Element 3 The instructor structured the debriefing in an organized way.	Overall Rating Element 3 _____
--	--

- The conversation progressed logically rather than jumping around from point to point.
- Near the beginning of the debriefing, I was encouraged to share my genuine reactions to the case(s) and the instructor seemed to take my remarks seriously.
- In the middle, the instructor helped me analyze actions and thought processes as we reviewed the case(s).
- At the end of the debriefing, there was a summary phase where the instructor helped tie observations together and relate the case(s) to ways I can improve my future clinical practice.

Element 4 The instructor provoked in-depth discussions that led me to reflect on my performance.	Overall Rating Element 4 _____
---	--

- The instructor used concrete examples—not just abstract or generalized comments—to get me to think about my performance.
- The instructor's point of view was clear; I didn't have to guess what the instructor was thinking.
- The instructor listened and made people feel heard by trying to include everyone, paraphrasing, and using non verbal actions like eye contact and nodding, etc.
- The instructor used video or recorded data to support analysis and learning.
- If someone got upset during the debriefing, the instructor was respectful and constructive in trying to help them deal with it.

Element 5 The instructor identified what I did well or poorly – and why.	Overall Rating Element 5 _____
---	--

- I received concrete feedback on my performance or that of my team based on the instructor's honest and accurate view.
- The instructor helped explore what I was thinking or trying to accomplish at key moments.

Element 6 The instructor helped me see how to improve or how to sustain good performance	Overall Rating Element 6 _____
---	--

- The instructor helped me learn how to improve weak areas or how to repeat good performance.
- The instructor was knowledgeable and used that knowledge to help me see how to perform well in the future.
- The instructor made sure we covered important topics.



Rady Faculty of Health Sciences

College of Nursing
 Helen Glass Centre for Nursing
 Winnipeg, Manitoba
 Canada R3T 2N2
 Telephone 204-474-7452
 Fax 204-474-7682

Appendix J- Additional Quantitative Questions

Little is known about participant experience during debriefing following simulation. You can add to professional knowledge by giving your opinions. Please complete the survey below. Your views are very valuable. There is no right or wrong answer

Circle the number below that best reflects your opinion about your debriefing experience.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1. Debriefing helped me to analyze my thoughts about the palliative simulation	1	2	3	4	5	N/A
2. Uncomfortable feelings experienced in the palliative SBE were addressed by debriefing	1	2	3	4	5	N/A
3. Debriefing assisted me in identifying my feelings and emotions experienced during the SBE	1	2	3	4	5	N/A
4. Debriefing assisted me in reflecting on my feelings and emotions experienced during the SBE	1	2	3	4	5	N/A
5. Debriefing assisted me in processing my feelings and emotions experienced during the SBE	1	2	3	4	5	N/A
6. Debriefing was effective in helping me learn how to cope with the feelings experienced in a palliative simulation	1	2	3	4	5	N/A
7. Debriefing was beneficial to my learning in a palliative SBE	1	2	3	4	5	N/A



College of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452
Fax 204-474-7682

Appendix K – Demographics

1. What gender do you identify with?
 Male
 Female
 Other
 Prefer not to answer
2. What is your age?
 19-25
 25-35
 35-45
 45<
3. What is the highest level of education you have completed?
 High School or equivalent
 Bachelor's Degree
 Master's Degree
 Other certificate/diploma
4. Do you have previous experience with death and dying?
 Yes
 No
5. If yes to Question 4, Have you ever cared for a dying person, either (you may select more than one answer):
 Personally
 Professionally



Rady Faculty of Health Sciences

College of Nursing
Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone 204-474-7452
Fax 204-474-7682

Appendix L- Interview Guide

1. What do you know about palliative care?
2. In general, what are your feelings about the nurse's role in palliative care?
3. Thinking back to your palliative SBE and the interactions between the nurse and the patient/family. Tell me what stood out in your mind the most about this palliative SBE?
4. What were your expectations of this simulation before your simulation day? Did they change during the simulation? Did they change during debriefing?
5. Did you feel that you were prepared for this kind of simulation? If so, what made you feel like you were? If not, what do you think you were missing?
6. Which emotions or feelings were the strongest during this simulation?
7. What was most helpful during debriefing to process your feelings and emotions?
8. What was least helpful during debriefing in processing your feelings and emotions?
9. Is there anything different that you would like to have seen during the debriefing that you believe would have assisted you in processing feelings and emotions experienced in the SBE?

Appendix M- TCPS 2: Core Certificate

